NORTH CAROLINA Health Wellness TRUST FUND

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

2008

www.HealthWellNC.com

NORTH CAROLINA Health Wellness TRUST FUND

2008 Annual Report to the Joint Legislative Commission on Governmental Operations and the Joint Legislative Health Care Oversight Committee

TABLE OF CONTENTS

State of North Carolina
Health & Wellness Trust Fund Commission

November 1, 2008

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

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

Subject: 2008 Annual Report

The North Carolina Health and Wellness Trust Fund Commission (HWTFC) was created in 2000 to receive 25% of North Carolina's share of the Tobacco Master Settlement Agreement. The enabling statute (N.C.G.S. 147-86.30 (e)) laid out the following as the Fund Purposes for HWTFC:

- To address the health needs of vulnerable and underserved populations in North Carolina.

- To fund programs and initiatives that include research, education, prevention, and treatment of health problems in North Carolina and to increase the capacity of communities to respond to the public's health needs.

- To develop a comprehensive, community-based plan with goals and objectives to improve the health and wellness of the people of North Carolina with a priority on preventing, reducing, and remedying the health effects of tobacco use and with an emphasis on reducing youth tobacco use. The plan shall include measurable health and wellness objectives and a proposed timetable for achieving these objectives. In developing the plan, the Commission shall consider all facets of health, including prevention, education, treatment, research, and related areas.

The following report summarizes how HWTFC is addressing each of the three Fund Purposes listed above. It also includes an analysis of the outcomes of each of its programs as well as next steps.

Vandana Shah, Executive Director
7090 Mail Service Center, Raleigh, NC 27699-7090 ● WoodOak Building, 1100 Navaho Drive, Ste. 203, Raleigh, NC 27609
Phone (919) 981-5000 ● Fax (919) 855-6894
www.HealthWellNC.com

SECTION I. IMPLEMENTATION OF THE ENABLING STATUTE

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

HWTFC INITIATIVES THAT ADDRESS THIS REQUIREMENT:

1. **HWTFC's *Eliminating Health Disparities Initiative* is addressing disparities related to cardiovascular disease, obesity, cancer and diabetes among African-Americans, Latinos and American Indians that are disparately affected by the prevalence and morbidity related to these diseases. The long-term goal of this effort is to ensure equal health quality for the entire population.**
2. ***Senior Care* provided prescription drug access for the state's most vulnerable and underserved seniors from 2003 through 2006 and HWTFC has continued that tradition with *NCRx* premium support over the last 18 months.**
3. **North Carolina Health Insurance Risk Pool, now called Inclusive Health was established in 2007 with $5 million in initial funding from HWTFC to provide insurance to individuals without any health care coverage as a result of pre-existing conditions.**
4. ***Task Force for a Healthier North Carolina* was commissioned in 2006 through a grant to the University of North Carolina at Chapel Hill to examine three critical health care issues affecting vulnerable populations: children's health insurance, Medicare Part D prescription drug benefit for seniors, and employer-sponsored health coverage. The *Task Force* has issued formal reports outlining recommendations on next steps to address these issues.**
5. **HWTFC committed $1 million to create North Carolina's *Rural HOPE Project* to provide North Carolina's small rural hospitals access to financing from private lending institutions that is needed to make critical technical and infrastructure upgrades.**

1. ELIMINATING HEALTH DISPARITIES INITIATIVE

BACKGROUND

For the period 1997-2001, African-Americans were 1.2 times more likely and Native Americans were 1.3 times more likely to die of heart disease in North Carolina than whites. 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 community 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 – PHASE I

- $12.5 million allocated over three years from HWTFC in 2004
- 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.
- 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
  - 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

- There are 24 grantee organizations providing direct services to residents in 59 counties across the state. The majority of these counties is rural and has significant minority and low-income populations that are chronically underserved. Two of the organizations that received grants have statewide projects that will have an impact in the remaining 41 counties. In addition to geographic diversity, grants were awarded to a variety of organizations across North Carolina:
  - 9 grants awarded to community / faith-based minority organizations
  - 7 grants awarded to health clinics / hospitals
  - 4 grants awarded to county health departments
  - 2 grants awarded to Historically Minority Colleges and Universities (HMCUs)
  - 2 grants awarded to physician medical societies / foundations
- Technical assistance is provided to grantees by health disparities experts from North Carolina Central University, Department of Public Health Education (NCCU)
- Outcomes analysis is conducted by East Carolina University, Department of Family Medicine, and Research Division (ECU).

NEXT STEPS

Grantees have fully implemented their projects during 2007-2008 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. Currently, there are no recommended national standards for a health disparities social marketing campaign, so HWTFC has had to conduct significant research to determine the most effective way to position the campaign for maximum impact.

The Commission remains committed to educating all North Carolinians about health disparities. A comprehensive social marketing campaign that includes television and radio ads, collateral materials and a Web site will launch early in the next reporting period.

In order to create long-term change, HWTFC will also partner with the Duke Global Health Institute and NCCU Department of Public Health Education to establish the NC Health Disparity Fellowship Program in fall 2008. The two-year Fellowship is an opportunity for mid-career public health professionals to gain skills that will allow them to effectively engage in efforts to decrease health disparities in North Carolina by increasing their knowledge about health disparities and related disciplines. Each year, five Fellows will be selected to participate in course modules that have been jointly developed by Duke and NCCU.

In May 2008, HWTFC allocated an additional $9 million to the *Eliminating Health Disparities Initiative* for a second phase of community grants. A Request for Proposals was distributed in fall 2008 and these new three-year grants will be awarded by the end of 2008 to start work in July 2009.

2. PRESCRIPTION DRUG PROGRAMS FOR SENIORS

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 their basic necessities such as food and housing or taking the medications they truly 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, HWTFC 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. HWTFC 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.

PROGRAM DESIGN

- 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
- Eligibility:
  - North Carolina resident
  - Medicare beneficiary
  - Age 65 or older
  - Income at or below $17,868 for individuals and $23,958 if you're married
  - Assets at or below $20,412 for individuals and $30,618 if you're married
  - 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

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

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 funding 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 pays up to $18 toward monthly premiums for Medicare prescription drug plans that work with *NCRx*.

o Expenditures and Enrollment (since January 2007):
- $1.5 million from July 2007 – June 2008
- 5,085 enrollees through June 2008
- Average annual cost per enrollee: $295
- Average monthly cost per enrollee: $24.58

NEXT STEPS

NCRx is still falling short of its enrollment goals, but since this program is only funded by HWTFC through 2009, the program is not expected to be redesigned by DHHS unless long-term funding can be secured from the General Assembly.

3. NORTH CAROLINA HEALTH INSURANCE RISK POOL (INCLUSIVE HEALTH)

BACKGROUND

The North Carolina Health Insurance Risk Pool, now known as Inclusive Health, was established by the NC General Assembly in summer 2007 to provide affordable, individual health insurance coverage for North Carolinians who do not have access to an employer health plan and face higher premiums due to a pre-existing medical condition. The initial funding for this effort will be provided through a $5 million grant from HWTFC. Inclusive Health will also offer coverage to individuals who are federally defined as HIPAA-eligibles or qualify due to loss of employment due to the effects of international trade under the Health Care Tax Credit.

PROGRAM DESIGN

o Eligibility Criteria: To be eligible for Inclusive Health coverage, individuals must:
- be a legal resident of the United States
- be a resident of the State of North Carolina
- *not* have access to group coverage as an employee or as a dependent of an employee
- *not* qualify for a government program such as Medicare or Medicaid

In addition, individuals must meet *one* of the following criteria:
- have been rejected or refused by an insurer for similar coverage for medical reasons
- have been offered coverage by an insurer but with conditional rider limiting coverage
- have been refused coverage except at a higher premium rate than Inclusive Health

- have similar coverage, but at a single rate higher than Inclusive Health
- have a diagnosed medical condition outlined by Inclusive Health, which allows automatic enrollment into Inclusive Health
- are a federally-qualified, HIPAA-eligible individual including those who currently have this coverage through an insurer
- are a resident eligible for the Federal Health Coverage Tax Credit (trade-displaced workers, PBGC recipients)
- are an eligible individual with other non-group coverage in place (can move to Inclusive Health at any time)

CURRENT REPORTING PERIOD

Inclusive Health's efforts were focused on developing eligibility criteria, hiring staff and getting its governance structure in place during this reporting period.

NEXT STEPS

Inclusive Health will open for enrollment on October 20, 2008. Individuals who enroll this fall will be eligible for coverage beginning January 1, 2009. Information on Inclusive Health's benefits, rates and how to apply can be found at www.inclusivehealth.org or by calling the toll-free line at (866) 665-2117.

4. TASK FORCE FOR A HEALTHIER NORTH CAROLINA

BACKGROUND

In 2006, HWTFC commissioned the *Task Force for a Healthier North Carolina* through a $300,000 grant to the University of North Carolina at Chapel Hill (UNC-CH). UNC-CH entered into a subcontract with the Lewin Group, a national health care and human services consulting firm, to provide additional analytical support to UNC-CH staff and the *Task Force*. The performance period for the HWTFC contract began July 15, 2006 and extended through December 31, 2007.

PROGRAM DESIGN

During 2006 and 2007, the *Task Force for a Healthier North Carolina* held public forums and made recommendations on strategies to improve access to health insurance for seniors, working families and small businesses. The three substantive policy topics of focus were:

- **Medicare Part D Program and Supporting Prescription Drug Coverage for Seniors**: Explore how the state and HWTFC can provide financial and/or other forms of assistance to Medicare drug coverage beneficiaries.
- **Enrollment in and Access to Public-Sponsored Health Coverage and Federal/State Tax Credits for Working Families**: Explore ways to improve access to and enrollment in public sector health programs for children (Medicaid, S-CHIP) and to provide mechanisms to support and assist taxpayers in claiming (income and health-related) federal and state income tax benefits (i.e., credits).
- **Small Business, Employer-Sponsored Health Insurance and the Underinsured**: Explore public and private strategies to strengthen employer provision of health insurance; improve small business access to affordable group health insurance coverage; improve employee

access to health insurance coverage in the individual and/or group market during employment transitions; and limit financial exposure for the underinsured.

CURRENT REPORTING PERIOD

The *Task Force* has issued formal reports outlining recommendations on next steps to address each of these issues. Along with assistance from many groups and individuals working on these issues, several of the task force recommendations have been implemented. These reports can be downloaded at http://www.healthwellnc.com/hwtfc/htmfiles/taskforceforhealthiernc.htm.

NEXT STEPS

The grant with UNC-CH for this effort ended on December 31, 2007, but HWTFC will continue to work to draw attention to the *Task Force's* policy recommendations so they can be adopted by the NC General Assembly and/or other appropriate agencies.

5. RURAL HOPE PROJECT

BACKGROUND

This new effort was the result of a collaboration between the North Carolina Hospital Association, HWTFC and the Golden Leaf Foundation to provide North Carolina's small rural hospitals access to financing from private lending institutions – financing that is needed to make critical upgrades and renovations to clinical equipment, physical facilities and health information technology systems.

PROGRAM DESIGN

In October of 2007, HWTFC committed $1 million to North Carolina's *Rural HOPE Project*. HWTFC's funding leveraged a matching grant from the Golden Leaf Foundation. Once the reserve fund is established, the grant funds will be obligated and leveraged to create a capital financing pool of approximately $100 million underwritten by NC-based lenders that will focus on the capital needs of small and rural hospitals.

The NC *Rural HOPE Project* is a comprehensive effort to organize capital funding to help 56 small and rural NC hospitals invest in desperately needed upgrades and renovations to medical and clinical equipment, plant and facilities, and health information technology. With the tightening of financial markets, small rural hospitals are essentially excluded from access to the capital necessary to invest in continuing patient care operations, patient service improvements and plant and facility upgrades and renovations.

CURRENT REPORTING PERIOD

Efforts are underway to create the capital investment pool and the governance structure.

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

HWTFC INITIATIVES THAT ADDRESS THIS REQUIREMENT:

1. **The *Medication Assistance Program* (MAP) has funded over 135 community-based organizations to help low-income seniors and underserved populations of all ages access free and low-cost prescription drugs.**

2. ***ChecKmeds NC*** **was launched in 2007 to address the medication therapy management needs of seniors enrolled in Medicare Part D plans, to help them use their prescription medications in a safe and effective manner in order to prevent adverse reactions from drug interactions and duplicative therapy.**
3. **HWTFC's *Oral Health Access Initiative* has been funded at $2.35 million in 2007 to address the oral health needs of underserved populations as well as to increase the capacity of community-based organizations to provide dental care to the uninsured and underinsured.**
4. ***Governor's Quality Initiative*** **(GQI) has been funded at $1.2 million over 3 years to increase the overall quality of care in the state and reduce the variability of care received from providers across North Carolina. GQI's initial focus is on five medical conditions: diabetes, asthma, congestive heart failure, high blood pressure and heart attacks.**

1. MEDICATION ASSISTANCE PROGRAM (MAP)

BACKGROUND

Uninsured North Carolinians, or even those who qualify for Part D 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 the acute need for access to medications among North Carolina seniors and low-income individuals under 65, 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 HWTFC's *Medication Assistance Program* (MAP) grants are still being funded five years later in its fourth phase of grants.

PROGRAM DESIGN

- Total MAP allocation from HWTFC = $19,322,200 over 5½ years
- Grant Program – Phase IV
  - Phase I: 23 local grants January 2003 – December 2005 including three emergency grants awarded in October 2003 to counties in central North Carolina affected by layoffs in the textile industry
  - Phase II: 58 local grants July 2004 – June 2006
  - Phase III: 51 local grants July 2006 – December 2007
  - Phase IV: 50 local grants January 2008 – June 2009
- Financial prescription assistance for low-income individuals of all ages
  - Provides access to free and low-cost medications to low-income individuals of all ages
  - Grantees use software programs to identify the best source for needed drugs and complete application forms for clients, including the Medication Access Review Program (MARP) developed by the NC DHHS Office of Research, Demonstrations, and Rural Health Development (ORDRHD) through previous HWTFC funding
  - Eligibility requirements are defined by pharmaceutical companies that sponsor such programs

CURRENT REPORTING PERIOD

Encouraged by the tremendous success and return on investment of the medication assistance component of the MAP grants, as well as the overwhelming need of low-income North Carolinians for these services, HWTF Commissioners voted to fund a fourth phase of MAP. Fifty Phase IV grants totaling over $2 million were awarded starting January 2008. These 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.

Based on over $27,562,500 being procured in free prescription medications over the last 12 months, **the return on investment (ROI) for MAP during this period has been $ 18.1,** the largest ROI since the program's inception. Nearly 100,000 individuals have received MAP services since the program started in 2002.

NEXT STEPS

The NC Department of Health and Human Services agreed to work with the General Assembly to sustain the *Medication Assistance Program* in the future when HWTFC funding expires in 2009. HWTFC is also working with all of the other major health care foundations in the state to link its MAP sites with the network of services providers in each community that provide services to the uninsured through the Care + Share Health Alliance.

2. CHECKMEDS NC

BACKGROUND

Medication therapy management (MTM) 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. The national Medicare Modernization Act included a MTM services requirement of participating Medicare Part D Prescription Drug Plans (PDP). PDP efforts around MTM have been primarily limited to telephone based screening systems for their enrollees identified as high risk. Use of face to face, community-based pharmacist encounters has thus far been very limited. As a result, HWTFC created and funded an MTM program for North Carolina seniors that is more effective and accessible than the services that are currently available. HWTFC has invested $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. By expanding the availability of counseling services through retail pharmacists, North Carolina has been the first state in the nation to utilize this type of proven, free service for all North Carolina residents age 65 or older who take part in a Medicare Prescription Drug Program.

PROGRAM DESIGN

- Total allocation = $2 million
- Objectives:
  - Provide a comprehensive MTM (brown bag) session for each enrollee to ensure that they are using their medications in the most safe and effective manner and are avoiding any adverse reactions as a result of drug interactions.
  - Identify a qualified network of pharmacists skilled in MTM and the use of an MTM evaluation tool. These pharmacists may include those in retail as well as community and clinical settings.

- Eligibility:
  - North Carolina residents
  - Age 65 years or older
  - Take part in a Medicare Prescription Drug Plan
- Covered Services:
  Pharmacies or pharmacists are reimbursed for providing the following covered services to eligible seniors:
  - Annual comprehensive medication reviews
  - Prescriber consultations
  - Patient compliance consultations
  - Patient education and monitoring
- Enrollment
  - 9,715 seniors have been served in the reporting period.

CURRENT REPORTING PERIOD

The *ChecKmeds NC* program was launched on October 25, 2007. Since that time, 9,715 seniors have been served in the reporting period. Enrollment has significantly exceeded expectations.

An estimated $4,991,984 in health care costs has been avoided in less than nine months of this program. This cost savings projection is based on an estimated cost savings algorithm that is being used by the *ChecKmeds* program vendor to determine the savings in health care services that have been avoided as a result of providing the service. The algorithm is based on the Cost of Illness model developed by Johnson and Bootman in 1995. This conservative estimate of costs savings translates to a **7.6:1 return on investment** for this program after factoring in the program and administrative costs for providing the services.

Pharmacists from every county in North Carolina have been trained and are using the program. Web-based training has been provided to 677 pharmacists across the state to assist them in filing claims and in general use of the *ChecKmeds* program.

NEXT STEPS

HWTFC plans to share the outcomes of this program with the federal government in order to make a case that the provision for providing medication therapy management in the Part D legislation should be strengthened considerably to cover this service once HWTFC funding expires in spring 2009.

3. ORAL HEALTH ACCESS INITIATIVE

BACKGROUND

Low-income North Carolinians face significant challenges accessing dental care, especially if they live in rural areas. In 2006, roughly 32% of North Carolina adults reported not visiting a dentist within the last year. Among minorities, the number who reported visiting a dentist within the past year was even lower (39% of Native Americans; 42% of African Americans; and 56% of Hispanics) – 22% reported that it had been at least five years since their last dental visit. Meeting the oral health needs of young children, older adults, people with disabilities, and other special populations is even more challenging. In 2007, nearly half (43%) of NC children ages 1-5 already had tooth decay, and 20% of children entering kindergarten had untreated tooth decay.

PROGRAM DESIGN

- Total allocation = $2.35 million
- $2 million will be used as new grant funding to increase access to care and enhance workforce training to expand the availability of dental care for vulnerable and underserved populations. The funds will be awarded to programs that will:
  - Increase access to treatment and prevention services for low-income, high-need populations and/or
  - Develop/train the dental workforce (dentists, dental hygienists, dental assistants) or broader health care workforce (physicians, nurses, physician assistants, etc.) to better address dental prevention and treatment for low-income, high-need populations.
- The remaining $350,000 will be use to provide technical assistance and evaluation to applicants and grantees.
- HWTFC will also create a social marketing campaign to support prevention efforts.

For this initiative, *low income* is defined as having an income at or below 200% of the Federal Poverty Guidelines (FPG); *high-need populations* are groups that are either low-income and underserved and/or part of a special population that is more likely to have oral health needs and is also underserved (e.g., elderly populations, people living in long-term care settings, people with developmental disabilities, infants and toddlers).

CURRENT REPORTING PERIOD

HWTFC developed criteria for the Request for Proposals (RFP) by interviewing an extensive group of experts and service providers across the state.

NEXT STEPS

HWTFC will release an RFP in October 2008 with a February 2009 application deadline. Applications will be reviewed in spring 2009, resulting in grant award in May 2009. The grant contract period will begin on July 1, 2009 and will be renewed annually based on the grantees programmatic, financial and grant administration performance through June 30, 2012.

4. GOVERNOR'S QUALITY INITIATIVE

BACKGROUND

The *Governor's Quality Initiative* (GQI) will increase the overall quality of care in the state and reduce the variability of care received from different providers and across North Carolina communities. The state's commitment to this issue is shared by a statewide consortium of partners, which includes all the major physician groups, hospitals, academic medical centers, nonprofit healthcare organizations, professional associations, insurers, and payers in the state. Together, these partners will develop a comprehensive system for measuring, reporting, improving, rewarding, monitoring, and supporting healthcare in North Carolina to ensure the highest quality is delivered. However, a community-based approach is needed to address the growing numbers of older adults and people with chronic illnesses.

PROGRAM DESIGN

- Total allocation = $1.2 million over 3 years
  - **Initially, GQI will focus on health care for five disease states: diabetes, asthma, congestive heart failure, high blood pressure, and heart attacks.** These conditions are

widely prevalent throughout North Carolina, and place a large burden on patients and their families.[1] In the long-term, GQI will extend to other disease states, provider types, and healthcare settings, including hospitals.

- GQI will be governed by the Governor's Quality Improvement Committee (GQIC), a group of health care stakeholders, including representatives from the Governor's office, insurers and payers, providers (North Carolina Medical Society and North Carolina Hospital Association), Area Health Education Centers, Community Care of North Carolina, North Carolina Institute of Medicine, North Carolina Health and Wellness Trust Fund Commission as well as others. Preliminary members of the GQIC have met weekly for several months in the reporting period to develop a plan.

CURRENT REPORTING PERIOD

GQI partners are working to adopt a common set of quality measures for all North Carolinians for the diseases listed above. Most payers have some quality improvement initiatives currently operating in North Carolina. However, the initiatives vary slightly in the specific quality measures. With one set of measures common across all payers, physicians will no longer need to evaluate the many different definitions of quality care for a given disease, but can focus on giving the best quality care possible.

NEXT STEPS

In the first year, GQI will collect claims-based measures statewide across payers for all conditions for which such measures are available. Chart audits, quality reports, and practice support will roll out regionally, to cover practices in five of the 14 Community Care of North Carolina (CCNC) networks in Year 1, another five CCNC networks in Year 2, and the remaining four networks by Year 3. Approximately 38% of North Carolinians live in the geographic area covered by the CCNC networks participating in the first year.

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

HWTFC INITIATIVES THAT ADDRESS THIS REQUIREMENT:

1. **The Teen 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 and enforcement of the state law restricting the sale of tobacco to minors.**
2. **A statewide mass media campaign called Tobacco.Reality.Unfiltered (TRU) educates youth on the dangers of tobacco use.**
3. **Tobacco-free Schools Initiative has helped all North Carolina schools adopt 100% tobacco-free school policies.**
4. **A statewide Quitline (1-800-QUIT-NOW) provides comprehensive cessation services to North Carolina youth, young adults as well as those who influence youth like caretakers and teachers.**
5. **Since 2006, HWTFC has expanded its efforts to address tobacco use among college-aged youth as well through its Tobacco-Free Colleges effort.**

All of these programs are part of a community-based plan aimed at reducing and remedying the health effects of tobacco use among North Carolina's youth and young adults.

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. However, since HWTFC began funding teen tobacco use prevention and cessation efforts in 2003, middle school smoking has decreased by 51.6% and high school smoking has decreased by 30.4% (North Carolina Youth Tobacco Survey, 2007). This translates into 34,000 fewer teen smokers since 2003. These are the lowest cigarette use rates for middle (4.5%) and high school (19.0%) students ever recorded in our state.

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.

- Total HWTFC budget allocation for overall tobacco efforts:
  - $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

1. COMMUNITY GRANTS

PROGRAM DESIGN

- 49 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:
    - El Pueblo
    - NC Commission of Indian Affairs
    - Old North State Medical Society
    - Center for Health and Healing

CURRENT REPORTING PERIOD

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

- 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 (ATS) for teens caught using tobacco at school, both sponsored by the American Lung Association, utilized $106,034.
- The NC DHHS Tobacco Prevention and Control Branch utilized $514,437 to provide statewide grantees with field support, community capacity development and expertise in a wide variety of tobacco-related areas.

- Enforcement of the ban on tobacco sales to minors by the Division of Alcohol Law Enforcement, utilized $527,487.
- The UNC School of Family Medicine's Tobacco Prevention and Evaluation Program utilized $495,954 to evaluate the overall outcomes and provide recommendations for future program direction.
- Sponsorship of two regional youth empowerment programs, called "Question Why," the statewide effort to train and support youth in tobacco prevention education and advocacy through school-based programs and a training summit. Question Why is managed by Wilmington Health Access for Teens in the east and by Youth Empowered Solutions in the west and central regions. Question Why expended $817,650 during 2007-08.

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. HWTFC will issue a RFP for Phase IV of the grants in fall 2008 and grants will be awarded in December 2008 for three years starting July 1, 2009.

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.

2. PAID MEDIA CAMPAIGN – TOBACCO.REALITY.UNFILTERED

PROGRAM DESIGN

- The North Carolina Health and Wellness Trust Fund Commission (HWTFC) is committed to dissuading our state's youth from using tobacco products through its tobacco use prevention campaign, Tobacco.Reality.Unfiltered (TRU), in operation since 2003.
- A paid media campaign entitled, TRU (Tobacco.Reality.Unfiltered.) was budgeted at $5 million in 2007-2008. A study by the UNC School of Medicine validated the campaign's effectiveness.
- HWTFC has achieved a high level of awareness of the TRU campaign (71% in 2007) and contributed to a dramatic reduction in youth tobacco use in North Carolina. When the HWTFC program began, the teen smoking rate was 27%, according to the state's 2003 Youth Tobacco Survey (YTS), and is now at an historic low of 19% (2007 NCYTS).

CURRENT REPORTING PERIOD

The HWTFC youth tobacco prevention ads that aired during fiscal year 07-08 were "Anna" and "Jacobi" – ads featuring real people (not actors) who both share true stories of how their family members experienced devastating health effects from tobacco use.

In September 2007, HWTFC announced a new and aggressive recruitment campaign goal for the 2007-2008 school year – to get 5,000 North Carolina teens to pledge to be tobacco-free. The home page of the TRU Web site (www.realityunfiltered.com) tracked pledges so grantees and youth could gauge the campaign's progress. The TRU Web site was also redesigned to further engage TRU youth and to provide interactive education to youth who were just discovering TRU for the first time. In order to facilitate grantees' efforts to recruit new youth and encourage more NC teens to pledge to be tobacco free, grantees were supplied with promotional resources. *HWTFC met its goal three months early of recruiting over 6,000 teens to the site by April 2008.*

NEXT STEPS

While progress is evident, continued efforts are critical to sustain the decline in tobacco use since new youth enter into the 12 to 17 year-old target age group every year, and the decision to remain tobacco free needs to be repeatedly reinforced.

This strategic direction of using real stories has been working effectively in our state, and HWTFC will continue to use this approach in FY09 by introducing the moving story of Reena, a 29-year-old single mother from Asheville, NC. Reena started smoking at 13, was diagnosed with throat cancer at 21, and had to have her voice box removed in order to survive.

A campaign will also be developed to address second hand smoke and to recruit more North Carolina teens to the TRU movement to continue to increase the number of North Carolina youth that pledge to remain tobacco-free.

3. TOBACCO FREE SCHOOLS

PROGRAM DESIGN

- One of the primary objectives for the Tobacco Use Prevention and Cessation Initiative was promoting local adoption of and compliance with 100% Tobacco-Free Schools (TFS) policies.
- A 100% Tobacco-Free School prohibits all tobacco use anytime, anywhere by anyone on all school property and at all school-sponsored events.
- From 1990 to 2002, 14 of North Carolina's 115 school districts passed 100% Tobacco-Free School (TFS) policies. HWTFC began to focus its efforts on TFS policy promotion in 2003, and by the summer of 2007, three-quarters of North Carolina school districts had adopted 100% TFS policies.
- In July 2007 the General Assembly passed Senate Bill 1086, which mandates that each school district pass and implement a 100% tobacco-free schools (TFS) policy by August 1, 2008. At the time of this bill's passage, 87 of North Carolina's 115 school districts had a tobacco-free policy. SB 1086 also tasks HWTFC with providing local school districts with the tools and resources to successfully implement a TFS policy.
- Grassroots organizing has been the single biggest factor in developing the 100% TFS initiative.
- In areas without HWTFC grants, HWTFC staff organized local efforts by recruiting local folks such as school nurses, students, health advocates and parents to lead efforts to convince school board members to support TFS.
- HWTFC provided these advocates with resources and assistance by holding community workshops, educating parents and school officials and developing resources (such as a

content-rich web site and printed boilerplate materials while assisting existing tobacco-free schools with their compliance efforts.

CURRENT REPORTING PERIOD

Before HWTFC took a leadership role in the TFS movement in 2003, only 14 school districts had adopted smoke-free policies. As of August 2008, all 115 school systems adopted 100% TFS policies.

Tobacco-Free School policies work in preventing tobacco use among youth. In fact, 2005 NC Youth Tobacco Survey data show that North Carolina high schools without a 100% TFS policy have the *highest* prevalence rates for both cigarettes (22%) and any tobacco use (31.2%) The study also shows that when compared to non-TFS districts, students attending high schools that have established 100% TFS policies are 32% less likely to be tobacco users and 40% less likely to be smokers.

Districts that adopt 100% Tobacco-Free School policies can obtain "100% Smoke-Free School" signage for their school grounds by contacting HWTFC. All signs are provided free of cost. HWTFC is also working to help all school districts implement these policies by providing trainings and resources.

NEXT STEPS

HWTFC has entered into a contract with the NC Tobacco Prevention and Control Branch to assist schools in implementing 100% 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 continually updated to reflect these local efforts. HWTFC will sponsor local compliance trainings. These trainings will target teachers, coaches and school administrators.

HWTFC will also provide grants to sponsor youth-based compliance trainings, to be done concurrently with the adult compliance trainings. Thus, trained youth will be able to monitor compliance rates in their school and provide that information to adult administrators for appropriate remedy. HWTFC will continue to provide signs (in both English and Spanish), banners, floor stands and other materials to school systems to help them publicize the tobacco-free schools policy.

4. QUITLINE NC

PROGRAM DESIGN

- In November 2005, HWTFC 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.
- HWTFC 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.
- Telephone "quitlines" help tobacco users quit their addiction by offering advice, support and referrals to local cessation resources. Research shows that quitlines are an effective and evidence-based approach to help tobacco users quit.

- In this program period, HWTFC has allocated $1.2 million for services and a corresponding amount for promotion of services – this is the recommended ratio from the Centers for Disease Control (CDC).

CURRENT REPORTING PERIOD

During 2007-2008, *QuitlineNC* has reached a significant number of tobacco-using youth, young adults and primary caregiver/school employees; in total, 7,332 calls were received and 54% were HWTFC-funded. At least one HWTFC-funded, tobacco-user from every county in North Carolina called *QuitlineNC* during Year 3 operations.

During Year 3, the HWTFC launched a multimedia quitline promotional campaign targeted to young adults. The "Call it Quits" campaign began in September 2007, making North Carolina one of the first states in the country to use a multimedia promotion targeting young adults. The campaign used television, radio, and print advertisements; a redesigned Quitline NC Web site (www.QuitlineNC.com); and online ads on the social networking Web site Facebook. The significant increase in young adult call volume during months in which these ads aired suggests that the "Call it Quits" media promotion was successful in reaching young adults.

During 2007-2008, the HWTFC also led an effort to promote *QuitlineNC* and its fax referral service to health professionals. The fax referral service is a special feature of Quitline NC designed to assist health professionals in connecting their patients to the quitline. Many doctors, dentists and other healthcare providers don't have time to offer comprehensive tobacco treatment. The fax referral service allows them, while in their office, to refer tobacco users directly to the Quitline for extensive one-on-one behavioral coaching. Health professionals can receive feedback through an outcome report on the services the tobacco user has received through the Quitline.

Over 10,000 North Carolina physicians received fax referral promotional materials as well as Quitline NC items to distribute to their patients who use tobacco. Materials were mailed to physicians beginning in March 2008 and continued through the end of Year 3 in June. Fax referrals for adult callers increased sharply in March and remained higher through the end of reporting period, compared with the months before the promotion began.

NEXT STEPS

QuitlineNC is a valuable resource for North Carolinians, and HWTFC will continue to develop targeted messages in order to better promote 1-800-QUIT-NOW amongst its target population of youth and young adults. As a result of healthcare provider focused promotions, the number of fax referrals to the quitline has increased. As promotions to providers continue, the number of referrals is expected to increase significantly, resulting in notable increases in call volume and ultimately in increased tobacco use cessation rates.

5. TOBACCO-FREE COLLEGES

BACKGROUND

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.

PROGRAM DESIGN

- In January 2006, HWTFC launched the first Tobacco-Free Colleges (TFC) Initiative in North Carolina by awarding $1.6 million to 20 grantees covering 58 college campuses.
- 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. Specifically, grantees are to develop activities that help:
  - 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
- A 2007 report issued by the University of North Carolina at Chapel Hill concluded that the initiative was successful in its first year with policy gains, new campus coalitions, increased QuitlineNC promotions to young adults, and strong support from college officials.

CURRENT REPORTING PERIOD

In January 2008, HWTFC began Phase II of the 100% Tobacco-Free Colleges Initiative by awarding more than $1.8 million in grant funding to 15 college-based tobacco use prevention and cessation projects serving 49 colleges, universities and community colleges. These grantees use evidence-based strategies to promote smoke-free campus environments and coordinate QuitlineNC outreach efforts to college-aged students in 44 counties.

In addition, Phase II of the project expanded the scope of the effort to provide assistance to all NC colleges campuses in adopting and implementing comprehensive, campus-wide tobacco use policies. This program is similar to HWTFC's highly successful 100% Tobacco Free Schools Initiative, which worked with all 115 school districts to adopt and implement 100% Tobacco Free School policies. The program directly worked with 9 non-funded campuses to develop tobacco-free policies and educated members of statewide organizations such as the NC Independent Colleges & Universities and the NC Department of Community Colleges about the health, economic and educational advantages of such policies.

Seventeen colleges, universities and community colleges have adopted comprehensive tobacco use policies as of Jun 30th, 2008, including 11 during this fiscal year. This number includes 3 UNC system schools (Elizabeth City State University, UNC-Chapel Hill, and Winston-Salem State University) that have adopted a 100-foot perimeter policy, the most restrictive policy that UNC system institutions are allowed. The remaining fourteen colleges and community colleges have adopted 100% tobacco free campus policies, which prohibit all forms of tobacco use on campus and at school-related events.

NEXT STEPS

HWTFC will continue its efforts to provide trainings and resources to all North Carolina colleges to promote tobacco-free policies on public and private campuses. HWTFC will also work to provide resources to colleges that have passed the policy to aid with implementation.

6. NEW TOBACCO EFFORTS

In May 2008, HWTF Commissioners funded two new programs to address tobacco use among special needs adult populations: those with mental health problems and pregnant women.

HWTFC's first new effort seeks to reduce the harmful effects that tobacco has on people with mental illness by providing them with equal access to smoke-free environments and cessation programs in addition to increasing their awareness about wellness. Approximately 70% of individuals with serious mental illness (SMI) smoke cigarettes. Individuals with mental illness and addiction consume nearly half of all cigarettes purchased in the United States. Individuals with psychiatric disorders die disproportionately from cardiovascular and respiratory illnesses and many will likely die of medical disorders caused by smoking.

In order to address this problem, HWTFC will work with NC Evidenced Based Practice Center, part of Southern Regional AHEC, to pilot a wellness and tobacco cessation program in 8 mental health community/day treatment centers (Clubhouses). With the support of this grant, North Carolina's Clubhouses and other similar treatment centers will have a sustainable and effective way to help their members quit smoking and adopt other healthy habits.

HWTFC's second new effort would like to decrease maternal and infant mortality and morbidity by reducing tobacco use and exposure. North Carolina has among the highest rates of infant death in the United States. The goal of the project is to increase the number of women who stop smoking during pregnancy and decrease the number of women who return to smoking after the baby is born. It has been established that the overall infant mortality rate in the state would drop between 10-20% if women were to stop smoking during pregnancy.[i]

HWTFC will work with the Center for Maternal and Infant Health at the University of North Carolina at Chapel Hill School of Medicine to conduct a 3-year prenatal and postpartum cessation program. The program will include a statewide education and outreach campaign. In addition, intensive pilot projects will be conducted through the local health department in four North Carolina counties where the smoking rate among pregnant women is at least 19%. Pilot programs will target Medicaid recipients. The pilot will develop 4 best-practice, sustainable, community based smoking cessation projects for this hard-to-reach population.

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

HWTFC INITIATIVES THAT ADDRESS THIS REQUIREMENT:

1. **Community grants: 21 grants awarded in 2003 and 2004 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.**
2. **HWTFC's Fit Families NC: A Study Committee for Childhood Obesity has convened statewide experts to review and recommend state, local and agency-level policy changes to address the epidemic**
3. **The *Fit Community NC* program recognizes and rewards efforts led by municipalities and counties to promote healthful living for their residents.**
4. **In addition to local grants, HWTFC's obesity initiative focuses efforts on statewide public education and awareness about individual behaviors as well as promoting adoption of local policies including employer based policies that address the underlying issues regarding this growing health problem.**

5. Through its *Fit Kids NC* effort, HWTFC is helping K-8 teachers across the state comply with the 30 minutes of physical activity per day requirement.

BACKGROUND

Alarmingly 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. A recent study by Be Active NC shows that physical inactivity and unhealthy eating, the two major risk factors associated with obesity, cost the state of North Carolina $57 billion annually in avoidable medical costs. 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.

1. OBESITY COMMUNITY GRANTS

PROGRAM DESIGN

- $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 was 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
- A cohort study performed by East Carolina University, and commissioned by HWTFC, found that the HWTFC grant funds were successful at reducing the obesity rate of children. Among the 1,346 children who participated in the study and grant program, their rates of obesity decreased slightly compared to the national average, which increased during that time period.

CURRENT REPORTING PERIOD

HWTFC's initial community grants ended in December 2007. East Carolina University Department of Family Medicine and the Pediatric Healthy Weight Research and Treatment Center conducted a two-part evaluation of the childhood obesity grants. For the first time in North Carolina, a cohort of 1500 children participating in the local interventions were followed over three years to assess changes in body mass index (BMI), and in important nutritional factors related to obesity and unhealthy weight. Grantees also facilitated 447 instances of significant policy development or policy changes in areas such as physical activity, poor dietary behaviors, and overweight. The outcomes analysis is discussed in depth in Section II of this report.

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 communities and schools 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.

2. FIT FAMILIES NC: STUDY COMMITTEE FOR CHILDHOOD OBESITY

PROGRAM DESIGN

- $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.
- The *Fit Families NC* Study Committee for Childhood Obesity released a report in 2005 that formed the basis for statewide policies that will be critical in North Carolina's future efforts to combat childhood obesity: Three recommendations included in the *Fit Families NC* report were taken to legislative bodies in North Carolina and resulted in statewide policy and legislation.
  - 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.
  - 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).
  - 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).

CURRENT REPORTING PERIOD

This Study Committee continued to meet in order to ensure the implementation of their recommendations related to the prevention of childhood obesity.

NEXT STEPS

HWTFC's Study Committee for Childhood Obesity will continue to work towards the implementation of its recommendations. During 2008-2009, it will conduct a retreat to finalize its work plan on moving the other recommendations forward, and will take into consideration the recommendations that will come out of the Legislative Obesity Task Force in January 2009 in determining its next steps.

3. FIT COMMUNITY NC

PROGRAM DESIGN

In 2005, HWTFC in partnership with Blue Cross and Blue Shield of North Carolina (BCBSNC) launched *Fit Community NC*, 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* designees 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* designees 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.

CURRENT REPORTING PERIOD

- The third class of Fit Community designees was named in June 2008. They are: Black Mountain, Jacksonville, and Tarboro
- The third phase of grant funding was made available for two-year grants of up to $30,000 annually and was announced in June 2008. Eight grants totaling nearly $500,000 were awarded to: Burlington, Caswell County, Central Park NC, Edenton, Faison, Pinehurst, Pitt County and Salisbury.
- Technical assistance is being provided by Active Living by Design, a national program housed at the UNC School of Public Health.
- A survey was conducted of 100 interested applicants across the state in order to tailor this program to better fit the needs of North Carolina's communities. As a result, the program was modified to include tiers. In addition, a promotional campaign is being developed for fall 2008 to promote the benefits of becoming a Fit Community. This campaign includes a Fit Community road show to relevant conferences across the state where key policy makers convene each year, as well as a radio and newspaper campaign.

NEXT STEPS

The *Fit Community* program will expand to include a fourth round of grants and designations. A request for proposals will be released in October 2008 and $500,000 in grants will be awarded in May 2009.

4. EDUCATION AND AWARENESS

PROGRAM DESIGN

A partnership with Blue Cross and Blue Shield of North Carolina (BCBSNC) was announced in April 2004 to conduct a statewide campaign called Fit Together, to raise awareness around the dangers of unhealthy weight. BCBSNC committed $3 million over three years to this partnership. A workplace wellness campaign was also launched in 2006.

CURRENT REPORTING PERIOD

Although the partnership expired in April 2007, HWTFC continues to maintain 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.

NEXT STEPS

HWTFC will also launch a new media campaign in 2009 to address individual behaviors related to obesity. HWTFC also plans to launch a second campaign including grassroots resources to promote workplace wellness among small businesses in early 2009.

5. FIT KIDS NC

- In support of the State Board of Education's 2005 30-minutes per school day physical activity mandate, HWTFC invested in research and development for evidence-based curricula for use by teachers during the school day as well as direct training on such curricula.
- In May 2006, Commissioners awarded $750,000 to Be Active NC and DPI to provide all NC elementary and middle school teachers with in-person training on curriculum-support activities that meet requirements of the mandate.
- 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 develop classroom-based physical activities that align with the NC Standard Course of Study. Resulting lesson plans are available at www.FitKidsNC.com.
- A $40,000 grant was awarded 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.

CURRENT REPORTING PERIOD

- Over 32,868 teachers have been trained on the Fit Kids Web site by the end of the reporting period on incorporating physical activity in the classroom in the 2006-2007 fiscal year.
- Over 43 school districts met their teacher training goal during this period and were eligible for a $1,000 incentive.

NEXT STEPS

HWTFC will continue to provide regional teacher trainings throughout North Carolina during 2008-2009; these will result at least 70% of all K-8 teachers in North Carolina being trained on effective implementation of the 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. The goal is to reach 40,000 teachers, the largest single teacher training initiative in the history of North Carolina.

6. NEW OBESITY PROGRAMS

HWTFC will launch a new program in fall 2008, the A+ Fit School grants and designation program, based on the successful Fit Community model. All North Carolina public schools K-12 are eligible to apply. A request for proposals will be released in late October 2008 and 10 schools will receive $7,500 each in grant funding in May 2009. This initiative will also designate 10 different schools as "A+ Fit Schools" and as a result, each school will receive a $1,000 stipend along with public recognition.

Another new obesity related effort that HWTFC will launch in fall 2008 is called IN4Kids. This program aims to reduce childhood obesity by providing an economically feasible way for physicians to incorporate nutritional counseling into their practices. This $1.5 million program will hire registered dieticians to work full or part-time at 6-8 primary care pediatric or family

medicine practices (each affiliated with one of the four NC academic medical centers) to provide services to children who are at risk for overweight, overweight, or obese.

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:

- Teen Tobacco Use Prevention and Cessation: UNC School of Family Medicine Tobacco Prevention and Evaluation Program (UNC-TPEP)
- Tobacco Free Colleges: UNC-TPEP
- Teen Tobacco Media Campaign: UNC-TPEP
- Quitline NC: UNC-TPEP and Free & Clear Clinical and Behavioral Sciences Division

- Youth Overweight and Obesity Prevention/Reduction Community Grants: Brody School of Medicine's East Carolina University, Department of Family Medicine Research Division
- Fit Community Program – Active Living by Design at UNC-Chapel Hill
- Fit Kids Program: UNC – Greensboro and Be Active North Carolina

- Eliminating Health Disparities: Brody School of Medicine's East Carolina University, Department of Family Medicine Research Division

- Medication Assistance Program: DHHS Office of Rural Health and HWTFC evaluation staff
- *ChecKmeds* program: Outcomes, Inc., which is the vendor that runs that program.

Key highlights of each of these outcomes evaluations are listed in Section II.

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)

The NC Health and Wellness Trust Fund Commission (HWTFC) 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 by addressing:

- Tobacco use and obesity among youth
- Increasing access to prescription drugs and medication therapy management for North Carolina seniors as well as non-seniors who were uninsured.

In year 4 of its existence, the Commission added health disparities as an area of critical focus and expanded its obesity effort to also cover adults.

The HWTF Commissioners also agreed that in order to meet its mandate from the General Assembly – *"…to develop a comprehensive plan to finance programs and initiatives to improve the health and wellness of the people of North Carolina"* – more detailed, North Carolina-specific research was necessary in critical areas of need. In May 2006, the Commission agreed to fund research on several complex issues facing North Carolina's most vulnerable populations by setting up the *Task Force for a Healthier North Carolina*. Expert study committees were assembled to seek innovative ways to:

- Expand health insurance coverage for employees of small businesses and children from low-income families
- Fill gaps in prescription drug coverage for seniors
- 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 direct future HWTFC efforts as well as programs and initiatives by other state agencies.

In addition to its four major initiatives: tobacco, obesity, prescription drugs and health disparities HWTFC also expanded its efforts to include several new programs that have significantly expanded its ability to develop a comprehensive approach to addressing North Carolina's critical health needs. These include the following:

- **GOVERNOR'S QUALITY INITIATIVE (GQI):** GQI strives to increase the overall quality of care in the state and to reduce the variability of care received from providers across North Carolina. GQI's initial focus is on five medical conditions: diabetes, asthma, congestive heart failure, high blood pressure and heart attacks. HWTFC is one of the key funders of this innovative public-private partnership, having allocated $1.2 million over three years.

- **NORTH CAROLINA'S RURAL HOPE PROJECT:** In October 2007, the HWTFC committed $1 million to the *Rural HOPE Project*. HWTFC's funding leveraged a matching grant from the Golden Leaf Foundation. This effort will provide North Carolina's small rural hospitals access to financing from private lending institutions – financing that is needed to make critical upgrades and renovations to clinical equipment, physical facilities and health information technology systems.

- **ORAL HEALTH ACCESS INITIATIVE:** In December, 2007, HWTFC committed $2.35 million for a new effort to increase access to care and enhance workforce training to expand the availability of dental care for vulnerable and underserved populations.

- **NORTH CAROLINA HEALTH INSURANCE RISK POOL (INCLUSIVE HEALTH):** HWTFC approved a one-time allocation of up to $5 million to support the establishment of a high-risk health insurance pool for North Carolinians with serious health conditions that render them uninsurable. The pool is expected to begin providing coverage to members in January 2009.

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

TOBACCO USE PREVENTION AND CESSATION INITIATIVE (TUPC)

HWTFC's Tobacco Prevention and Cessation Initiative (TUPC) continues to build upon its strong and cohesive network and effective tobacco use prevention programs to ensure that significant reductions in smoking rates are achieved through adhering to the best practices for tobacco programs outlined by the Centers for Disease Control and Prevention (CDC). Therefore, North Carolina has one of the most comprehensive and coordinated youth tobacco programs in the country and continues to make great accomplishments in overall program outcomes, 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.

- **TEEN TOBACCO PREVENTION AND CESSATION PROGRAM (TTUPC)**

The HWTFC *Teen Tobacco Use Prevention and Cessation Initiative* (TTUPC) continues to grow in the realization of increasing policy outcomes and the number of individuals and groups involved. Since the *TTUPC* began in 2003, the number of grantees has increased from 30 to 46 in 2006. Substantial activity, progress and program outcomes continue to occur statewide across the *TTUPC* program goal areas in 2007-08, with nearly all grantees working in almost all focus areas. Exceptional program successes occurred, particularly data showing:

- Continued declines in middle and high school youth cigarette and tobacco use
  - Rate of decline is higher from 2003-2007 (during HWTFC funding of the *Teen Initiative*) than from 1999-2003
- Tobacco.Reality.Unfiltered (TRU) media campaign and brand has established strong identity among youth and is now the primary source of anti-tobacco media exposure for North Carolina youth:
  - Specific ads are recognized by over 80% of all youth
  - Brand awareness is increasing significantly from 2005-2007

2007 Youth Tobacco Survey Data

Administered by the NC Department of Health and Human Services (NC DHHS) and analyzed by the CDC, the Youth Tobacco Survey (YTS) is the definitive study of tobacco use among young people in North Carolina. Below are some highlights from the 2007 YTS:

- ***34,000 fewer teens are smoking cigarettes in NC than there were in 2003***
- ***The rate of decline in high school-aged smokers has more than tripled since HWTFC began funding teen tobacco use prevention and cessation efforts***
- ***Since 2003, youth smoking rates have decreased significantly:***
  - ***High school students – dropped from 27.3% to 19.0%***
  - ***Middle School students – dropped 9.3% to 4.5%***
- ***Both middle and high school rates of smoking have dropped below the national average***
- ***High schools in districts that had 100% Tobacco-Free Schools (TFS) policies in effect for at least four years reported 32% fewer tobacco users and 40% fewer cigarette smokers compared to schools without the policy.***

Due largely to the effectiveness of HWTFC's comprehensive TTUPC Initiative, 2007 YTS data shows the lowest cigarette use rates for middle and high school students ever recorded in North Carolina, eclipsing the rates reported in 2005.

Youth Empowerment

The UNC School of Medicine Tobacco Prevention and Evaluation Program (TPEP) was contracted by HWTFC to evaluate outcomes of HWTFC's *Teen Tobacco Use Prevention and Cessation* (TTUPC) Initiative. TPEP found the following related to youth empowerment and involvement in tobacco prevention:

- The tobacco use prevention movement among North Carolina youth is growing:
  - There are over 100 youth groups across the state
  - More than 1,000 teens involved in planning and implementing activities
  - Youth empowerment activities now account for 55% of all programmatic activities
- ***Over 500,000 youth across the state are aware of the TRU media campaign, and youth are responding positively to the ad campaign.***
- ***More than 6,000 teens across the state have visited the TRU Web site and signed the pledge to be tobacco-free.***
- Chad Bullock, a youth actively involved with the HWTFC youth empowerment program, was one of nine finalists in the "Do Something Awards" presented to a young person who is making a difference in the world and their own communities. He was nominated for his advocacy work in tobacco prevention through Question Why Youth Empowerment, which is funded entirely by the HWTFC Teen Tobacco Initiative. (Chad was the national winner of this award in August, 2008.)
- Reducing Youth Exposure to Second-Hand Smoke**:**
  - Increased areas frequented by youth are smoke-free at the end of 2007-08 due to grantee and youth empowerment activities across the state. These include restaurants, places of worship, and policies that affect multiple locations (i.e., recreation sites) and many new secondhand smoke (SHS) policies being adopted in areas frequented by youth.

Reducing Health Disparities Among Youth Attributable to Tobacco Use

- HWTFC currently funds grantees that provide services to minority populations:
  - Three grantees that serve largely American Indian populations
  - One grantee that serves Latino populations
  - Several grantees that serve largely African-American populations.
- Although all grantee activities attract widely diverse populations, grantees are also required to separately track those activities that are uniquely designed for populations experiencing tobacco-related disparities.
- Approximately 14% (876 of 6,410) of all activities reported were uniquely designed for populations:
  - 25% of these specifically targeted African-American youth
  - 22% targeted American Indian youth
    - Many uniquely designed tobacco use prevention activities for American Indian youth continued to take place in 2007-08.
  - 17% targeted Hispanic youth
  - 22% targeted youth from low socioeconomic or low literacy populations.

• MEDIA CAMPAIGN OUTCOMES

The UNC School of Medicine Tobacco Prevention and Evaluation Program (TPEP) was contracted by HWTFC to evaluate the effectiveness of HWTFC's Tobacco.Reality.Unfiltered (TRU) media campaign. Below are some highlights from the evaluation of the 2007 TRU campaign:

- **Youth awareness of the TRU campaign increased by nearly one-third from 2006 to 2007:**
  - **Awareness of the campaign rose from 54% in 2006 to 71% in 2007**
  - **Over 500,000 youth (11-17) in NC have seen and are aware of the TRU campaign**
- Awareness of TRU campaign brands and slogans rose substantially from 2006 to 2007:
  - Youth awareness of the TRU brand rose from 42% in 2006 to 58% in 2007
  - Youth awareness of the TRU slogan increased from 48% in 2006 to 55% in 2007
- NC youth responded positively to the ads run in 2007:
  - **More than 95% of NC youth who had seen the 2007 ads reported that they were convincing, attention-grabbing, and gave good reasons not to use tobacco**
  - Over 25% of NC youth reported that they talked to their friends about the ads, indicating high "chat value"
- Anti-tobacco and pro-health attitudes among NC youth have remained stable and strong.
  - Over 90% of NC youth did not believe that young people who smoke cigarettes had more friends, that smoking cigarettes made youth look cool or fit in, or that smoking made youth look attractive
- The majority of youth continue to be exposed to cigarette advertising and believe that cigarette ads portray smoking as acceptable or "cool"
- Most youth support tobacco-free policies in places they frequent, including schools, indoor places such as restaurants, and outdoor areas such as parks
- The Youth Tobacco Survey (YTS) data showed that awareness of the TRU ads and brand remains high among North Carolina youth:

- 84.7% of middle school students and 88.8% of high school students reported having seen ads that were part of the TRU campaign
- 54.6% of middle school students and 62.5% of high school students reported seeing television ads with the TRU brand at least once during the previous month

o **More than 6,000 teens across the state have visited the TRU Web site (www.realityunfiltered.com) and signed the pledge to be tobacco-free.**

- **100% TOBACCO-FREE SCHOOLS**

Following are the activities that occurred during fiscal year 2007-2008:

o **Twenty-five schools in North Carolina passed 100% tobacco-free school policies**
  - **As a result, 114 of the state's 115 school systems have adopted 100% TFS by June 30, 2008 with the remaining one going tobacco free in the first week of July.**

o HWTFC grantees facilitated the adoption of Alternative to Suspension (ATS) programs (part of a 100% TFS policy) in 39 schools, bringing the total number schools with ATS programs (among directly funded counties) to over 140

o HWTFC provided the following various free materials to 17 different school districts:
  - 2,183 free signs (in both English and Spanish)
  - 105 banners
  - 103 floor stands

o HWTFC also sponsored 11 local assistance workshops in various communities throughout the state, which trained local teachers and other school officials about policy implementation

o Below are the schools that adopted 100% tobacco free policies:

	School	**Date**
1	Hyde County Schools	July 2007
2	Alexander County Schools	August 2007
3	Macon County Schools	August 2007
4	Forsyth County Schools	September 2007
5	Franklin County Schools	September 2007
6	Wake County Schools	September 2007
7	Stokes County Schools	October 2007
8	Wayne County Schools	October 2007
9	Macon County Schools	October 2007
10	Madison County Schools	October 2007
11	Nash County Schools	October 2007
12	Harnett County Schools	November 2007
13	Caswell County Schools	December 2007
14	Edgecombe County Schools	December 2007
15	Wilson County Schools	March 2008
16	Randolph County Schools	March 2008
17	Hoke County Schools	March 2008
18	Columbus County Schools	March 2008
19	Robeson County Schools	March 2008
20	Cabarrus County Schools	March 2008

	School	Date
21	Sampson County Schools	March 2008
22	Beaufort County Schools	April 2008
23	Bladen County Schools	April 2008
24	Johnston County Schools	May 2008
25	Scotland County Schools	May 2008

- HWTFC sponsored two regionally based assistance workshops and five local compliance workshops throughout the state. These workshops focused on the compliance needs to school systems that have long-standing TFS policies but may need renewed emphasis on compliance. A total of 18 school districts were represented at those events.
- HWTFC also developed and distributed "*From Policy to Practice"*, a 56-page TFS compliance manual with step-by-step instructions about ways to successfully implement the policy. Manuals were mailed to each school system, and were provided to state officials in the NC Department of Public Instruction and the NC Division of Public Health. The manual is also available at www.tobaccofreeschoolsnc.org
- 16 school officials and parents in five Eastern NC counties also participated in the Real Time Community Change (RTCC) project, which was administered by Question Why East, an HWTFC grantee. RTCC participants where given substantial, one-on-one technical assistance to help them implement TFS policy in their particular school system over a six-month period.

- **TOBACCO-FREE COLLEGES**

HWTFC started funding its Tobacco-Free Colleges Initiative in 2006 and expanded its effort to all colleges statewide in January 2008.

- **11 NC schools adopted comprehensive tobacco use policies in FY 2007-2008:**

	School	Date	Policy Type
1	Haywood Community College	√ Jul 07	100% tobacco-free
2	Greensboro College	√ Aug 07	100% tobacco-free
3	Wake Technical Community College	√ Aug 07	100% tobacco-free
4	Roanoke-Chowan Community College	√ Aug 07	100% tobacco-free
5	UNC-Chapel Hill	√ Oct 07	Comprehensive
6	Guilford Technical Community College	√ Oct 07	100% tobacco-free
7	Winston Salem State University	√ Dec 07	Comprehensive
8	Wingate University	√ Jan 08	100% tobacco-free
9	Montreat College	√ Jan 08	100% tobacco-free
10	Louisburg College	√ Apr 08	100% tobacco-free
11	Elizabeth City State University	√ Jun 08	Comprehensive

Note: *100% tobacco-free (TF) policy prohibits tobacco use anytime, anywhere by anyone on campus grounds. Comprehensive policies, which are the most restrictive level allowed for UNC system schools, prohibit smoking within 100 feet of campus buildings.*

- 29 more limited tobacco use policies (smoke-free dorms, tobacco-free fraternities & sororities, etc) have been adopted with the direct or indirect assistance of grantees

- **QUITLINE NC**

The UNC School of Medicine Tobacco Prevention and Evaluation Program (TPEP) was contracted by HWTFC to evaluate outcomes of the HWTFC-funded portion of *QuitlineNC*, particularly services provided to youth and young adults. In addition, the quitline vendor; Free & Clear, assesses *QuitlineNC* callers' success with quitting and satisfaction with quitline services through an end-of-program survey administered to a subset of callers.

The following section highlights key outcomes of the HWTFC-funded portion of *QuitlineNC* during its third year of operation:

Quitline Operation and Call Volume

- Overall funding for *QuitlineNC* increased 100% in Year 3
- **In total, *QuitlineNC* received 7,332 calls during Year 3, an average of 611 calls per month. Average monthly call volume in Year 3 increased by 56% compared to the previous two years.**
- **Youth calls increased by 31.5% and young adult calls increased by 63% in Year 3. The total number of callers from HWTFC target populations increased by 15%.**
- *QuitlineNC* call volume peaked and remained higher during the five months in which television and radio ads from the HWTFC-funded "Call it Quits" promotional campaign were aired. 67% of all HWTFC calls were received during these months.
- Young adult callers to *QuitlineNC* came predominately from targeted, at-risk populations.
  - Most (63%) young adult callers did not attend school.
  - Young adult callers who were not currently in college were more likely to report Hispanic ethnicity, have no health insurance, have Medicaid coverage, and use multiple forms of tobacco compared to young adult callers in college.
- In Year 3, *QuitlineNC* reached many adults who are caretakers and role models for children and youth in their home and school environments.
  - 29% (1,817) of all callers who used tobacco were primary caregivers and/or childcare / school employees supported by HWTFC funds
  - 6% (218) of all female, HWTFC-funded callers were either planning a pregnancy, pregnant, or breastfeeding (58% of these callers were young adults and 4% were youth)

Satisfaction with services and Quit Rates

- About 90% of all HWTFC survey respondents reported that they were satisfied with *QuitlineNC* services. Overall, 92% of young adults and 100% of youth reported satisfaction with *QuitlineNC* services (few youth callers completed the survey).
- Analysis by *Quitline NC* vendor, Free & Clear, Inc. demonstrated a 10.8% 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).

Fax Referral Service

HWTFC promoted the fax referral service statewide through a campaign that began in March 2008 and continued through the end of Year 3.

- The number of *QuitlineNC* callers (both HWTFC and DHHS-funded callers) who were referred by fax increased sharply in March (27 to 42) and remained higher through the end of the fiscal year, compared with the months before the promotion began.
- Utilization of the fax referral service was moderate overall:
  - 265 (4%) of all tobacco-using callers referred by fax during Year 3
  - Among HWTFC-funded callers, 122 (3.5%) were referred by fax, of whom 86% were primary caregivers or school employees

ELIMINATING HEALTH DISPARITIES INITIATIVE (HDI)

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. Eliminating Health Disparities Initiative (HDI) grants were awarded for a three-year period starting July 1, 2006 and ending on June 30, 2009. The majority of grants awarded addressed obesity and chronic diseases related to obesity especially diabetes, cardiovascular disease and cancer among African-American, American Indian, Latino and other populations with low-socio-economic status. Six of the grants awarded were awarded to community-based minority organizations, two 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.

There was a significant focus on planning in the first year of the initiative. In Year 2, grantees fully implemented their projects and began providing direct services to target populations all across North Carolina.

- **COHORT STUDY**

To examine the impact of the initiative, eighteen grantees were recruited to follow a longitudinal cohort of participants from their grant-funded programs. Measures for each participant are taken when s/he is first enrolled in the cohort study and then every six months until the end of the grant period. The biological markers for the cohort study are:

- Systolic blood pressure
- Body mass index (BMI)
- Cholesterol (for those grantees focusing on cardiovascular disease)
- HbA1c – a test that measures the amount of glycated hemoglobin in your blood (for those grantees focusing on diabetes)

Cohort Participants

By June 30, there were 2,471 participants enrolled in the cohort study:

- 1,011 participants with data from two time periods
- Data will continue to be collected at six month intervals through the end of Year 3
- Demographics:

- 73% female
- Average age 52.8 years (18 to 92 year range)
- 79% African-American
- 10% Caucasian
- 8% Native American
- 3% Other racial/ethnic group

Major Findings of Cohort Study Analysis

- **Systolic blood pressure was reduced among participants in projects focusing on cardiovascular disease (CVD), diabetes, and obesity.**
- **Among participants who are presumed to have diabetes, average HbA1c (which is a key diabetes measure) was significantly reduced while the percentage of participants with HbA1c lower than 7 increased from approximately 25% to 40%.**

These preliminary outcomes suggest that the HDI interventions are positively impacting the health of North Carolinians, especially underserved minority citizens. Improvements of this magnitude, if maintained, have been associated with reductions in diabetes and cardiovascular morbidity and mortality. Additional follow-up data will be carefully evaluated to confirm these initial findings.

Beginning in February 2008, participants were also asked to complete a Health Survey. Grantees were instructed to administer the survey the next time that they saw each participant and then every six months following. The goal was to have the survey administered on the same schedule as the biological measures were collected. Survey measures include: fruit and vegetable consumption, physical activity, quality of life, and access to care. Time 2 data has not yet been widely collected, but will be collected throughout Year 3 of the grant funding and reported in the next reporting period.

Process Evaluation: Progress toward HDI goals and objectives

The Brody School of Medicine's East Carolina University, Department of Family Medicine Research Division was contracted by HWTFC to evaluate HDI outcomes. Grantees are required to input their activities on a monthly basis in an online reporting database called HDI Check that was recently updated and revised for grantees' ease of use. The assessment of grantees' progress towards the goals and objectives of the Eliminating Health Disparities Initiative is conducted through an analysis of these online data submissions. Grantees reported over 3,000 events in Year 2 of grant funding. In year 2, grantees moved from "groundwork" (planning) to "action" type activities. "Action" activities in year 2 included:

- Partnering Events: building new or maintaining existing partnerships in the community to obtain HDI goals (160)
- Services Provided: providing services to the faith community (592), the general community (531) and in healthcare settings (229)
- Training: through 67 training or skill building events, grantees have reached 940 individuals, including teachers, childcare providers, and healthcare professionals
- Environmental / Policy Advocacy: recommendations to key decision-makers / groups of influence to advocate for environmental or policy level change to reduce health disparities (44 events)

- Media: grantees publicized local projects and HDI health issues through radio, newspaper, newsletters, brochures, television, and e-mail, flyers, and word-of-mouth (over 1 million brochures, e-mails, flyers and newsletters were distributed).

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 community-based grants statewide to address childhood overweight / obesity. Grant funds are used to provide intervention programs for overweight children including after school exercise programs and nutritional counseling. Grantees also focused efforts on public education and adoption of local policies that address the underlying issues. A social marketing campaign was developed to communicate effectively with minority communities, where the problem is especially acute. UNC-TV 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.

HWTFC also launched *Fit Community NC,* a grants and designation program, designed to recognize and reward municipalities and counties in their efforts to promote healthy living by providing opportunities for physical activity and healthy nutrition choices. The program has provided three phases of grants and designations across the state.

In response to the State Board of Education's resolution to require all K-8 schools to provide 30 minutes of physical activity per school day, HWTFC launched its *Fit Kids NC* effort to support the unfunded mandate. The initiative will provide in-person trainings to every K-8 teacher on how to incorporate physical activity in the classroom. It also created classroom-based activities that are available to all teachers through its www.fitkidsnc.com Web site.

In late 2003, recognizing that North Carolina was experiencing an obesity epidemic, HWTFC spearheaded the creation of a study committee for 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 2005.

- **CHILDHOOD OBESITY GRANTS**

East Carolina University Department of Family Medicine and the Pediatric Healthy Weight Research and Treatment Center conducted a two-part evaluation of the childhood obesity grants – a cohort study of children followed over three years to assess changes in body mass index (BMI) and an assessment of grantee activities and outcomes.

Cohort Study

For the first time in an HWTFC-funded initiative, a cohort of children participating in the local interventions were followed over three years to assess changes in BMI and in important nutritional factors related to obesity and unhealthy weight. The cohort study included 1,346 North Carolina children in grades K–12 (average age 9.5 years, range 4.1 – 18.6 years) who were measured at both the beginning and end of the projects.

- **At baseline**:
  - 17.2% were overweight and 26.8% were obese
  - Three in five children drank two or more sugar-sweetened drinks per day
  - Two in five children drank whole milk instead of skim
  - 83% of children ate french fries or chips daily
  - Nearly 65% ate fast food at least weekly with 24% super sizing their meal

- **At the end of the grant period**, the following changes were demonstrated in the cohort:
  - **90% of the children maintained or improved their weight classification**
    - **35% of overweight children improved their weight classification**
    - **16% of obese children improved their weight classification**
  - 62% of those who ate zero daily servings of fruit at baseline report eating at least one serving per day at final data collection
  - 57% of those who ate zero daily servings of vegetables at baseline reported eating at least one serving per day at final data collection
  - The percentage of children who did not drink soda on a typical day increased from 38.7% to 40.6% as did the percentage that did not drink sweetened beverages (14.4% to 16.4%).
  - At baseline, 32% of children drank a sweetened beverage 3 or more times on a typical day, at final data collection this decreased to 23.8%. This decrease in sweetened beverage consumption did not differ by weight status, gender or race. This is especially noteworthy in North Carolina where many children drink sweetened beverages such as sweet tea and sports drinks in addition to soda.
  - Whole milk consumption decreased from 44.9% to 40.5%.
  - Of the 472 children who reported drinking whole milk at baseline, 24.8% reported drinking reduced fat (2%), low fat (1/2% to 1%) or nonfat milk at final data collection. It is notable that the reduction was largest in the children who were classified as obese. This finding is encouraging also, in that it shows that it is possible for children to change their behavior to adopt a healthier lifestyle.

Assessment of Grantee Activities and Outcomes

The second component of the evaluation was an assessment of grantee activities and outcomes. Based on data provided by each grantee, the following programmatic indicators were achieved:

- **Grantees facilitated 447 instances of significant policy development or policy changes in areas such as physical activity, poor dietary behaviors and overweight.** Examples of policies successfully implemented by the grantees during the three-year period include:
  - Implementing the Winner's Circle Dining Program© so students could easily identify healthy food offerings
  - Passing a policy to govern school lunches, party snacks, vending and a la carte items
  - Instituting a mandatory physical activity and nutrition curriculum training for teachers
  - Requiring teachers to develop plans for how to meet the Healthy Active Children policy
  - Implementing policies related to healthy snacks for YMCA after-school programs, summer camps and events
- In addition, slightly over $1 million in direct and in-kind resources were generated to supplement and enhance local efforts beyond what was available in HWTFC funding.

In final reports to HWTFC, grantees described their key achievements:

- One third of grantees believe their key achievement was increasing awareness of childhood obesity in their local community; one fifth report it was establishing or strengthening relationships with their partners.
- Others named key products, activities or events that impacted a large number of individuals in their community or school such as the development of walking trails, providing physical activity equipment to students or creating a new wellness position.

- **FIT COMMUNITY NC**

HWTFC has invested $1.5 million in helping 24 communities become healthier places to live. The University of North Carolina's Active Living by Design has been collecting key data to help inform an evaluation of the *Fit Community NC* program. This data is organized by the following **5 P Model**, which increases the chance for project success and sustainability:

1. ***Preparation*** strategies involve setting the groundwork for successful community-wide action related to physical activity and/or healthy eating. It is important to create a partnership (if one does not already exist) with representatives from local organizations and the target population who can help identify and address current barriers to, as well as new opportunities for, increasing routine physical activity and/or healthy eating.
   - $408,000 of direct and indirect funding has been leveraged by *Fit Community NC* grantees in order to contribute and ensure the continued success of these communities.
   - Ashe County: 1) Secured a commitment from a local landowner to donate land for park. 2) Arranged survey and site plan development of Lansing Park. 3) Identified a vacant building adjacent to the park for possible public bathrooms in the future.

2. ***Promotion*** strategies should increase understanding of the benefits of routine physical activity and/or healthy eating, *and* highlight recommendations, publicize existing local opportunities, and communicate the need for additional community supports. In a well-integrated plan,

promotional tactics and activities should link with and support programs, policy, and physical project strategies.

- 13 grantees held community-wide events to publicize their programs, and physical projects and received media publicity through town newsletters, local papers, public service announcements (PSA) on the radio, and/ or through flyers that were handed out at health departments
- Graham Children's Health: Received local newspaper coverage about the "ground-breaking" of the Burnsville gym, which gave a blanket solicitation to businesses and individuals for funding contributions.
- Haywood County: Presented to 30 members of the Beaverdam Community Development Association about the planned RC Watershed Trail on October 8, 2007.
- Mecklenburg County: Conducted a successful media promotions workplace wellness campaign by earning in-kind media

3. ***Programs*** strategies are designed to provide ongoing, structured opportunities for physical activity and/or healthy eating.
   - Two grantees established community gardens in elementary school programs that encouraged healthy eating habits and fresh produce for the children and their families
   - Town of Black Mountain: Extensive community garden program that has distributed over 9,000 pounds of fresh produce
   - Sampson County: Created logistical tools such as walking logs for participants, and an incentives system

4. ***Policy*** strategies influence public decisions, such as the creation or change of regulations, guidelines, or local policies that promote routine physical activity and/or healthy eating. Examples include requiring sidewalks in all new developments, creating mixed-use zoning ordinances to put more daily trips within walking/bicycling distance, changing school policies to require more daily physical activity and healthy food options for all children, and implementing changes in worksite or church policies to promote physical activity and/or healthy eating.
   - Six grantees established worksite wellness policies with a local business, hospital or other organization in their community
   - Town of Shelby: Has a Comprehensive Pedestrian Plan that prioritizes sidewalk and greenway connections
   - Greensboro: Initiated an easement document which will allow Greensboro College to provide public access on their property for physical fitness opportunities

5. ***Physical Projects*** strategies involve changes that make the physical environment more conducive to routine physical activity and/or healthy eating. Specific tactics may include the (partial) construction of walking trails, parks or greenways; working with officials to implement traffic-calming measures such as crosswalks or roundabouts; and improving access to destinations such as grocery stores, farmers' markets, or community gardens.
   - 11 Fit Community grantees created walking trails, paths, and greenways in their communities
   - City of Greensboro: Has 89 miles of new sidewalks, over 80 miles of trails, and 20 planned trail miles in the works

- Pitt County: Has achieved an extensive parks and trails network – 85% of residents live within 2 miles of a park
- Northampton: Purchased and installed new basketball court and tennis equipment for new recreation facility.

- **FIT KIDS NC**

The Healthy Active Children Policy, created by the North Carolina State Board of Education, became mandatory during the 2006-07 school year. This unfunded policy requires several action steps from each school or school district in North Carolina, including schools to provide 30 minutes of moderate to vigorous physical activity during the school day for each K-8 student.

In May 2006, Commissioners awarded $750,000 to Be Active NC and the NC Department of Public Instruction (DPI) to provide NC elementary and middle school teachers with research-based, expert training on curriculum-support activities that meet requirements of the mandate.

- **HWTFC has trained 32,347 teachers to date and as a result has reached 808,675 students in the state (based on an average classroom size of 25 students) on how to be more physically active and live healthier lives.**
  - 48 school districts trained at least 70% of their certified teachers
  - 88 school districts participated in at least one training
  - Continuing Education Unit (CEU) credit accepted by 100 school districts

- *Fit Kids NC* Web site update (www.fitkidsnc.com):
  - Approximately 434 activities incorporating physical activity into the North Carolina Standard Course of Study (SCOS) are available on the Web site (developed through a grant to Wake Forest University)
  - Over 5000 teachers have established a *Fit Kids NC* teacher account and are using the site's resources.

- Be Active NC subcontracted with an evaluation team at UNC-Greensboro to assess the effectiveness of the *Fit Kids NC* policy-related teacher trainings. Surveys were conducted with participants at the beginning of the trainings, at the end of the training, and 30 days following the training to assess both intended and actual implementation of strategies learned. Highlights from the evaluation include:
  - **Almost all (97%) of the teachers trained intended to implement the policy to standards immediately following the training**
  - A dramatic increase in implementation of the resources introduced; a 14% increase in the number of teachers using *Fit Kids NC* activities and a 24% increase in those using Energizers. Considering that Energizers have been freely available on the internet since 2005, a 24% increase in use following training is noteworthy.
  - Additionally, students reported that participating in physical activities in the classroom is engaging and improves their mood, decreases restlessness and enhances learning during traditional instruction afterward.

- **The teacher trainings and Web site development will continue through the 2008-2009 school year in order to reach approximately 40,000 teachers; it is the largest single teacher training initiative in the history of North Carolina.**

- **FIT FAMILIES NC: A STUDY COMMITTEE FOR CHILDHOOD OBESITY**

The *Fit Families NC* Study Committee for Childhood Obesity released a report in 2005 that formed the basis for statewide policies that will be critical in North Carolina's future efforts to combat childhood obesity. Three recommendations included in the *Fit Families NC* report were taken to legislative bodies in North Carolina and resulted in statewide policy and legislation.

- In April 2005, 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.
- 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).
- 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).

The *Fit Families NC* Study Committee for Childhood Obesity continues to meet today and plans to hold its next meeting in January 2009. The study committee examines how they can support and evaluate the implementation of their recommendations, which can be found at: www.healthwellnc.com/hwtfc/pdffiles/FitFamilies-StudyCommitteeReport05.pdf .

MEDICATION ASSISTANCE PROGRAM (MAP)

Recognizing that access to prescription drugs was a critical need for all low-income North Carolinians, the Commission added value to *Senior Care* in 2002 by funding community-based organizations to use customized software to access the free drug programs run by various pharmaceutical companies. This effort was titled the Medication Assistance Program (MAP).

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". Since MAP has become such a critical part of the safety net, HWTFC has continued to fund the program over the last six years and is currently in its fourth phase of funding. MAP grantees have reached large numbers of people through community-based efforts.

- Since the program's inception, MAP grantee sites have provided over $146 million in free and low-cost medications to nearly 100,000 patients from January 2003 through June 2008.
- In the current reporting period FY 07-08:
  - **27,418 low-income individuals received medication assistance**
  - **Over $27 million in free medication was accessed for patients through approximately $1,487,844 million in grant funding**
    - **Return on investment for FY 07-08: 18:1 (**Each $1 spent resulted in $18 in free medication). This is the highest return on investment since the program's inception.

CHECKMEDS NC

In spring 2007, HWTFC selected Outcomes, Inc. – a national medication therapy management (MTM) company – to run *ChecKmeds NC*, a unique and innovative MTM program to help seniors avoid adverse reactions from 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 has contracted with the DHHS Office of Research, Demonstrations, and Rural Health Development (ORDRHD) to provide management and oversight for the program.

The *ChecKmeds NC* program was launched on October 25, 2007. In the first year of the program (8 months):

- **9,715 seniors were served**
- 18,632 claims by pharmacists for MTM services
  - 48% Comprehensive Medication Review
  - 27% Patient Education and Monitoring
  - 17% Prescriber Consultation
  - 9% Patient Compliance and Consultation

The estimated cost savings in medication-related morbidity and mortality for the *ChecKmeds NC* program is $4,991,984 in less than 9 months. This conservative estimate of costs savings translates to a 7.6:1 Return on Investment (ROI) for this initiative.

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.**

Recognizing the acute need for prescription assistance by North Carolina senior citizens, HWTFC 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.

HWTFC continued its commitment to North Carolina's needy seniors even after the launch of the Medicare Part D benefit on January 1, 2007 by creating *NCRx*, to help low-income seniors participate in the Medicare prescription drug program. The *NCRx* program has 5,085 enrollees through June 2008 with expenditures of $1.5 million for an average monthly cost per enrollee of $24.58.

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:

- 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
- 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
- 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%

TASK FORCE FOR A HEALTHIER NORTH CAROLINA

HWTFC commissioned the *Task Force for a Healthier North Carolina* in 2006 to examine and issue recommendations on three key areas that were critical to improving health care quality and access to North Carolinians. The following is a summary of the key recommendations and their current implementation status:

- **PRESCRIPTION DRUG COVERAGE FOR SENIORS**

The *Task Force* called for increased outreach efforts to individuals who were eligible for, but not enrolled in, existing assistance programs. In September 2007, the General Assembly approved $250,000 to the Seniors Health Insurance Information Program (SHIIP) to provide grants to the direct service agencies working with seniors and enrolling them into existing assistance programs (both *NCRx* and the federal low-income subsidy program).

The *Task Force* also recommended increasing the premium assistance offered in the *NCRx* program. Initially, the premium assistance amount was set at $18 per month, which was just enough to fully cover the premium amount of the least expensive plan. That plan, however,

carried a $265 annual deductible. The *NCRx* premium assistance has now been raised to $29, which fully covers several plans that offer a $0 deductible.

- **CHILDREN'S HEALTH INSURANCE**

The *Task Force* called for increased outreach and enrollment efforts for Health Check / Health Choice including strengthening the involvement of outreach coordinators, school-based clinics, hospital emergency rooms as well as working through existing programs with similar eligibility criteria. Due in part to this recommendation, outreach agencies have strengthened their focus on these entry points to help get eligible children enrolled in the programs.

The *Task Force* also recommended expanding health coverage for children in families with incomes between 200% and 300% of the federal poverty level (FPL). Many advocates had been working on the NC Kids' Care proposal to expand coverage to this population and the *Task Force* reaffirmed these efforts. The *Task Force* recommended including additional funding in order to cover the appropriate outreach and enrollment support necessary to reach newly eligible families.

Additionally, the *Task Force* recommended strengthening the process of linking children to a primary care provider through the CCNC network. A follow up report, as requested by the *Task Force*, followed up on the findings and recommendations related to the transition of children ages 0 to 5 years old from Health Choice into Medicaid and the linkage to a primary care provider. This supplemental report has been circulated among many stakeholders involved in the linkage process.

- **HEALTH INSURANCE COVERAGE FOR SMALL BUSINESS**

The *Task Force* recommended the creation of a state-wide Office of Small Business Health Insurance Partnerships (OSBHIP) to serve the major needs of small employers and employees including:

- Provide a single source of information on and portal to purchase private health plans
- Direct technical and financial assistance for small employers who wish to offer flexible and portable health insurance coverage to their employees.

The *Task Force* also recommended that OSBHIP offer information and assistance to small employers that wish to offer workplace wellness programs as well as employers that wish to offer benefits such as pre-tax deductions for health expenses, child care and dependent care.

In conjunction with the work of the *Task Force*, UNC and the NC Rural Center conducted a survey of small employers to better understand their views on health insurance and the tax credit available to small businesses that offer coverage to their employees. The survey results indicated that many small employers were unaware of the tax credit and that the current benefit level ($250 per year) was too small to encourage them to offer coverage.

HWTFC
Financial Report

HEALTH AND WELLNESS TRUST FUND COMMISSION
ANNUAL REPORT TO THE
JOINT LEGISLATIVE COMMISSION ON GOVERNMENTAL OPERATIONS
FY 07-08 FINANCIAL OBLIGATIONS AND DISBURSEMENTS

Purpose of Disbursement	Organization's Name	Category of Recipient	Cumulative Commitment	FY 07-08 Disbursements	Total Disbursements
SENIOR CARE PROGRAM					
Drug Benefit / Program Admin	DHHS Office of Rural Health	State Agency	77,808,479	-	77,808,479
PDAP Transition Drug Benefit	DHHS Office of Rural Health	State Agency	1,182,265	-	1,182,265
Program Evaluation	UNC School Public Health	State University	212,794	-	212,794
Program Evaluation	NC A&T University	State University	142,760	-	142,760
	Program Total		**79,346,298**	**-**	**79,346,297**
MEDICATION ASSISTANCE PROGRAM					
Local Program Implementation	Access East, Inc	Grantee	40,000	-	-
Local Program Implementation	Access II	Grantee	120,000	-	-
Local Program Implementation	Alamance Regional Medical Center	Grantee	377,500	-	377,500
Local Program Implementation	Albemarle Hospitial Foundation	Grantee	207,310	29,496	143,981
Local Program Implementation	Angel Medical Center	Grantee	130,000	21,629	96,896
Local Program Implementation	Appalachian Healthcare/Watauga	Grantee	130,000	27,881	98,527
Local Program Implementation	Ashe Memorial Hospital	Grantee	80,000	22,812	43,916
Local Program Implementation	Asheville-Buncombe Christian Ministry	Grantee	140,000	48,887	93,333
Local Program Implementation	Betsy Johnson Regional	Grantee	130,000	26,972	101,016
Local Program Implementation	Black River Health Services	Grantee	50,000	-	50,000
Local Program Implementation	Bladen HealthWatch	Grantee	320,768	40,077	267,549
Local Program Implementation	Boomer Medical Center	Grantee	30,000	7,653	7,653
Local Program Implementation	Brunswick Senior Services	Grantee	80,000	26,668	48,888
Local Program Implementation	Cabarrus Health Alliance	Grantee	90,000	13,200	93,886
Local Program Implementation	Cabarrus Memorial Hospital	Grantee	40,000	20,193	39,999
Local Program Implementation	Caldwell Senior Center	Grantee	256,500	23,141	226,228
Local Program Implementation	Cape Fear Council of Government AAA	Grantee	398,000	-	392,184
Local Program Implementation	Cape Fear Valley Medical	Grantee	800,000	21,488	676,014
Local Program Implementation	Carolina Family Health Centers	Grantee	749,000	51,979	694,554
Local Program Implementation	Carolinas Poison Center	Grantee	50,000	-	49,530
Local Program Implementation	Chatuga Family Practice	Grantee	80,000	15,890	40,000
Local Program Implementation	Cherokee Cnty Health Dept	Grantee	444,696		402,874
Local Program Implementation	Columbus County Dept of Aging	Grantee	80,000	25,963	49,340
Local Program Implementation	Community Care Center	Grantee	115,000	18,855	85,738
Local Program Implementation	Community Care Center of Dare	Grantee	40,000	-	-
Local Program Implementation	Community Care Clinic of Rowan Cty	Grantee	430,000	27,861	393,004
Local Program Implementation	Community Free Clinic of Cabarrus Cty	Grantee	427,500	36,469	377,441
Local Program Implementation	Cooperative Christian Ministries	Grantee	147,500	35,329	97,874
Local Program Implementation	Community Health Partners	Grantee	40,000	-	-
Local Program Implementation	Crisis Control Ministry	Grantee	332,500	26,666	301,389
Local Program Implementation	Davidson Medical Ministries	Grantee	252,500	-	252,458
Local Program Implementation	Diakonos, Inc.	Grantee	203,896	31,425	174,686
Local Program Implementation	Duplin County Services	Grantee	65,083	-	27,530
Local Program Implementation	Duplin Medical Association	Grantee	110,160	14,587	70,033
Local Program Implementation	Eastern Carolina Council AAA	Grantee	86,387	-	367,148
Local Program Implementation	FirstHealth of the Carolinas	Grantee	289,766	34,434	249,339
Local Program Implementation	Franklin County Volunteers in Health	Grantee	38,000	3,750	3,750
Local Program Implementation	Gaston Family Health Center	Grantee	347,750	26,092	317,370
Local Program Implementation	Good Samaritan Clinic	Grantee	127,500	18,590	86,461
Local Program Implementation	Greene County Council	Grantee	22,406	-	25,672
Local Program Implementation	Guilford Cnty Dept of Public Health	Grantee	793,957	36,105	751,179
Local Program Implementation	Healthquest of Union County	Grantee	132,500	8,558	61,058
Local Program Implementation	Healthreach Commuity Clinic	Grantee	40,000	-	-
Local Program Implementation	Helping Hands Clinic	Grantee	80,000	29,370	51,180
Local Program Implementation	Hertford County Public	Grantee	125,000	-	107,900
Local Program Implementation	Hyde County Health Department	Grantee	91,831	10,822	46,886
Local Program Implementation	Indian Health Care	Grantee	50,000	-	49,503
Local Program Implementation	Isothermal Planning Commission AAA	Grantee	741,521	28,448	704,020
Local Program Implementation	Kinston Community Health	Grantee	127,700	22,918	95,634
Local Program Implementation	Lenoir Memorial Hospital	Grantee	64,638	-	64,638
Local Program Implementation	Leon Mann Jr Enrichment	Grantee	62,090	-	50,202
Local Program Implementation	Lumber River Council of Government	Grantee	466,000	-	441,371
Local Program Implementation	Maria Parham Healthcare Association	Grantee	40,000	-	-
Local Program Implementation	Martin-Tyrrell-Washington District	Grantee	449,000	44,603	421,042
Local Program Implementation	MedAssist of Mecklenburg	Grantee	605,500	-	605,500
Local Program Implementation	Metropolitan Community Health Svcs	Grantee	130,000	19,236	97,971
Local Program Implementation	Mid-East Commission AAA	Grantee	516,960	49,303	516,622
Local Program Implementation	Mission Healthcare	Grantee	581,100	-	581,100
Local Program Implementation	Moore Health	Grantee	40,000	-	-
Local Program Implementation	Mt. Olive Family Medicine	Grantee	90,000	-	50,000
Local Program Implementation	NCHICA	Grantee	50,000	-	50,000
Local Program Implementation	New Hanover Health Network	Grantee	87,181	-	35,397
Local Program Implementation	Northwest Community Care	Grantee	40,000	-	-
Local Program Implementation	NC Foundation Advanced Health	Grantee	45,000	390	390
Local Program Implementation	Onslow County Senior Services	Grantee	68,389	-	38,178
Local Program Implementation	Pamlico County Senior Services	Grantee	46,939	19,694	45,985
Local Program Implementation	Pender Adult Services, Inc.	Grantee	75,000	25,375	45,741

HEALTH AND WELLNESS TRUST FUND COMMISSION
ANNUAL REPORT TO THE
JOINT LEGISLATIVE COMMISSION ON GOVERNMENTAL OPERATIONS
FY 07-08 FINANCIAL OBLIGATIONS AND DISBURSEMENTS

Purpose of Disbursement	Organization's Name	Category of Recipient	Cumulative Commitment	FY 07-08 Disbursements	Total Disbursements
Local Program Implementation	Piedmont Health Services	Grantee	276,688	12,031	264,379
Local Program Implementation	Piedmont Triad Council of Government	Grantee	45,000	-	38,222
Local Program Implementation	Pitt Council on Aging	Grantee	40,000	10,859	39,999
Local Program Implementation	Randolph County Senior	Grantee	100,000	8,422	100,000
Local Program Implementation	Resources for Seniors	Grantee	778,500	46,476	778,406
Local Program Implementation	Richmond County Health Dept	Grantee	80,000	23,500	49,500
Local Program Implementation	Roanoke Chowan Community Health Ctr	Grantee	40,000	-	-
Local Program Implementation	Rockingham County Council	Grantee	50,000	46,551	96,504
Local Program Implementation	Rockingham County Health Department	Grantee	365,000	-	256,207
Local Program Implementation	Rural Health Group	Grantee	412,200	-	368,625
Local Program Implementation	Saluda Medical Center	Grantee	87,400	17,084	47,388
Local Program Implementation	Scotland Neck Family Medical	Grantee	115,000	19,459	82,071
Local Program Implementation	Senior PHARMAssist	Grantee	210,500	-	210,500
Local Program Implementation	Senior Services of Hoke County	Grantee	39,000	5,577	18,345
Local Program Implementation	Servant's House Ministry	Grantee	40,000	-	-
Local Program Implementation	Southeastern Regional Medical Ctr	Grantee	80,000	18,913	46,019
Local Program Implementation	Stokes Family Health Center	Grantee	40,000	-	-
Local Program Implementation	Stovall Medical Center	Grantee	40,000	-	-
Local Program Implementation	Surry County Senior Services	Grantee	130,000	29,793	102,443
Local Program Implementation	The Hunger Coalition	Grantee	403,000	20,704	381,059
Local Program Implementation	Thomasville Medical Center	Grantee	126,500	33,257	88,681
Local Program Implementation	Transylvania County Vounteers in Med	Grantee	23,000	3,698	3,698
Local Program Implementation	Tri-Cnty Community Health Project.	Grantee	40,000	-	-
Local Program Implementation	UNC School of Pharmacy	Grantee	256,846	-	256,546
Local Program Implementation	Upper Coastal Plains Council	Grantee	112,500	46,070	98,570
Local Program Implementation	Urban Ministries of Wake	Grantee	130,000	23,025	93,253
Local Program Implementation	Warren County Free Clinic	Grantee	40,000	-	-
Local Program Implementation	Wayne Action Group	Grantee	238,016	35,267	208,201
Local Program Implementation	West Caldwell Health	Grantee	130,000	23,333	103,332
Local Program Implementation	Westcare Health System	Grantee	341,471	34,328	297,478
Local Program Implementation	Wilkes Regional Medical	Grantee	290,000	13,000	290,000
Local Program Implementation	Winston-Salem Urban league	Grantee	312,000	23,726	300,351
Technical Assistance Provider	DHHS Office of Rural Health	State Agency	1,545,592	-	1,545,592
Pharmacist Training	Area Health Education Centers	State University	62,344	-	62,344
Program Evaluators	A&TSU, UNC-CH and Contractor	Univ/Contract	131,770	-	131,770
	Program Total		**20,692,355**	**1,487,884**	18,094,744
					-
TEEN SMOKING PREVENTION AND CESSATION PROGRAM					-
Local Program Implementation	Alamance-Caswell Area MH/DD/SA	Grantee	508,000	91,829	336,093
Local Program Implementation	Alleghany County Schools	Grantee	393,243	48,845	241,644
Local Program Implementation	American Cancer Society	Grantee	271,026	-	240,828
Not On Tobacco Implementation	American Lung Association	Grantee	1,050,000	106,034	665,708
Local Program Implementation	ARP/Pheonix/Question Why	Grantee	561,455	72,246	561,455
Local Program Implementation	Ashe Cnty Schools	Grantee	431,640	69,199	329,216
Local Program Implementation	Blue Ridge Healthcare	Grantee	367,400	42,231	170,214
Local Program Implementation	Buncombe Cnty Schools	Grantee	659,727	105,589	487,019
Local Program Implementation	Buncombe County Health Center	Grantee	92,585	-	92,585
Local Program Implementation	Cabarrus Health Alliance	Grantee	300,000	110,438	171,548
Local Program Implementation	Cancer Services of Gaston Cnty	Grantee	500,000	56,347	381,881
Local Program Implementation	Catawba Cnty Public Health Dept	Grantee	594,000	61,328	363,782
Local Program Implementation	Center for Health & Healing, GBSC	Grantee	950,000	97,009	696,624
Local Program Implementation	Chatham Cnty Health Dept	Grantee	563,596	25,489	299,631
Local Program Implementation	Cherokee County Schools	Grantee	734,000	106,079	298,964
Local Program Implementation	Chowan Regional Health Care Found	Grantee	695,000	122,105	553,367
Local Program Implementation	Cleveland County Health Dept	Grantee	300,000	64,315	104,613
Local Program Implementation	Coastal Horizons Center	Grantee	499,076	104,788	381,118
Local Program Implementation	County of Onslow	Grantee	134,807	-	120,039
Local Program Implementation	Duplin County Health Services	Grantee	300,000	75,184	139,326
Local Program Implementation	Durham AreaCorp, Inc.	Grantee	1,064,837	195,144	1,064,837
Local Program Implementation	Durham Cnty Health Dept	Grantee	587,156	108,128	388,739
Local Program Implementation	El Pueblo	Grantee	1,088,100	127,434	825,715
Local Program Implementation	FirstHealth of the Carolinas	Grantee	580,613	61,809	393,262
Local Program Implementation	Forsyth Co Dept of Public	Grantee	334,839	51,588	207,866
Local Program Implementation	Governor's Institute	Grantee	350,000	97,319	202,104
Local Program Implementation	Greene County Health Dept	Grantee	175,000	36,938	64,510
Local Program Implementation	Guilford Cnty Dept of Public Health	Grantee	225,013	23,869	23,869
Local Program Implementation	Halifax County Schools	Grantee	592,080	83,206	434,813
Local Program Implementation	Haliwa-Saponi Indian Tribe	Grantee	210,000	61,637	102,836
Local Program Implementation	Haywood County Health Dept NCSTEP	Grantee	784,500	122,566	539,425
Local Program Implementation	Haywood County Health Dept (ASSIST)	Grantee	500,000	72,142	250,590
Local Program Implementation	Healthy Caldwellians	Grantee	483,568	79,913	327,080
Local Program Implementation	Hertford CountyHealth Dept	Grantee	498,307	60,055	289,682
Local Program Implementation	Lenoir County Health Dept	Grantee	300,000	16,691	43,097
Local Program Implementation	Lumbee Nation Tribal	Grantee	500,000	87,398	277,391
Local Program Implementation	Macon Cnty Public Health Center	Grantee	303,366	48,147	224,038

HEALTH AND WELLNESS TRUST FUND COMMISSION
ANNUAL REPORT TO THE
JOINT LEGISLATIVE COMMISSION ON GOVERNMENTAL OPERATIONS
FY 07-08 FINANCIAL OBLIGATIONS AND DISBURSEMENTS

Purpose of Disbursement	Organization's Name	Category of Recipient	Cumulative Commitment	FY 07-08 Disbursements	Total Disbursements
Local Program Implementation	McDowell Cnty Schools	Grantee	590,000	84,350	425,681
Local Program Implementation	Mecklenburg Cnty Health Dept	Grantee	600,000	76,542	430,782
Local Program Implementation	Mitchell Cnty Schools	Grantee	578,750	58,569	347,991
Local Program Implementation	Moses Cone Wesley Long	Grantee	551,400	84,188	551,400
Local Program Implementation	N.C. Amateur Sports	Grantee	285,000	-	217,633
Local Program Implementation	NC Commission of Indian Affairs	Grantee	875,000	150,702	634,291
Local Program Implementation	Nash County Health Dept	Grantee	230,000	52,123	94,482
Local Program Implementation	Old North State Medical Society	Grantee	1,085,000	102,946	977,516
Local Program Implementation	Orange Cnty Health Dept	Grantee	521,848	57,494	292,648
Local Program Implementation	Partnership for Health	Grantee	300,000	82,739	155,692
Local Program Implementation	Public Schools of Robeson Cnty	Grantee	283,500		208,059
Local Program Implementation	Rowan Cnty Health Dept	Grantee	723,198	81,344	440,725
Local Program Implementation	SAVE of NC GASP	Grantee	660,000	117,619	557,244
Local Program Implementation	Surry Cnty Health and Nutrition Center	Grantee	528,346	77,807	377,541
Local Program Implementation	Toe River Health District	Grantee	169,000	51,361	90,866
Local Program Implementation	Tri-Cnty Community Health Project.	Grantee	170,103	-	170,103
Local Program Implementation	UNC-NC Institute for Public Health	Grantee	1,945,904	97,369	915,747
Local Program Implementation	Union Cnty Public Schools	Grantee	859,232	142,685	678,390
Local Program Implementation	Vance County Schools	Grantee	300,000	71,285	115,732
Local Program Implementation	Watauga Cnty Schools	Grantee	596,000	86,064	463,509
Local Program Implementation	Wilkes County Schools	Grantee	408,104	69,477	244,875
Local Program Implementation	Wilmington Health Access for Teens	Grantee	888,372	348,204	1,624,667
Local Program Implementation	Youth Empowered Solutions	Grantee	831,178	202,056	202,056
100% TFS Mini Grant					-
Tobacco-Free Schools	Buncombe County Public Schools	Grantee	5,000	-	5,000
Tobacco-Free Schools	Butler Dream Team	Grantee	5,000	-	4,994
Tobacco-Free Schools	Catawba County Schools	Grantee	5,000	-	5,000
Tobacco-Free Schools	Cancer Services of Gaston Cnty	Grantee	5,000	-	5,000
Tobacco-Free Schools	Cherokee County Schools	Grantee	5,000	-	810
Tobacco-Free Schools	Clay County Schools	Grantee	4,000	-	3,933
Tobacco-Free Schools	Durham County Health Dept	Grantee	5,000	-	4,986
Tobacco-Free Schools	Jones County Health Dept	Grantee	3,492	-	2,401
Tobacco-Free Schools	Mitchell Cnty Schools	Grantee	5,000	-	740
Tobacco-Free Schools	Robeson County Dept of P	Grantee	5,000	-	3,097
Tobacco-Free Schools	Southwest High School(Onslow Co)	Grantee	4,074	-	4,074
Tobacco-Free Schools	Tyrrell County Public Schools	Grantee	5,000	-	5,000
Tobacco-Free Schools	Union Cnty Public Schools	Grantee	3,900	-	3,900
Technical Assistance Provider	NC Prevention Partners	Contractor	52,000	-	-
NC Quitline	DHHS Tobacco Prevent/Control	State Agency	4,500,000	829,671	1,488,306
Technical Assistance Provider	DHHS Tobacco Prevent/Control	State Agency	1,511,523	514,437	2,101,146
Technical Assistance Provider	DHHS Minority Health	State Agency	225,000	-	171,569
Tobacco Sales Law Enforcement	DHHS Substance Abuse Section	State Agency	3,500,000	527,487	2,416,354
Pregnant Teen Cessation	DHHS Women/Children Health	State Agency	300,000	-	328,705
Program Evaluation	UNC School of Family Medicine	State University	2,950,000	495,945	2,524,128
Technical Assistance Provider	UNCCH School of Public Health	Contractor	$530,000.00	-	522,151
Technical Assistance Provider	UNCCH-School of Medicine EnTER	Contractor	$47,783.20	102,902	150,686
Media Campaign	Vendors awarded through bids	Contractors	7,822,450	7,709,520	18,369,928
Misc Program Expenses	Signage and Printing, Travel	Contracts	69,633	16,766	103,918
Salary/Benefits	Program Specific Personnel	Employee	1,640,834	436,295	863,109
	Program Total		**54,031,724**	**15,420,986**	51,602,070
					-
COLLEGE TOBACCO USE PREVENTION AND CESSATION PROGRAM					-
Local Program Implementation	Alamance Community College	Grantee	$74,967.00	9,562	9,562
Local Program Implementation	Albemarle Regional Health Services	Grantee	$289,960.00	34,171	145,267
Local Program Implementation	American Lung Association	Grantee	$38,500.00	4,086	15,145
Local Program Implementation	Appalachian State University	Grantee	$75,000.00	3,016	3,016
Local Program Implementation	Asheville-Buncombe Tech Com College	Grantee	$80,000.00	15,314	28,115
Local Program Implementation	Caldwell Commmunity College	Grantee	$40,000.00	9,530	32,219
Local Program Implementation	Cleveland Community College	Grantee	$40,000.00	10,838	24,593
Local Program Implementation	East Carolina University	Grantee	$149,930.00	34,905	74,402
Local Program Implementation	Elizabeth City State University	Grantee	$39,996.00	6,520	6,520
Local Program Implementation	Fayetteville State University	Grantee	$40,000.00	-	6,460
Local Program Implementation	First Health of the Carolinas	Grantee	$75,000.00	1,129	1,129
Local Program Implementation	Guilford County Dept of Public Health	Grantee	$275,000.00	22,203	22,203
Local Program Implementation	Lenoir County Health Department	Grantee	$40,000.00	169	2,144
Local Program Implementation	Mecklenburg County Health Department	Grantee	$475,000.00	99,960	226,091
Local Program Implementation	Montreat College	Grantee	$74,755.00	12,735	12,735
Local Program Implementation	Moses Cone Wesley Long Foundation	Grantee	$61,310.00	44,829	50,961
Local Program Implementation	NC A&T State University	Grantee	$80,000.00	23,022	34,533
Local Program Implementation	NC Central University	Grantee	$164,153.00	53,260	125,692
Local Program Implementation	Pitt Community College	Grantee	$67,846.00	10,378	10,378
Local Program Implementation	Rowan Cabarrus Community College	Grantee	$45,000.00	2,392	2,392
Local Program Implementation	SAVE of NC GASP	Grantee	$80,000.00	3,825	37,672
Local Program Implementation	Surry County Health & Nutrition Center	Grantee	$112,750.00	13,551	33,558
Local Program Implementation	UNC Chapel-Hill	Grantee	$120,000.00	16,935	63,487

HEALTH AND WELLNESS TRUST FUND COMMISSION
ANNUAL REPORT TO THE
JOINT LEGISLATIVE COMMISSION ON GOVERNMENTAL OPERATIONS
FY 07-08 FINANCIAL OBLIGATIONS AND DISBURSEMENTS

Purpose of Disbursement	Organization's Name	Category of Recipient	Cumulative Commitment	FY 07-08 Disbursements	Total Disbursements
Local Program Implementation	UNC Pembroke	Grantee	$114,290.00	25,633	34,906
Local Program Implementation	UNC Wilmington	Grantee	$75,243.00	11,645	28,652
Local Program Implementation	Wake Tech Community College	Grantee	$75,000.00	1,965	1,965
Local Program Implementation	Western Piedmont Community College	Grantee	$75,000.00	24	24
Local Program Implementation	Wilkes Community College	Grantee	$155,000.00	48,253	95,087
Local Program Implementation	Wilson Technical Community College	Grantee	$60,000.00	19,388	36,779
Salary/Benefits/Admin	Program Specific Personnel	Employee	$59,914.00	6,519	59,914
Technical Assistance Provider	UNCCH-School of Medicine EnTER	Contractor	$359,717.00	25,622	173,711
	Program Total		**3,438,364**	**571,380**	1,399,310
					-
***FitTogether* (Child/Community Obesity Prevention)**					-
Local Program Implementation	Albemarle Regional Health	Grantee	450,000	42,556	364,450
Local Program Implementation	Ashe Memorial Hospital	Grantee	56,012	31,383	50,859
Local Program Implementation	Avery County Schools	Grantee	204,827	53,539	204,151
Local Program Implementation	Be Active North Carolina, Inc.	Grantee	330,796	25,994	306,968
Teacher Training Grant	Be Active North Carolina, Inc.	Grantee	875,270	198,820	669,870
Local Program Implementation	Caswell County Health Department	Grantee	60,000	-	-
Local Program Implementation	Children First of Buncombe County	Grantee	434,283	(4,083)	430,200
Local Program Implementation	City of Burlington	Grantee	54,000	-	-
Local Program Implementation	City of Graham	Grantee	59,900	4,306	30,575
Local Program Implementation	City of Greensboro	Grantee	60,000	3,500	3,500
Local Program Implementation	City of Shelby	Grantee	56,000	2,879	2,879
Local Program Implementation	Cleveland County Health	Grantee	450,000	86,989	413,501
Local Program Implementation	Cumberland County Schools	Grantee	445,096	118,468	432,227
Local Program Implementation	Duplin Partnres for Health	Grantee	60,000	22,521	40,512
Local Program Implementation	Durham Public Schools	Grantee	441,945	-	416,399
Local Program Implementation	FirstHealth of the Carolinas	Grantee	446,436	36,671	412,224
Local Program Implementation	FirstHealth of the Carolinas	Grantee	57,000	-	-
Local Program Implementation	Foundation for the Carolinas	Grantee	22,451	22,451	22,451
Local Program Implementation	Goldsboro Family YMCA	Grantee	450,000	27,862	344,452
Local Program Implementation	Graham's Childrens Health	Grantee	60,000	19,677	19,677
Local Program Implementation	Halifax County Health Dept	Grantee	236,362	34,730	231,031
Local Program Implementation	Haywood County Health Dept	Grantee	60,000	-	30,000
Local Program Implementation	Heartworks	Grantee	59,975	15,327	31,409
Local Program Implementation	Lumberton Parks and Recreation	Grantee	60,000	-	10,946
Local Program Implementation	Mecklenburg County Health Dept	Grantee	450,000	69,094	452,809
Local Program Implementation	Mecklenburg County Health Dept	Grantee	60,000	24,966	40,281
Local Program Implementation	Mitchell County Schools	Grantee	245,179	(6,147)	235,051
Local Program Implementation	NC Academy of Family Physicians	Grantee	417,678	82,179	412,226
Local Program Implementation	New Life Women's Leadership Project	Grantee	337,082	3,042	340,124
Local Program Implementation	NC Division of Public Health	Grantee	371,032	6,811	295,072
Local Program Implementation	Northampton County Health Depart	Grantee	58,480	27,948	27,948
Local Program Implementation	Orange County Partnership	Grantee	51,300	17,533	17,533
Local Program Implementation	Partnership for Health, Inc.	Grantee	442,245	(23,943)	359,010
Local Program Implementation	Person County Schools	Grantee	450,000	28	404,537
Local Program Implementation	Pitt County Schools	Grantee	449,028	49,868	439,487
Local Program Implementation	Pitt County	Grantee	54,000	-	-
Local Program Implementation	Sampson County Parks & Recreation	Grantee	60,000	17,697	25,197
Local Program Implementation	Stokes-Reynolds Memorial Hospital	Grantee	60,000	10,389	10,389
Local Program Implementation	Southeastern Regional Medical Center	Grantee	450,000	7,102	445,524
Local Program Implementation	Town of Black Mountain	Grantee	58,592	16,111	16,111
Local Program Implementation	Town of Edenton	Grantee	60,000	-	-
Local Program Implementation	Town of Faison	Grantee	60,000	-	-
Local Program Implementation	Town of Salisbury	Grantee	60,000	-	-
Local Program Implementation	Town of Spring Lake	Grantee	60,000	7,500	7,500
Local Program Implementation	UNC-TV	Grantee	449,970	49,929	359,341
Local Program Implementation	Wake Forest University School of Med	Grantee	450,000	18,719	467,072
Program Development/Testing Fit	Wake Forest University School of Med	Grantee	420,000	239,621	366,736
Local Program Implementation	Yadkin-Pee Dee Lakes Project	Grantee	54,000	-	-
Technical Assistance Provider	Duke University Div of Comm Health	Contractor	805,000	123,529	946,546
Program Evaluation	ECU Brody School of Medicine	State University	414,500	83,641	489,928
Fit Together Best Practices	ECU Brody School of Medicine	State University	35,000	-	28,407
FitTogether Website Content	NC Academy of Family Physicians	Contractor	174,000	-	166,299
Local Program Implementation	NC Alliance for Healthy Communities	Grantee	17,000	-	7,000
Interactive Diagnostic Database	Profile Health	Contractor	81,000	-	81,000
Media	The Stone Agency	Contractor	710,000	-	705,136
Signage	DOC Enterprise	State Agecny	60,000	8,484	8,484
Interactive Communication	Market Smart Advertising	Contractor	1,500,000	346,059	541,419
Energizers for Fit Together	NC Department of Public Instruction	Contractor	40,000	-	40,000
Technical Assist/Fit Communities	Active Living By Design	Contractor	300,000	165,431	353,016
Obesitee Study Committee	Committee of NC Obesity Experts	Committee	300,000	50,662	238,399
	Program Total		**15,555,439**	**2,139,845**	12,795,864
					-
HEALTH DISPARITIES					-
Local Program Implementation	Sisters Network	Grantee	$66,000	-	65,815

HEALTH AND WELLNESS TRUST FUND COMMISSION
ANNUAL REPORT TO THE
JOINT LEGISLATIVE COMMISSION ON GOVERNMENTAL OPERATIONS
FY 07-08 FINANCIAL OBLIGATIONS AND DISBURSEMENTS

Purpose of Disbursement	Organization's Name	Category of Recipient	Cumulative Commitment	FY 07-08 Disbursements	Total Disbursements
Local Program Implementation	ACESS III of Lower Cape Fear	Grantee	$390,000	112,677	250,597
Local Program Implementation	American Indian Mothers	Grantee	$120,632	43,150	120,632
Local Program Implementation	Buncombe County Medical Society	Grantee	$360,000	128,724	203,901
Local Program Implementation	Charlotte Communities of Shalom	Grantee	$360,000	138,290	257,830
Local Program Implementation	Chatham Hospital Immigrant Health	Grantee	$360,000	112,221	211,839
Local Program Implementation	Cleveland County Health Department	Grantee	$360,000	108,021	163,182
Local Program Implementation	Cornerstone Ministries, Inc	Grantee	$360,000	136,264	236,707
Local Program Implementation	Dare County Dept of Health	Grantee	$330,000	91,006	168,807
Local Program Implementation	Elizabeth City State Univeristy	Grantee	$400,000	88,785	123,630
Local Program Implementation	Fayetteville State University	Grantee	$390,000	-	-
Local Program Implementation	Forsyth Medical Center	Grantee	$425,000	128,961	166,956
Local Program Implementation	GBO Partnership for Children, Inc	Grantee	$330,000	93,106	204,786
Local Program Implementation	Greene County Health Care, Inc.	Grantee	$360,000	105,334	207,271
Local Program Implementation	Haliwa-Saponi Indian Tribe	Grantee	$18,750	967	967
Local Program Implementation	Hertford County Public Health Authority	Grantee	$800,000	262,834	443,758
Local Program Implementation	Johnston County Health Department	Grantee	$18,750	5,359	5,359
Local Program Implementation	Lee County Health Department	Grantee	$18,750	-	-
Local Program Implementation	Lincoln Community Health Clinic	Grantee	$360,000	105,769	157,270
Local Program Implementation	NC Academy of Family Physicians	Grantee	$360,000	99,176	157,453
Local Program Implementation	NC A& T Univeristy	Grantee	$360,000	55,010	131,625
Local Program Implementation	NCAAHPERD	Grantee	$400,000	178,330	273,432
Local Program Implementation	Roanoke Chowan Community Health	Grantee	$435,000	95,911	309,233
Local Program Implementation	Robeson County Health Department	Grantee	$660,000	219,822	356,931
Local Program Implementation	Robeson Health Care Corp	Grantee	$326,699	24,189	24,189
Local Program Implementation	Rural Health Group, Inc	Grantee	$360,000	133,120	198,600
Local Program Implementation	Shaw University	Grantee	$500,000	89,666	196,236
Local Program Implementation	Strengthening the Black Family, Inc	Grantee	$360,000	111,783	215,689
Local Program Implementation	Vance County Health Dept	Grantee	$18,750	23	17,240
Local Program Implementation	Wake County Human Services-	Grantee	$390,000	116,105	197,831
Local Program Implementation	Zara Betterment Corp	Grantee	$289,896	44,354	44,354
Media Campaign	Ballen Media	Contractor	$1,500,000	178,115	178,115
Salary/Benefits/Support	Program Specific Personnel	Employee	$537,116	50,713	270,242
Program Evaluation	East Carolina University	State University	$303,764	40,183	40,183
Technical Assistance Provider	NC Central University	State University	$731,844	239,276	487,152
	Program Total		**13,360,951**	**3,337,242**	6,087,812
					-
Debt Service per H1264	Debt Service on Capital Projects at Universities/Juvenile Facilities per H1264 passed in 03-04 Legislative session	NC General Fund	**-**	**6,353,724**	11,149,508
					-
Study Committees	UNC-CH	State University	**349,262**	**155,557**	307,286
					-
NCRx Premium Assistance	DHHS Office of Rural Health	State Agency		**1,500,000**	**1,500,000**
					-
CheckMedsNC	DHHS Office of Rural Health	State Agency		**483,721**	**483,721**
					-
Governor's Quality Initative	Foundation for Advanced Health	Grantee		**99,818**	**99,818**
					-
ADMINISTRATIVE COSTS					-
Commission operating costs				**742,682**	4,689,457
MSA Legal Services				**87,461**	167,528
TOTAL DISBURSEMENTS FY 06-07				**32,380,300**	**187,623,597**

HWTFC
Media

HWTFC Public Education Campaigns FY08

Tobacco.Reality.Unfiltered (TRU) Prevention Media Campaigns

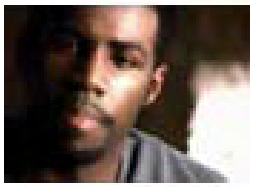
TRU Stories

The North Carolina Health and Wellness Trust Fund Commission (HWTFC) is committed to dissuading our state's youth from using tobacco products through its tobacco use prevention campaign, *Tobacco.Reality.Unfiltered* (TRU), in operation since 2003. HWTFC has achieved a high level of awareness of the TRU campaign (71% in 2007) and contributed to a dramatic reduction in youth tobacco use in North Carolina. When the HWTFC program began, the teen smoking rate was 27%, according to the state's 2003 Youth Tobacco Survey (YTS), and is now at an historic low of 19% (2007 YTS).

While progress is evident, continued efforts are critical to sustain the decline in tobacco use since new youth enter into the 12 to 17 year old target age group every year, and the decision to remain tobacco free needs to be repeatedly reinforced.

Television Ads

The HWTFC youth tobacco prevention ads aired during FY07-08 were "Anna" and "Jacobi" – ads featuring real people (not actors) who both share true stories of how their family members have experienced devastating health effects from tobacco use. HWTFC's evidence-based communications strategy of using testimonials that focus on tobacco's serious health consequences was further supported in a monograph recently released by the National Cancer Institute, *The Role of the Media in Promoting and Reducing Tobacco Use* (NCI Tobacco Control Monograph #19, NIH, US DHHS, June 2008), which noted that "numerous studies have shown consistently that advertising carrying strong negative messages about health consequences performs better in affecting target audience appraisals."



This strategic direction has been working effectively in our state, and HWTFC will continue to use this approach in FY08-09 by introducing the moving story of Reena, a 29-year-old single mother from Asheville, NC. Reena started smoking at 13, was diagnosed with throat cancer at 21, and had to have her voice box removed in order to survive.

HWTFC Public Education Campaigns FY08

Campaign Impact

Below are some highlights from the 2007 TRU media campaign, according to the UNC School of Family Medicine Tobacco Prevention and Evaluation Program (TPEP), the program's outcomes evaluator:

- Youth awareness of the TRU campaign increased by nearly one-third from 2006 to 2007.
  - Awareness of the campaign rose from 54% in 2006 to 71% in 2007.
  - Over 500,000 youth (11-17) in NC have seen and are aware of the NC TRU campaign.
- Awareness of TRU campaign brands and slogans rose substantially from 2006 to 2007.
  - Youth awareness of the TRU brand rose from 42% to 58%
  - Youth awareness of the TRU slogan increased from 48% to 55%
- NC youth responded positively to the ads run in 2007.
  - More than 95% of NC youth who had seen the 2007 ads reported that they were convincing, attention-grabbing, and gave good reasons not to use tobacco.
  - Over 25% of NC youth reported that they talked to their friends about the ads, indicating high "chat value".
- Anti-tobacco and pro-health attitudes among NC youth have remained stable and strong.
  - Over 90% of NC youth did not believe that young people who smoke cigarettes had more friends, that smoking cigarettes made youth look cool or fit in, or that smoking made youth look attractive.
- The majority of youth continue to be exposed to cigarette advertising and believe that cigarette ads portray smoking as acceptable or "cool".
- Most youth support tobacco-free policies in places they frequent, including schools, indoor places such as restaurants, and outdoor areas such as parks.
- The Youth Tobacco Survey data showed that awareness of the TRU ads and brand remains high among North Carolina youth: 84.7% of middle school students and 88.8% of high school students reported having seen ads that were part of the TRU campaign. In addition, 54.6% of middle school students and 62.5% of high school

students reported seeing television ads with the TRU brand at least once during the previous month.

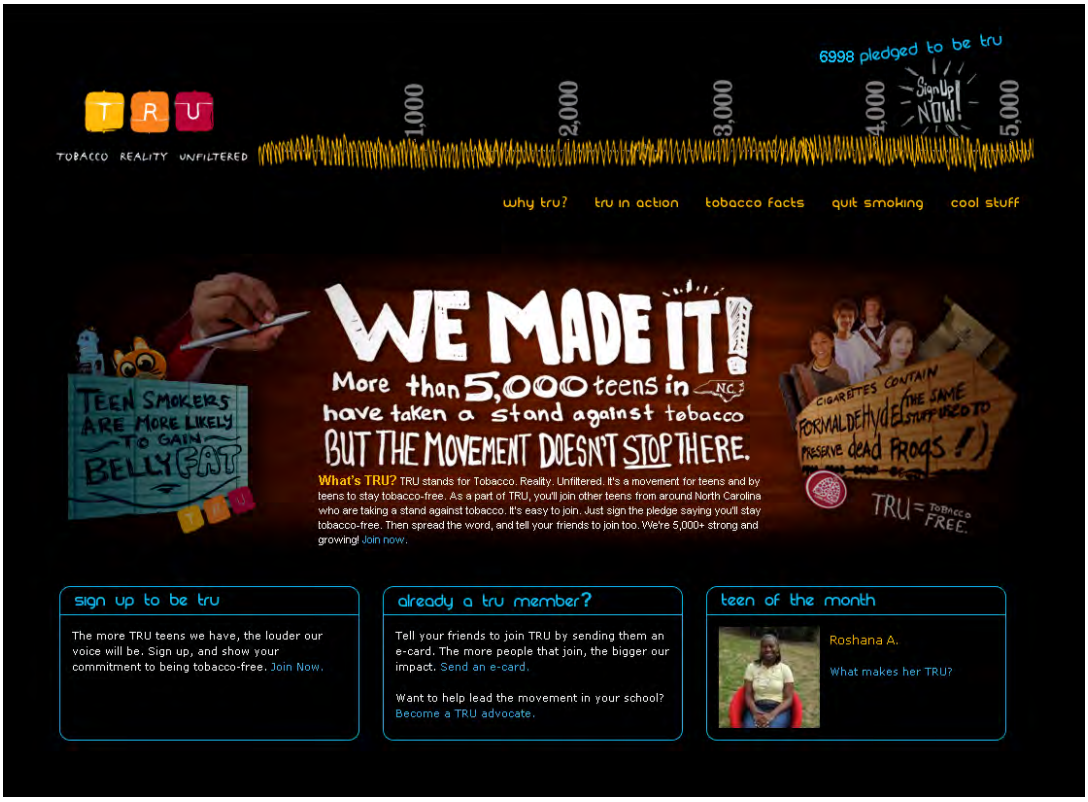
- More than 6,000 teens across the state have visited the TRU Web site and signed the pledge to be tobacco-free.

A detailed report of the outcomes of this media campaign is included in this report.

TRU Recruitment Campaign

Another effective strategy for youth tobacco prevention is to engage youth in prevention activities. According to the Centers for Disease Control guidebook, *Designing and Implementing an Effective Tobacco Counter-Marketing Campaign*, youth who are involved in tobacco prevention activities "are less likely to smoke or chew tobacco themselves" and are more likely to urge their friends to quit. This type of peer-to-peer influence makes a powerful contribution to prevention efforts.

In September 2007, HWTFC announced the recruitment campaign goal for the 2007-2008 school year -- to get 5,000 NC teens to pledge to be tobacco free. The home page of the TRU Web site (www.realityunfiltered.com) tracked the pledges so that grantees and youth could gauge the campaign's progress.



The TRU Web site was also redesigned to further engage TRU youth and to provide interactive education to youth who were just discovering TRU for the first time. Through the revamped Web site, TRU youth are now able to send an e-card to their friends encouraging them to visit the Web site and to join the TRU movement. Games like

"TRU Quiz" and "Whack a Pack" educate youth about tobacco in an entertaining way that also encourages them to tell others about the Web site. Youth can also view the prevention ads that aired during the year.

In order to facilitate grantees' efforts to recruit new youth and encourage more NC teens to pledge to be tobacco free, grantees were supplied with resources through an online toolkit. Pledge forms, badges, web images, web banners, and bookmarks were made available to grantees along with numerous TRU-branded items that could be purchased through an online store. Grantees' efforts accounted for much of the recruitment campaign success.

In order to expand interest in the TRU youth movement and to get more NC youth to take the pledge to remain tobacco free, HWTF sponsored a "Teen of the Month" contest beginning in February 2008 where NC teens submitted entries in a variety of formats (e.g., essays, poems, song lyrics) that addressed why they chose to avoid tobacco.

Throughout the spring of 2008, winners were featured in their own TV ads as well as on the TRU Web site (www.realityunfiltered.com).

Cody Tobacco Creed

To smoking, I say, no!
Snuff and pipes, I say go!
I wish my life simply to be;
Clear of lungs, tobacco free!

No smelly breath when morning comes;
No cancer cells, but clean clear lungs!
Demolishing coughs, yellowing teeth and such;
Visiting doctors and dentists, too much!

Today, I solemnly make this decree;
The oath to self, to others, to **me.**
I hereby avow with mind, soul, and heart;
That **tobacco products** and I will remain apart.

For years to come in my future plan;
I shall keep this vow before God and Man.

To smoking, I say, no!
Snuff and pipes, I say go!
I wish my life simply to be;
Clear of lungs, tobacco free!

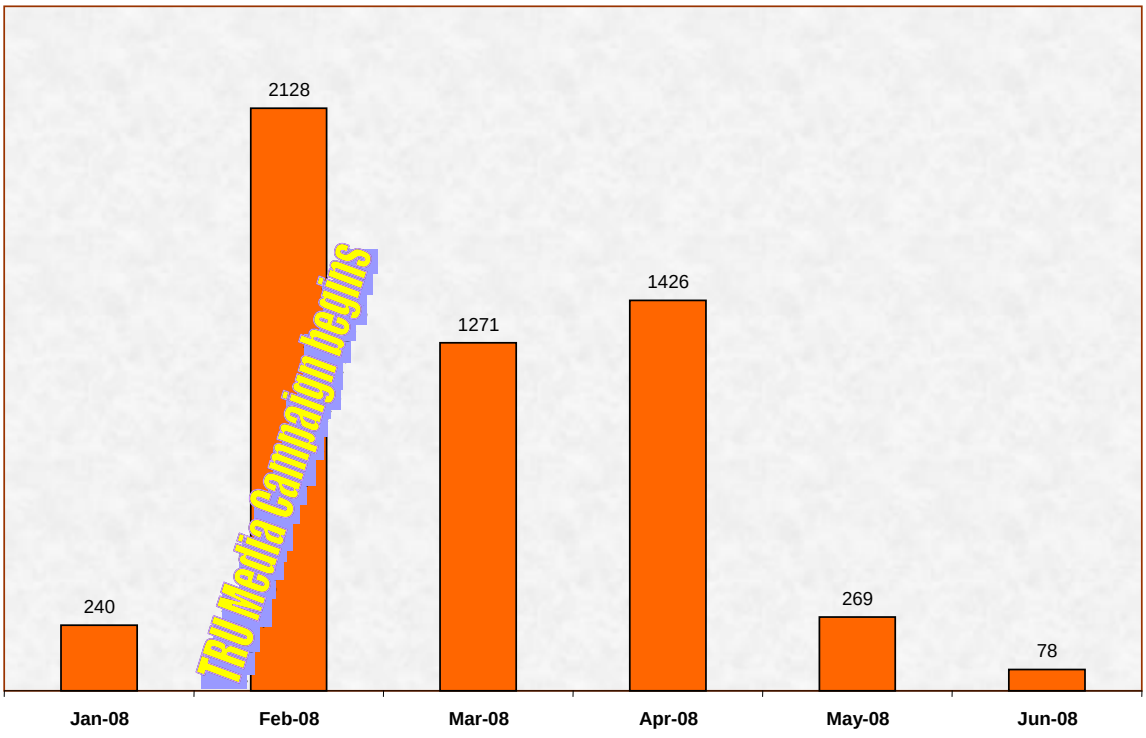
Campaign Impact

The goal for the recruitment campaign was, by the end of the 2007-2008 school year, to get 5,000 NC teens to pledge to stay tobacco free. The campaign, in combination with the impressive efforts of TRU grantees working in their communities, resulted in achieving the goal two months ahead of schedule, with well over 6,000 having taken the pledge to date.

Another indicator of the impact of both types of prevention campaigns is hits to the TRU Web site. The table below demonstrates the impact of the campaigns on web hits. In January, no ads were running until the 28th of the month when the “Anna” and “Jacody” ads began airing. The first Teen of the Month ad began airing during February as well, likely accounting for some of the increase in web hits.

HWTFC Public Education Campaigns FY08

TRU Website Hits



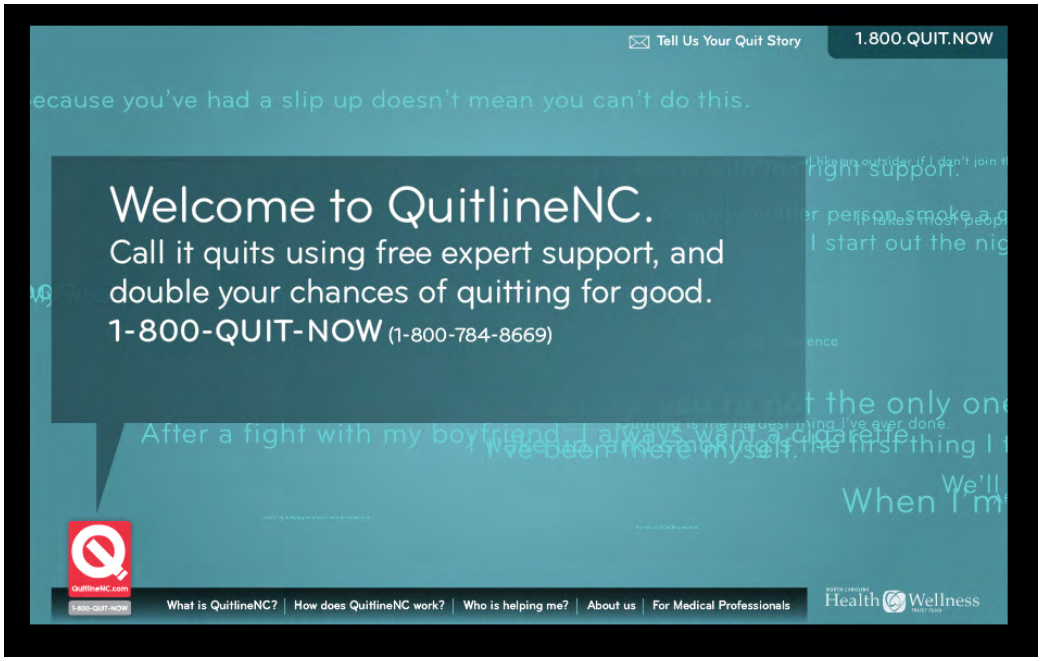
HWTFC Public Education Campaigns FY08

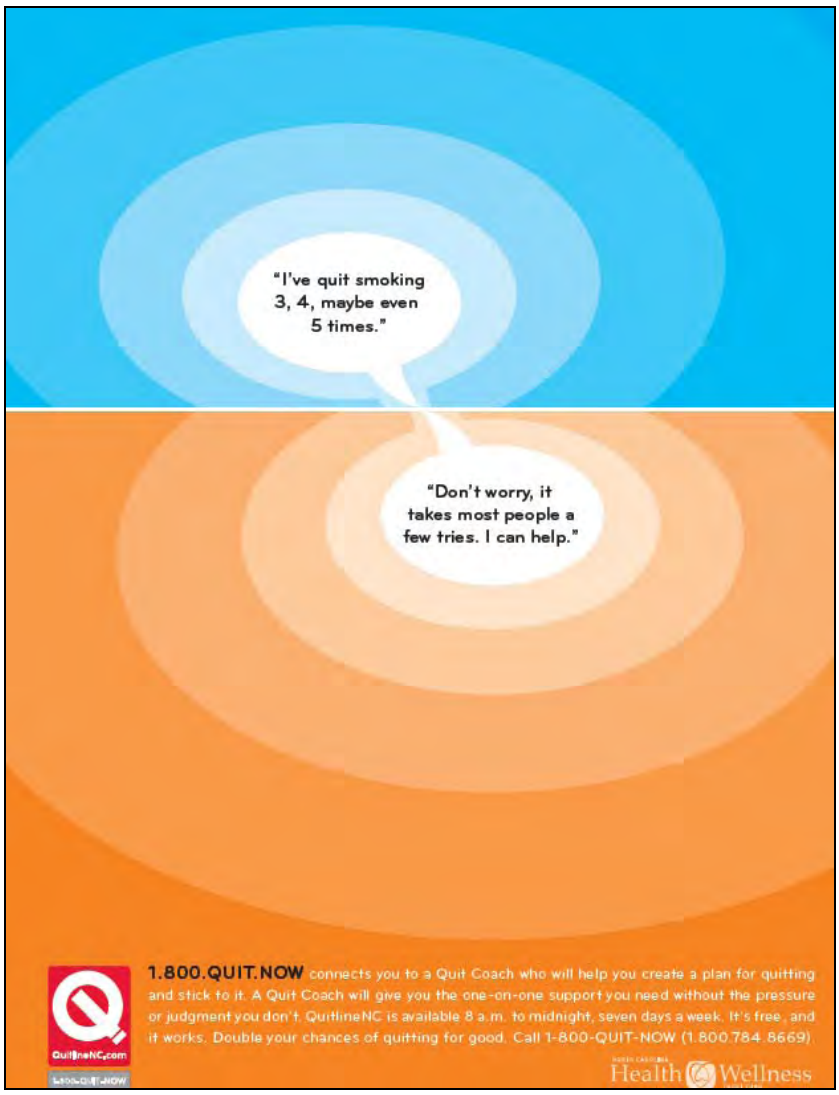
Quitline NC Promotion Campaign

On September 10, 2007, the HWTFC launched North Carolina's first ever multi-media advertising campaign to promote Quitline NC to 18-24 year olds. The smoking prevalence among young adults is the highest of any age group in the state. According to the CDC, nearly 28 percent of 18 to 24 year-olds in North Carolina smoke – and more than half have tried to quit in the past year.

The new "Call it Quits" campaign combined TV, radio, print and interactive components. The campaign provided smokers with an inside look at how Quitline NC works by simulating a call between a smoker and a Quitline quit coach. The Web site (www.quitlinenc.com) was designed to encourage youth and young adults to call QuitlineNC (1-800-QUIT-NOW) by emphasizing the efficacy of the service and providing a better understanding of how the service works and who would be providing the quit "coaching."

Demystifying the quitline, and highlighting the fact that using quitline services can "double your chances of quitting for good" are well-established communication strategies for quitline promotion, as is the acknowledgement that quitting is difficult, and that it may take multiple quit attempts before being able to quit for good. These strategies were successfully employed in HWTFC's campaign materials.

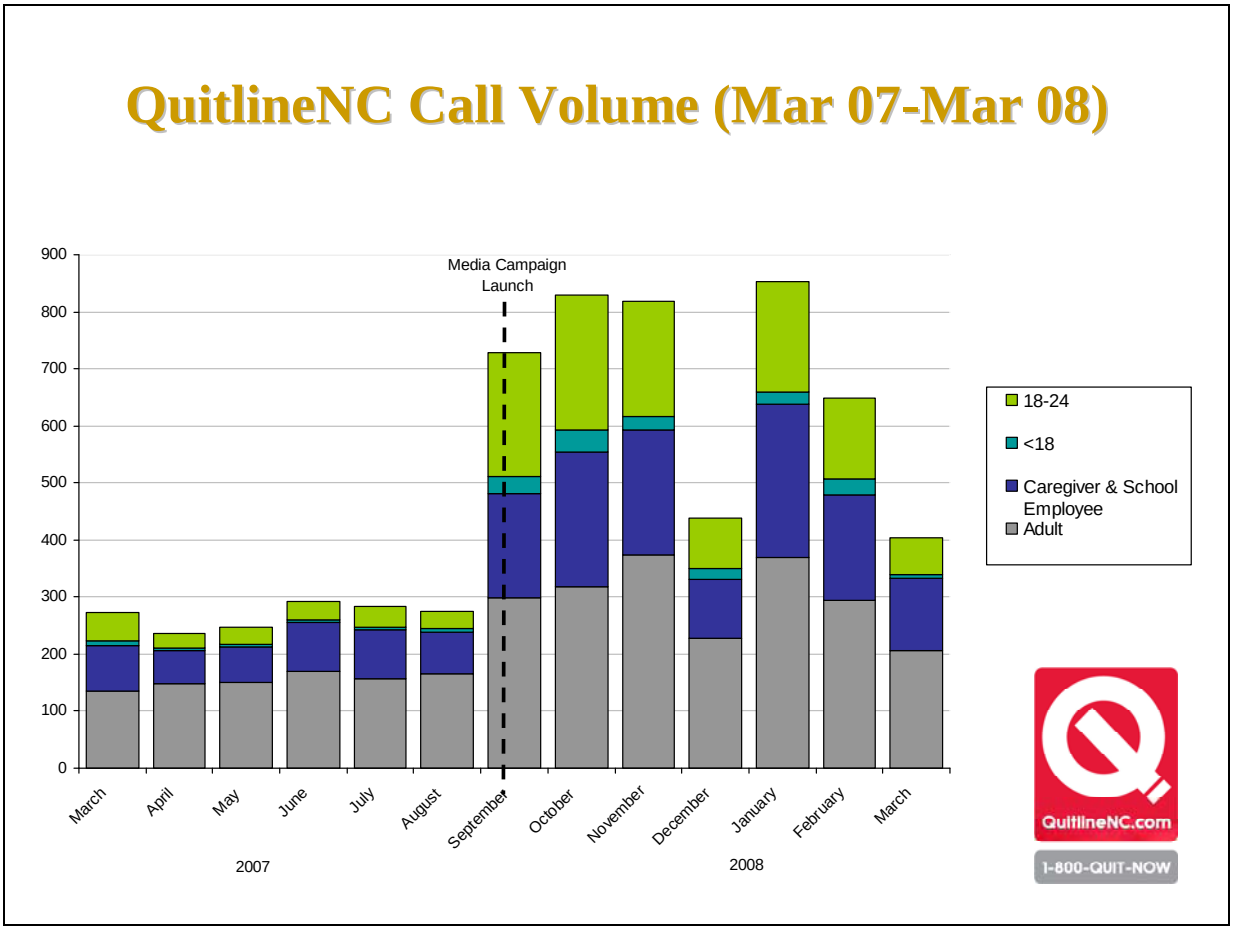




Campaign Impact

During the first two months of the "Call It Quits" campaign, QuitlineNC received a record number of calls from NC young adults. In the six months preceding the campaign, the monthly average number of young adult registrants for quitline services was 34; that number rose nearly sevenfold during the campaign months, to an average of 228 young adult registrants per month.

The monthly average number of QuitlineNC callers increased 69% in one year, from 262 in 2006 to 442 in 2007. By April 2008, QuitlineNC had nearly 14,000 registered callers.

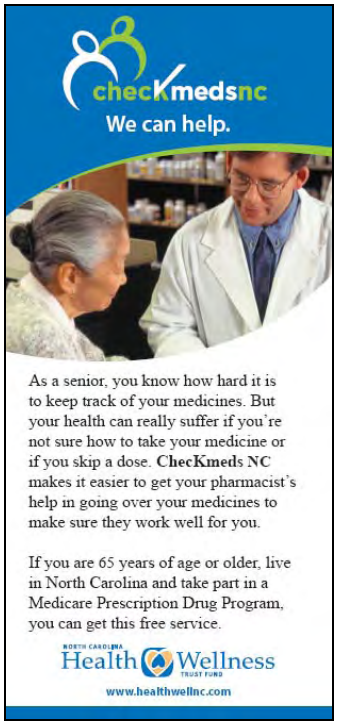

QuitlineNC Call Volume (Mar 07-Mar 08)
900
800
700
600
500
400
300
200
100
0
Media Campaign Launch
March
April
May
June
July
August
September
October
November
December
January
February
March
2007
2008
18-24
<18
Caregiver & School Employee
Adult
QuitlineNC.com
1-800-QUIT-NOW

HWTFC Public Education Campaigns FY08

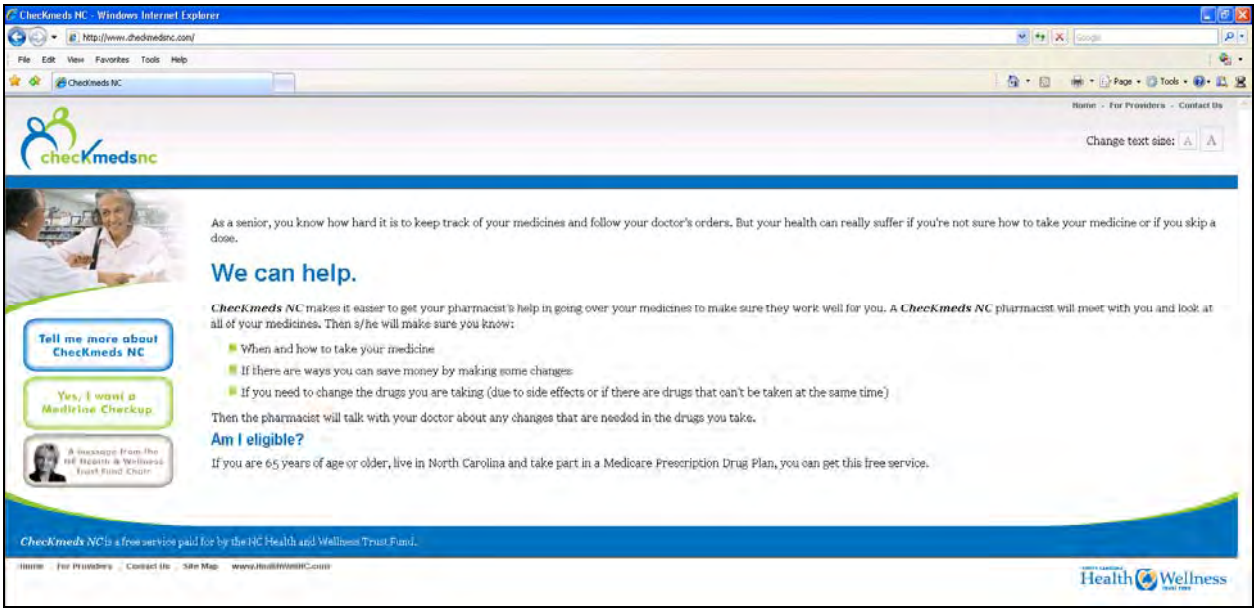
ChecKmeds NC

On October 25, 2007, the HWTFC kicked off a unique and innovative program to provide Medication Therapy Management (MTM) services to NC seniors age 65 and older enrolled in a federal Medicare prescription drug program.

ChecKmeds NC is funded through a $2 million HWTF Commission allocation over a two-year period and implemented through the NC Office of Rural Health and Community Care and will offer MTM services free to the estimated 650,000 NC seniors who are eligible for the program. An outreach campaign directed to NC's eligible seniors and Web site (www.checkmedsnc.com) were launched simultaneously. The outreach campaign used print and online advertising, as well as direct mail to AARP members, recipients of NCRx services, and placement of campaign materials in pharmacies and senior centers across the state.



The main section of the Web site was designed for seniors who wanted more information about *ChecKmeds NC*, and the Web site also included a section for pharmacists where details about becoming a *ChecKmeds NC* pharmacist were provided.



Direct mail was also used to encourage NC pharmacists to undergo the training to become *ChecKmeds NC* pharmacists. Participating pharmacists were offered countertop-display boards with patient brochures to further encourage seniors to make use of *ChecKmeds NC* services.

Campaign Impact

- During the reporting period 9,715 NC seniors received medication therapy management services through *ChecKmeds NC*. Over 677 NC pharmacists were trained to use the *ChecKmeds NC* program and provide the MTM services.

HWTFC Public Education Campaigns FY08

Eliminating Health Disparities Initiative Campaign

In the upcoming fiscal year (beginning in August 2008), the NC Health and Wellness Trust Fund (HWTFC) is launching the state's first-ever media campaign to reduce health disparities related to diabetes in North Carolina. The death rate from diabetes among African American residents in our state (175 per 100,000) is twice that of White residents (83 per 100,000), and it is nearly double for American Indians as well (149 per 100,000).

The diabetes-focused campaign is part of HWTFC's $12.6 million Eliminating Health Disparities Initiative, a statewide effort which began in 2006. The initiative includes grant awards to 25 community-based projects that focus on reducing health disparities related to diabetes, cardiovascular disease, and cancer among African Americans, Latinos/Hispanics and American Indians across the state.

The campaign debuts with a television ad designed to appeal to African American adults, and will be followed by radio ads for American Indian and Hispanic/Latino audiences. The television ad features real people: three North Carolinians who have a family history of diabetes, two of whom have diabetes and are determined to manage it well to live healthier lives for themselves and their loved ones. The third individual featured in the ad watched his mother suffer from diabetes and has made healthful changes in his life to prevent diabetes, and he prompts others to do the same, "If you love yourself, you will take care of yourself."

The ads urge viewers to access the new diabetes resources that are available to them. One such resource is the HWTFC health disparities Web site www.CaretoActNC.com, where the campaign ads can be played and where people can learn more about diabetes prevention, testing, and management.

HWTFC Public Education Campaigns FY08

HWTFC is also funding toll-free phone services through the CARE-LINE (1-800-662-7030) for those who may lack internet access. NC residents can call for diabetes information packets to be mailed to them or find out about local service providers in their areas of the state by calling the toll-free number. The CARE-LINE operates out of the NC DHHS Office of Citizens Services 24 hours a day, seven days a week.

Governor's Quality Initiative (GQI)

GOVERNOR'S QUALITY INITIATIVE

Opportunity and Need for the GQI

Nationally, studies have shown patients receive just over half of all recommended health care services. North Carolina has great doctors who are dedicated to delivering high quality care to their patients. However, with the advancement of medicine and technologies, the body of medical knowledge has grown so fast, physicians cannot realistically be expected to keep up with all the newest recommended care guidelines. For example, the National Guideline Clearinghouse contains 1844 clinical guidelines for care {{120 Agency for Healthcare Research and Quality}} and not all guidelines are evidence based.

New models of practice will be required to effectively implement these guidelines, improve quality of care, and positively effect health outcomes. Those new models must include support from others in the office, as well as the broader community. If we all work together, we can improve the quality of health care delivered to the people of North Carolina by ensuring that evidence-based best practices are applied uniformly across the entire state.

We all benefit from quality improvements. Most importantly, improving the quality of healthcare should lead to better health outcomes. Better health care also means lower health care costs for employers, government, and individuals. It also means a healthier workforce, positioning North Carolina to compete in a global economy.

Overview

Governor Easley insists that North Carolinians deserve and can have the best quality of care in the nation. To do so, he has "called to action" the North Carolina healthcare system and developed the Governor's Quality Initiative (GQI). This initiative will increase the overall quality of care in the state and reduce the variability of care received from different providers and across North Carolina communities. The Governor's commitment to this issue is shared by a statewide consortium of partners, which includes all the major physician groups, hospitals, academic medical centers, nonprofit healthcare organizations, professional associations, insurers, and payers[1] in the state. Together, these partners will develop a comprehensive system for measuring, reporting, improving, rewarding, monitoring, and supporting healthcare in North Carolina to ensure the highest quality is delivered.

Physicians are trained to treat individual patients. However, a community-based approach is needed to address the growing numbers of older adults and people with chronic illnesses. The one-on-one relationships between physicians and their patients can be enhanced, or impaired, by the availability or lack of community supports addressing the patients' needs. Similarly, the work of other organizations in promoting population health will be enhanced through the work of the medical community. A community-wide effort, involving teams of providers and others, is needed to effectively manage the health of our state in the future. Helping physicians adapt to the changing environment will improve the health of all North Carolinians.

Initially, the GQI will focus on health care for five disease states: diabetes, asthma, congestive heart failure, high blood pressure, and heart attacks. These conditions are widely

[1] For simplicity, hereafter "payers" will be used to refer to both payers and insurers.

prevalent throughout North Carolina, and place a large burden on patients and their families.[2] In the long-term, the GQI will extend to other disease states, provider types, and healthcare settings, including hospitals.

GQI partners will adopt a common set of quality measures[3] for all North Carolinians. Most payers have some quality improvement initiatives currently operating in North Carolina. However, the initiatives vary slightly in the specific quality measures. With one set of measures common across all payers, physicians will no longer need to evaluate the many different definitions of quality care for a given disease, but can focus on giving the best quality care possible.

Governance and Operations

The GQI will be governed by the Governor's Quality Improvement Committee (GQIC), a group of health care stakeholders, including representatives of Governor Easley's office, insurers and payers, providers (North Carolina Medical Society and North Carolina Hospital Association), Area Health Education Centers program, Community Care of North Carolina, North Carolina Institute of Medicine, the North Carolina Health and Wellness Trust Fund Commission, and others. Preliminary members of the GQIC have met weekly for the past few months to develop a plan for implementing the Governor's vision. At some point in the future, the GQIC may need to become a formal structure (e.g. 501(c)(3) so that it can act as a repository for funds and enter into contractual arrangements, clarify legal issues around data ownership, and/or institutionalize the organizational structure.

Until a more formal structure is developed, the NC Foundation for Advanced Health Programs (NCFAHP) will act as the fiscal agent of GQIC. The GQIC will develop specific contractual language outlining how NCFAHP will disburse funds and execute the plan according to the wishes of the GQIC. The NC Institute of Medicine will provide the staff support and help coordinate the work of the Governor's Quality Initiative.

A clinical advisory committee, consisting of 15-25 providers, will advise the GQI on quality measures and diseases/conditions that should be removed from, added to, or modified from the GQI measure set. These clinical experts will include primary care physicians, specialists related to the GQI disease conditions, and other health care professionals (e.g. nurses, physician assistants, pharmacists). They will be drawn from other organizational quality initiatives or clinical advisory groups, including insurers, payers, and professional organizations, and will represent North Carolina's diversity in race, ethnicity, and geography. Although the clinical advisory committee will be offering guidance, all final decisions regarding measures, standards, and procedures will be made by the Governor's Quality Improvement Committee.

---

[2] North Carolina, for example, has higher rates of diabetes (8.5 percent NC vs. 7.3 percent US) and high blood pressure (29.2 percent NC vs. 25.5 percent US) in the adult population in 2005. Source: Centers for Disease Control, Behavioral Risk Factor Surveillance System. Web based query at http://apps.nccd.cdc.gov/brfss/index.asp.

[3] *Measures* are clinical descriptions (e.g. a HbA1C test), *specifications* are formal definitions of numerator and denominator (e.g. a list of ICD-9 diagnoses), *targets* are values or goals (e.g. 70 percent of patients had a specific test), and *guidelines* are lists of clinical processes for specific conditions (e.g. ADA recommends that people with diabetes receive foot exams, annual eye exams, regular hemoglobin A1C tests, etc.).

The GQI will continuously assess its efforts to improve health care quality in North Carolina. The initiative will be a dynamic process; the design of the GQI will be refined over time to increasingly raise standards and broaden its reach and effectiveness.

Data Collection

Quality measures are computed in two manners. One is by using claims data. The other is by chart audits. Claims-based measures are cheaper, easier, and faster to calculate, but chart audit measures are often more accurate and informative. Both types will be used by GQI. In Year 1, the GQI will collect claims-based measures statewide across payers for all conditions for which such measures are available. Chart audits, quality reports, and practice support will roll out regionally, to cover practices in five of the 14 Community Care of North Carolina (CCNC) networks in Year 1, another five CCNC networks in Year 2, and the remaining four networks by Year 3. Approximately 38 percent of North Carolinians live in the geographic area covered by the CCNC networks participating in the first year.

Initially, practices that are members of CCNC will participate. Practices that are not currently members of CCNC but who wish to participate in the Governor's Quality Initiative may join CCNC. Claims-based quality measures will be computed for *all* practices, regardless of whether they participate in the GQI.

Payers will process their own claims data to identify individuals with any of the five diseases/conditions. Definitions of the diseases will be based on nationally adopted standards, such as those developed by the National Committee on Quality Assurance (NCQA) and the American Medical Association Physician Consortium for Performance Improvement (AMA PCPI) and endorsed by the National Quality Forum (NQF), and will closely align with the standards adopted and implemented by Community Care of North Carolina. Payers will submit the list of members who have these conditions to a Central Data Warehouse (CDW).

Payers will process their own claims data to determine claims-based quality measures at the patient level (e.g. whether a particular patient with diabetes received an HbA1c test). Payers will electronically submit the values for these quality measures to the CDW. The CDW will be designed to ensure absolutely the security and privacy of protected health information.

Chart auditors from Community Care of North Carolina or the Area Health Education Centers program will visit each participating practice. A random sample of medical records will be reviewed to compute the chart audit measures for each condition. Every effort will be made over time to reduce the cost and administrative burden on practitioners of additional data collection activities.

Participation in the GQI does not preclude payers from conducting other quality improvement efforts that are not part of the common set of quality measures.

Data Storage / Processing

A central data warehouse (CDW) contractor will be selected. The CDW contractor will securely store, process, update, and manage the data used to compute the quality measures. The CDW will develop processes for receiving the claims data from payers and chart audit data from the field agents.

The CDW will produce electronic lists of individuals identified as having one of the five conditions. These lists will be distributed to the practices to allow them to create their own disease registries. Because of this function, the CDW will have protected health information, such as patient names. The CDW will develop processes to protect against the unauthorized release of protected health information. For example, the databases may use a scrambled patient identifier that can be linked to a file with patient names that is kept only on CD in a locked file cabinet and used only for developing the list used to pre-populate the registry.

The CDW will develop a system to securely deliver quality reports to practices via the internet. Until the CDW is fully online, an interim data warehouse may be developed.

Quality Reporting

Practices will receive semi-annual reports on the quality of the health care they deliver to their patients. These reports will analyze the percentage of patients with a specific health condition that receive the care that is part of the quality initiative. Practices will be able to compare their performance to those of their peers, as measured by averages of peers in their community and across the state. The reports will be available on-line via a secure web-based system.

The quality measures will be used to identify opportunities for quality improvement. By receiving reports, practices will be able to identify strategies useful in improving the quality of health care delivered to patients. Communities will better understand where to focus their efforts for improving the health of their residents.

Data viewing rights will vary:

- Statewide averages for the quality measures will be publicly available.
- Community (e.g. county, CCNC network, or AHEC region) averages for the quality measures will be publicly available.
- Payer-specific averages for the quality measures will be available to the specific payer.
- Practice-specific averages for the quality measures will be available to the specific practice, payers, and quality improvement consultants. Payers will not use the quality measure values to solely or primarily change the practice's underlying reimbursement. Payers may use the aggregate quality measures for non-punitive quality improvement purposes.

Practice Support

One of the unique features of the GQI is the support that will be available to participating practices to help them improve quality.

GQI will offer the following to participating practices:

- Provide evidence-based best practices for care and materials and other practice supports to help practices improve their health care quality.
- Provide regular reports on quality of care.
- Offer consultation with CCME about implementation of disease registries and EHRs, and, along with vendors, provide technical support for installation
- Support practice development of a practice-based disease registry across all payors.

- Provide a quality improvement consultant (QIC) working with CCNC and AHEC to work regularly with the practice to develop office systems to improve the quality of care. The QICs will work closely with CCNC case managers using a common training system.
- Offer physicians the ability to participate in quality collaboratives and other high intensity support to improve office systems as quickly as possible.
- Provide data from the practice that can be used for Maintenance of Certification Part IV or any other purpose, such as Bridges to Excellence.
- Facilitate free CME up to 50 hours/year for clinician involvement - all which is necessary to maintain licensure in North Carolina.
- Help practices reach NCQA standards.
- Offer opportunities for staff development and continuing education.
- Provide an opportunity to work with colleagues in the community to improve the quality of care.
- Free access to the AHEC digital library, with online availability to a wide variety of medical resources
- Work to streamline and coordinate practice support from multiple sources
- Provide public recognition for participation in the program
- Continue to work with all stakeholders across to state to make it easier to improve quality of care in the practice, including promoting e-prescription tools and developing/spreading opportunities for increased reimbursement on the basis of quality of care.

Financing

There are two types of implementation costs: one-time/start-up costs and ongoing/maintenance costs. The state and non-governmental payers will contribute to the Governor's Quality Initiative. External funding (e.g. foundations) will also be sought. These "start-up" funds will support the first three years of the initiative. After return on investment has been demonstrated, payers recognize that to the extent that GQI efforts duplicate current efforts and that improved quality shows a return on investment, they may contribute to maintenance costs.

Practices implementing the new standards will also face start-up and maintenance costs. However, the financial benefits that accrue from implementation of the measures will largely be returned to the payers, rather than to the providers. To help offset initial costs to the practices, the GQI has built in funding for one-time support to participating practices to help them pay for any additional costs they may incur in participating in this initiative.

NC Rural Hope Project

North Carolina Rural Hospital Capital Investment Project
Grant Narrative

Proposed by the North Carolina Hospital Foundation

Proposal Description

The NC Rural Hospital Capital Investment Project is a comprehensive effort to organize capital funding to help 56 small and rural NC hospitals invest in desperately needed upgrades and renovations to medical and clinical equipment, plant and facilities, and health information technology. With the tightening of financial markets, small, rural hospitals are essentially excluded from access to the capital necessary to invest in continuing patient care operations, patient service improvements and plant and facility upgrades and renovations.

The NC Rural Hospital Capital Investment Project proposes to create a $100 million capital financing pool, underwritten by NC-based lenders, that will focus on the capital needs of small and rural hospitals. The primary mechanism for encouraging lenders to participate in the project, and thereby create the financing pool, is a debt service reserve fund (loan loss reserve) that would improve the credit characteristics of the Investment Project. Because many of the small and rural hospitals that require capital funding to improve their facilities and services are not viable credit risks on their own accord, a loss reserve fund is necessary to encourage lenders to provide credit enhancement (i.e., letters of credit) for rural hospital borrowers. The capital investment program as proposed would involve issuing tax-exempt variable rate bonds backed by a letter-of-credit (LOC) underwritten by a NC-based lender or a bank syndicate. A significant partner involved in the development of the Investment Project, BB&T Bank, is a prime example of a lending partner that will commit to this capital program. BB&T Bank has a track record as the most active provider of credit enhancement to lower-rated healthcare providers in North Carolina.

The project has an initial funding commitment from Golden Leaf that forms a $1 million challenge grant for other NC foundations to contribute an additional $4 million in grants to establish an initial loss reserve fund totaling $5 million. Once the reserve fund is established, the grant funds will be obligated and leveraged to create a capital financing pool of approximately $100 million. The capital investment pool will then be utilized by small and rural NC hospitals to develop significant capital investments, including large-scale renovations and facility replacements. It is important to note that the Golden Leaf funds will not be obligated until the remaining portion of the loan loss reserve fund ($3 million to $4 million in additional funding) is capitalized and the trust fund for the loss reserve fund is established and operational (anticipated by Fall 2007).

Organization Requesting Grant Funding

The North Carolina Hospital Foundation is the 501(c)3 subsidiary of the North Carolina Hospital Association (NCHA), a non-profit, statewide trade association representing 135 hospitals and health networks. NCHA's mission is to promote improved community health status and delivery of quality healthcare through leadership, information, education and advocacy for hospitals and healthcare systems and the communities they serve.

The NC Hospital Foundation is governed by a board of directors composed of the officers of NCHA. The NC Hospital Foundation routinely seeks grants and foundation support for activities that support the mission of NCHA. Recent grants received by the NC Hospital Foundation

include a $5 million commitment from The Duke Endowment to create the NC Center for Hospital Quality and Patient Safety, $150,000 from the Robert Wood Johnson Foundation to establish medical emergency teams at NC hospitals, and annual funding for the NC Rural Health Center, a resource center for rural health organizations and the communities they serve.

The NC Rural Hospital Improvement Project will be managed by a partnership organized by the NC Rural Health Center based at NCHA. The NC Rural Health Center was created in 1996 through a grant funded by the Kate B. Reynolds Charitable Trust. The mission of the NC Rural Health Center is to encourage innovative, collaborative, community-focused healthcare networks in North Carolina and assure continued, appropriate healthcare services in rural communities.

The objectives of the NC Rural Health Center include:

- Be a statewide resource for rural health organizations and communities.
- Advise rural health organizations and communities regarding community health improvement, collaboration, and strategic planning.
- Promote leadership and cooperation among rural health organizations and communities in their common mission to achieve a healthy community.
- Perform as a catalyst and leader among public and private organizations that address rural health issues.
- Organize strategies to encourage the transformation of rural health toward results-oriented community health models.

Recent accomplishments of the NC Rural Health Center include:

- Twenty-one small and rural hospitals successfully enrolled in the critical access hospital program, creating $7.35 million annually in additional revenues for small hospitals and the rural communities they serve.
- Forty-six hospitals enrolled in the 340B drug program, generating $16 million annually in cost savings for rural hospitals and increased access to drug prescriptions for low income rural residents.

Anticipated Project Outcomes

The projects created by the Investment Project will enhance the service base of small and rural hospitals, allowing improved access to needed healthcare services and technologies. Also, rural hospitals are among the largest, most active investors in rural economies and communities. The hospitals eligible for the Investment Project provide over $4 billion annually in economic benefit for their rural communities and regions. Improving the plant and facilities of these rural hospitals is certainly an investment in community development.

Grant Beneficiaries

The primary beneficiaries of the capital investments created by the Investment Project are the rural communities served by NC's small and rural hospitals (see map and list of 56 eligible rural hospitals). The hospitals involved are selected according to the following criteria: caring for less than 100 inpatients per day; public or non-profit healthcare organizations; located in a rural county according to the NC Rural Center definition; or designated a critical access hospital (CAH). The 56 rural hospitals eligible for the capital pool provide care for 160,209 inpatients

annually and directly employ 17,316 healthcare workers and professionals (2005 statistics). According to 2001 estimates, the small and rural hospitals eligible for the Investment Project contributed $4.31 billion annually in economic benefit to their communities and $1.65 billion in labor income for a community-wide employment base of 52,306 rural residents.

The small and rural hospitals eligible for the project include a special category of hospitals known as critical access hospitals. These hospitals are located in rural communities, serve vulnerable rural populations and are obligated to care for 25 inpatients or less on a daily basis. North Carolina has 21 CAHs, all of which are eligible for the Investment Project. North Carolina's CAHs are among the most financially needy hospitals in the state.

General Implementation Plan

The intent of the Investment Project is to develop and obligate a capital development pool that will be fully utilized by small and rural hospitals across NC. The loss reserve fund that is guaranteed by the foundation commitments of $5 million will support the entire $100 million loan pool. Technical assistance will be provided to the eligible small and rural hospitals to help them plan and develop capital improvement projects that will utilize the capital pool, as well as provide the financial expertise for hospitals to engage the lenders that are participating in the capital investment pool.

Significant work will be required to complete the initialization of the loss reserve fund, creation of a trust fund and identification of a manager for the loss reserve fund, development of the capital pool funding instruments, evaluation of the lending and risk potential of each eligible small and rural hospital, and the development of rural hospital capital projects that will be underwritten by the Investment Project.

Sustainability

Once the loss reserve fund is established, six to twelve months will be required to organize the loan pool and promote the availability of the capital funding. It is expected that small and rural hospitals will require one to three years to plan, develop and seek approval for the capital projects that will be funded by the capital investment pool. As a result, it is initially estimated that the $100 million loan pool requires a five-year planning and implementation horizon (June 2007 to June 2012) to reach full obligation and commitment. If the Investment Project is fully subscribed in an earlier timeframe or demand for capital funding by small and rural hospitals is greater than expected, additional grant funds, and possibly an appropriation from the NC General Assembly, will be sought to expand the loss reserve fund beyond the initial $5 million target.

Expected Outcomes and Measuring Success

Success will be measured by the total amount of capital funds engaged and obligated by small and rural NC hospitals. Secondary measures will also be monitored by the project managers including the economic impact of the hospitals involved in the capital pool, patients served by the projects funded by the capital pool and the direct and indirect employment related to the capital improvement projects developed by the hospitals. The NC Hospital Foundation will produce an annual report on the progress of the Investment Project until all capital funding is obligated and expended.

As an initial estimate, the rural hospitals eligible for the project directly employ 17,316 health care workers. It is estimated that the capital loan pool, when fully obligated, may have the potential to help these hospitals retain 10% of their workforce, leading to an estimated 1,732 jobs retained. In addition, the economic benefit multiplier for investments for the eligible small, rural hospitals is 1.63 based on IMPLAN estimates. Consequently, if the entire capital pool of $100 million is fully obligated, the potential economic return is estimated to be $163 million over five years for rural communities and their residents.

At the close of each calendar year, the project managers will report to the partnership organizations and the original foundation investors, including Golden Leaf and the Health and Wellness Trust, the current status of the Investment Project, the amount of funds committed and obligated, and the rural hospital projects supported by the capital pool.

Leadership for the Investment Project

The establishment of the Investment Project is currently managed by a leadership group involving:

Billy Ray Hall
President, NC Rural Center

Roberts A. Bass
Senior Vice President
Corporate Banking Manager
BB&T Capital Markets

John R. Franklin
Senior Vice President
Health Care Finance Group
BB&T Capital Markets

Bill Pully
President
NCHA

Jeff Spade
Vice President, NCHA
Executive Director, NC Rural Health Center

Development Process Timeline

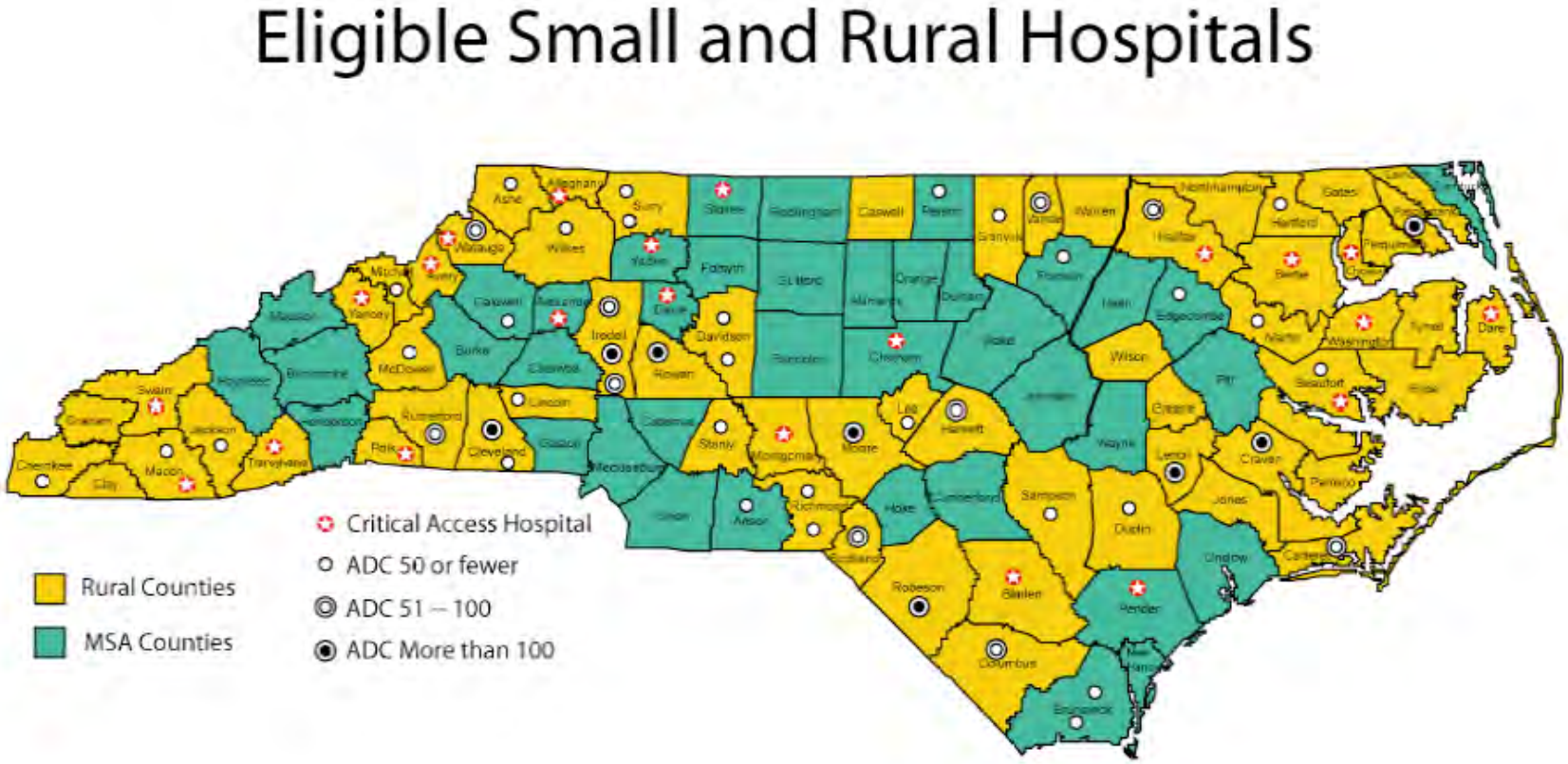
- Summer 2006 to Spring 2007
  - Establish loss reserve fund to initialize the capital pool
  - Approach NC-based community and healthcare foundations for support

- Spring 2007 to Fall 2007
  - Establish a trust to hold the loss reserve fund for the financing program
  - Create a board, bylaws and criteria to govern the trust and use of the reserve fund
  - Creation of bond document templates
- Fall 2007 to Summer 2008
  - Outreach training and education of eligible small and rural hospitals
  - Bond counsel (BB&T Bank) creates a standard tax exempt bond/letter of credit documentation package for use by the participants
- Spring 2008 to Spring 2009
  - Individual hospitals submit financing requests to BB&T Bank for credit approval
  - Each hospital's credit potential is rated according to their risk profile, as supported by the loss reserve fund
  - Eligible small, rural hospitals begin development of capital projects that will benefit from investment created by the capital investment pool.
- 2008 through 2012
  - Small and rural hospitals continue to develop capital investment projects until the capital investment pool is completely obligated.

Project Budget

1) Capital initialization for the loss reserve fund (by Fall 2007)
   - $5 million
2) Development costs for Investment Project (legal, financial, technical assistance)
   - $250,000

Eligible Small and Rural Hospitals	
Ave Daily Census < 50	Spruce Pine Community Hospital
Alleghany Memorial Hospital	Stanly Memorial Hospital
Angel Medical Center	St Luke's Hospital
Anson Community Hospital	Stokes-Reynolds Memorial Hospital
Ashe Memorial Hospital	Swain Co Hospital
Beaufort County Hospital	Sampson Regional Medical Center
Bertie Memorial Hospital	Transylvania Community Hospital
Bladen County Hospital	Washington Co Hospital
Blowing Rock Hospital	Wilkes Regional Medical Center
Brunswick Community Hospital	
Caldwell Memorial Hospital	
Charles A Cannon Jr Memorial Hospital	**Ave Daily Census 51 to 100**
Chatham Hospital	Albemarle Hospital
Chowan Hospital	Betsy Johnson Regional Hospital
Davie County Hospital	Carteret General Hospital
Duplin General Hospital	Columbus County Hospital
FirstHealth Montgomery Memorial	Haywood Regional Medical Center
FirstHealth Richmond Memorial Hospital	Morehead Memorial Hospital
Franklin Regional Medical Center	Rutherford Hospital
Granville Medical Center	Scotland Memorial Hospital
Harris Regional Hospital	Watauga Medical Center
Highlands Cashiers Hospital	Wilson Memorial Hospital
Hoots Memorial Hospital	Halifax Regional Medical Center
J Arthur Dosher Memorial Hospital	Onslow Memorial Hospital
Kings Mountain Hospital	
Lexington Memorial Hospital	
Lincoln Medical Center	**ADC = Average Daily Inpatient Census**
McDowell Hospital	
Murphy Medical Center	
Northern Hospital of Surry County	**Eligibility Criteria**
Our Community Hospital	Public or private non-profit hospital
Outer Banks Hospital	Located in rural county
Pender Memorial Hospital	Ave Daily Census < 100
Person County Memorial Hospital	All Critical Access Hospitals
Pungo District Hospital Corporation	
Roanoke-Chowan Hospital	


Eligible Small and Rural Hospitals
Critical Access Hospital
ADC 50 or fewer
ADC 51 – 100
ADC More than 100
Rural Counties
MSA Counties

NORTH CAROLINA Health Wellness TRUST FUND

Oral Health Access Initiative

NC Health and Wellness Trust Fund Commission
Oral Health Access Initiative

Background

Low-income North Carolinians face significant challenges accessing dental care, especially if they live in rural areas. In 2006, roughly 32% of North Carolina adults reported not visiting a dentist within the last year. Among minorities, the number who reported visiting a dentist within the past year was even lower (39% of Native Americans; 42% of African Americans; and 56% of Hispanics—22% reported that it had been at least five years since their last dental visit). Meeting the oral health needs of young children, older adults, people with disabilities, and other special populations is even more challenging. In 2007, nearly half (43%) of NC children ages 1-5 already had tooth decay, and 20% of children entering kindergarten had untreated tooth decay.

In December, the NC Health and Wellness Trust Fund Commission (HWTFC) allocated $2.35 million to fund an oral health initiative. Two million dollars will be used as new grant funding to increase access to care and enhance workforce training to expand the availability of dental care for vulnerable and underserved populations. The funds will be awarded to programs that will:

(1) Increase access to treatment and prevention services for low-income, high-need populations and/or
(2) Develop/train the dental workforce (dentists, dental hygienists, dental assistants) or broader health care workforce (physicians, nurses, physician assistants, etc.) to better address dental prevention and treatment for low-income, high-need populations.

For this initiative, *low income* is defined as having an income at or below 200% of the Federal Poverty Guidelines (FPG); *high-need populations* are groups that are either low-income and underserved and/or part of a special population that is more likely to have oral health needs and is also underserved (e.g., elderly populations, people living in long-term care settings, people with developmental disabilities, infants and toddlers).

The remaining $350,000 will be use to provide technical assistance and evaluation to applicants and grantees. HWTFC will also create a social marketing campaign to support prevention efforts (funded through existing HWTF media contracts).

Request for Proposals (RFP)

HWTFC released an RFP in October 2008 with a February 2009 application deadline. Applications will be reviewed in spring 2009 resulting in a grant award at the May 2009 Commission meeting. The grant contract period will begin on July 1, 2009 and will be renewed annually based on the grantees programmatic, financial and grant administration performance through June 30, 2012.

Grants will be awarded to programs that can demonstrate an ability to provide services to a previously underserved population. In scoring applications, points will be given to the number of people served in a given area as a result of grant funding. HWTF is also seeking to award grants that introduce innovative strategies to leverage community resources, develop effective ways to utilize new and existing partnerships, and implement successful delivery models that can be replicated in other North Carolina communities.

HWTFC Oral Health Access Initiative

Successful proposals will develop community-oriented solutions that address the oral health needs of a geographic area or specific population in North Carolina and plan for sustainability once the grant funding is expended. These proposals will also describe the need in their area and provide an outcomes-based evaluation plan.

Grant recipients will be expected to coordinate with the community's CareShare Health Alliance or HealthNet network to make the oral health care program more easily accessible to all low-income, uninsured residents in their community. As part of the grant agreement, grantees will be required to become an integral part of their community's CareShare Health Alliance or HealthNet network, helping low-income residents with oral health care needs.

High Risk Insurance Pool (Inclusive Health)

North Carolina Health Insurance Risk Pool (Inclusive Health)

The NC Health and Wellness Trust Fund provided $5 million for initial operating funds to help establish the North Carolina Health Insurance Risk Pool (NCHIRP), now called Inclusive Health. The NCHIRP was established by the NC General Assembly to provide affordable, individual health insurance coverage for North Carolinians who do not have access to an employer health plan and face higher premiums due to a pre-existing medical condition. NCHIRP will also offer coverage to individuals who are federally defined HIPAA eligibles or qualify due to loss of employment due to the effects of international trade under the Health Care Tax Credit.

Coverage and Premiums

Inclusive Health opened for enrollment on Oct. 20. Individuals who enroll this fall will be eligible for coverage beginning Jan. 1, 2009. Information on Inclusive Health's benefits, rates and how to apply can be found at www.inclusivehealth.org or by calling toll-free at 1-866-665-2117.

Eligibility Criteria

To be eligible for Inclusive Health coverage, individuals must:

- be a legal resident of the United States.
- be a resident of the State of North Carolina.
- *not* have access to group coverage as an employee or as a dependent of an employee.
- *not* qualify for a government program such as Medicare or Medicaid.

In addition, individuals must meet *one* of the following criteria:

- have been rejected or refused by an insurer for similar coverage for medical reasons.
- have been offered coverage by an insurer but with conditional rider limiting coverage.
- have been refused coverage except at a higher premium rate than Inclusive Health.
- have similar coverage, but at a single rate higher than Inclusive Health.
- have a diagnosed medical condition, outlined by Inclusive Health, which allows automatic enrollment into Inclusive Health.
- are a federally-qualified, HIPAA-eligible individual, including those who currently have this coverage through an insurer.
- are a resident eligible for the Federal Health Coverage Tax Credit (trade-displaced workers, PBGC recipients).
- are an eligible individual with other non-group coverage in place; you can move to Inclusive Health at any time.

Governance

Inclusive Health is a non-profit entity. It is not part of the state government but operates under the supervision and control of its Board. The NCHIRP Board of Directors is made up of appointees from the Governor, the Speaker of the House, the President Pro Tempore of the Senate, and the Commissioner of Insurance. The Commissioner also serves on the Board as an ex officio non-voting member.

Funding

Startup Funds:

- Special funds for start-up (i.e., development of the Pool's products and operations) will come from a one-time $250,000 appropriation by the State and a federal high-risk pool grant in the amount of $850,000.

Funds for Ongoing Operations:

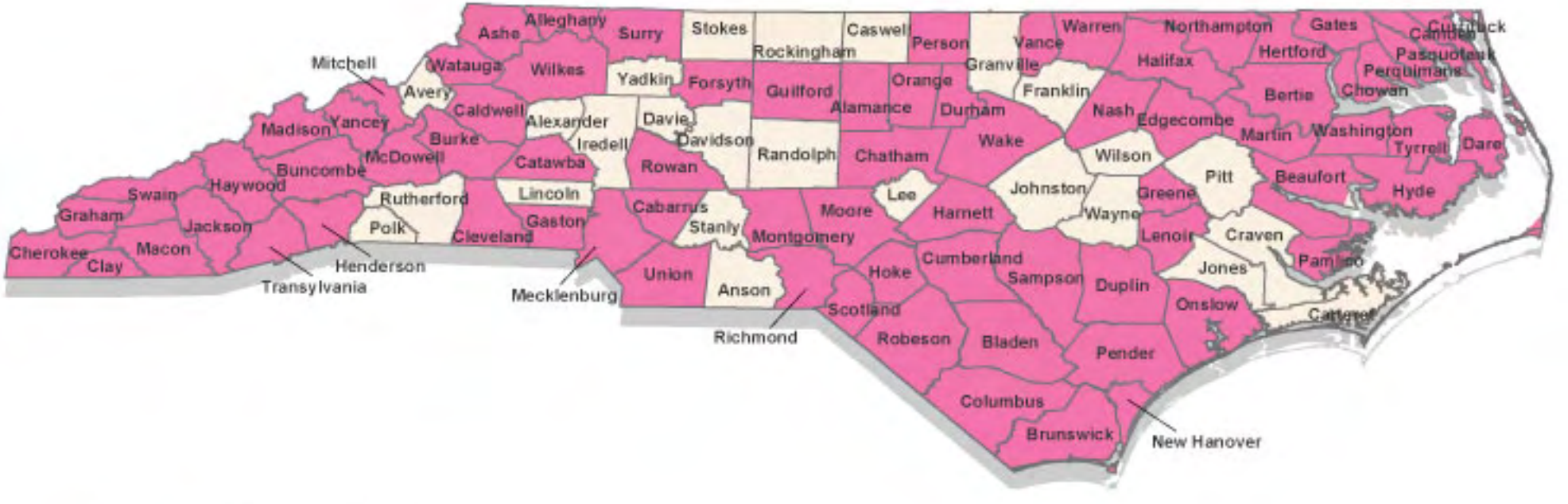
- Premiums from enrolled individuals.
- A one-time $5 million from the NC Health & Wellness Trust Fund.
- The annual transfer of state premium tax collections (a portion of revenue growth on existing taxes).
- An annual payment from the NC State Health Plan.

NORTH CAROLINA Health Wellness TRUST FUND

Tobacco Use Prevention and Cessation (TUPC)

NORTH CAROLINA Health Wellness TRUST FUND

Teen Tobacco Use Prevention & Cessation Initiative
Counties Covered by Grantees



Counties covered by grants

Gap counties covered by Question Why (QY) Youth Empowerment Centers*

* QY Centers provide statewide coverage

Updated: 11-01-08

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 Tyrell 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

Training and Technical Assistance Annual Progress Report

July 1, 2007- June 30, 2008

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

Year 3 Report
August 31, 2008

NC Tobacco Prevention and Control Branch

North Carolina Public Health

Training and Technical Assistance Annual Report 2007 – 2008

Table of Contents

Overview

The NC Tobacco Prevention and Control Branch (TPCB) entered a new Agreement on July 1, 2007 with the NC Health and Wellness Trust Fund (HWTF) to continue as a lead agency to provide training and technical assistance on evidence-based teen tobacco use prevention and cessation interventions for 49 Community/School Grantees and Priority Population Grantees.

The HWTF Teen Tobacco Use Prevention and Cessation (TTUPC) Initiative from the outset has been built upon four goal areas:

1) Prevent youth initiation of tobacco use;
2) Eliminate youth exposure to secondhand smoke;
3) Provide tobacco cessation among youth; and
4) Reduce health disparities among youth attributable to tobacco use.

This year has seen many successes for the North Carolina Teen Tobacco Use Prevention and Cessation Initiative (TTUPC) and for tobacco use prevention in general. The NC Tobacco Prevention and Control Branch (TPCB) has collaborated with various partners, including the HWTF to implement statewide legislation that will help to insure that North Carolina's youth can remain tobacco free from preschool through college and beyond.

In turn, the TPCB has worked hand-in-hand with the HWTF to provide evidence-based cessation support for youth and their caregivers who want to quit and stay quit by promoting and supporting the NC Quitline. Knowing that quitting is not easy, the TPCB has educated all of the TTUPC grantees across the state in 5A's (Ask, Advice, Assess, Assist, Arrange) method that is available for health care professionals to use in making referrals to the Quitline.

Other key accomplishments include the surveillance and evaluation that generated the Youth Tobacco Survey (YTS) results of historic low levels of tobacco use among North Carolina's youth. The TPCB collaborated with the HWTF and the NC Commission of Indian Affairs (NCCIA) to assess priority and disparate populations, reflecting that 4,000 American Indian students from 25 schools participated in a supplemental survey as part of the Youth Tobacco Survey (YTS).

The TPCB's role as a lead technical assistance provider has afforded the TTUPC grantees, their coalition members, and the college grantees with specific training events. In order to facilitate learning and travel obstacles, meetings were delivered via various platforms including but not limited to regional and local events, conference calls, webinars, and multiple combinations. Therefore, grantees have attended numerous sessions on adult leadership and youth involvement, youth and tobacco pricing, action planning, TFS compliance, media and marketing, cultural competencies, and evaluation to name a few.

This annual report details the quantitative data and provides summary qualitative information for each of the goal areas, focus areas, SMART Objectives, and deliverables in the FY07-08 Contractual Agreement.

Goal Area: Preventing the initiation of tobacco use among young people

Focus Area 1: Encourage implementation and compliance of Tobacco Free School (TFS) policy throughout all of North Carolina's 115 school districts (LEAs).

SMART Objective: By June 30, 2008 the Tobacco Free Schools Director, with assistance from the TFS Coordinators, will provide training to the remaining 28 LEAs on TFS compliance; provide compliance materials to all local school systems, evaluate and revise as needed TFS compliance materials to insure local usability; and revise TFS web sites and online resources to reflect emphasis on compliance resources and training. "Train the Trainers" meetings will be held to educate HWTF TTUPC grantees as well as individuals from school districts in counties not receiving HWTF funding to be local compliance resources.

Table 1.1.1 – Deliverables provided to encourage implementation/compliance of TFS policy

Type of Deliverables	Attainment
▪ 4 regional "Train the Trainer" meetings.	1
▪ 8 regional TFS compliance workshops for all 115 LEAs.	2
▪ Consultations with TTUPC grantees and Real-Time Community Change grant recipients to encourage 100% TFS compliance.	60
▪ Evaluate and revise TFS compliance materials as needed.	16
▪ Distribute HWTF approved compliance manuals for all NC Superintendents and Principals.	136
▪ Identify needs and provide technical assistance to school systems with TFS policies.	62
▪ 100% TFS signs disseminated.	8672
▪ Provide new copy and other appropriate changes to TFS web site to reflect new emphasis on compliance.	4
▪ Provide a minimum of 28 school districts with model policies.	39
▪ Provide other technical assistance to assist with TFS policy Implementation.	71
▪ Develop and deliver one mailing to school board members and Superintendents in each school district that have not adopted a TFS policy by January 1, 2008.	Completed
▪ Develop and deliver recommended public communications plan to HWTF to assure compliance with G.S. 115c-407 as amended by SL2007-236 by August 10, 2007.	Completed

Key Accomplishments:

- Hosted two (2) TFS regional assistance compliance forums, with participants from 18 school systems. Based on attendance per region, the Tobacco Free School Director decided that only two forums were necessary.
- As of June 30, 2008, 98 percent of NC school districts are 100% tobacco free. New TFS policies in Bladen, Scotland, Beaufort and Caswell County Schools; the only school districts remaining without TFS policy as of July 1st are Alamance County and Mooresville Graded

School District. Those districts plan to adopt the policy during July.
- A total of 8672 TFS signs were successfully purchased and delivered this year with 4,639 this quarter to school districts across the state.

Goal Area 1: Preventing the initiation of tobacco use among young people

Focus Area 2: Promote awareness of enforcement of underage tobacco sales laws and reduce advertising that appeals to youth.

SMART Objective: By November 1, 2007, TPCB will develop a packet of activities, materials and a plan for HWTF TTUPC grantees to use to reduce the impact of tobacco advertising that appeals to youth in their communities.

Table 1.2.2 - Deliverables provided by TPCB to reduce impact of tobacco advertising.

Type of Deliverables	Attainment
▪ **Develop for review and distribution appropriate teen activities to track local tobacco marketing.**	**Delivered pending response**
▪ **Develop for review and posting at least one appropriate media literacy fact sheet.**	**Delivered pending response**
▪ **TPCB will notify HWTF of advertising by tobacco manufacturers that NC teens and adults identify as potentially targeting teens.**	**Delivered pending response**

Challenges:
- TPCB still awaits guidance from HWTF on how HWTF would permit the tobacco marketing issue to be approached this funding year.

Goal Area 1: Preventing the initiation of tobacco use among young people

Focus Area 3: Promote awareness of the research that cites a relationship between price of tobacco products and tobacco use initiation among youth and young adults and cessation.

SMART Objective: By October 2007, TPCB staff will work with national experts to develop updated factual materials for dissemination to all local health departments including but not limited to HWTF TTUPC grantees for use in presentations/publications focusing on what works in tobacco prevention and cessation.

Table 1.3.3 - Deliverables provided by TPCB to promote awareness of the relationship between price of tobacco products and tobacco use initiation among youth and young adults and cessation.

Type of Deliverables	Attainment
▪ **Adapt materials designed to calculate the cost of smoking and tobacco use for teen and young adult population by December 15, 2007.**	**Completed**
▪ **Develop a PowerPoint presentation on Tobacco Price and its public health impact by December 15, 2007.**	**Completed**
▪ **Provide a brief update about the effectiveness of tobacco price**	**Updated in**

increases on tobacco initiation and cessation at the 2007-2008 state conference.	**June**

Key Accomplishments:

- Completed updated factual PowerPoint presentation and fact sheets based on national and NC tobacco price data related to price as a deterrent to teen tobacco use from Frank Chaloupka, Director of ImpacTEEN, University of Illinois at Chicago.
- TPCB responded to four (4) requests from HWTF to make presentations on pricing as a deterrent to teen tobacco use.

Unplanned Opportunities:

- At the request of a HWTF Grants Manager, submitted PowerPoint entitled a Primer on Price as a Deterrent to Teen Tobacco Use developed for HWTF in coordination with ImpacTEEN Director Frank Chaloupka for HWTF in October 2007.
- TPCB Director of Policy and Programs was invited to conduct a session on "the impact of pricing and youth initiation" at the Eastern Regional Spit Tobacco Task Force Meeting held on April 10, 2008.

Goal Area 2: Eliminating young people's exposure to secondhand smoke (SHS)

Focus Area 1: Increase smoke-free policies through active youth involvement in both indoor and outdoor venues identified by youth to be places that they frequent often such as: restaurants, recreation facilities, bowling alleys, malls, movie theaters, parks, places of worship, amusement areas, convenience stores, sports venues, and ball fields.

SMART Objective: By June 30, 2008, the TPCB will assist HWTF TTUPC grantees to increase the number of youth-oriented smoke-free venues by promoting evidence-based tobacco free policies and norms.

Table 2.1.1 - Deliverables provided by TPCB to increase the number of youth oriented smoke-free venues.

Type of Deliverables	Attainment
▪ **TPCB will prepare and present evidence-based options within HWTF approved SHS activities for grantees to work on SHS by September 30, 2007.**	**Completed**
▪ **Assist with the design and development of a pre-packaged "cookie cutter" Media and Youth Empowerment SHS Campaign for TTUPC grantees.**	**Pending response**
▪ **Provide training to TTUPC grantees on how to use the cookie cutter media campaign to increase smoke free policies in youth-oriented venues.**	**Pending response**
▪ **Work with HWTF to examine the effectiveness of the pre-packaged Media and Youth Empowerment SHS Campaign for TTUPC grantees.**	**Pending response**
▪ **Develop 12 seasonal SHS "Swiss Cheese" News Releases by**	**Completed**

January 1, 2008.	
▪ **Work to promote earned media opportunities and messages related to secondhand smoke and smoke-free policies statewide.**	**Ongoing**
▪ **Provide program development and technical assistance to HWTF TTUPC grantees and gap counties on HWTF approved tobacco free policies and norms.**	**Ongoing**

Key Accomplishments:

- ***S1669:*** Local **community colleges** bill passed in the Short Session on July 1, 2008 and was signed by the Governor July 11, 2008. The new law grants local governing boards of local community colleges the clear local authority and guidance to prohibit tobacco use on the grounds of their community college campuses, all other property, and community college sponsored events. The TPCB helped build support for this clarifying legislation. We learned from working with the Community Colleges Systems leadership that more than 28,000 high school students currently take classes on community college campuses. At the request of the Community Colleges Chief Operating Officer, the TPCB Head sent talking points on April 8, 2008 for the President's address to the Community Colleges Presidents. The TPCB Director of Policy and Programs worked with the Institute of Government on the language of the legislation, and worked with HWTF Director of Tobacco Free Campuses, NC Heart Disease and Stroke Prevention Task Force and NC Alliance for Health in providing technical assistance.

Challenges:

- TPCB still awaits guidance from HWTF on how SHS issues should be approached this funding year.

Goal Area 3: Promote quitting among young people and adults as role models for young people.

Focus Area 1: Provide access to effective tobacco cessation resources.

SMART Objective: By June 30, 2008, TPCB will disseminate HWTF approved evidence-based cessation resources targeting teens, young adults and school personnel to HWTF TTUPC and CTUPC grantees, as well as all local health departments. In the absence of evidence-based resources, the TPCB will provide assistance and support in development of local initiatives to promote the NC Quitline and the fax referral system. The Quitline referrals are designed to increase cessation among teens, those adults whose tobacco use impacts teen prevalence, and young adults. Successful local strategies will be shared with other HWTF TTUPC/CTUPC grantees.

Table 3.1.1 - Deliverables provided by TPCB to HWTF: Approved evidence-based cessation resources targeting teens, young adults and school personnel to HWTF TTUPC and CTUPC grantees, as well as all local health departments.

Type of Deliverables	Attainment
▪ Conduct at least 5 presentations to health care providers who work with teens and young adults on promising tobacco cessation interventions in the clinical setting by May 31, 2008.	11
▪ Design and implement 2 clinic based demonstration projects to incorporate 5A's/best practices in gap counties.	Completed
▪ Train all HWTF TTUPC/CTUPC grantees on how to work with local health care providers to integrate the 5As into their dental and pediatric/family medical practices who reach HWTF target populations by December 15, 2007.	Completed
▪ Develop a cessation training kit for HWTF TTUPC/CTUPC grantees, focusing on HWTF approved populations of teens, young adults up to age 24, primary caregivers with children in the home, and school personnel by December 15, 2007.	Completed
▪ Support the implementation of HWTF TTUPC/CTUPC grantee cessation trainings, the provision of technical assistance, and other activities as requested by HWTF TTUPC/CTUPC grantees and approved by the HWTF Tobacco Officer.	Completed
▪ The TPCB Medical Director will work with HWTF staff, the North Carolina Medical Board, the North Carolina Medical Society, and QuitlineNC to implement and distribute nicotine replacement therapy to eligible callers by January 31, 2008.	Completed
▪ Provide technical assistance for a marketing campaign promoting the QuitlineNC that targets 18-24 year old high-risk tobacco users who are unemployed and/or not attending college by June 30, 2008.	Completed
▪ Provide cessation assistance through promotion of the Quitline and fax referral system to local health departments and schools in gap counties.	Completed
▪ Assist with earned media messages promoting cessation among HWTF cessation target populations.	Completed
▪ Identify and provide to HWTF a list of possible tailored web-based cessation services proven effective with youth and/or young adults. This will be accomplished by December 31, 2007.	Completed
▪ Continue to develop collaborations with national, state, and local partners on promotion of 1-800-QUIT-NOW (Quitline NC).	On-going
▪ Provide feedback for HWTF on the number, types, and dates of assistance provided to TTUPC/CTUPC grantees as well as non-grantee communities in gap counties.	Completed

Key Accomplishments:

- All HWTF grantees attended a training session on evidence-based cessation interventions and resources conducted by the TPCB Tobacco Cessation Specialist at the HWTF Statewide TTUPC Grantee Conference, September 2007.
- Exceeded the target number of 5 by conducting 11 training to health care providers who work with teens and young adults on promising tobacco cessation interventions in the clinical setting
- The TPCB Tobacco Cessation Specialist presented at the March 12-13, 2008, TTUPC Annual Action Planning meeting and distributed Tobacco Cessation Speaker Kits to grantees.
- NC General Assembly approved legislative language in the budget bill regarding the provision of Nicotine Replacement Therapy (NRT) via the Quitline vendor.

Unplanned Opportunities:

- NC DPH joined 15 other states to become members of the National Alliance for Tobacco Cessation and the *Become an Ex* program, increasing the reach of the NC Tobacco Use Quitline through prominent display of the Quitline number on the website.

Challenges:

- Staffing Change: Medical Director and NC Tobacco Use Quitline Director Dr. Jana Johnson resigned. The TPCB Branch Head has taken on interim direction of the Quitline, including managing the re-compete for the Quitline contract. The Division of Public Health Chief of the Chronic Disease and Injury Section has recruited Dr. Jacquie Halladay to provide part-time clinical supervision to the Branch's cessation work, including the Quitline. A full-time Director of Tobacco Cessation is being recruited who will serve as the NC Tobacco Use Quitline Administrator.
- Legal barriers reduced the Quitline's capacity to offer NRT to callers during the fiscal year.

Goal Area 4: Reducing health disparities related to tobacco use.

Focus Area 1: Identify and eliminate the disparities related to tobacco use and its effects among HWTF TTUPC grantees that serve populations that are predominantly minority youth through grants monitoring, training, and technical assistance.

SMART Objective: Throughout the contract period, the TPCB Director of Parity and Diversity will provide technical assistance, support and grant monitoring to HWTF TTUPC grantees that serve populations that are predominantly minority youth. Grant monitoring and accountability will be in accordance with HWTF grant monitoring standards/practices. These grantees include North Carolina Commission of Indian Affairs, El Pueblo, Center for Health and Healing (C4HH), Old North State Medical Society (ONSMS), Lumbee Tribe, and Haliwa-Saponi Tribe; assistance to Coastal Horizons may also be provided based on the number of activities that specifically address the Latino community.

Table 4.1.1 – Deliverables provided by TPCB to reduce health disparities related to tobacco use.

Type of Deliverable	Attainment
▪ **Monitor the 6 HWTF TTPUC grantees that specifically focus on minority populations.**	**Completed**
▪ **Receive and implement guidance and training from the HWTF Tobacco Program Officer and other appropriate HWTF staff on HWTF grant management/monitoring policies and procedures, participate in HWTF Grants Management meetings, and attend NC Auditor's trainings to further grant management skills.**	**Completed**
▪ **Conduct a minimum of 4 site visits (quarterly) with each assigned HWTF TTUPC grantee.**	**32**
▪ **Maintain ongoing contact (at least monthly) with these grantees to review monthly progress reports, discuss progress toward AAP goals and objectives, celebrate accomplishments, and identify strategies to overcome barriers.**	**Completed**
▪ **Work with assigned HWTF TTUPC grantees and HWTF Tobacco Program Officer to assess needs and design plans to implement specific projects to strengthen grantee capacity.**	**Completed**
▪ **Participate in annual action plan review for assigned HWTF TTUPC grantees to identify health disparity issues and provide recommendations for grantees.**	**Completed**
▪ **Attend CDC Identification and Elimination of Tobacco-Related Disparities meeting in 2008.**	**Not held**

Key Accomplishments:

- Conducted six (6) initial site visits with each grantee to review activities listed in their action plan. Conducted follow-up site visits with ONSMS and C4HH to review forecasting tool they developed based on my recommendations.
- On August 13, 2007, conducted a cultural competency training for Question Why youth and adult leaders.
- Director of Parity and Diversity attended trainings on Grants Administration and Basics of Internal Control from the Office of the State Auditor.
- Conducted mid-year site reviews with all grantees.

SMART Objective: By June 30, 2008, the TPCB will conduct grantee and staff development activities to increase expertise in addressing tobacco prevention and cessation health disparity issues. Work in coordination with HWTF Tobacco Program Officer and Grantee Development and Evaluation Director regarding needs assessments.

Table 4.1.2 – Deliverables provided by TPCB to increase expertise in addressing tobacco prevention and cessation health disparity issues.

Type of Deliverable	Attainment
▪ **Prepare an updated report (maximum 10 pages) on tobacco-attributable health disparities and make recommendations to HWTF on action steps to address these disparities.**	**Completed**
▪ **Conduct at least 1 cultural competency session for HWTF TTUPC grantees by December 31, 2007.**	**Completed**
▪ **Conduct 3 regional diversity trainings for HWTF TTUPC grantees by April 30, 2008.**	**Completed**
▪ **Host at least one (1) meeting with HWTF TTUPC grantees that serve populations that are predominantly minority youth, HWTF staff, and key stakeholders to gain feedback on recommendations to identify and eliminate tobacco attributable health disparities.**	**Completed**
▪ **Reassess the current status of activities to address tobacco-attributable health disparities statewide, including updating the current quantitative and qualitative data related to disparities and provide a report of findings with recommendations to HWTF by December 31, 2007.**	**Completed**
▪ **Compile and disseminate evidence-based strategies to specifically address disparities identified during SOW implementation.**	**Completed**

Key Accomplishments:

- On September 28, 2007, the TPCB Director of Parity and Diversity conducted a cultural competency training session for all grantees and technical assistance providers at the HWTF annual meeting.
- Conducted Cultural Competency Workshop for Fit Together Training on October 15, 2008.
- Submitted 15-page report on tobacco-related health disparities in North Carolina to HWTF Staff.
- Presented tobacco-related disparities report to priority population grantees to obtain feedback on content. Conducted initial feasibility analysis of tobacco related disparities and recommendations were presented to HWTF, TPCB Staff and other partners.

Goal Area 5: Administration

Focus Area 1: Surveillance and Evaluation

SMART Objective: By December 30, 2007, the TPCB Tobacco Epidemiologist, with input from other TPCB staff will plan, recruit schools, track surveys and collect data for the NC YTS 2007. The data will be submitted to CDC/RTI for processing and cleaning.

SMART Objective: By June 30, 2008, TPCB Tobacco Epidemiologist, with input from other TPCB staff, will generate and compile new surveillance and evaluation tools based on additional data sources including BRFSS, CHAMPS, YRBS, and RHHS.

Table 5.1.1 - Deliverables provided by TPCB to generate surveillance and evaluation tools based on YTS, BRFSS, CHAMPS, YRBS & RHHS.

Type of Deliverables	Attainment
▪ **Plan and conduct the statewide 2007 NC Youth Tobacco Survey (NC YTS) for more than 7,000 middle and high school students by December 2007.**	**Completed**
▪ **Provide input for survey planning, coordination, implementation, and results dissemination for YTS, BRFSS, CHAMPS, YRBS, and others as identified.**	**5**
▪ **Create 6 CHAMP fact sheets, 1 BRFSS short report and 1 general report outlining YRBS tobacco results.**	BRFSS report completed; 6 CHAMPS reports created and soon to be posted to web; 3 PRAMS fact sheets added; YRBS not yet complete

Key Accomplishments:

- More than 11,000 surveys have been distributed to 400 classrooms in 194 schools at 74 LEAs. All 74 LEAs agreed to participate for a 100% response rate at the district level.
- An analysis of changes in teen smoking rates obtained from YTS survey administered from 1999 through 2007 showed a dramatic decline in prevalence between 2003 and 2005.

- Lt. Governor presented the historic low 2007 NC Youth Tobacco Survey results at Jordan High School, Durham, NC on April 15, 2008. Most background materials were created and generated by the YTS Team.
- YTS TPCB Team presented YTS results to HWTF Teen Prevention Task Force on May 2 , 2008 and to the full HWTF Commission meeting on May 13, 2008.
- Short Supplemental Youth Tobacco Survey (SSYTS) preliminary results presented to the TPCB Director of Parity and Diversity on (March 26th), NCCIA (March 26th) and the HWTF Director of Evaluation and Development on (May 2nd). SSYTS data has been presented to Tribal Councils in 3 areas: Waccamaw-Siouan (May 15th); Coharie (May 19th); Eastern Band of Cherokee (June 12 th).

Unplanned Opportunities/Changes:

- A supplemental survey intended to increase the sample size for American Indian students was conducted with the support and partnership of NCCIA. More than 4,000 students took part in this supplemental survey from 25 schools with greater than 10% American Indian populations.

Challenges:

- Staffing change: Scott Proescholdbell has led the Epidemiology and Evaluation Section within TPCB for the past 6 years. He has recently changed roles within DPH and now serves as Epi Unit Manager for Injury Prevention Branch.

Focus Area 2: Training/Technical Assistance Evaluation.

SMART Objective: By June 2008, develop evaluation materials to support TA and Training offered by TPCB and TA providers to HWTF TTUPC grantees. Specifically, TPCB will develop an easy to use evaluation toolkit to provide standardized training evaluation forms, and to better assess provision of TA and training.

Table 5.2.1 - Deliverables provided by TPCB to evaluate TA and Training

Type of Deliverable	Attainment
▪ **Assist in the development and analysis of evaluation studies for TTUPC grantees and TTUPC TA providers as requested by HWTF.**	**24**
▪ **Develop, disseminate, and analyze process evaluation instruments and needs assessment tools for NCSTEP and SAVE or other TA providers as requested.**	**9**
▪ **Collaborate with HWTF TTUPC grantees and TA providers to develop evaluation instruments.**	**7**
▪ **Publish web-based instruments for TA providers and TTUPC grantees to access.**	**4**
▪ **Download and analyze data from web-based surveys and generate report describing results to HWTF and TA Provider.**	**2**
▪ **Pre-test tobacco use prevention and/or cessation materials as requested by HWTF and HWTF TTUPC grantees and TA**	**None requested**

providers.	

Key Accomplishments:

- Developed and piloted instruments for SAVE and NCSTEP. Provided ongoing evaluation of events.
- Conducted evaluation and disseminated report on statewide HWTFT TUPC conference.
- Conducted an analysis of changes in teen smoking rates obtained from YTS survey administered from 1999 through 2007. Results showed a dramatic decline in prevalence between 2003 and 2005.

Unplanned Opportunities/Changes:

- Developed a web-based questionnaire to update information on HWTF grantees and to assess planning meeting for college grantees.

Challenges:

- The TPCB evaluation examines the training process, training experience and improved self-efficacy. The outcomes are generally positive. But, the connection between training and technical assistance to grant performance is often ambiguous. The intended impact of training on deliverables for specific grantees is unstated.

Goal Area 5: Administration

Focus Area 3: Media consultation, monitoring, and training

SMART Objective: By June 30, 2008, the Director of Public Education will provide media consultation, monitoring (in-kind) and training for HWTF TTUPC grantees, staff, and gap counties.

Table 5.3.1 – Deliverables provided by TPCB: media consultations, monitoring and training

Type of Deliverable	Attainment
• **Conduct quarterly media-related conference calls for HWTF TTUPC grantees.**	**3**
• **Conduct 2 (two) day-long media trainings for HWTF TTUPC grantees, TPCB and HWTF on serving as a spokesperson, media advocacy and media guidelines by December 30, 2007.**	**2**
• **Provide technical assistance and guidance on the development of statewide media campaigns as requested.**	**Completed (1)**
• **Review for compliance with HWTF guidelines media pieces**	**116**

requested by HWTF TTUPC grantees.	
• **Provide training and technical assistance to HWTF TTUPC grantees regarding media and communications issues.**	**30**
• **Provide support to HWTF TTUPC grantees in preparing state and local staff for interviews as requested.**	**4**
• **Review drafts of state and local news releases, Letters to Editors, other written communication, and media advocacy plans as requested.**	**7**

Key Accomplishments:

- Prior to the contract year the Director of Public Education participated in early planning for the HWTF's Quitline media campaign launched this year.
- Trained 18 TTUPC HWTF grantees at the spokesperson training events on November 9, 2007 in Wilson, NC and February 13, 2008 in Shelby, NC.
- Trained five TTUPC HWTF grantees at the spokesperson training on November 9, 2007 in Wilson, NC.
- Based on HWTF recommendation, the Director of Public Education and Communication developed 13 "Swiss Cheese" News Releases focused on specific teen tobacco use prevention themes. The news releases will be submitted to the media at various times throughout the year.

Unplanned Opportunities/Changes:

- The Director of Public Education has been called upon to assist in the selection of TRU Teen of the Month Contest winners. Those selected are serving as talent in yet-to-be-released TRU TV ads.

Goal Area 5: Administration

Focus Area 4: Training

SMART Objective: By June 30, 2008 TPCB Director of Training, in coordination with TPCB staff, HWTF staff, other technical assistance and resource providers, and others as identified, and utilizing the HWTF information on TTUPC grantee needs, will plan statewide, regional, local, in-person, and on-line training events for local health departments including but not limited to HWTF TTUPC grantees.

Table 5.4.1 - Deliverables provided by TPCB to plan statewide, regional, local, in-person, and on-line training events.

Type of Deliverable	Attainment
▪ **Coordinate with HWTF Tobacco Program Officer to facilitate quarterly HWTF TTUPC Grantee Technical Assistance calls.**	**4**
▪ **Develop and provide Tobacco 101 *Part 1* CD-Rom and take home challenges on tobacco prevention and control problem descriptions/data, and key resources.**	**Completed**
▪ **Plan and conduct three (3) regional Tobacco 101 trainings with Tobacco 101 *Part 2* CD-Rom and take home challenges for all HWTF TTUPC grantees by March 2008.**	**Completed**
▪ **Collaborate with HWTF Tobacco Program Officer and planning committee to design, implement and evaluate annual tobacco use prevention and cessation training meeting December 15, 2008.**	**Completed**

▪ **Collaborate with the HWTF Tobacco Program Officer to coordinate, plan, implement, and evaluate a 2-day TTUPC Annual Action Plan (AAP) meeting and planning workshop for the tobacco-related grantees by April 15, 2008.**	**Completed**
▪ **At the request of HWTF, provide a policy update on the 2007 legislative session related to tobacco prevention and control to HWTF Commission Tobacco Task Force and at their request to the full Commission.**	**None requested**
▪ **Coordinate training opportunities for HWTF TTUPC grantees and other participants pre-approved by HWTF.**	**14**
▪ **Organize training specific teams to plan training events that are based on current data, recommended best practices, needs expressed by the grantees and recommendations from technical assistance and resource providers, and HWTF staff as required.**	**None requested**
▪ **Plan, conduct, and evaluate a minimum of 3 regional Adult Leader Trainings with Question Why for HWTF TTUPC grantee and other participants pre-approved by HWTF by June 30, 2008.**	**Completed**
▪ **Plan, conduct, and evaluate a minimum of 3 additional regional meetings and information exchanges on topics defined through coordination with HWTF by June 30, 2008.**	**Completed**
▪ **Work with HWTF Tobacco Program Officer to identify opportunities for additional region-focused training efforts.**	**ongoing**

Key Accomplishments:

- Used web- based meeting platform to help Grants Managers conduct Annual Action Plan reviews with individual grantees. Also worked with Director of Tobacco Free Campuses to conduct a follow-up meeting for College Grantees using the web platform on April 8, 2008.
- Collaborated with Question Why and North Carolina Spit Tobacco Education Program to conduct trainings for grantees across the state.

- In late July, the Tobacco Prevention and Control Branch Director of Training was asked by the HWTF to schedule the Statewide Annual Teen Tobacco Use Prevention and Cessation Grantee meeting for late September. The Annual Grantee event was held on September 27-28, 2007 at the Embassy Suites Greensboro Airport. One hundred- nine (109) individuals attended the meeting including special guests, the honorable Howard Lee, Representative Maggie Jeffus, and Senator Katie Dorsett.
- Assisted the North Carolina Spit Tobacco Education Program (NCSTEP) in developing Eastern and Central Region Task Forces.
- The TPCB Director of Training worked with a HWTF Tobacco Officer, Grants Managers, and TPCB Director of Evaluation to plan and implement the TTUPC Annual Action Plan held on March 12-13, 2008 in Hickory, NC. One-hundred and two (102) individuals participated in the meeting including grantees, technical assistance providers, and HWTF staff.

Unplanned Opportunities/Changes:

- An excellent opportunity was presented to the TPCB Director of Training to assist in planning the Phase 2, TEAM 2 Tobacco Free College Grantee Annual Action Planning Meetings.

Challenges:

- TPCB still awaits final feedback or guidance from HWTF on how HWTF would permit the Tobacco 101/202 instructional CD ROM and regional trainings to be approached this funding year.

Goal Area 5: Administration

Focus Area 5: Administration, Coordination, and Accountability

SMART Objective: By June 30, 2008, the TPCB staff will participate in the Grants Resource Management Council (GRMC) as requested and meet all contractual reporting requirements.

Table 5.5.1 - Deliverables provided by TPCB to participate in GRMC & meet all contractual reporting requirements.

Type of Deliverable	Attainment
▪ **Participate in the Grants Resource Management Council (GRMC), as requested by HWTF.**	**None scheduled**
▪ **Prepare and submit quarterly progress reports on TPCB program activities, significant achievements and challenges, trends, recommendations, and other items as negotiated to HWTF.**	**Completed (4)**
▪ **Prepare and submit an annual report to HWTF summarizing the TPCB's tobacco use prevention and control program deliverables and provide other reports as requested.**	**Completed**

Summary of Deliverables for 2007-2008

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:

Initiation

Deliverables provided to encourage implementation/compliance of TFS policy

Type of Deliverable	Attainment
▪ 4 regional "Train the Trainer" meetings (need reassessed; strong attendance)	1
▪ 8 regional TFS compliance workshops for all 115 LEA's (need reassessed; strong attendance)	2
▪ Consultations with TTUPC grantees and Real-Time Community Change grant recipients to encourage 100% TFS compliance	60
▪ Evaluate and revise TFS compliance materials as needed	16
▪ Distribute HWTF approved compliance manuals for all NC superintendents and principals.	136
▪ Identify needs and provide technical assistance to school systems with TFS policies.	62
▪ 100% TFS signs disseminated	Completed 8672 signs
▪ Provide new copy and other appropriate changes to TFS web site to reflect new emphasis on compliance.	4
▪ Provide a minimum of 28 school districts with model policies	39
▪ Provide other technical assistance to assist with TFS policy implementation.	71
▪ Develop and deliver one mailing to school board members and superintendents in each school district that have not adopted a TFS policy by January 1, 2008.	Completed
▪ Develop and deliver recommended public communications plan to HWTF to assure compliance with G.S. 115c-407 as amended by SL2007-236 by August 10, 2007.	Completed

Deliverables to reduce impact of tobacco advertising

Type of Deliverable	Attainment
▪ Develop for review and distribution appropriate teen activities to track local tobacco marketing.	Delivered pending response
▪ Develop for review and posting at least one appropriate media literacy fact sheet.	Delivered pending response
▪ TPCB will notify HWTF of advertising by tobacco manufacturers that NC teens and adults identify as potentially targeting teens.	Delivered pending response

Deliverables to promote awareness of the relationship between price of tobacco products and tobacco use initiation among youth and young adults and cessation

Type of Deliverable	Attainment
• Adapt materials designed to calculate the cost of smoking and tobacco use for a teen and young adult population by December 15, 2007.	Completed
• Develop a PowerPoint presentation on Tobacco Price and its public health impact by December 15, 2007.	Completed
• Provide a brief update about the effectiveness of tobacco price increases on tobacco initiation and cessation at the 2007-2008 state conference.	Updated in June

Secondhand Smoke (SHS)

Deliverables to increase the number of youth oriented smoke-free venues

Type of Deliverable	Attainment
• TPCB will prepare and present evidence based options within HWTF approved SHS activities for grantees to work on SHS by September 30, 2007.	Complete
▪ Assist with the design and development of a pre-packaged "cookie cutter" Media and Youth Empowerment SHS Campaign for TTUPC grantees.	Pending response
▪ Provide training to TTUPC grantees on how to use the cookie cutter media campaign to increase smoke free policies in youth-oriented venues.	Pending response
▪ Work with HWTF to examine the effectiveness of the pre-packaged Media and Youth Empowerment SHS Campaign for TTUPC grantees.	Pending response
▪ Develop 12 seasonal SHS "Swiss Cheese" News Releases by January 1, 2008.	Complete
▪ Work to promote earned media opportunities and messages related to secondhand smoke and smoke-free policies statewide.	Ongoing
▪ Provide program development and technical assistance to HWTF TTUPC grantees and gap counties on HWTF approved tobacco free policies and norms.	Ongoing

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).*

Deliverables to advance quitting targeting teens, young adults and school personnel to HWTF TTUPC, CTUPC grantees & health departments.

Type of Deliverable	Attainment
▪ Conduct at least 5 presentations to health care providers who work with teens and young adults on promising tobacco cessation interventions in the clinical setting by May 31, 2008.	11
▪ Design and implement 2 clinic based demonstration projects to incorporate 5A's/best practices in gap counties.	Completed
▪ Train all HWTF TTUPC/CTUPC grantees on how to work with local health care providers to integrate the 5As into their dental and pediatric/family medical practices who reach HWTF target populations by Dec. 15, 2007.	Completed
▪ Develop a cessation training kit for HWTF TTUPC/CTUPC grantees, focusing on HWTF approved populations of teens, young adults up to age 24, primary caregivers with children in the home, and school personnel by December 15, 2007.	Completed
▪ Support the implementation of HWTF TTUPC/CTUPC grantee cessation trainings, the provision of technical assistance, and other activities as requested by HWTF TTUPC/CTUPC grantees and approved by the HWTF Tobacco Officer.	Completed
▪ DPH/TPCB will work with HWTF staff, the North Carolina Medical Board, the North Carolina Medical Society, and the NC Tobacco Use Quitline vendor to allow the vendor to advise on and distribute nicotine replacement therapy to eligible callers by January 31, 2008.	Special Provision Passed Logistics in progress
▪ Provide technical assistance for a marketing campaign promoting the NC Tobacco Use Quitline targeting 18-24 year old high-risk tobacco users who are unemployed and/or not attending college by June 30, 2008.	Completed
▪ Provide cessation assistance through promotion of the Quitline and fax referral system to local health departments and schools in gap counties.	Completed
▪ Assist with earned media messages promoting cessation among HWTF cessation target populations.	Completed
▪ Identify and provide to HWTF a list of possible tailored web-based cessation services proven effective with youth and/or young adults by December 31, 2007.	Completed
▪ Continue to develop collaborations with national, state, and local partners on promotion of the NC Tobacco Use Quitline at 1-800-QUIT-NOW (Quitline NC).	On-going
▪ Provide feedback for HWTF on the number, types, and dates of assistance provided to TTUPC/CTUPC grantees as well as non-grantee communities in gap counties.	Completed

Disparities

Deliverables provided by TPCB to reduce health disparities related to tobacco use

Type of Deliverable	Attainment
• Monitor the 6 HWTF TTPUC grantees that specifically focus on minority populations.	Completed
• Receive and implement guidance and training from the HWTF Tobacco Program Officer and other appropriate HWTF staff on HWTF grant management/monitoring policies and procedures, participate in HWTF Grants Management meetings, and attend NC Auditor's trainings to further grant management skills.	Completed
• Conduct a minimum of 4 site visits (quarterly) with each assigned HWTF TTUPC grantee.	32
• Maintain ongoing contact (at least monthly) with these grantees to review monthly progress reports, discuss progress toward AAP goals and objectives, celebrate accomplishments, and identify strategies to overcome barriers.	Completed
• Work with assigned HWTF TTUPC grantees and HWTF Tobacco Program Officer to assess needs and design plans to implement specific projects to strengthen grantee capacity.	Completed
• Participate in annual action plan review for assigned HWTF TTUPC grantees to identify health disparity issues and provide recommendations for grantees.	Completed
• Attend CDC Identification and Elimination of Tobacco-Related Disparities meeting in 2008.	Not Held

Deliverables to increase expertise in addressing tobacco prevention and cessation health disparity issues

Type of Deliverable	Attainment
• Prepare an updated report (maximum 10 pages) on tobacco-attributable health disparities and make	Completed

recommendations to HWTF on action steps to address these disparities.	
• Conduct at least 1 cultural competency session for HWTF TTUPC grantees by December 31, 2007.	Completed
• Conduct 3 regional diversity trainings for HWTF TTUPC grantees by April 30, 2008.	Completed
• Host at least one (1) meeting with HWTF TTUPC grantees that serve populations that are predominantly minority youth, HWTF staff, and key stakeholders to gain feedback on recommendations to identify and eliminate tobacco attributable health disparities.	Completed
• Reassess the current status of activities to address tobacco-attributable health disparities statewide, including updating the current quantitative and qualitative data related to disparities and provide a report of findings with recommendations to HWTF by December 31, 2007.	Completed
• Compile and disseminate evidence based strategies to specifically address disparities identified during SOW implementation.	Completed

Administrative Services

Deliverables to generate surveillance and evaluation tools based on YTS, BRFSS, CHAMPS, YRBS & RHHS

Type of Deliverable	Attainment
• Plan and conduct the statewide 2007 NC Youth Tobacco Survey (NC YTS) for more than 7,000 middle and high school students by December 2007.	Completed
• Provide input for survey planning, coordination, implementation, and results dissemination for YTS, BRFSS, CHAMPS, YRBS, and others as identified.	Accomplished 5 dissemination completed
• Create 6 CHAMP fact sheets, 1 BRFSS short report and 1 general report outlining YRBS tobacco results	BRFSS report completed; 6 CHAMPS reports created and soon to be posted to web; 3 PRAMS fact sheets added; YRBS not yet complete

Deliverables to evaluate TA and Training

Type of Deliverable	Attainment
• Assist in the development and analysis of evaluation studies for TTUPC grantees and TTUPC TA providers as requested by HWTF.	24
• Develop, disseminate, and analyze process evaluation instruments and needs assessment tools for NC STEP and SAVE or other TA providers as requested.	9
• Collaborate with HWTF TTUPC grantees and TA providers to develop evaluation instruments.	7
• Publish web-based instruments for TA providers and TTUPC grantees to access.	4
• Download and analyze data from web-based surveys and generate report describing results to HWTF and TA Provider.	2
• Pre-test tobacco use prevention and/or cessation materials as requested by HWTF and HWTF TTUPC grantees and TA providers.	None requested

Deliverables to assist, monitor and train HWTF & TTUPC grantees on Media

Type of Deliverable	Attainment
• Conduct quarterly media-related conference calls for HWTF TTUPC grantees.	3
• Conduct 2 (two) day-long media trainings for HWTF TTUPC grantees, TPCB and HWTF on serving as a	2

spokesperson, media advocacy and media guidelines by December 30, 2007.	
• Provide technical assistance and guidance on the development of statewide media campaigns as requested.	Completed (1)
• Review for compliance with HWTF guidelines media pieces requested by HWTF TTUPC grantees.	116 media pieces reviewed
• Provide training and technical assistance to HWTF TTUPC grantees regarding media and communications issues.	30 TA responses
• Provide support to HWTF TTUPC grantees in preparing state and local staff for interviews as requested.	4
• Review drafts of state and local news releases, Letters to Editors, other written communication, and media advocacy plans as requested.	7 drafts reviewed

Deliverables to plan statewide, regional, local, in-person, and on-line training events

Type of Deliverable	Attainment
• Coordinate with HWTF Tobacco Program Officer to facilitate quarterly HWTF TTUPC Grantee Technical Assistance calls.	4
▪ Develop and provide Tobacco 101 *Part 1* CD-Rom and take home challenges on tobacco prevention and control problem descriptions/data, and key resources.	Completed
▪ Plan and conduct three (3) regional Tobacco 101 trainings with Tobacco 101 *Part 2* CD-Rom and take home challenges for all HWTF TTUPC grantees by March 2008.	Completed
▪ Collaborate with HWTF Tobacco Program Officer and planning committee to design, implement and evaluate annual tobacco use prevention and cessation training meeting December 15, 2008.	Completed
▪ Collaborate with the HWTF Tobacco Program Officer to coordinate, plan, implement, and evaluate a 2-day TTUPC Annual Action Plan (AAP) meeting and planning workshop for the tobacco-related grantees by April 15, 2008.	Completed
• At the request of HWTF, provide a policy update on the 2007 legislative session related to tobacco prevention and control to HWTF Commission Tobacco Task Force and at their request to the full Commission.	None requested
• Coordinate training opportunities for HWTF TTUPC grantees and other participants pre-approved by HWTF	14
• Organize training specific teams to plan training events that are based on current data, recommended best practices, needs expressed by the grantees and recommendations from technical assistance and resource providers, and HWTF staff as required.	None requested
• Plan, conduct, and evaluate a minimum of 3 regional Adult Leader Trainings with Question Why for HWTF TTUPC grantee and other participants pre-approved by HWTF by June 30, 2008.	Completed
• Plan, conduct, and evaluate a minimum of 3 additional regional meetings and information exchanges on topics defined through coordination with HWTF by June 30, 2008.	Completed
• Work with HWTF Tobacco Program Officer to identify opportunities for additional region-focused training efforts.	ongoing

Table 5.5.1 - Deliverables provided by TPCB to participate in GRMC & meet all contractual reporting requirements

Type of Deliverable	Attainment
• Participate in the Grants Resource Management Council (GRMC), as requested by HWTF.	Not held
• Prepare and submit quarterly progress reports on TPCB program activities, significant achievements and challenges, trends, recommendations, and other items as negotiated to HWTF.	Completed (4)
• Prepare and submit an annual report to HWTF summarizing the TPCB's tobacco use prevention and control program deliverables and provide other reports as requested.	To be submitted by 8-30-08

2007-2008 ?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 were developed such as the Teen Tobacco Prevention Twister activity. Adult and youth trainings were exceeded by 60% of what the statement of work required. This year we expanded the adult and youth Real Time Community Change (RTCC) project and modified it from the previous year that did increase its effectiveness. What follows are the summaries of each the youth development, trainings, and RTCC project highlights.

Youth Development

In August of 2007, the Statewide Question Why regions brought their Youth Staff together for the annual Brown Summit Youth Retreat in Brown Summit, NC. This summit gave Youth the chance to develop new, innovative, activities and modules such as the Smoke-free Dining module and the Teen Tobacco Prevention Twister activity produced by Question Why East to enhance the Question Why Training series, as well to receive some specialized training in cultural diversity around the topic of teen tobacco prevention. In May of 2008, the Question Why East Youth leaders went through their annual Real Time Community Change workshop, where they developed an advocacy action plan that targeted a local bowling alley and their smoking policy. The Youth Leaders were engaged independently in the community and with the media. The youth generated 7 earned media articles. During the 2007-2008 year, out of the 20 Youth trainings that were provided by Question Why East, 75% were led by our Question Why East Youth Staff. Two Question Why East Youth Leaders moved in to Senior Positions which were the Senior Youth Program Manager and Senior Youth Evaluator. Many new partnerships were developed in schools and community programs and organizations that will lend to recruitment and retention of future Question Why youth.

Youth & Adult Training

Question Why East provided a total of 26 youth and adult trainings, exceeding the statement of work by 11 trainings. Our goal of 12 youth trainings was exceeded by 8 for a total of 20 trainings. Trainings were hosted in 13 eastern NC counties with nine of the 20 youth trainings having youth from 2 or more counties participating. Three trainings were conducted specifically for Priority Populations grantees and six trainings had a majority of gap county participants. The total number of youth training contacts was 504. One training was conducted with youth in direct preparation for a presentation to the local board of education regarding a 100% TFS policy. Question Why East's goal of 3 adult leader trainings was exceeded by 3 for a total of 6 adult leader trainings**.** Question Why staff shared the question why model and other teen tobacco use prevention topics with 94 new and existing partners through three Real Time Community Change workshops and one other adult leader regional training. Staff also trained adults at the NC SOPHE (Society of Public Health Educators) annual conference and the National 2008

Access Conference: Building a Tobacco-Free Future. The total number of adult training contacts was 154.

Real Time Community Change

Real Time Community Change worked with three adult teams and six youth teams for the 2007-2008 year for a total of nine teams. All teams were strategically chosen based primarily on their status of being "gap" counties. The three adult teams were from Sampson County, Johnston County, and Wayne County. Adult teams were committed to a six-month process, with funding of $1500 per team. Their implementation workshop was held in Goldsboro. Every team member came back to the midpoint luncheon in January, and most team members came back to the Final Forum as closure to the project in April. The six youth teams were from Wayne, Onslow, and New Hanover Counties. Youth teams were committed to an eight-week process, with funding of $500 per team. Their implementation workshops and final forums were held in each of the mentioned counties.

Adult Team Highlights

SAMPSON:

- Sampson county team presented to their Board of Education twice
- Sampson team received earned media in local newspaper twice
- Team was able to pass a 100% TFS policy change

JOHNSTON:

- Prepared for TFS compliance in the fall by purchasing TRU T-shirts to promote the policy change.
- Team was able to get buy-in for policy promotion though local dentists offices

WAYNE:

- Team was able to ensure that every staff member on all of Wayne's campuses is aware of the new TFS policy change, when it will be implemented, and how offenses will be dealt with.
- They focused heavily on policy communication to ensure a smooth transition.
- Team received earned media coverage in local newspaper and in their school's newspaper

Youth Team Highlights

WAYNE:

- Worked with three teams from three different high schools in Wayne County.
- All teams worked on policy communication through creative and educational peer education programs.

ONSLOW:

- Worked with two teams from Southwest High School.
- Worked towards creating a smoke-free policy at a restaurant as well as a smoke-free bowling ally policy change.
- Used surveys to gather data to assess local feelings about changing the policy at the bowling ally.
- Did not succeed yet, but want to return to this project in the fall and work towards a city-wide policy change.

NEW HANOVER:

- Offered RTCC to Question Why staff as professional development and part of their training.
- Worked towards creating the only smoke-free bowling ally in Wilmington.
- Received earned media coverage in local newspaper and on TV.

North Carolina Health & Wellness Trust Fund Commission
Annual Progress Report

ORGANIZATION NAME: Youth Empowered Solutions (YES!)
PROGRAM NAMES: Question Why West and Question Why Central
FEDERAL ID: 06-1813332

REPORTING PERIOD: January 1, 2008 – June 30, 2008

Note: This report covers the timeframe of January 1-June 30, 2008 due to the creation of the non-profit organization of Youth Empowered Solutions (YES!) to house the Question Why (?Y) Western and Central Programs and its subsequent funding by the NC Health and Wellness Trust Fund Commission beginning January 1, 2008.

YOUTH LEADER TRAININGS

YES! youth leader trainings are youth-led and adult-assisted, providing skill-building and youth-led prevention and advocacy activities. The topic areas focus on Tobacco 101, Media Literacy, Youth Advocacy, Red Flag/Merchant Education, and Tobacco 202.

From 01/01/08 through 06/30/08, the ?Y West, Central-West, and Central-East programs of YES! provided 23 youth leader trainings, including 12 Tobacco 101, 1 Media Literacy, 8 Youth Advocacy, and 2 Red Flag/Merchant Education. These trainings served 250 grantee youth, 165 non-grantee youth, 36 grantee adults, and 4 non-grantee adults in the counties of Orange, Wake, Durham, Catawba, Buncombe, Gaston, Mecklenburg, Macon, Rowan, Cabarrus, Burke, Vance, Transylvania, Cherokee, Clay, Graham, and Chatham counties and the priority populations of the Commission on Indian Affairs and Lumbee Tribe (Robeson County).
(a total of 415 youth and 50 adult leaders)

In order to follow the youth-led training philosophy, YES! has maintained a staff of 13-18 high school students ("youth leaders"). This youth staff reflects the diversity of the regions in age, gender, culture, ethnicity, and socio-economic status. Each youth leader participates in an intensive orientation and training, and then becomes an active member in researching, planning, implementing and evaluating ?Y trainings and activities.

Furthermore, ?Y West and ?Y Central continue to concentrate on providing cutting-edge resources and inspirational trainings to the regions. Resources and activities developed for trainings by ?Y include: How to Do Kick Butts Day, Online Social Networking Do's and Don'ts, Cultural Competency, How to Prepare Youth to be Spokespeople, Potentially Reduced Exposure Products, Recommended Videos, Recommended Websites, and Facts and Statistics about Tobacco Use. In order to stay current on information, YES! staff attended professional development courses on such things as leadership and media literacy. YES! is constantly modifying and creating activities and

resources to vary the trainings and workshops and best serve the needs of the state for teen tobacco use prevention and cessation.

ADULT LEADER TRAININGS

From 01/01/08 through 06/30/08, YES! planned and facilitated four adult leader workshops that provided information on youth tobacco use prevention, youth empowerment, youth advocacy, and skill-building for leading youth groups and youth-led prevention activities: Resource Sharing and Cultural Competency (Western Region, January 30), Resource Sharing and Social Networking (Central Region, February 7), Pieces of the Puzzle Resources and Networking (Western Region, May 20), and Pieces of the Puzzle Resources and Networking (Central Region, June 4). Speakers at the workshops included grants managers from the North Carolina Health and Wellness Trust Fund (HWTF), Tish Singletary and Jim Martin from the Department of Health and Human Services North Carolina Tobacco Prevention and Control Branch (TPCB), Demetrius Harvey from the American Lung Association (ALA), Carol Morris from the Alcohol and Tobacco Law Enforcement (ALE), Margaret Brake from the Department of Health and Human Services (DHHS), and Paul Turner from the North Carolina Spit Tobacco Education Program (NC STEP).

Representatives from the counties of Henderson, Yancey, Cleveland, Buncombe, Graham, Ashe, Haywood, Swain, Transylvania, Jackson, Madison, Eastern Band of Cherokee Indians, Caldwell, Cherokee, Clay, Watauga, Mitchell, Wilkes, Catawba, Burke, McDowell, Macon, Madison, Union, Mecklenburg, Gaston, Rowan, Cabarrus, Moore, Alamance, Chatham, Durham, Forsyth, Guilford, Montgomery, Richmond, Hoke, Orange, Randolph, Richmond, and Surry counties attended the adult leader workshops, along with the priority population of the Center for Health and Healing—Picture Me Tobacco Free Project.
(a total of 113 adults)

These adult leader workshops consistently obtain high ratings for their networking opportunities, resource-sharing, new information and activities shared, and youth perspectives.

TECHNICAL ASSISTANCE

YES! takes the issue of providing efficient and practical technical assistance (TA) on youth tobacco use prevention, empowerment, and advocacy very seriously, responding to 142 specific requests and providing 198 instances of TA in the form of sharing resources, answering requests and questions, developing materials, talking on the phone, interacting via email, attending meetings, coordinating technical assistance, and assisting in planning projects/events.

HWTF-funded community and school grantees and priority populations that have received TA from YES! include: Buncombe, Burke, Caldwell, Catawba, Tri-County (representing Cherokee, Clay, and Graham), Cleveland, TRU-6 (representing Haywood, Transylvania, Madison, Jackson, Swain, and the Eastern Band of Cherokee Indians),

Henderson, Macon, Watauga, Wilkes, Yancey, Cabarrus, Forsyth, Gaston, Mecklenburg, Rowan, Surry, Union, Alamance, Chatham, Durham, Guilford, Hoke, Orange, Moore, Wake, and Vance counties, and the Haliwa-Saponi and Lumbee Tribes. Counties that currently do not receive HWTF funding also received TA, including Iredell, Franklin, Harnett, and Randolph.

In addition, YES! shares TA and resources via the Question Why website of www.questionwhy.org. There were 17 updates to the website, including adding training overviews, advocacy project summaries, and tobacco use prevention resources, and the website received over 5,000 hits.

COLLABORATIONS AND COMMUNICATION

YES! works closely with the NC HWTF, NC TPCB, and NC HWTF-funded TA providers such as NC STEP, ALA, and ALE. YES! staff participated on 2 of the grantee calls scheduled by grants manager Sterling Fulton-Smith, presented on a TPCB media conference call, consulted on the Step Up NC website, attended the NC STEP Western and Central region meetings, participated in the Annual Action Planning Conference, is a member of the statewide Grants Resource Management Committee (GRMC), and participated in the HWTF and Media conference calls. YES! staff also met with local, regional, and national partners such as the Buncombe County Project ASSIST coalition, Campaign for Tobacco Free Kids, El Pueblo, ALA, and the Northwest Tobacco Prevention Coalition.

In order to coordinate ?Y statewide efforts, YES! participates in regularly-scheduled statewide planning and coordinating meetings that focus on programmatic needs, resource development, strategic planning, and program sustainability. This includes ?Y bi-weekly statewide staff and directors conference calls (21), and ?Y quarterly planning and coordinating staff meetings (2).

YOUTH ADVOCACY

Youth advocacy projects to promote tobacco-free policies and compliance are researched, planned, and facilitated by YES! youth staff. These advocacy projects are for the professional development of the youth staff, so that they are educated and gain experience doing advocacy and can effectively share their experiences with the youth that they train. Two advocacy projects were planned: a Policymaker's Luncheon in the Western Region that reviewed tobacco-free policy efforts to local and regional legislators, and a Kick Butts Day Talent Show in the Central-East Region that was a social norming event to raise awareness of tobacco-free lifestyles and cessation options while endorsing/promoting the Tobacco Reality Unfiltered (TRU) Campaign. These advocacy projects allowed the youth to interact with partners such as NC STEP, Durham County Health Department, Mission Hospital, and Buncombe County ASSIST Coalition, as well as with other youth and adult leaders. In addition, YES! youth staff actively participated in a Press Conference releasing the Youth Tobacco Survey 2007 results, a Town Hall meeting, Adolescent Health Advocacy Day, the Asheville Tourists tobacco-free minor league baseball event, and cigarette butt pick-ups.

In addition, YES! youth staff focuses on researching, writing, and trying to get earned media on youth tobacco use prevention efforts published. This media advocacy is for the professional development of the youth staff, so that they are educated and gain experience researching, writing, and trying to get media published. To this end, YES! youth staff had 3 pro-health media spots and 1 letter-to-the editor published.

CUSTOMER SATISFACTION INVENTORY

In order to guide resource development, trainings and TA, YES! worked in conjunction with ?Y East to develop a customer satisfaction inventory (CSI) for all youth tobacco use prevention-related agencies. This inventory was distributed to 132 grantee and non-grantee programs via the Survey Monkey on-line program and received 76 completed surveys. Of these 76 surveys, 86% identified as adults and 14% as youth leaders.

According to the CSI, 97% of respondents knew about the ?Y youth-led trainings, 92% about the ?Y adult leader trainings, 85% about the technical assistance that ?Y provides, and 92% about the ?Y website. In addition, an overwhelming majority of respondents responded “extremely satisfied” or “satisfied” with staff interactions, staff availability, response time, quality of TA, quality of trainings, variety of youth leader trainings, and variety of adult leader workshops.

Suggestions from the respondents on what new resources and activities they would like ?Y to develop were incorporated into the deliverables for the YES! Statement of Work 2008-2009.

SUSTAINABILITY PLAN

For sustainability, the YES! 501c3 nonprofit organization structure was created to house the ?Y West and ?Y Central programs. Research and networking have been taking place to look into future funding opportunities. In addition, the YES! Board of Directors and staff developed a 3-year strategic plan that includes programmatic, organizational infrastructure and financial goals.

Youth Empowered Solutions (YES!) Goals and Deliverables
FY 2007: 1 January 2008 to 30 June 2008

Focus Area: **Provide youth tobacco use prevention education and empowerment opportunities in schools and the community**		
Quarterly Reporting Key: **Blue=January-March 2008** **Red=April-June 2008**		
	SMART Objective:	By June 30, 2008 Youth Empowered Solutions (YES) will provide at least 11 youth trainings to Health and Wellness Trust Fund (HWTF) community & schools grantees and non-grantees in the central and western region providing intensive skill building education in the topics of Tobacco 101, Media Literacy, Youth Advocacy, Tobacco 202, and Red Flag/Merchant Education. Based on the training topic, information will include: peer education, excise tax, underage sales and access to tobacco, media analysis, 100% Tobacco-Free Schools (TFS) adoption and compliance, surveillance, smoke-free and/or tobacco-free policy advocacy, and youth cessation, based on the needs and demands of grantees.
	Indicator(s):	# of youth leader trainings provided 16 (7 Tobacco 101, 1 Media Literacy, 6 Youth Advocacy, and 2 Red Flag/Merchant Education) 7 (5 Tobacco 101, 2 Youth Advocacy) # of HWTF grantees participating in the trainings 218 grantee youth, 30 grantee adults 32 grantee youth, 6 grantee adults # of non-grantees participating in the trainings 140 non-grantee youth, 3 non-grantee adults 25 non-grantee youth, 1 non-grantee adult
	SMART Objective 10:	By June 30, 2007, YES will provide at least 4 adult leader workshops to HWTF community & schools grantees and non-grantees based on the *Question Why Model* and the principles of youth empowerment and youth advocacy.
	Indicator(s):	# of adult leader workshops provided 2 (Resource Sharing and Cultural Competency—January 30 Western Region, Resource Sharing and Social Networking—February 7 Central Region) 2 (Pieces of the Puzzle—May 20 Western Region, June 4 Central Region) # of HWTF grantees participating in the workshops 30 grantee adults 57 grantee adults # of non-grantees participating in the workshops 21 non-grantee adults 5 non-grantee adults
	SMART Objective 13:	By June 30, 2008 YES will collaborate with the Tobacco Prevention & Control Branch (TPCB) and the Health and Wellness Trust Fund on at least 2 events during the year in which YES provides information and/or resources to the grantees. This can include but is not limited to the Annual Action Planning Conference (AAP), TFS events, and statewide media promotions.

Youth Empowered Solutions (YES!) Goals and Deliverables
FY 2007: 1 January 2008 to 30 June 2008

	Indicator(s):	# of collaborations 5 (this includes participation on 2 of the Grantee Calls scheduled by grants manager Sterling Fulton-Smith—the Pre-AAP Call and the Youth Empowerment and Recruitment Call; 2 collaborations with the TPCB on media—consultation on the step up nc website and a guest presentation on a Tobacco Reality Unfiltered (TRU) Media Conference Call; and participation at the Annual Action Planning Conference)
	SMART Objective	By June 30, 2008, YES will maintain a website with relevant youth tobacco use prevention information, statewide resources on adult/youth trainings, technical assistance, materials, referrals to cessation, and other opportunities.
	Indicator(s):	# of website updates 7, 9 # of website hits 2500, 2541
	SMART Objective	By June 30, 2008, YES will research, organize, and facilitate at least 2 tobacco use prevention advocacy projects to promote tobacco-free policy changes and compliance in the region. This project will give the ?Y youth leaders direct experience, promote tobacco-free policy changes and compliance in the counties, encourage partnering with agencies and organizations, and serve as effective ways to raise awareness of youth tobacco use prevention efforts utilizing the youth empowerment model. This advocacy project may include bringing in a national speaker such as Samuel Allen or Rick Stoddard. This advocacy project will be reviewed by the HWTF.
	Indicator(s):	# of direct advocacy projects 1 (Policymaker's Luncheon—Western Region), 1 (Kick Butts Day Talent Show—Central East Region) # of partners in advocacy projects 4 (Buncombe County and Asheville City Schools, NC Spit Tobacco Education Program (NC STEP), Mission Hospital, Buncombe County ASSIST Coalition), 1 (Durham County Health Department) # of pro-health media spots earned 0 (press release sent out), 1 Letter to the editor (Asheville Citizen Times) # of policy changes 0 (Support verbalized by policy makers, better awareness about tobacco use prevention and advocacy by policy makers), (better awareness of TRU and Question Why by students, better awareness of Kick Butts Day and what it means)
	SMART Objective	By June 30, 2008, YES will provide technical assistance (TA) on youth empowerment, youth advocacy, and tobacco use prevention to funded and non-funded counties.
	Indicator(s):	# of fulfilled requests 77, 65 # of resources and materials developed/shared (in addition to TA requests) 23, 33 # of grantees that have received technical assistance 28, 34 school & community grantees, 4 priority population grantees # of non-grantees that have received technical assistance 6, 3
	SMART Objective	By June 30, 2008, YES will provide technical assistance or training for the generation of youth tobacco use prevention and cessation oriented pro-health media articles or news stories.
	Indicator(s)	# of published earned media pro-health spots 2, 1 # of editorials and/or letters to the editor 0, 1
	SMART Objective 10:	By December 31, 2007,?Y West and ?Y Central will work in conjunction with ?Y East to develop a customer satisfaction instrument to be used with youth and adults for tobacco use prevention and cessation initiatives. This instrument will assess levels of customer satisfaction and topic areas of interest of adults and youth to better serve youth groups and the youth tobacco use prevention efforts, and to serve as the basis for the development of new resources and materials.
	Indicator(s):	Development of customer satisfaction instrument 1 # of grantee completions of customer satisfaction instrument the instrument was distributed to 132 adult leaders (grantee and gap)—76 started the survey and 66 completed the survey # of non-grantee completions of customer satisfaction instrument the instrument was distributed to 132 adult leaders (grantee and gap)—76 started the survey and 66 completed the survey

		Completion of summary document 05/23/08

Focus Area:	**Other administrative measures**	
	SMART Objective 2:	By June 30, 2008 YES will maintain a youth staff team of at least 12 and not more than 20 youth leaders through recruitment, training and retention.
	Indicator(s):	# of newly hired youth staff members 0 (recruitment beginning April 2008), 4 # of total youth staff members 13 (4 Western Region, 5 Central Western Region, 4 Central Eastern Region), 17 (6 Western Region, 5 Central Western Region, 6 Central Eastern Region) + 3 college interns
.	SMART Objective 2:	By June 30, 2008 YES will develop a plan for the future sustainability of the youth empowerment program. This includes researching health initiatives, youth empowerment techniques, and funding opportunities.
	Indicator(s) 2:	# of sustainability plans completed Research currently taking place into future funding possibilities 1—YES Board of Directors and Staff have developed a 3 year strategic plan that includes programmatic, organizational infrastructure and financial goals.
	SMART Objective 2:	By June 30, 2008, each YES adult staff member will complete at least one professional development course or training to raise skills, critical awareness, and opportunities for youth empowerment and advocacy.
	Indicator(s) 2:	# of adult professional development courses or trainings completed (specify staff and course completed) 0 1 Jeanne Dairaghi, Principles of Leadership and Networking, Swain County, NC 1 Christine Laucher, Media Ready Media Literacy, Union County, NC 1 Katie Spears, Media Ready Media Literacy, Union County, NC 1 Bronwyn Lucas, Youth: the Future of the South, Little Rock, AK 1 (all YES! staff), Smoking in China by Ann Staples, Pitt County, NC
	SMART Objective 2:	By June 30, 2008 YES will participate in 2 (quarterly) planning and coordinating retreats with all ?Y regional staff.
	Indicator(s) 2:	# of quarterly planning and coordinating retreats completed 1 (March 11, 2008—Hickory), 1 (May 28-29, 2008—Greenville) # of staff participating in quarterly planning/coordinating retreats 5 (2 on planning committee), 5 (1 on planning committee
	SMART Objective 2:	By June 30, 2008 YES will participate in 11 (bi-weekly) conference calls for planning and coordination with other ?Y regional staff.
	Indicator(s) 2:	# of bi-weekly conference calls for planning and coordination with other ?Y regional staff 11, 10

Youth Empowered Solutions (YES!) Goals and Deliverables
FY 2007: 1 January 2008 to 30 June 2008

	SMART Objective 1:	By June 30, 2008, YES will meet at least 4 times with each of the following for networking and partnering: grants evaluation & development manager(s), ASSIST coordinators, 100% TFS director, TPCB media director, TPCB health disparities director, and other TA providers (as needed).
	Indicator(s) 1:	# of meetings to coordinate technical assistance, training information, and strategies 28 (partners include the HWTF, TPCB, ASSIST, Campaign for Tobacco Free Kids (CFTFK), El Pueblo, American Lung Association (ALA), ARP Phoenix Prevention Services, International House of Mecklenburg County, and the Northwest Tobacco Prevention Coalition), 9 (partners include the HWTF, TPCB, ASSIST, CFTFK, ALA, ARP Phoenix, NC STEP Western and Central regions)
	SMART Objective 2:	By June 30, 2008, YES will participate in 100% of technical assistance coordination meetings (Grants Resource Management Group--GRMC) with HWTF staff and other technical assistance and resource providers.
	Indicator(s) 2:	# of GRMC meetings No meetings scheduled to date (YES! staff did participate in the TA Providers meeting during the AAP conference) , no meetings scheduled
.	SMART Objective 2:	By June 30, 2008 YES will submit two cumulative quarterly progress reports to HWTF contract manager including completion of indicator assessment and significant progress/challenge narrative. These will be due no later than 15 days from the close of each quarter.
	Indicator(s) 2:	# quarterly reports submitted to HWTF program manager 1 (funding began January 1, 2008), 1 (due July 15)
	SMART Objective 2:	By NLT than 15 days after FY08 end (June 30, 2008) YES will complete and annual progress summary report for the Question Why program to the HWTF teen tobacco program officer.
	Indicator(s) 2:	# of completed annual reports submitted 1 (due July 15)

SAVE's Annual Teen Tobacco Initiative Report

REPORTING PERIOD: July to September 2007

Community and School Presentations
# of Presentations to HWTF Grantees: 12
# of Participants in HWTF Grantee Presentations: 586
# of Presentations to Non-HWTF Grantees: 1
# of Participants in Non-HWTF Grantee Presentations: 215
# of Agencies and Geographic Locations Covered: 5 counties covered by HWTF grants (Burke, Mecklenburg, Montgomery, Rowan, and Union) and 1 gap county (Alexander)

Infrastructure
Website updates included adding former SAVE survivor Rachel Biddix's tribute video and the American Cancer Society ad featuring SAVE survivor Sandra League to the SAVE site.
Adopted the updated version of the HWTF's reimbursement policy, which provides an increase in mileage from $0.405 to $0.445.
SAVE Project Director Katherine Hampton worked with SAVE survivors Terrie Hall and Sandra League to create survivor presentation guidelines.
Began work on evaluation form for SAVE survivor presentations.

Meetings/Trainings Attended
SAVE Program Coordinator Le-Anne Russell participated in a HWTF grantee/TA conference call on August 16th.
SAVE survivor Sandra League took part in a Question Why Western Region training seminar on September 12th in Brevard.
SAVE survivors Donald Cole and Terrie Hall attended a Question Why Central Region networking meeting on September 18th in Winston-Salem.
SAVE survivor Michael Dreisbach participated in an Alternative to Suspension training meeting on September 25th in Wilmington.
SAVE Project Director Katherine Hampton and SAVE survivor Sandra League attended the statewide HWTF TTUPC Annual Meeting on September 27th and 28th in Greensboro.

REPORTING PERIOD: October to December 2007

Community and School Presentations
# of Presentations to HWTF Grantees: 147
# of Participants in HWTF Grantee Presentations: 5,737
# of Presentations to Non-HWTF Grantees: 16
# of Participants in Non-HWTF Grantee Presentations: 893
# of Agencies and Geographic Locations Covered: 14 counties covered by HWTF grants (Cabarrus, Caldwell, Clay, Cleveland, Forsyth, Guilford, Lenoir, Mecklenburg, Nash, Rowan, Swain, Transylvania, Union, and Watauga) and 3 gap counties (Alexander, Randolph, and Stanly)

Media
**SAVE survivor Sandra League was featured in a Watauga County newspaper article and photograph in November. The article spoke of League's November 15th tobacco education and prevention presentations to Watauga County high school students. The presentations were part

of a Great American Smokeout event hosted by Dana Holden, Watauga County's tobacco prevention coordinator.**

Infrastructure

The SAVE office worked with Mike Placona, with the NC Tobacco Prevention and Control Branch, to develop student evaluation forms for survivor presentations.
The SAVE office worked with Capstrat to provide leads to possible survivors to be featured in new TRU television advertisements.
The SAVE office provided its survivors with information concerning the new TRU website.
SAVE Project Director Katherine Hampton, along with SAVE survivor Sandra League, worked with new SAVE survivor Reena Roberts to continue her training for survivor presentations.
The SAVE office provided all of its survivors with updated presentation display tools and handouts to be distributed during their presentations.
The majority of SAVE employees' office time was spent coordinating survivor presentations due to the high demand for them on and around the Great American Smokeout on November 15th. November is traditionally the, or one of the, busiest months of the year for the SAVE program.

Meetings/Trainings/Technical Assistance

SAVE Project Director Katherine Hampton and SAVE survivor Sandra League attended the three-day National Tobacco Conference in late October in Minneapolis, Minnesota.
SAVE Project Director Katherine Hampton and SAVE Program Coordinator Le-Anne Russell participated in a HWTF grantee/TA conference call.
SAVE survivor Terrie Hall attended a strategy meeting concerning the prevention of the use of smokeless tobacco products on December 19th in Monroe. Paul Turner hosted the meeting.
SAVE Project Director Katherine Hampton worked with the Anson County Health Department to provide information and referrals for the initiation of the "Go Light Campaign" in Anson County. The "Go Light Campaign" focuses on promoting smoke-free dining facilities.

REPORTING PERIOD: January to March 2008

Community and School Presentations

(1) # of Presentations to HWTF Grantees: 63
(2) # of Participants in HWTF Grantee Presentations: 5,029
(3) # of Presentations to Non-HWTF Grantees: 11
(4) # of Participants in Non-HWTF Presentations: 1,040
(5) # of Agencies and Geographic Locations Covered: 12 counties covered by HWTF grants (Catawba, Duplin, Forsyth, Graham, Halifax, Mecklenburg, Moore, Nash, Orange, Rowan, Union, and Wilkes) and 3 gap counties (Alexander, Anson, and Stanly)

Media

(1) During school presentations in both Rowan and Wilkes counties, several SAVE survivors were interviewed by newspaper reporters. To the SAVE office's knowledge, however, articles have yet to be printed.

Infrastructure

SAVE's Annual Teen Tobacco Initiative Report

(1) Two students enrolled in the Service Learning Program at Stanly Community College (in Stanly County) are each volunteering 20 hours of their time (for a total of 40 hours) to the SAVE program to help remedy problems with its website.
(2) SAVE Project Director Katherine Hampton is participating in a web-based training entitled Fundamentals of Evaluation offered through the Tobacco Technical Assistance Consortium (TTAC).
(3) The SAVE office is collaborating with its survivors to update their presentation outlines and powerpoint slides.
(4) The SAVE office is continuing its work with Mike Placona, with the NC Tobacco Prevention and Control Branch, to collect student questionnaires that evaluate its survivor presentations.

Meetings/Trainings/Technical Assistance

(1) SAVE survivor Wade Hampton participated in the Question Why Eastern Region Adult Leader Training seminar on January 11th in Nash County.
(2) SAVE Project Director Katherine Hampton and SAVE Program Coordinator Le-Anne Russell took part in the HWTF Teen Tobacco Media Technical Assistance Conference Call, hosted by Ann Staples, on January 16th.
(3) SAVE survivors Terrie Hall, Fred Haywood, Sandy League, and Reena Roberts attended the Media Spokesperson Training seminar, hosted by Ann Staples, on February 13th at Cleveland Community College in Shelby.
(4) SAVE Project Director Katherine Hampton and SAVE Program Coordinator Le-Anne Russell participated in the TTUPC Grantee Conference Call on February 21st.
(5) SAVE Program Coordinator Le-Anne Russell took part in the HWTF Teen Tobacco Media Technical Assistance Conference Call, hosted by Ann Staples, on February 27th.
(6) SAVE survivor Reena Roberts met with Capstrat representatives in late February to begin filming four TRU television commercials.
(7) SAVE Project Director Katherine Hampton, along with SAVE survivors Terrie Hall and Sandy League, attended the Annual Action Planning meeting on March 12th and 13th in Hickory.
(8) SAVE Project Director Katherine Hampton, SAVE Program Coordinator Le-Anne Russell, Mecklenburg County Teen Tobacco Prevention Coordinator Joy Beck, and six SAVE survivors met on March 27th in Charlotte to discuss SAVE's 2008 statement of work as well as increasing survivor involvement in cessation training and programs. Also during the meeting, Ms. Beck explained the fax referral sheet.

REPORTING PERIOD: April to June 2008

Community and School Presentations

(1) # of Presentations to HWTF Grantees: 72
(2) # of Participants in HWTF Grantee Presentations: 7,740
(3) # of Presentations to Non-HWTF Grantees: 15
(4) # of Participants in Non-HWTF Presentations: 879
(5) # of Agencies and Geographic Locations Covered: 20 counties covered by HWTF grants (Alleghany, Ashe, Bertie, Burke, Cabarrus, Caldwell, Catawba, Cherokee, Chowan, Cleveland, Duplin, Edgecombe, Forsyth, Hoke, Mecklenburg, Northampton, Orange, Rowan, Surry, and Union) and 4 gap counties (Alexander, Johnston, Pitt, and Stanly)

SAVE's Annual Teen Tobacco Initiative Report

Media

(1) SAVE survivor Michael Dreisbach was featured in an article in the *Daily Herald*, a Roanoke Rapids newspaper, on April 9th, only two days after speaking to Northampton County high school students about the dangers of tobacco usage. The *Daily Herald* article was accompanied by a photograph of Mr. Dreisbach.
(2) SAVE survivor Terrie Hall was featured in an article in *The Alleghany News*, a Sparta newspaper, on May 8th following her participation in an Alleghany High School health fair on April 25th. A photograph of Ms. Hall was run alongside the May 8th article.
(3) During school presentations in Ashe County, several SAVE survivors were interviewed and photographed by newspaper reporters. To the SAVE office's knowledge, however, articles have yet to be printed.

Infrastructure

(1) SAVE Project Director Katherine Hampton completed a web-based training entitled Fundamentals of Evaluation offered through the Tobacco Technical Assistance Consortium (TTAC).
(2) The SAVE office's efforts with Mike Placona, of the NC Tobacco Prevention and Control Branch, to collect student questionnaires that evaluate its survivor presentations remain underway.

Meetings/Trainings/Technical Assistance

(1) SAVE Project Director Katherine Hampton made a presentation to a Winston-Salem laryngectomee support group. She spoke about SAVE's participation in the TRU campaign and how the Winston-Salem group could support that effort.
(2) SAVE Project Director Katherine Hampton and SAVE Program Coordinator Le-Anne Russell took part in a HWTF Teen Tobacco Media Technical Assistance Conference Call hosted by Ann Staples.
(3) SAVE Project Director Katherine Hampton and SAVE Program Coordinator Le-Anne Russell participated in a TTUPC Grantee Conference Call.
(4) SAVE survivor Sandy League attended the Question Why Western Region Adult Leader Training seminar on May 20th in Madison County.
(5) SAVE survivor Terrie Hall spoke to a group of roughly 30 adults on May 30th in Winston-Salem during a tobacco workshop for DSS (Department of Social Services) representatives.
(6) SAVE Project Director Katherine Hampton, along with SAVE survivor Sandy League, took part in the Question Why Central Region Adult Leader Training workshop in early June.
(7) SAVE Project Director Katherine Hampton attended a NC Auditor's seminar entitled Basic Accounting for Grants on June 11th and then a second seminar entitled The Basis of Financial Internal Controls on June 18th. **As of June 18th, Mrs. Hampton has completed the requirements necessary for certification from the NC Auditor's Training Program.**
(8) SAVE Project Director Katherine Hampton, SAVE Program Coordinator Le-Anne Russell, and SAVE survivor Reena Roberts all participated in a June 30th conference call with NC HWTF representative Barbara Moeykens and Capstrat officials. The call focused on the media protocol for inquiries regarding the 2008 TRU television ads featuring Ms. Roberts and her personal story. The ads, scheduled to be launched across the state in coming weeks, tell the story of Ms. Roberts, a young woman dealing with the negative health effects associated with teenage smoking.

North Carolina Spit Tobacco Education Program (NC STEP)
Significant Highlights

July 1, 2007 – June 30, 2008

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 2008. The following is the more compelling results:

- Provided consultation and/or information to 172 individuals and/or agencies. Many of these individuals/agencies received multiple consultations during the year.
- Provided 78,841 different of health educational materials and tools (pamphlets, posters, videos, and CDs).
- Provided 288 school lesson modules across the state. Since the creation of the module, 1196 have now been distributed.
- Provided 906 cessation and treatment guides. Since the guide was created, 5098 have now been distributed statewide.
- Provided the NC STEP display six times for use at school/community venues.
- Made 61 presentations to school, community, and faith groups with attendance composed of 5869 youth/athletes, 1062 coaches, teachers and adult leaders.
- Increased the speaker's bureau by 75 professionals. The bureau now has 141 speakers who have made 143 presentations to 7200 youth and 1254 adults/professionals.
- Provided 13 training sessions for youth peer leaders that were attended by 136 youth leaders.
- Provided 31 training sessions that were attended by 196 school professionals, 104 medical professionals, 385 dental professionals, and 114 public health professionals.
- Used the TRU link 30 times to promote NC STEP technical assistance and spit tobacco information.
- Launched the NC STEP "No Spit" All Star Campaign that resulted in 21 media releases and more than 270,000 hits on the "The Sports Flash" web site.

I. iPTS Goal Area: Preventing Initiation		
Focus Area #1: Provide youth tobacco use prevention education and empowerment opportunities in schools and the community		
1.	SMART Objective 1:	By June 30, 2008 NCSTEP will provide **(150)** consultations and/or information about spit tobacco to HWTF community and schools grantees and **(22)** consultations and/or information to non-grantees.
	Indicator(s) 1:	# of consultations and/or information provided to HWTF grantees = 141 # of consultations and/or information provided to non-grantees = 27 **Comments: The number of request for information and consultation far exceed the numbers shown above. Only one request per agency or individual is shown per quarter. Some HWTF grantees request information from NC STEP several times during a quarter.**
2.	SMART Objective 2:	By June 30, 2008 NCSTEP will provide **(55,000)** educational materials and school tools to HWTF grantees and our partners for educating students, teachers, coaches and other adult leaders about the health problems associated with spit tobacco use.
	Indicator(s) 2:	# of prevention oriented educational materials distributed – 78,841 # of school lesson modules distributed = 288 # of cessation oriented educational materials distributed = 906 **Comments: The demand for educational materials continues to increase. During the month prior to "Through with Chew Week" HWTF grant recipients requested high amounts of health educational materials.**
3.	SMART Objective 3:	By June 30, 2008 NCSTEP will conduct **(40)** educational presentation about spit tobacco prevention and cessation at state and regional meetings to schools, youth groups, community groups, professional conferences, and other opportunities.
	Indicator(s) 3:	# of presentations made = 61 # of students/youth in attendance = 5869 # of adults/teachers/coaches in attendance – 1062 **Comments: The demand for school presentations increased as the year progressed.**
4.	SMART Objective 4:	By June 30, 2008 NCSTEP will maintain a Speakers' Bureau that will be composed of **(40)** volunteers from the medical, dental, public health, and school communities to provide presentations to community groups, schools, and professional organizations/groups.
	Indicator(s) 4:	# of speakers recruited into the Speakers' Bureau = 75 # of presentations conducted by Speakers' Bureau members = 83 # of youth in attendance = 3679

		# of adults/professionals in attendance – 758 **Comments: The number of professionals recruited during training far exceeded expectations. The 83 presentations that were made by the speaker's bureau were a tremendous complement to NC STEP educational efforts.**
5.	SMART Objective 5:	By June 30, 2008 NCSTEP will have **(10)** media interviews about spit tobacco prevention and cessation.
	Indicator(s) 5:	# of media interviews, articles, and/or media programs featuring spit tobacco prevention and cessation = 30 **Comments: The NC STEP "No Spit" All Star Campaign resulted in a very intense media campaign.**
6.	SMART Objective 6:	By June 30, 2008 NCSTEP will provide **(6)** trainings to SWAT and TATU teams about spit tobacco prevention and equip them to educate peers.
	Indicator(s) 6:	# youth trainings conducted = 13 # of SWAT youth trained = 22 # of TATU youth trained = 91 # of other youth leaders trained = 23 **Comments: All youth peer groups need to be trained on the new spit/ smokeless tobacco products. The issue is nicotine addiction and youth leaders need to understand all delivery systems.**

II. iPTS Goal Area: Secondhand Smoke

Focus Area #: n/a

1.	SMART Objective 1:	n/a
	Indicator(s) 1:	n/a
2.	SMART Objective 2:	n/a
	Indicator(s) 2:	n/a
3.	SMART Objective 2:	n/a
	Indicator(s) 2:	n/a

III. iPTS Goal Area: Cessation		
Focus Area #7: Provide access to effective tobacco use cessation resources		
1.	SMART Objective 1:	By June 30, 2008, NCSTEP will provide **(18)** spit tobacco cessation trainings to HWTF grantees and non-grantees.
	Indicator(s) 1:	# of prevention and cessation trainings provided for HWTF grantees, AHEC, and NCTPCB = 31 # of medical professionals trained = 104 # of dental professionals trained = 385 # of public health professionals trained = 114 # of school professionals trained = 196 **Comments: The demand for training continues to increase. NC STEP and the NCTPCB offer quality training that is in high demand.**

IV. iPTS Goal Area: Administrative		
Focus Area #8: Other administrative measures		
1.	SMART Objective 1:	By June 30, 2008 NCSTEP will participate in at least four (quarterly) Grant Management Resource Counsel (GRMC) meetings
	Indicator(s) 1:	# of GRMC meetings attended = 0 **Comments: No GRMC meetings were conducted during the year.**
2.	SMART Objective 2:	By June 30, 2008 NC STEP will submit four cumulative quarterly progress reports to HWTF to program manager
	Indicator(s) 2:	# quarterly reports submitted to HWTF program manager = 4 **Comments: All reports were sent in a timely fashion**.
3.	SMART Objective 3:	By June 30, 2008 NCSTEP will enter **(10)** postings on the TRU list serve containing information, updates, and research related to spit tobacco and the NC STEP program.

	Indicator(s) 3:	# of postings on TRU list serve = 30 **Comments: The NC STEP "No Spit" All Star Campaign was responsible for a major increase in TRU link postings.**

4. Smart Objective 4: By December 31, 2007 NCSTEP along with HWTF and Capstrat will develop NCSTEP web page on the TRU site.

Indicator(s) 4: Web page was created.

Comment: The NCTPCB created a NC STEP webpage on their web site. A second NC STEP page is being created on the NC HWTF web site.

5. Smart Objective 5: By June 30, 2008 NCSTEP working with HWTF and NCTPCB will develop spit tobacco task forces in the central and eastern regions of North Carolina.

Indicator(s) 5: Task forces in central and eastern North Carolina were created.

Comment: The central and eastern STEP task forces were created and each met twice during the year.

Summary of the HWTF 2007-08 Annual Report
American Lung Association of North Carolina

We apologize for the inconsistencies in last year's reports and for the inconvenience our errors have caused. This summary report addresses those errors. During the grant year, we had a change in staff and the new staff had not been responsible for reporting previously. For future reports, the Regional Director of Mission Services will review the reports. Having an additional person review all documents will enable us to avoid this situation in the future. We appreciate your patience and, again, apologize for the inconvenience we have caused.

TATU

- Total trainings: 3
- Adult non-grantees trained: 22
- Adult grantees trained: 11
- Counties represented: 25
- Mini-grants were awarded: 7
- Surveys sent quarterly to TATU facilitators: 242
- Surveys returned: 43
- Programs implemented: 23

Corrections were made to the original report as follows: The first quarterly report for TATU should be blank except for the surveys. The information from quarterly report 2 was transposed to quarterly report 1. All numbers on the reports have been changed to reflect this correction. Please note: the first quarter of the year is always slow since students and teachers are just returning to school. The ALANC work accomplished in the first quarter lays the groundwork for subsequent quarters.

N-O-T and ATS

- Adult facilitator trainings: 4
- Adult non-grantees: 60
- Adult grantees: 11
- Counties represented in these trainings: 14
- Surveys sent to N-O-T facilitators quarterly: 285
- Programs implemented: 17
- Enhancement grants awarded to non-grantees: 5

Corrections were made to the original report as follows: Quarterly report 1 for N-O-T should be blank except for the surveys. The information from quarterly report 2 was transposed to quarterly report 1. On the attached surveys, the numbers have been changed to reflect this correction. As with TATU, the first quarter for N-O-T is always slow since students and teachers are just returning to the schools. The ALANC work accomplished in the first quarter lays the groundwork for future program success.

Summary of the HWTF 2007-08 Annual Report
American Lung Association of North Carolina

ATS

The ATS program was included as part of the N-O-T training sessions to enhance the cessation opportunities for the schools that needed a punitive program and to help facilitators understand the uniqueness of a voluntary cessation program like N-O-T. In the trainings, we stressed the fact that N-O-T is best used as a voluntary cessation program and that ATS is used as a consequence for students who violate tobacco policy. Secondly, by combining the trainings, we were able to certify the same people for both N-O-T and ATS.

Last year, legislation requiring smoke-free campuses was not in place, but as that legislation became imminent, interest in ATS began to rise. As a result, the tobacco program manager and trainer conducted a six-county road trip across North Carolina from Waynesville to Wilmington to train ATS facilitators. The trip was accomplished in three days by providing trainings in two different locations each day.

As a result of the ATS road trip:

Adult facilitators trained:	56
Surveys sent quarterly:	285
ATS programs implemented:	12

Additional Accomplishments:

- Newsletters sent quarterly to 850 individuals. (A correction to the newsletter report is as follows: quarter 3 reports 2 newsletters sent. The number should be 1.)
- Technical assistance for the year totaled 642 e-mails and phone calls.
- (Correction for the technical assistance report is as follows: The 4th quarter report should read 107 e-mails.)
- 9 additional meetings and one conference call included Adult Leadership, LCAT, Annual Action Planning and RMMC.

Beginning in August 2008, the demand for N-O-T and ATS has increased. We feel this is the result of the 100% tobacco-free policy that is now in place in schools. The new ATS kits were completed in July of 08 and have already been distributed to 12 school districts, which is a strong indication that the third year of this grant will be a solid one.

If you have further questions please contact Demetrius Harvey at dharvey@lungnc.org or Miriam McLaughlin at mmclaughlin@lungnc.org.

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, 2007 – June 30, 2008

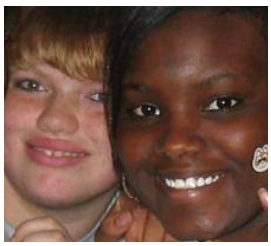
An Education & Enforcement Program to Reduce Youth Access to Tobacco Products

GOALS/OBJECTIVES	PROGRESS INDICATORS
Conduct at least 600 compliance checks or 7,200 annually during SFY 2006-07.	Conducted 7,009 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 305 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 32 earned media stories.
Conduct 2-3 booster activities to maintain momentum and support of the Red Flag Campaign (i.e. direct mail to retailers, earned media, special events, stepped up dissemination of Red Flag materials in high risk areas)	In June 2008, a direct mail campaign (letters and Red Flag brochures) was conducted with 5,800 retailers to reinforce the message of not selling tobacco products to minors and to further promote the Red Flag program. As a result, retailers responded by requesting additional materials for their employees and asking questions about G.S. 14-313 and the color coded driver's license system. Promoted Red Flag with Special Populations: • Conducted Red Flag Training with Adult Coordinators with the NC Commission of Indian Affairs on February 19, 2008 to increase their awareness of the program and how it can be implemented in their local communities. • Held two meetings with local coordinators and staff of El Pueblo, Inc. to assess and develop strategies to work

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

GOALS/OBJECTIVES	PROGRESS INDICATORS
	more effectively with Latino retailers to reduce tobacco sales to minors in their communities. A result of this effort was to have Red Flag Merchant Education materials translated into Spanish language.
Collaborate with HWTF grantees, other state/local agencies and coalitions to conduct at least 6 community events, merchant education or youth access related training activities.	Participated in 13 trainings and events with HWTF grantees, local agencies and other organizations. 1. Youth Access Forum in Chapel Hill on September 26, 2008 2. Seven Red Flag Merchant Education Trainings with youth and adult leaders in Weldon, Kenansville, Kannapolis, Red Springs, Manteo, Hollister, and Raleigh NC 3. Red Flag/ Environmental Strategies that Prevent Teen Tobacco Use workshop sponsored by Watauga County Schools grantee for teachers' staff development (November 17, 2008) 4. Reducing Youth Access / Red Flag session at State of the Child Conference, Mount Olive, NC (March 7, 2008). 5. Participated in three Adult Leaders' Trainings sponsored by Question Why in Nashville, Morganton and Kannapolis, NC (Jan.-Feb. 2008).
Provide positive recognition for clerks that that do not sell tobacco products to minors during enforcement operations.	ALE Agents awarded 3,755 TEE (Tobacco Enforcement Excellence) Certificates to store clerks who did not sell during compliance checks conducted statewide.




North Carolina Health and Wellness Trust Fund Tobacco Initiatives

Outcomes Evaluation Annual Report 2007 - 2008

Prepared for
North Carolina Health and Wellness Trust Fund

Prepared by
UNC School of Medicine
Tobacco Prevention and Evaluation Program

NORTH CAROLINA Health Wellness TRUST FUND

UNC SCHOOL OF MEDICINE

Table of Contents

Executive Summary

The North Carolina Health and Wellness Trust Fund (HWTF) works to reduce and prevent tobacco use among youth and young adults in North Carolina through three major Tobacco Initiatives, each with their own media campaign:

- Teen Tobacco Use Prevention and Cessation Initiative (Teen Initiative);
- Tobacco-Free Colleges Initiative (Colleges Initiative); and
- North Carolina Tobacco Quitline (Quitline NC).

The HWTF was created by the North Carolina General Assembly in 2001 with 25% of the state's share of the Tobacco Master Settlement Agreement. HWTF created the Teen Initiative in 2003, began funding components of Quitline NC in 2005, and expanded to the Colleges Initiative in 2006. Over the last year, the Tobacco Initiatives have become more integrated as a comprehensive program for North Carolina youth and young adults, and the program will soon expand with seed funding for several new pilot programs targeting adult populations.

In Fiscal Year (FY) 2007-08, the independent outcomes evaluation of the HWTF Tobacco Initiatives showed successes, with the combined programs reaching more North Carolinians than in any previous year since funding began.

Teen Initiative

In 2007, tobacco use among North Carolina youth declined to the lowest levels ever recorded. The HWTF was instrumental in the passage of legislation requiring all North Carolina school districts to adopt 100% tobacco-free school (TFS) policies by August 2008. With HWTF involvement, 114 of 115 school districts had already adopted a 100% TFS policy by June 30, 2008. Youth empowerment played a strong role in the Initiative, with the most youth trainings and youth leadership opportunities occurring since the program began. More than four out of five North Carolina youth reported awareness of the youth-focused tobacco prevention media campaign, Tobacco.Reality.Unfiltered. or TRU.

Colleges Initiative

North Carolina's Tobacco-Free Colleges Initiative has become a nationwide leader in the promotion and adoption of 100% tobacco-free campus policies. Seventeen North Carolina campuses have now adopted 100% tobacco-free policies or comprehensive campus tobacco policies. HWTF grantees continued to build support for future policy adoptions and to promote tobacco cessation services on college campuses through Quitline NC.

Quitline NC

In 2007-08, HWTF launched North Carolina's first multi-media Quitline NC promotional campaign targeted to young adults, "Call it Quits," as well as a new effort to promote the quitline's fax referral system to health professionals. As a result, Quitline NC reached more youth and young adults in 2007-08 than ever before and continued to reach adults who were primary caregivers for youth or school employees. Fax referral service for the quitline also increased, and quit rates for callers remained steady.

Challenges and Recommendations

North Carolina's tobacco efforts also continue to face challenges. The greatest challenge to the HWTF Tobacco Initiatives' sustained success is maintaining sufficient funds to provide an effective comprehensive statewide tobacco program. With $17.1 million in funding, the HWTF is only able to fund its Tobacco Initiatives at 16% of the $106.8 million that the Centers for Disease Control and Prevention (CDC) recommends North Carolina spend annually for tobacco control. In addition, the percentage of young adults 18 to 24 using tobacco remains high, as a result of the much higher tobacco use among young adults not in college. Fewer off-campus venues frequented by youth and young adults adopted 100% smoke-free policies in 2007-08 than in previous years.

Future program recommendations are to:

- Continue current comprehensive program efforts and pilot programs that expand resources to at-risk populations;
- Establish a specific, shared statewide policy outcome for youth empowerment activities across all grantees;
- Engage the State's Department of Public Instruction in discussions about the tobacco prevention curriculum in North Carolina schools;
- Renew efforts to reduce youth secondhand smoke exposure through smoke-free policy adoptions;
- Pilot new efforts, such as a media campaign, to further reduce youth exposure to secondhand smoke;
- Begin tracking tobacco industry promotions that affect youth and young adults;
- Continue the Colleges Initiative and expand the program to include off-campus areas;
- Expand the program to include young adults 18-24 not in college, as well as other adult populations that disproportionately use tobacco products;
- Expand funding for the Quitline NC media campaign to drive more calls to Quitline NC; and
- Disseminate HWTF Tobacco Initiatives' successes nationally.

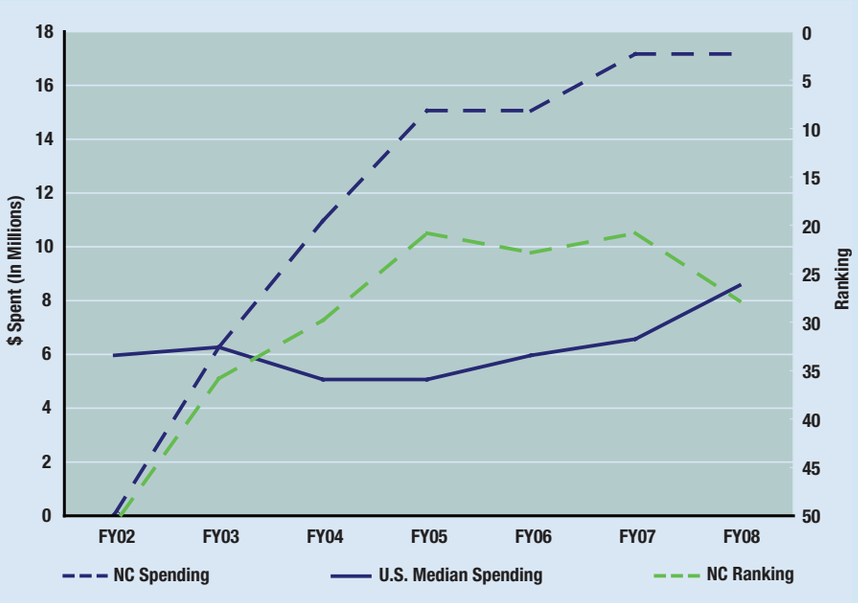
The above recommendations are based on data analyses and review of evaluation models. Specific recommendations and evaluation models can be found in each Initiative's report at **www.tpep.unc.edu**.

Introduction

Approximately three million youth in the United States are current smokers, and nearly 90% of adult smokers started by the time they were 18.[1] In North Carolina, young adults 18 to 24 have the highest smoking rates of any age group.[2] Seventy percent of adult smokers want to quit, but only four to seven percent of those who try are successful each year.[3]

HWTF addresses these issues through its three major Tobacco Initiatives. The total funding allocated for the three tobacco programs in Fiscal Year 2007-08 (July 1, 2007- June 30, 2008) was $17.1 million, placing North Carolina 28th in the rankings of tobacco control spending in the nation.[4] The total funding includes $12.3 million for the Teen Initiative (including $5.5 million for the statewide media campaign), $668,000 for the Colleges Initiative, and $3 million for Quitline NC (including $2.1 million for media). The CDC recommends that North Carolina spend $106.8 million annually for tobacco control (recommended amount includes programs for both adults and youth).[5] Figure 1 shows North Carolina spending for tobacco control compared to the national average.

Figure 1. History of North Carolina Spending for Tobacco Prevention, FY02-FY08 (Campaign for Tobacco Free Kids)



CDC Best Practices

HWTF Tobacco Initiatives include the components outlined by the CDC for effective tobacco control programs: state and community interventions, health communication programs, cessation interventions, surveillance and evaluation, and administration and management. The Initiatives address the four goals for tobacco prevention outlined by the CDC as they relate to youth and young adults:

1. Prevent youth initiation of tobacco use;

2. Eliminate youth exposure to secondhand smoke;

3. Promote cessation among youth; and

4. Reduce health disparities among youth attributable to tobacco use.

Report Overview

This report highlights outcomes of the Teen Initiative, Colleges Initiative, and Quitline NC for FY 2007-08, assesses program progress in meeting objectives, and gives recommendations for FY 2008-09. The University of North Carolina (UNC) Tobacco Prevention and Evaluation Program (TPEP) provides an independent evaluation of the HWTF Tobacco Initiatives. UNC TPEP utilizes multiple data sources for its evaluation, including grantees' monthly progress reports (referred to in this report as "WiPTS", the web-based indicator progress tracking system), grantees' semi-annual surveys, the North Carolina Youth Tobacco Survey (YTS), the North Carolina Behavioral Risk Factor Surveillance System (BRFSS), and Quitline NC call data (provided by the Quitline NC vendor Free and Clear). Previous Annual Reports on the HWTF Tobacco Initiatives can be found at **www.tpep.unc.edu**.

Teen Initiative

In 2003, the North Carolina Health and Wellness Trust Fund created the North Carolina Teen Tobacco Use Prevention and Cessation Initiative (Teen Initiative), which has received $29.4 million in grant funding.

In FY 2007-08, the Teen Initiative funded 40 local community and school grantees and six additional disparities-focused grantees to conduct activities designed to address the problem of tobacco use among North Carolina youth. Twenty-seven of these grantees have received funding since the Initiative's inception in 2003.

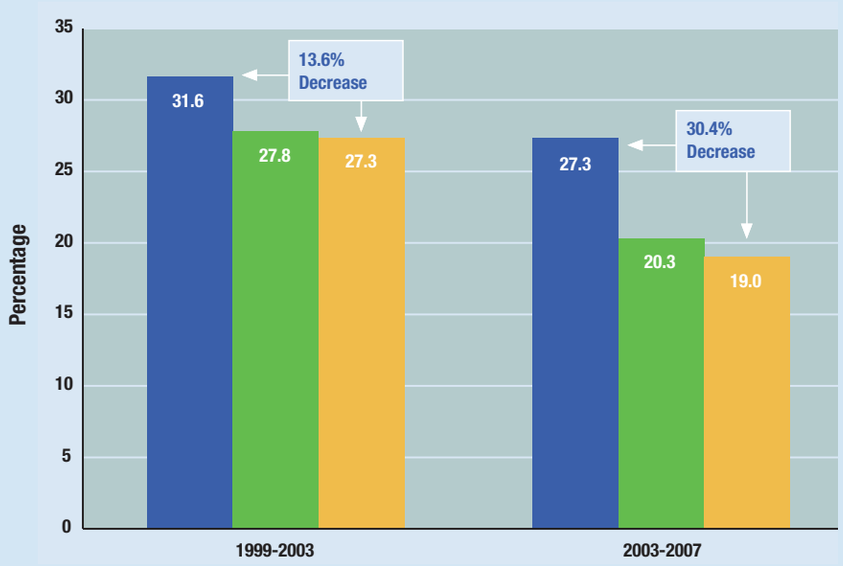
The fifth year of the Teen Initiative saw continued growth of the tobacco prevention movement among youth. Successes occurred across all major goal areas, particularly youth empowerment and tobacco-free schools. Additionally, this year saw more access than ever before to effective cessation resources for youth, such as Quitline NC, as well as more presentations given on product pricing as it relates to youth tobacco consumption. However, challenges in the past year show that while youth continued to have increased access to smoke-free venues, policy outcomes to reduce secondhand smoke exposure decreased in number relative to previous years. The following section details the Teen Initiative's progress and challenges in 2007-08.

Tobacco Use Declines to Lowest Ever for North Carolina Youth

Teen tobacco use in North Carolina continued to decline, a trend that has accelerated since HWTF began funding of the Teen Initiative. Middle school cigarette use is at 4.5%, down from 5.8% in 2005 (2007 YTS). Nineteen percent of high school students smoke cigarettes, a decrease from 20.3% in 2005. The number of students who report ever having used tobacco also decreased.

These declines in use have occurred more rapidly since 2003 when HWTF-funded grantees began working in local communities and schools. From 1999-2003, middle school smoking decreased by 38% and during 2003-07 it decreased by 51.6%. Similarly, from 1999-2003, high school smoking decreased by 13.6% and from 2003-07 by 30.4% (Figure 2).

Figure 2. Declines in Cigarette Use among North Carolina High School Youth, Before and After HWTF Funding (NC YTS)



Tobacco Initiatives
Outcomes Evaluation
2007-2008

Teen tobacco use continues to decline more rapidly since HWTF funding began.

100% Tobacco-Free School Policies Adopted Statewide

In accordance with best practice guidelines, grantees worked to promote adoption of and compliance with 100% Tobacco-Free School (TFS) policies. From 1990 to 2002, 15 of North Carolina's 115 school districts passed 100% TFS policies. HWTF grantees began to focus on TFS policy promotion in 2003, and by the summer of 2007, three-quarters of North Carolina school districts had adopted 100% TFS policies. Ten additional schools adopted 100% TFS policies in 2007-08. Thirty-nine schools also adopted Alternative to Suspension (ATS) programs (part of a 100% TFS), bringing the total to over 140 schools offering the program across the state.

In July 2007, the North Carolina General Assembly passed legislation that required all North Carolina public school districts to adopt 100% TFS policies by August 2008.

The Youth Tobacco Survey data also indicated that tobacco use on school property has decreased since 2003, though there is still not full policy compliance. Only 1.3% of middle school youth and 7.6% of high school youth reported smoking on school property in the past 30 days, down from 2.7% of middle school youth and 12.3% of high school youth in 2003. Similarly, youth reported seeing fewer adults (teachers, staff, volunteers) using tobacco products at school.

Youth Empowerment Plays Key Role

Youth empowerment continues to be an important component of the Teen Initiative. In 2007-08, the Teen Initiative had the most youth trainings and youth leadership opportunities occurring since the Initiative began.

- Fifty-five percent of all programmatic indicator changes were youth-led this year, compared to 47% in 2006-07 and 30% in 2005-06.
- Grantees reported a total of 535 skill-building trainings for youth this year, more than twice the 232 trainings reported in 2006-07.
- Grantees sponsored approximately 150 youth groups across the state with more than 1,900 youth actively involved in planning and implementing tobacco prevention activities (Figure 3). Over half of the youth represent populations historically experiencing tobacco-related health disparities (i.e. African American, Latino, American Indian, gay and lesbian youth, low socioeconomic status, etc.).

In September 2007, HWTF launched the TRU Recruitment Campaign to recruit 5,000 youth to sign a pledge to be tobacco-free and to refer their friends to the TRU website and its resources. Teens were also encouraged to get directly involved by contacting their local HWTF grantees. HWTF reached its goal of having 5,000 youth sign the on-line pledge in April 2008.

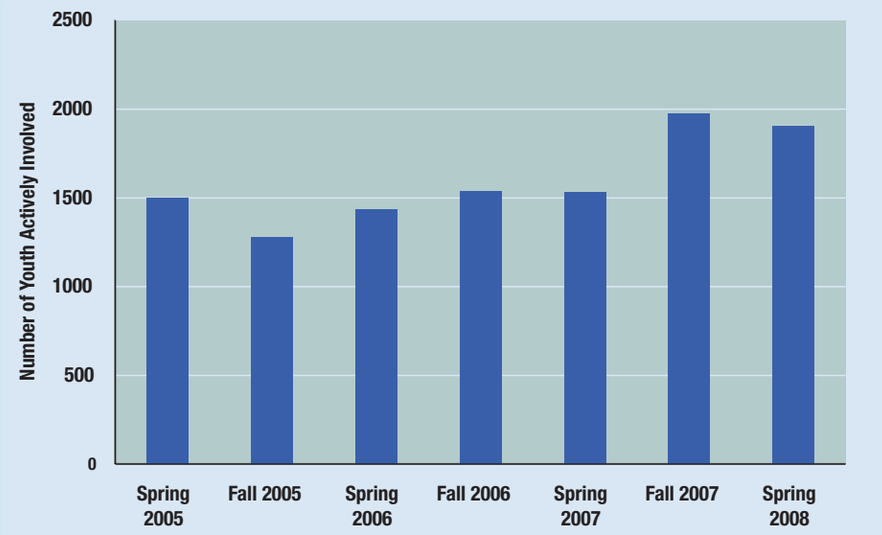
Statewide 100% tobacco-free school legislation enacted.

Fewer youth using tobacco on school grounds.

More youth training and opportunities than ever before.

Tobacco Initiatives Outcomes Evaluation 2007-2008

Figure 3. Number of Youth Actively Involved in Tobacco Prevention Activities, 2005-2008 (Grantee Semi-Annual Survey)



Youth Awareness of North Carolina Media Campaign High

North Carolina's tobacco prevention media campaign, Tobacco.Reality. Unfiltered. or TRU, continued to air during the 2007-08 year. The campaign targets youth aged 11 to 17 with television ads featuring real North Carolinians describing their personal experiences with the serious health consequences of tobacco use. (View the ads at http://www.realityunfiltered.com/TRUtv.aspx)

The Youth Tobacco Survey data showed that awareness of the TRU ads and brand remains high among North Carolina youth: 84.7% of middle school students and 88.8% of high school students reported having seen ads that were part of the TRU campaign (Figure 4). In addition, 54.6% of middle school students and 62.5% of high school students reported seeing television ads with the TRU brand at least once during the previous month.

Awareness of the Tobacco.Reality.Unfiltered. brand increased significantly from 2005 to 2007, from 40.5% of middle school and 48.5% of high school students in 2005 to 61.8% of middle school and 68.3% of high school students in 2007. In comparison, youth reported steady or decreased viewing of the American Legacy Foundation's national "truth®" campaign in the past 30 days, compared to 2005.

In the spring of 2008, HWTF launched a new campaign, "TRU Teens of the Month," featuring NC teens who had entered and won local contests with entries highlighting the importance of being tobacco-free.

Data from the 5th wave of the Media Tracking Survey evaluating the TRU campaign will be available in the 2008-09 Annual Report.

Nearly 90% of NC high school youth report having seen a TRU ad.

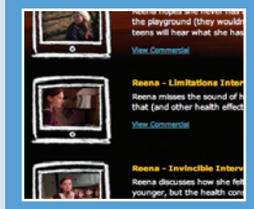
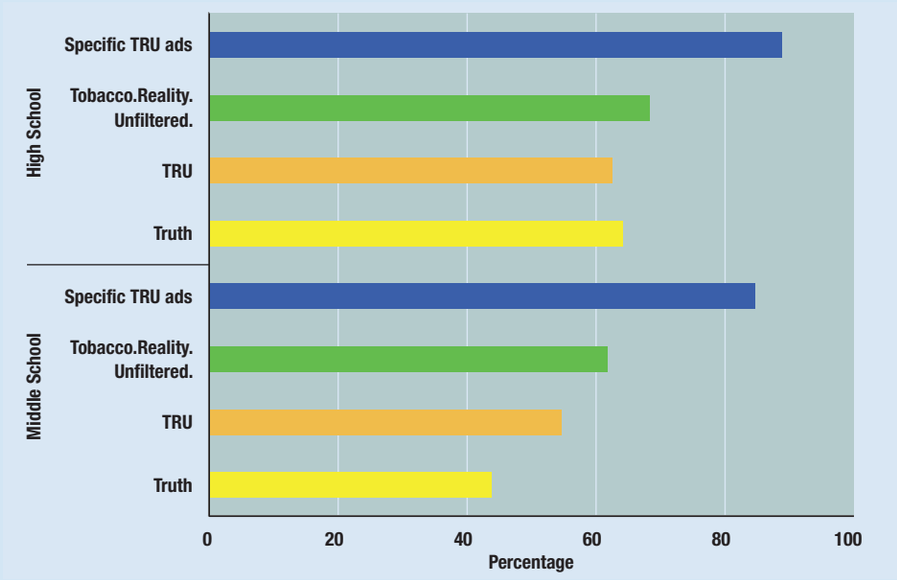


Figure 4. Youth Awareness of Tobacco Prevention Media Brands and Specific TRU Ads, 2007 (NC YTS)



Youth Attitudes against Tobacco Use Remain Strong

Youth responses on the 2007 Youth Tobacco Survey demonstrated that North Carolina youth continue to believe that tobacco is addictive, and attitudes against tobacco use remain strong. Over 85% of middle and high school students:

- said that people can get addicted to using tobacco similarly to cocaine or heroin;
- disagreed that smoking cigarettes makes young people look cool or fit in; and
- stated that young people risk harming themselves if they smoke one to five cigarettes per day.

Teens' beliefs about tobacco use differed by smoking status. Three times as many current smokers (44.5%) as never smokers (15.2%) thought that "young people who smoke cigarettes have more friends". More than six times as many students who are current smokers (26.1%) thought "it is safe to smoke for a year or two, as long as you quit after that" than students who have never smoked (4.1%).

Most North Carolina youth have strong attitudes against tobacco use.

Tobacco Initiatives
Outcomes Evaluation
2007-2008

Youth Report Low Exposure to Tobacco Prevention Curricula in Schools

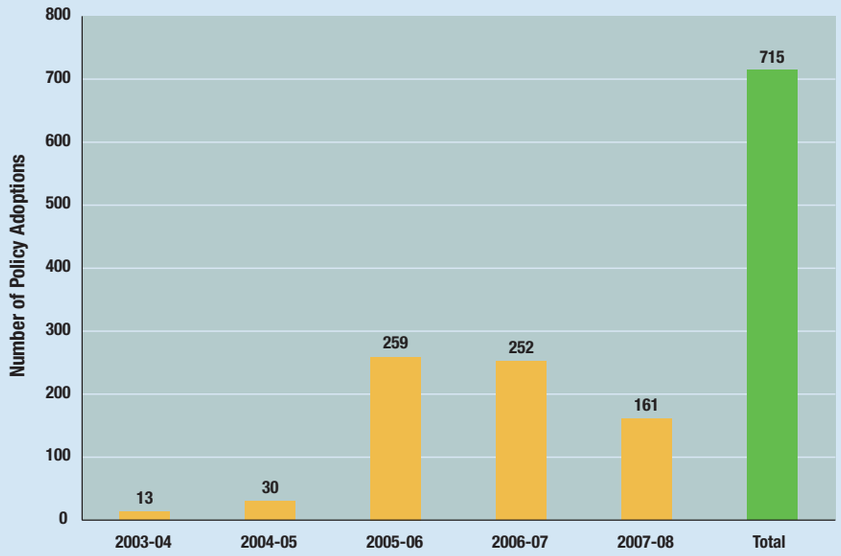
HWTF grantees are not involved in development of classroom curricula. According to the 2007 YTS, less than 40% of youth (39.7% of middle school youth and 30.5% of high school youth) reported learning about the dangers of tobacco use at school. In addition, only 13.6% of high school youth reported practicing ways to say "no" to tobacco in class. The percentage of middle school youth who reported that they practiced ways to say "no" to tobacco in class declined from 33.2% in 2003 to 23.2% in 2007.

Smoke-Free Policy Adoption Continues

Adoption of 100% smoke-free policies in venues frequented by youth continued to occur with 161 new policy adoptions in 2007-08, and over 700 since the Initiative began (Figure 5). The number of policy adoptions decreased, however, in 2007-08 compared to the previous year. Seventeen grantees reported no new smoke-free policy adoptions in 2007-08. Grantees held 224 meetings with key business leaders to promote adoption of smoke-free policies and conducted 79 patron survey campaigns/ petition drives; both activities occurred at reduced rates compared to 2006-07. Declines in adoption and activities may reflect reduced programmatic emphasis on smoke-free policy adoption compared to other focus areas such as youth recruitment and youth empowerment.

The majority of smoke-free policy adoptions continued to occur in restaurants; however, grantees also reported 41 smoke-free policy adoptions this year in places of worship, compared to 35 in 2006-07 (Figure 6).

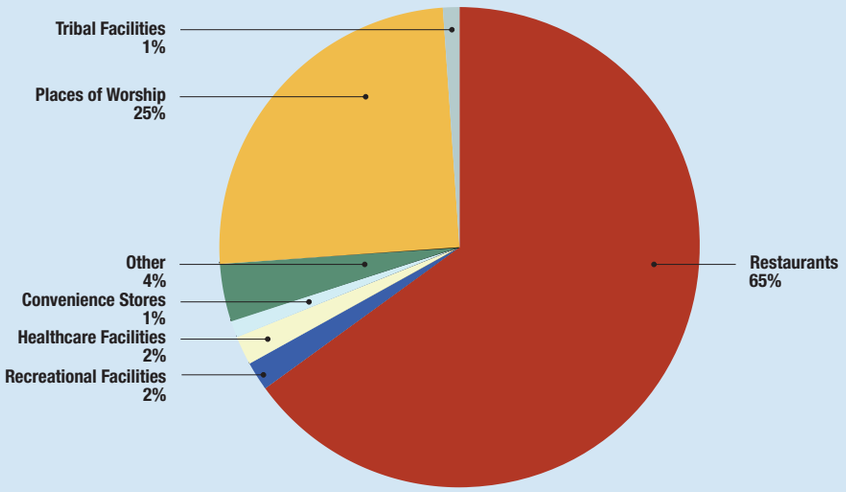
Figure 5. Number of Smoke-Free Policies Adopted, 2003-2008 (WiPTS)



Less than 40% of youth report being taught at school about the dangers of tobacco use.

Smoke-free policy adoptions continue, but at lower rates.

Figure 6. 100% Smoke-Free Policies Adopted by Type of Venue, 2007-08 (WiPTS), (n=161)



Slight Decrease in Youth Exposure to Secondhand Smoke

Concurrent with grantee work on secondhand smoke reduction in public places over the past five years, data from the Youth Tobacco Survey showed that youth exposure to secondhand smoke decreased among high school students. From 2003 to 2007, the number of high school youth who reported spending no time in the same room with someone who was smoking during the past week increased from 28% to 36%. Reports of no exposure to secondhand smoke in cars also increased for high school youth from 46.6% in 2003 to 54.1% in 2007. There were no significant changes in secondhand smoke exposure for middle school students. Half of middle school students reported being in the same room with someone who was smoking, and 38.9% reported being in a car with someone who was smoking, during the previous seven days.

Secondhand smoke exposure for youth remains too high.

Promotion of Cessation Resources for Youth Increased

Grantee reports on promoting cessation resources for youth indicated their increased efforts in this focus area, relative to all previous years. In 2007-08, grantees reported:

- 372 institutions adopted best practices for cessation (e.g., Quitline NC, 5As, and NCSTEP);
- 609 cessation media messages, compared to 207 in 2006-07; and
- Nearly 400 presentations/meetings promoting youth cessation resources, compared to 147 such presentations in 2006-07.

Grantees also promoted Quitline NC to youth and their caregivers. In 2007-08, more than 200 youth aged 14 to 17 and over 1,800 adult caretakers or role models for youth in home and school environments called the North Carolina Quitline.

Increased promotion of cessation resources for youth occurring statewide.

Tobacco Initiatives Outcomes Evaluation 2007-2008

Continued Merchant Education Regarding Tobacco Sales Law

Grantees continued to report substantial involvement in activities geared toward educating merchants about North Carolina tobacco sales laws and increasing compliance with these laws.

The federal Synar Amendment requires all states to have tobacco sales rates to minors under 20%, and North Carolina's goal rate is 5%. The 2007 rate of tobacco sales to minors was 11.5%, up slightly from the 2006 rate of 10.3%. In general, the rate of sales to minors has decreased steadily since it was first measured in 1996 at 50.0%.

Advocates Continue Work to Reduce Tobacco Advertising that Appeals to Youth

HWTF grantees worked with youth to educate merchants about the effects of industry marketing on youth tobacco use. Youth advocates encouraged local stores to remove industry advertising. Grantees reported only two stores removing tobacco ads completely from their buildings in 2007-08, compared to nine in the previous year.

While the percentage of youth reporting that they bought or received anything with tobacco industry names or logos has decreased since 2003, 12.8% of middle school youth and 19.6% of high school youth still reported receiving or buying items with industry names or pictures. Youth who said they would buy or have received a tobacco industry item were 2.2 times more likely to have ever smoked a cigarette (2007 YTS).

North Carolina youth remain susceptible to tobacco industry advertising.

Increased Work on Product Pricing Education

The number of indicator changes in the area of product pricing increased nearly five-fold in 2007-08, compared to 2006-07. In 2007-08, 27 grantees reported 69 educational presentations to school and community members about the link between tobacco pricing and youth initiation of tobacco use.

Tobacco-Free Colleges Initiative

The statewide Colleges Initiative works to prevent and reduce tobacco use among North Carolina young adults through the promotion of tobacco-free policies and cessation services on college campuses and in college communities across the state.

Phase I of the Colleges Initiative began in January 2006 with $1.6 million in grant funding. After two successful years, including 53 policy adoptions on North Carolina campuses, the Initiative was expanded in January 2008 with an additional $1.4 million in Phase II funding. Grants were awarded to 14 campus and community-based organizations, including six returning Phase I grantees.

Phase II grantees work with 50 campuses in 33 counties including 19 community colleges, 8 public, and 23 private colleges and universities. Five of these campuses are historically black colleges and universities.

In addition to these 50 grantee-supported campuses, HWTF started offering technical assistance to all North Carolina college and community college campuses through a newly appointed 100% Tobacco-Free Campuses Director. The Director supports Phase II grantees and leaders on other campuses across North Carolina who seek assistance with tobacco-related campus policy initiatives.

The following section highlights grantee successes and program activities for the first six months of Phase II (January-June 2008). This shortened report period is the result of a shift to change the previous January-December fiscal year to a July-June fiscal year, allowing the Initiative to be consistent with other HWTF tobacco programs.

Tobacco Use Highest among 18 to 24 Age Group

Young adults, age 18 to 24, continue to have the highest rates of smoking among all age groups in North Carolina, with 31% identified as current smokers. Nearly 60% of North Carolina young adult smokers have made quit attempts in the last year.2 Young adults attending college are exposed to intensive marketing by the tobacco industry.[6,7]

Continued Tobacco-Free Policy Adoption on College Campuses

As of June 2008, 17 North Carolina campuses have adopted 100% Tobacco-Free Policies or Comprehensive Campus Tobacco Policies (i.e., 100 ft. perimeter policies at UNC system schools) (Figure 7, Table 1).

- Twelve (71%) policy adoptions occurred with the direct or indirect support of HWTF grantees in Phase I. Two (12%) policy adoptions occurred with grantee support in the first six months of Phase II. Prior to the Colleges Initiative, only one campus in North Carolina had adopted a 100% tobacco-free policy.

- In addition to the two 100% tobacco-free policies adopted in the first six months of Phase II (at Montreat College and Wingate University), 16 colleges adopted partial tobacco-related policies with grantee support in the first six months of Phase II. These include two perimeter policies (50 ft. at Appalachian State University and 25 ft. at Sandhills Community College), and seven tobacco-free campus organization policies. Surry Community College also adopted policies that substantially limit the use, sale, and promotion of tobacco products on campus. In total, 71 tobacco-related policies have occurred on 32 campuses with varying levels of grantee support since the beginning of Phase I.

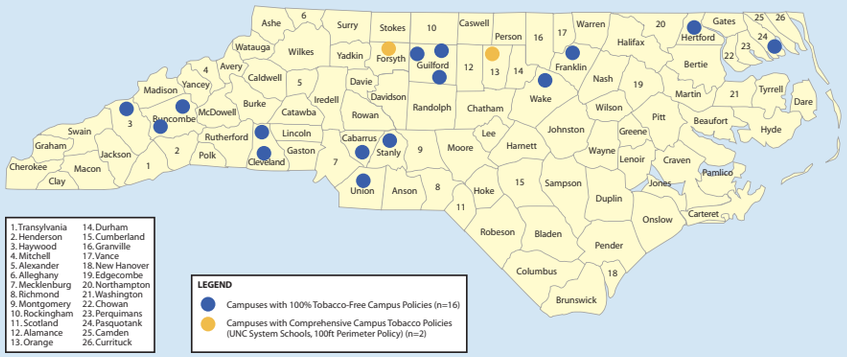
The Colleges Initiative includes funding for 50 campuses in 33 counties.

Seventy-one new policies have occurred on 32 campuses since the start of the Colleges Initiative.

Table 1. 100% Tobacco-Free and Comprehensive Campus Policies in NC

#	Campus	Date Enacted
1	Bennett College	Pre-grant: 2004
2	Barber Scotia College	August 2006
3	Gardner-Webb University	November 2006
4	College of the Albemarle	December 2006
5	Stanly Community College	January 2007
6	Asheville-Buncombe Technical CC	February 2007
7	Cleveland Community College	March 2007
8	Haywood Community College	July 2007
9	Greensboro College	August 2007
10	Wake Technical Community College	August 2007
11	Roanoke-Chowan Community College	August 2007±
12	UNC-Chapel Hill	October 2007
13	Guilford Technical Community College	October 2007
14	Winston Salem State University	December 2007
15	Wingate University	January 2008
16	Montreat College	January 2008
17	Louisburg College	April 2008

Figure 7. Map of 100% Tobacco-Free Policies and Comprehensive Campus Tobacco Policies as of June 2008



Tobacco Initiatives Outcomes Evaluation 2007-2008

Building Support for Policy Change on College Campuses

Six grantees reported 10 new tobacco-related policies that underwent formal consideration by college officials for the first time in Phase II, including three comprehensive campus tobacco policies under consideration at Elizabeth City State University, Western Carolina University, and UNC-Pembroke. Support for policy changes occurred through multiple channels.

Since the beginning of the Initiative, grantees have garnered the support of over 450 college officials for policy adoption on 37 campuses, and over 900 campus organizations, staff, faculty, and student leaders have offered support. As of June 2008, 92% (46) of all Phase II grantee-supported campuses have established coalitions. Coalitions assist grant coordinators in carrying out their scope of work (e.g., implementing petitions) and building support for policies on campus. In the first six months of Phase II:

- Grantees participated in 184 meetings with key decision makers, organizations, and students to advance tobacco-related policies.
- Twenty-eight media messages promoting support for campus policy adoption and compliance were disseminated on and around college campuses.
- Eleven campuses established new tobacco use prevention coalitions with the support of four grantees in Phase II.

Promoting Tobacco Cessation Services on College Campuses through Quitline NC

All grantees promoted Quitline NC during the first six months of Phase II through the following activities:

- Grantees conducted 165 Quitline NC promotions (e.g., campus-wide events, presentations at meetings) to college students. Approximately one-fifth of these promotions specifically targeted a priority population on campus to reduce tobacco disparities (e.g., students in fraternities/sororities, African Americans). Over 1,300 Quitline NC promotions have been conducted by grantees since the beginning of Phase I.
- Grantees reported 51 earned and 13 paid radio, TV, and newspaper media messages promoting Quitline NC in Phase II.
- Eight grantees reported 22 meetings with campus-based health providers in the first six months of Phase II to promote Quitline NC fax referral utilization for young adults interested in quitting tobacco use.

Since the start of the Initiative, support for policy change has come from over:

• 450 college officials (e.g., Deans, upper level administrators) and

• 900 campus organizations, faculty, staff, and student leaders

Tobacco Initiatives
Outcomes Evaluation
2007-2008

Quitline NC

Quitline NC was created in 2005 as a telephone-based, tobacco cessation service that provides free support to all North Carolina residents who want to quit using tobacco. Research shows that quitlines are an effective and evidence-based approach to tobacco cessation. Proactive quitlines, like Quitline NC, have been shown to significantly increase quit rates compared to quitting without support.[8]

Quitline NC receives funding from both HWTF and the North Carolina Department of Health and Human Services (DHHS). The HWTF provides funding for services for callers ages 24 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. DHHS provides funding for all other callers.

Quitline NC completed its first year of operation in October 2006. Due to changes in the HWTF fiscal year, the eight month period through June 2007 constitutes Year 2. Year 3 of Quitline NC encompasses July 2007 through June 2008.

In its third year, Quitline NC reached more youth, young adults, primary caregivers, and school employees who serve as caretakers and models for youth. Quitline NC served individuals from all counties in North Carolina and many who traditionally have limited access to cessation services. The following section details key outcomes from Year 3.

Quitline NC Promoted through Comprehensive Campaign

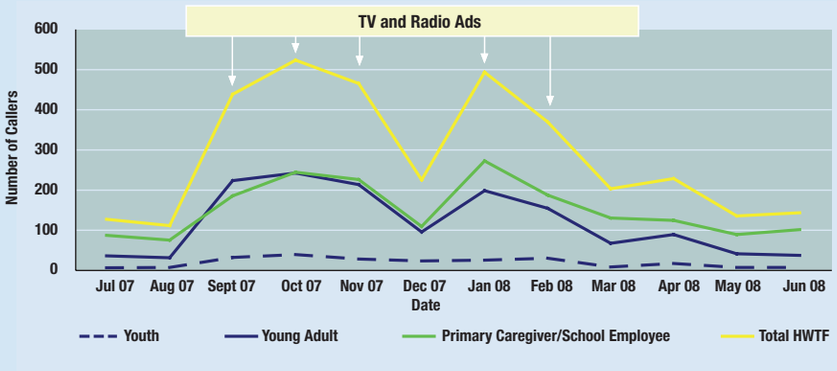
The HWTF launched NC's first multi-media Quitline NC promotional campaign targeted to young adults in September 2007. The "Call it Quits" campaign combined TV, radio, print, and online Quitline NC promotions that featured simulated calls between a smoker and a Quitline coach. Online components included a newly designed website (www.QuitlineNC.com) and targeted advertisements on social networking websites. North Carolina is one of the first states to launch a multi-media promotional campaign targeted specifically to young adults.

Spikes in young adult and primary caregiver/school employee call volumes coincided with TV and radio ads, suggesting that the campaign successfully reached its target audience and had spillover effect on adult callers (Figure 8).

Information about other Quitline NC promotion specific to teens and college students is included in the Teen Initiative and Colleges Initiative sections of this report.

Quitline NC reached more HWTF targeted youth, young adults, primary caregivers, and school employees than ever before.

Figure 8. Year 3 HWTF-Funded Callers by Month (Free and Clear)



Quitline NC Media Driving Awareness

According to the North Carolina Behavioral Risk Factor Surveillance System, almost half (48.7%) of North Carolina smokers were aware of Quitline NC in 2007. The majority of those who were aware of the Quitline heard about it through the media, and 11.2% reported that their doctor referred them.

Call Volume Increased

Quitline NC received a total of 7,322 calls during Year 3. Over half of all calls from tobacco users (54% or 3,448 calls) came from populations supported by HWTF funding. All HWTF-funded callers during Year 3 were tobacco users.

An average of 287 HWTF-funded callers called Quitline NC per month during Year 3, a marked increase from an average of 214 HWTF-funded calls per month during Year 2. Young adults experienced the largest increase in average monthly call volume, from 69.1 calls per month in Year 2 to 117.8 calls per month in Year 3 (70.5% increase). Average monthly call volume for youth increased by 56%, from 11.6 calls per month in Year 2 to 18.1 calls per month in Year 3. Primary caregivers and school employee calls increased by 13.5%, from 133.4 calls per month in Year 2 to 151.4 calls per month in Year 3.

Quitline Reaching More Young Adults and Youth

Based on CDC guidelines[9], Quitline NC ultimately aims to provide services to 2% of North Carolina tobacco users each year. Quitline NC's reach is calculated based on the number of unique callers to Quitline NC as a percentage of the total smoking population in North Carolina. (Smoking data are used as overall tobacco use prevalence rates are not available).

In Year 3, Quitline NC served approximately 0.36% of North Carolina's adult smoking population, similar to its reach (0.39%) during the first 20 months of operation. Year 3 did show marked success in increasing the reach of Quitline NC to both young adult and youth callers. The percentage of young adult

The average call volume increased 33% (from 214 to 287 calls per month) in Year 3.

The HWTF-funded portion of Quitline NC reached every corner of North Carolina, with at least one caller from each of NC's 100 counties.

Tobacco Initiatives Outcomes Evaluation 2007-2008

smokers ages 18-24 served by Quitline NC increased from 0.31% in the first 20 months to 0.45% during Year 3, and youth ages 14-17 served increased from 0.15% in the first 20 months to 0.22% during Year 3.

Target Populations Using Quitline

Quitline NC reached 3,448 youth, young adults, and primary caregivers/school employees who used tobacco during Year 3. Among this HWTF-funded group:

- 217 were youth ages 14-17; 1,414 were young adults ages 18-24; and 1,817 were adult caretakers and role models for children and youth in home and school environments;
- Nearly one-third (31%) of callers were African American, and 2.3% were American Indian;
- 7.3% of callers were Hispanic, and 4% completed calls in Spanish;
- 6.3% (218) of all female callers were either pregnant, planning pregnancy, or breastfeeding;
- Approximately 11.9% of callers had chronic asthma;
- Over half (51.6%) of callers were using Medicaid or had no health insurance coverage;
- The majority of callers (89%) were in the preparation stage of quitting, indicating they were ready to quit; and
- Most (87%) callers smoked cigarettes every day.

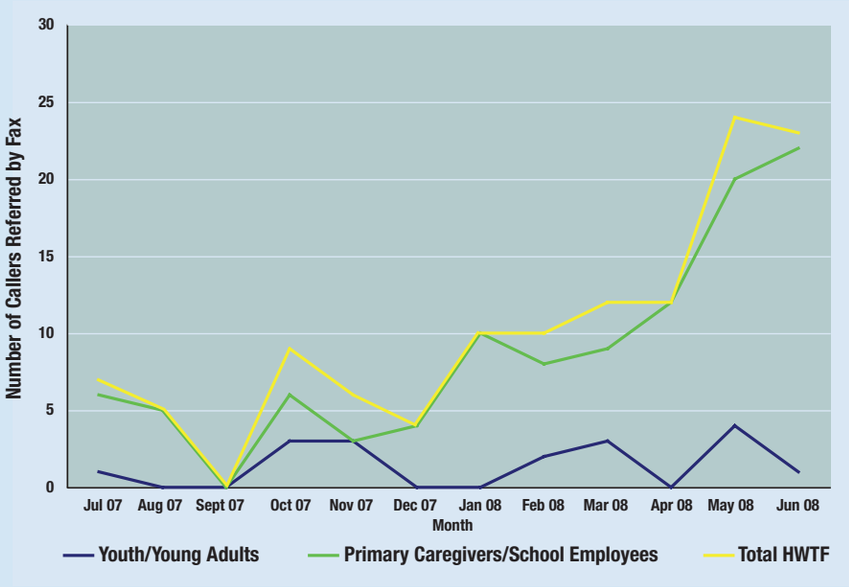
Fax Referral Service Slowly Increases

During Year 3, the HWTF led a new effort to promote Quitline NC and the fax referral system to health professionals. Over 10,000 North Carolina physicians received fax referral materials and Quitline NC promotional items to distribute to their patients who smoke.

The number of completed calls that were referred by fax is tracked. While the use of the fax referral system remained relatively low, the number of HWTF-funded callers referred by fax increased steadily throughout Year 3 (Figure 9). Among HWTF-funded callers, 122 (3.5%) were referred by fax, of whom 86% were primary caregivers/school employees.

During Year 3, Quitline NC reached a substantial number of callers from populations who experience disparities in tobacco use, effects of tobacco- related diseases, and limited access to healthcare or other cessation resources.

Figure 9. Fax Referrals for HWTF-Funded Callers (Free and Clear)



Quit Rates Remain Steady

The Quitline NC vendor, Free & Clear, Inc., estimated an 11.8% 30-day quit rate among all HWTF-funded callers. This estimate is based on the number of HWTF-funded callers who responded to a follow-up survey and reported being tobacco-free for 30 days.10 This number is comparable with an estimated quit rate of 11.1% for Quitline NC callers during the first 20 months of operation.

Future Directions

The HWTF Tobacco Initiatives continued to boast a number of successes in 2007-08. The recommendations listed on page two of this report address program challenges and provide direction for program continuation and growth. Additional information and specific recommendations for each Initiative can be found at **www.tpep.unc.edu**.

Among those responding to a follow up survey, 90% of HWTF-funded callers reported satisfaction with the services provided by Quitline NC.

References

1. Campaign for Tobacco-Free Kids. Tobacco use among youth. Available from: http://www.tobaccofreekids.org/research/factsheets/pdf/0002.pdf Accessed August 2008.

2. North Carolina State Center for Health Statistics. BRFSS 2007. Available from: http://www.schs.state.nc.us/SCHS/brfss/2007/index.html Accessed August 2008.

3. Fiore MC, Jaen Cr, Baker TB, et al. Treating Tobacco Use and Dependence: 2008 Update. Clinical Practice Guideline. Rockville, MD: U.S. Department of Health and Human Services. Public Health Service. May 2008.

4. Campaign for Tobacco-Free Kids. Key state-specific tobacco-related data and rankings. Available from: http://tobaccofreekids.org/research/factsheets/pdf/0176.pdf Accessed August 2008.

5. Centers for Disease Control and Prevention. Best Practices for Comprehensive Tobacco Control Programs – 2007. 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; October 2007.

6. Rigotti NA, Moran SE, Wechsler H. US college students' exposure to tobacco promotions: prevalence and association with tobacco use. Am J Public Health. 2005 Jan;95(1):138-44.

7. American Lung Association Tobacco Policy Project. Big tobacco on campus: ending the addiction. 2008. Available from: http://www.lungusa.org

8. Stead LF, Lancaster T, Perera R. Telephone counseling for smoking cessation. Cochrane Database Syst Rev 2003: CDOO2850.

9. 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.





For more information about the North Carolina Health and Wellness Trust Fund Tobacco Initiatives, contact:

North Carolina Health and Wellness Trust Fund
7090 Mail Service Center
Raleigh, NC 27699-7090

T: 919-981-5000
F: 919-855-6894
Web: www.healthwellnc.com
Email: hwtfc@healthwellnc.com

For more information about the Outcomes Evaluation of the North Carolina Health and Wellness Trust Fund Tobacco Initiatives, contact:

Tobacco Prevention and Evaluation Program
University of North Carolina School of Medicine
590 Manning Drive, CB #7595
Chapel Hill, NC 27599

T: 919-843-9751
F: 919-966-9435
Web: www.tpep.unc.edu
Email: tpep@med.unc.edu

Evaluation of the 2006 North Carolina TRU Media Campaign

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

August 30, 2007

For more information about the NC Tobacco. Reality. Unfiltered. Media Campaign Evaluation, please contact:

Tobacco Prevention and Evaluation Program

University of North Carolina at Chapel Hill
School of Medicine
Department of Family Medicine
CB #7595, Manning Drive
Chapel Hill, NC 27599
T: 919-843-9751
F: 919-966-9435

Web: www.fammed.unc.edu/TPEP
Email: tpep@med.unc.edu

Table of Contents

Page

1. Executive Summary

North Carolina's Teen Tobacco Use Prevention and Cessation Initiative, funded by the NC Health and Wellness Trust Fund (HWTF), has included a statewide media campaign called *Tobacco.Reality. Unfiltered*, or TRU, since 2004. The campaign utilizes a theme of the serious health consequences of tobacco use affecting real people in North Carolina and is evaluated using telephone surveys with a cohort of NC youth. After a baseline survey in early 2004, follow-up surveys to examine the impact of the campaign took place later in 2004 and in 2006. These evaluations showed favorable youth reaction to and increasing youth awareness of the campaign. The HWTF subsequently increased the budget for the TRU media campaign in the fall of 2006 to $4.5 million annually, an increase of about $3 million. The 2007 TRU media evaluation began four months after the funding increase.

Highlights from the evaluation of the 2007 TRU media campaign include:

- Youth awareness of the TRU campaign increased by nearly one-third from 2006 to 2007.
  - Awareness of the campaign rose from 54% in 2006 to 71% in 2007.
  - Over 500,000 youth (11-17) in NC have seen and are aware of the NC TRU campaign.
- Awareness of TRU campaign brands and slogans rose substantially from 2006 to 2007.
  - Youth awareness of the TRU brand rose from 42% in 2006 to 58% in 2007.
  - Youth awareness of the *Tobacco.Reality.Unfiltered*. slogan increased from 48% in 2006 to 55% in 2007.
- NC youth responded positively to the ads run in 2007.
  - More than 95% of NC youth who had seen the 2007 ads reported that they were convincing, attention-grabbing, and gave good reasons not to use tobacco.
  - Over 25% of NC youth reported that they talked to their friends about the ads, indicating high "chat value".
- Anti-tobacco and pro-health attitudes among NC youth have remained stable and strong.
  - Over 90% of NC youth did not believe that young people who smoke cigarettes had more friends, that smoking cigarettes made youth look cool or fit in, or that smoking made youth look attractive.
- The majority of youth continue to be exposed to cigarette advertising and believe that cigarette ads portray smoking as acceptable or "cool".
- Most youth support tobacco-free policies in places they frequent, including schools, indoor places such as restaurants, and outdoor areas such as parks.

The 2007 evaluation also notes:

- Current research continues to support inclusion of a mass media campaign as an important component of North Carolina's comprehensive tobacco prevention and control program.
- One-third of NC youth remain susceptible to smoking. While the long-term impact of the TRU campaign on this population is inconclusive, the TRU campaign, as part of a comprehensive program, must continue to target this group of at-risk youth.
- For the TRU media campaign to continue to move in the right direction in constructing and delivering effective messages that best impact NC youth, it should aim to:
  - Increase campaign awareness by 2008 to over 80% (a rate close to levels seen in other successful state campaigns).
  - Develop and air new ads to continue to capture youth attention. (Current ads may have reached their maximum impact in terms of receptivity among NC youth.)
  - Increase ad "chat value" (the percentage of youth that report talking to their friends about the ads) from the current rate of 25% to 30%.
  - Continue to integrate the TRU campaign with community and school programs to maximize campaign effectiveness. (2007 data indicate that at least one-fourth of youth participated in a school or community event in the last year to prevent tobacco use.)

2. Introduction

Tobacco use is the leading cause of preventable death in the United States and in North Carolina.[1] Most tobacco users start as youth. 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, one-fourth of youth have tried smoking, and by their senior year that proportion climbs to 47%. While smoking rates have been on the decline since the mid-1990s, the rate of decline has slowed nationally in recent years. [3]

In North Carolina, the 2005 Youth Tobacco Survey (YTS) 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.[4] The next North Carolina YTS will be conducted in the fall of 2007.

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 initiative received funding of $15 million annually for 2005 and 2006, and the HWTF increased funding for the initiative to $17 million a year in 2007.[5] Following CDC guidelines for comprehensive programs to reduce youth smoking [6], 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 as part of the overall campaign at $1.7 million for 2005-2006.[7] In the fall of 2006, the annual funding level was increased to $4.5 million.

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 by Capstrat, an advertising agency in Raleigh, NC, 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.[8] This report suggested that an effective mass media campaign in North Carolina could include true stories told by real people in North Carolina about the serious health consequences of tobacco use, projecting 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 by the media vendors around NC, also featuring youth telling stories about loved ones suffering serious health consequences from tobacco use. *Travelogue* was part of this series, and additional ads featured a young man who had lost his mother and a teenage girl whose grandmother had died from tobacco-related disease. 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 from spit tobacco use.

In 2006, a new ad was added to the TRU rotation, *Truth and Consequences*. Based on focus group feedback showing strong, positive youth reaction to cancer survivor Terrie Hall, who had appeared in *Travelogue* and the 2005 ads, an ad was developed featuring Terrie’s story. This ad ran in 2006 and 2007.

The 2006 TRU media campaign was evaluated based on a logic model developed for the TRU campaign (see Appendix). Since the TRU campaign is television and website-based, major outputs of the campaign include gross ratings points 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, 2005, and 2006, as well as the first quarter of 2007, ads appear in Table 2A..

Table 2A: Gross Ratings Points for 2004-06 and 2007, Q1 TRU Ads

Market	Total GRPs			
	2004	**2005**	**2006**	**2007, quarter 1**
Asheville	N/A	481	1,312	869
Charlotte	5,800	1,535	2,627	1,411
Greensboro/Winston-Salem	4,200	1,451	2,985	1,262
Greenville/New Bern	3,400	1,605	2,280	1,129
Raleigh/Durham	3,600	1,484	3,790	1,482
Norfolk (NC counties)	1,000	388 spots	1384 spots	547 spots
Myrtle Beach (NC counties)	1,800	N/A	N/A	N/A
Wilmington	3,400	1,313	2,089	742
TOTAL (excluding Norfolk)	**22,200**	**7,869**	**15,083**	**6,895 (quarter 1 only)**

As shown in the table, with the funding increase in late 2006, the 2007 campaign appears on track to be the largest campaign yet, if quarter 1 dosage remains similar or higher in quarters 2 through 4.

Major outcomes measured through this current evaluation include campaign awareness (both ad and brand awareness) and ad receptivity. Brand 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 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.

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

This report provides evaluation results of the 2006 TRU television campaign. Prior evaluations of earlier phases of this campaign are available at http://fammed.unc.edu/TPEP/tru_media.htm.

3. Methods

The media vendor created ads for the *Tobacco.Reality.Unfiltered*., or TRU, media campaign using best practices reports and focus group studies. While the long-term goal of the media campaign is to prevent youth 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 aired on teen-friendly channels such as the CW, 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 conducted baseline and follow-up interviews with a cohort of NC youth to assess tobacco use, attitudes toward tobacco use, and awareness of anti-tobacco media campaigns.

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

The second wave of the survey (T2) took place immediately following the fall flight of the 2004 media campaign. The T2 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 in early 2006, 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 of new North Carolina specific anti-tobacco ads; comparison to national ads; and attitudes and receptivity to tobacco advertising.

The fourth wave of the survey (T4) took place in March and April of 2007 and assessed these same areas, as well as an added domain of support for tobacco-free policies. The methodology reported here refers to the T4 data collection period.

Eligibility for participation in T4 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 older by the T4 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 to T3 data are based on population counts for 11-17 year old teens living in NC, not those 18 or older. Specifically, weights could not be produced for this group without losing comparability to the previous three rounds of data collection. Therefore, cross-sectional weights were provided as part of the T4 dataset to allow for direct comparisons between rounds to determine, for example, if smoking rates changed or if attitudes toward smoking changed.

The sample design for T4 is classified as a stratified, multi-round longitudinal study with supplementation. Stratification was based on a dual-frame sample design used at all data collection points 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, nonworking telephone number, respondent otherwise unreachable); refusals to participate in follow-up calls; and baseline respondents who had aged-out so that 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 2,831 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 657 sample phone numbers targeting households with one or more residents 11-17 years of age (inclusive). Stratification and proportionate allocation to strata were done in the same way as the RDD frame.

There were 670 follow-up numbers available for calling at T4 data collection. One-hundred and four cases were pulled out and treated separately to determine whether they had 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
In cohort since T1	387
Entered study at T3	283
Supplementation at T4	6,379
Total	7,049

At the end of calling, there were 707 completed interviews. The breakdown is provided in Table 3A.2.

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

Classification	Completes	Refusals	Ineligibles	Not Screened	Totals
In cohort since T1	**252**	67	68	0	387
Entered study at T3	**172**	73	38	0	283
Supplementation at T4	**283**	227	4,963*	906	6,379
Total	**707**	367	5,069	906	7,049

* Ineligible cases include business or other non-residential numbers, non-working numbers, and numbers reached without a youth in the target age range.

The overall response rate was 57.4% as given by the standards set by the American Association for Public Opinion Research. A breakdown of response rates is given in Table 3A.3.

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

Classification	Response Rate	Joint RR
In cohort since T1	79.0%	34.5% (From Baseline to T4)
Entered study at T3	70.2%	38.1% (From T3 to T4)
Supplementation at T4	47.6 %	
Total	57.4 %	

Statistical Analysis

All data were analyzed using SAS survey procedures to account for both complex survey designs (e.g. stratification) and sampling weights. Descriptive data analysis was performed on selected variables. Results are presented as frequencies.

4. Results

4A. Demographics

Since the data are weighted to the US Census tract, demographic characteristics reflect those of youth in the state. Table 4A summarizes gender, age, and race.

Table 4A: Demographics (T4)*

Variable	%
Gender	
Male	50
Female	50
Age	
11	7
12	19
13	18
14	14
15	15
16	12
17	14
Mean Age = 14	
Race	
White	68
Non-white	32

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

4B. Tobacco Questions

***4B.1** Tobacco use*

Behaviors related to tobacco use are shown in Table 4B.1. Although behavioral changes are not statistically significant, they do appear to be moving in the right direction with decreases in current cigarette and chewing tobacco use, as well as a decreased proportion of youth who report that they have ever tried either tobacco product.

Table 4B.1: Tobacco use behaviors (T1-T4)

Behavior	% Yes			
	Time 1	Time 2	Time 3	Time 4
Ever used any tobacco product	*	*	17	14
Cigarettes				
Ever tried cigarette smoking, even 1 or 2 puffs	16	18	14	12
Current cigarette smoking	3	6	5	3
Chewing tobacco, snuff, or dip				
Ever used chewing tobacco, snuff, or dip	*	*	5	4
Current use of chewing tobacco, snuff, or dip	*	*	2	1

* Not asked at T1 or T2.

4B.2 *Desire to quit*

Of the 3% of youth in the sample who were current smokers at T4, a little over half (56%) reported wanting to quit. This compares to over 80% of youth smokers at T3 who reported wanting to completely stop smoking. One possible explanation is that some youth who reported wanting to stop smoking at T3 did quit in the past year. (The T3 smoking rate was 5%.)

4B.3 *Susceptibility to smoking*

Susceptibility to smoking is a measure of "likelihood to smoke" based on a youth's responses to several 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 (Table 4B.3). The percentage susceptible at T4 was similar at 35%. Susceptibility to smokeless tobacco has stayed fairly constant in the past year, at 11% for T3 and 12% at T4.

Table 4B.3: Susceptibility for tobacco use (T1-T4)

Susceptibility	%			
	T1	T2	T3	T4
Smoking susceptibility (non-smokers)				
Susceptible	37	39	34	35
Non-susceptible	63	61	66	65
Smokeless tobacco susceptibility (non-dippers only)				
Susceptible	*	*	11	12
Non-susceptible	*	*	89	88

* Not asked at T1 or 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 (Table 4B.4a). This is consistent with T3 data.

Table 4B.4a: Household smoking behaviors and health issues (T4)

Question	**% Yes**
Other than yourself, does anyone who lives in your home smoke cigarettes?	26
Of those responding "yes" to the above question: How many people in your house, not including you, are smokers?	**%**
1	64
2	23
3	6
4 or more	7
	% Yes
Do you have asthma or other severe breathing problems?	13
Does anyone else in your household have asthma or other severe breathing problems?	25

Youth responses about their household smoking rules are shown in Table 4B.4b. The percentage of youth who report that smoking is not allowed in their homes has remained relatively stable, though the proportion reporting that there are no rules about smoking in the home appears to be decreasing over time.

Table 4B.4b: Household smoking rules over time (T1-T4)

Question	**%***			
	T1	**T2**	**T3**	**T4**
What are the rules about smoking in your home?				
People can't smoke in the house	73	76	75	75
People can smoke only in certain rooms of the house	6	6	7	6
There are no rules about smoking at home	20	16	15	13

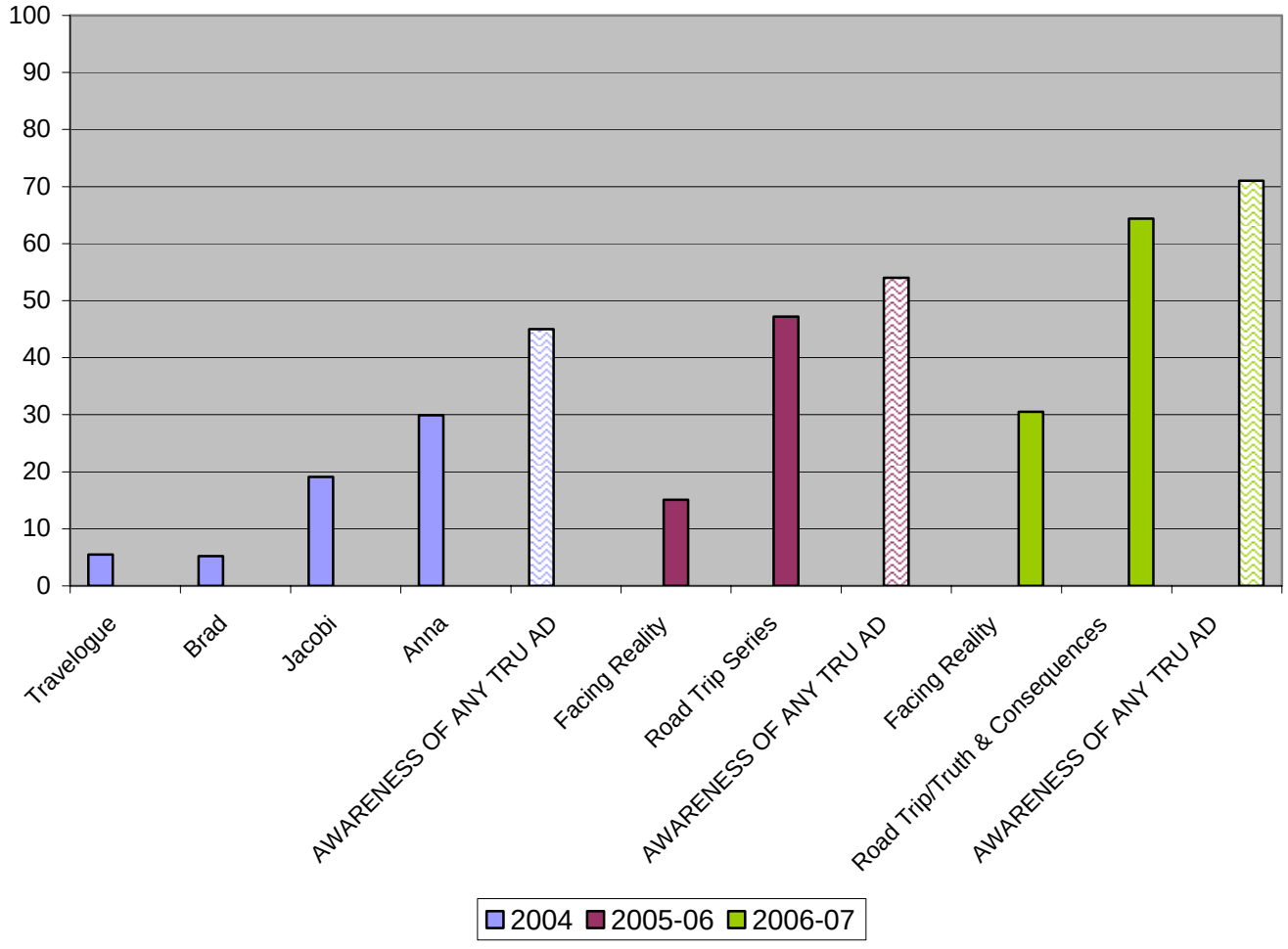
* Percentages do not add to 100 because of an "other" category.

4C. Campaign Effects

4C.1. Campaign awareness

Confirmed awareness for the TRU ads (awareness of at least one TRU ad) increased from 54% in 2005-06 to 71% in 2006-07 among NC youth (a 31% increase). The chart below indicates awareness for individual ads, followed by a total rate of awareness for any TRU ad for each year of the campaign. Both awareness of individual ads or series of ads, as well as overall campaign awareness rates, have increased steadily since 2004. The effect of campaign awareness on tobacco use or susceptibility is indeterminate.

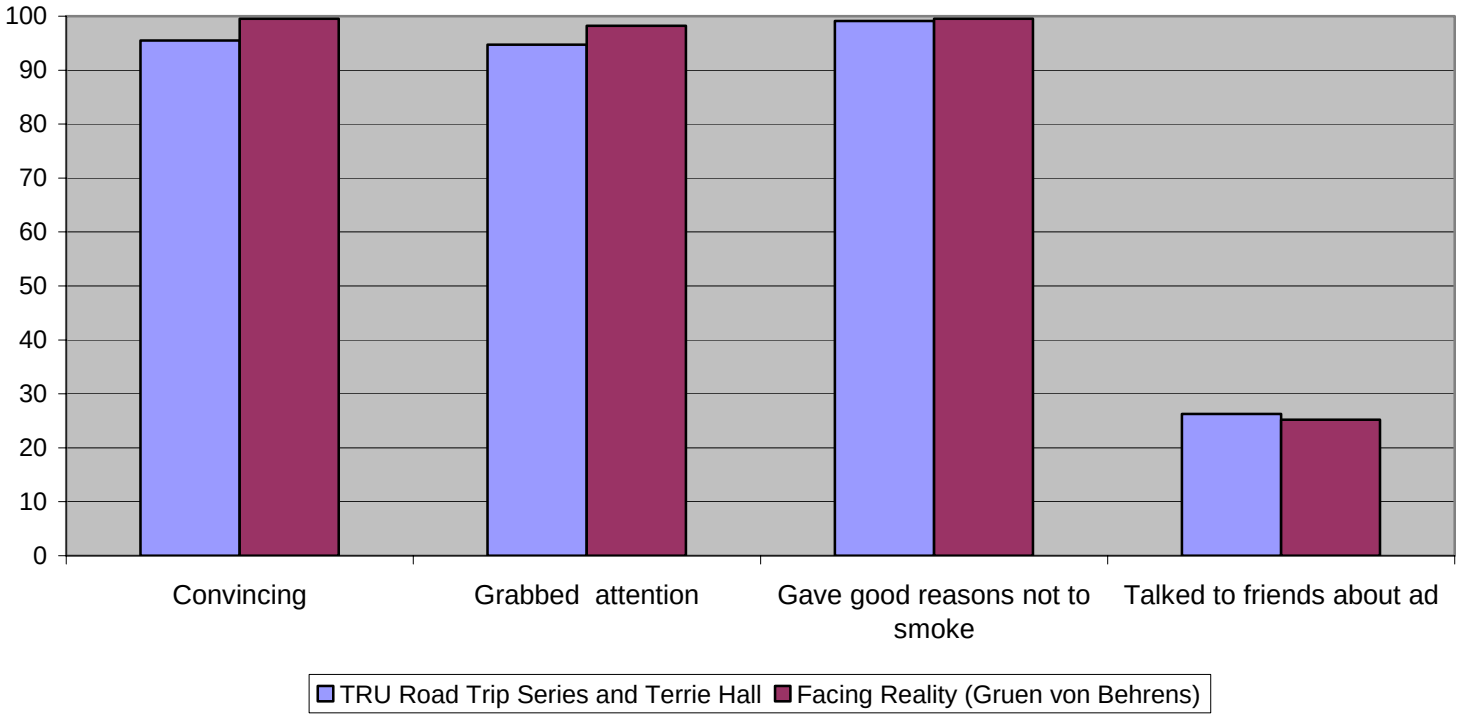
Figure 4C.1: Confirmed awareness of TRU ads by NC youth (T2-T4)



***4C.2** Ad receptivity*

Youth who had seen one or more TRU ads at T4 responded positively to the ads. Of the youth who had confirmed awareness of the individual ads (Figure 4C.1), over 94% reported that the 2006 ads, the TRU Road Trip Series, including *Truth and Consequences* (Terrie Hall), and *Facing Reality* (Gruen) grabbed their attention, and over 95% found these ads convincing (Figure 4C.2). Nearly 100% of youth surveyed said these ads gave good reasons not to use tobacco. Over 25% of youth who have seen the ads reported that they talked to their friends about the ads. This receptivity is at or above prior year results.

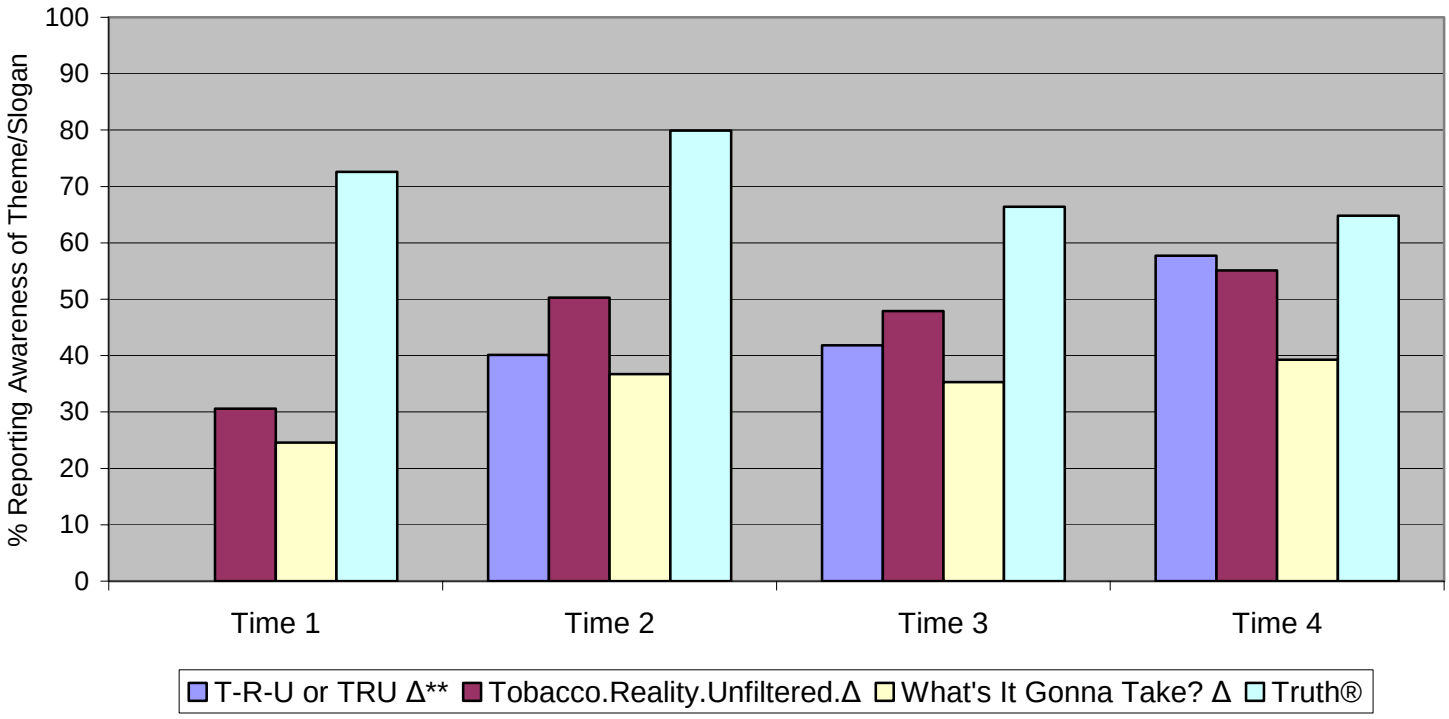
Figure 4C.2: Reactions to TRU ads among NC youth with confirmed awareness (T4)



4C.3 *Brand awareness*

Recognition of the three North Carolina specific media brands/slogans (*TRU*, *Tobacco.Reality.Unfiltered.*, and *What's it gonna take?*) increased from T3. The slogan *What's it gonna take?* increased by 11% (from 35% to 39%), and *Tobacco.Reality.Unfiltered* increased 15% (from 48% to 55%). The TRU brand increased by 38% (from 42% to 58%). While recognition of North Carolina specific media brands and slogans is still less than the national truth® campaign (which has been airing since 2000 and had an awareness rate of 65% at T4) the difference in awareness rates between North Carolina and national campaigns is lessening.

Figure 4C.3: NC youth awareness* of anti-tobacco campaign themes or slogans (T1-T4)



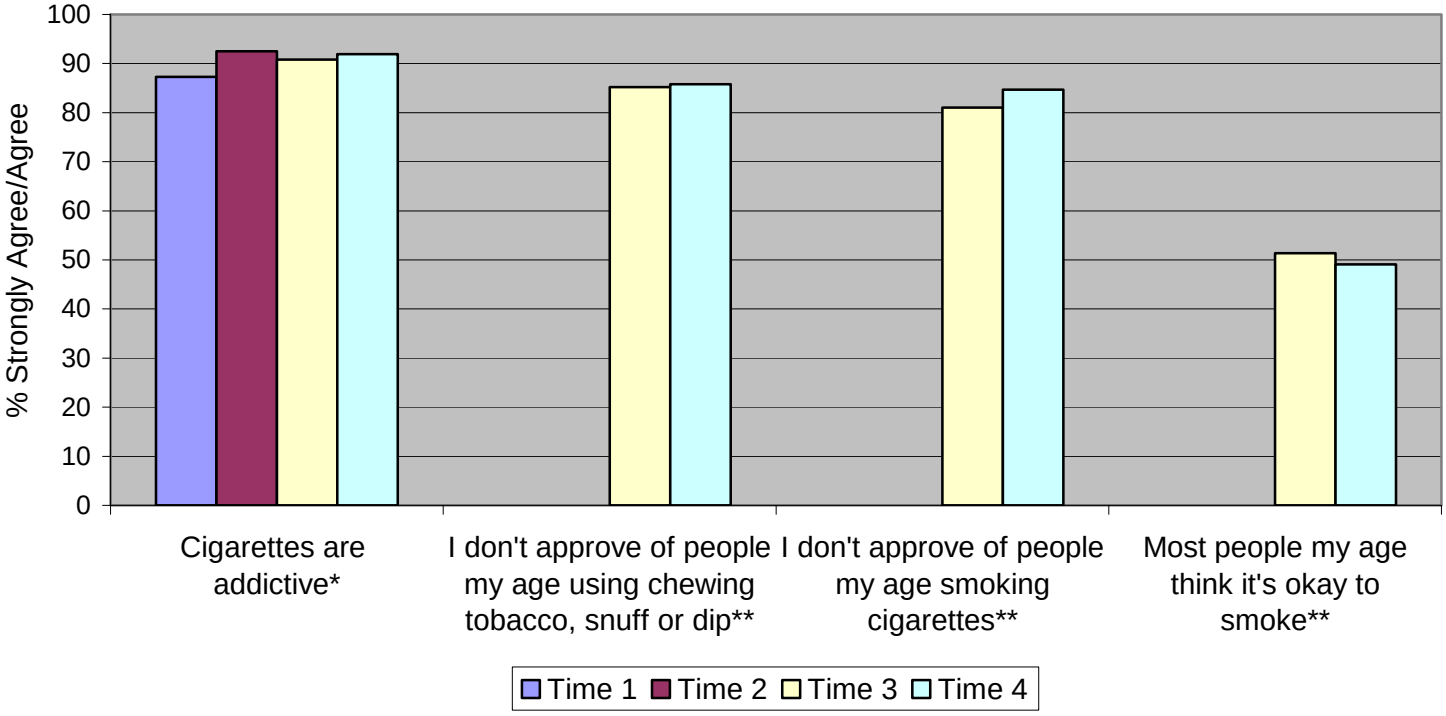
* Aided Awareness
® National Legacy Campaign
Δ NC TRU Media Campaign
** Not asked at T1

4D. Youth Attitudes

4D.1 Youth attitudes toward smoking

Youth attitudes against smoking remain very strong from T1 to T4, with over 90% of youth stating that cigarettes are addictive and approximately 85% saying that they did not approve of their peers using cigarettes or spit tobacco. However, nearly half of youth still believe that their peers think it is okay to smoke.

Figure 4D.1: NC youth attitudes towards harm or approval of tobacco use (T1-T4)

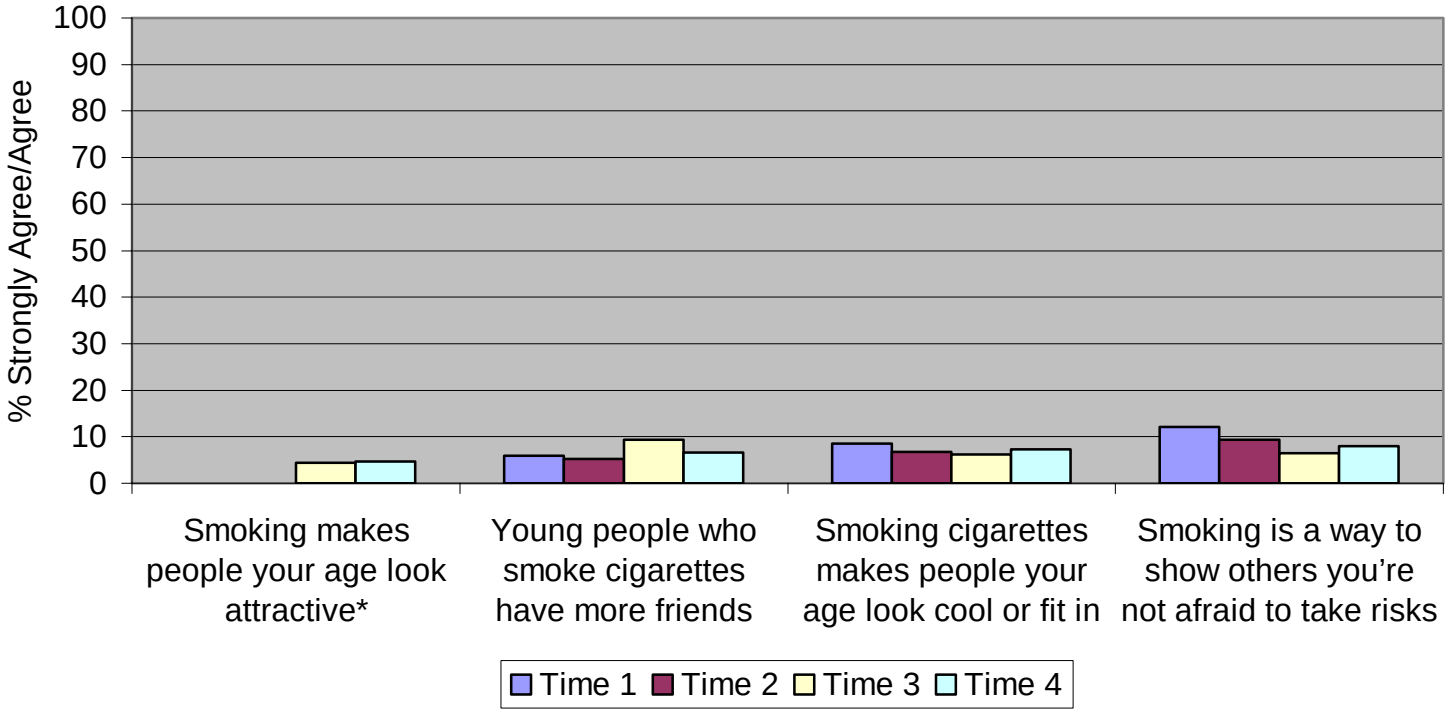


* Question asked in Times 1-3 as "Cigarettes are not addictive"
**Not asked at T1 or T2

4D.2 *Social acceptability of smoking*

The social acceptability of cigarette smoking among NC youth is mixed (Figures 4D.1 and 4D.2). While very few youth believe that smoking makes youth look attractive or cool, or that smoking shows one is not afraid to take risks, nearly 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.2: NC youth views on social acceptability of cigarette smoking (T1-T4)

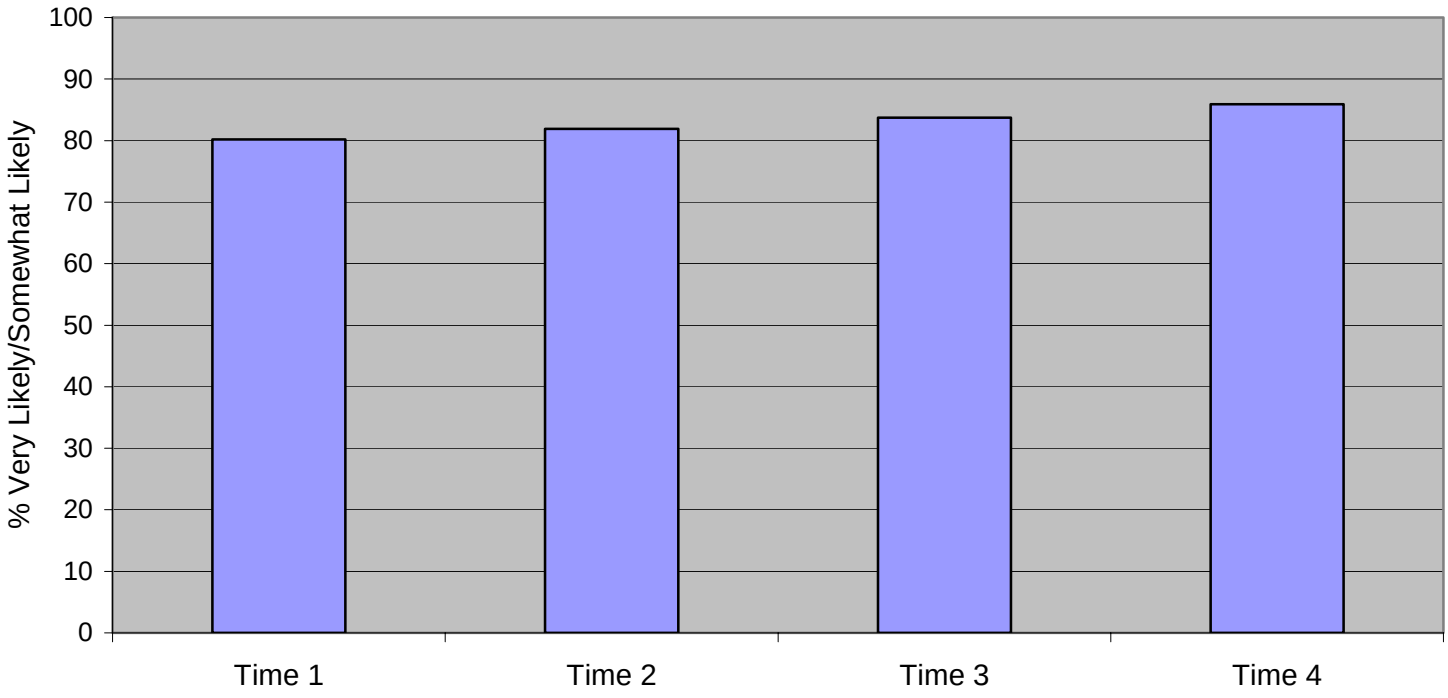


*Not asked at T1 or T2

4D.3 *Belief about harms of smoking*

NC youth continue to show strong beliefs (over 80%) that their heath would be damaged if they started smoking. This belief is consistent across all four time periods and may be increasing over time.

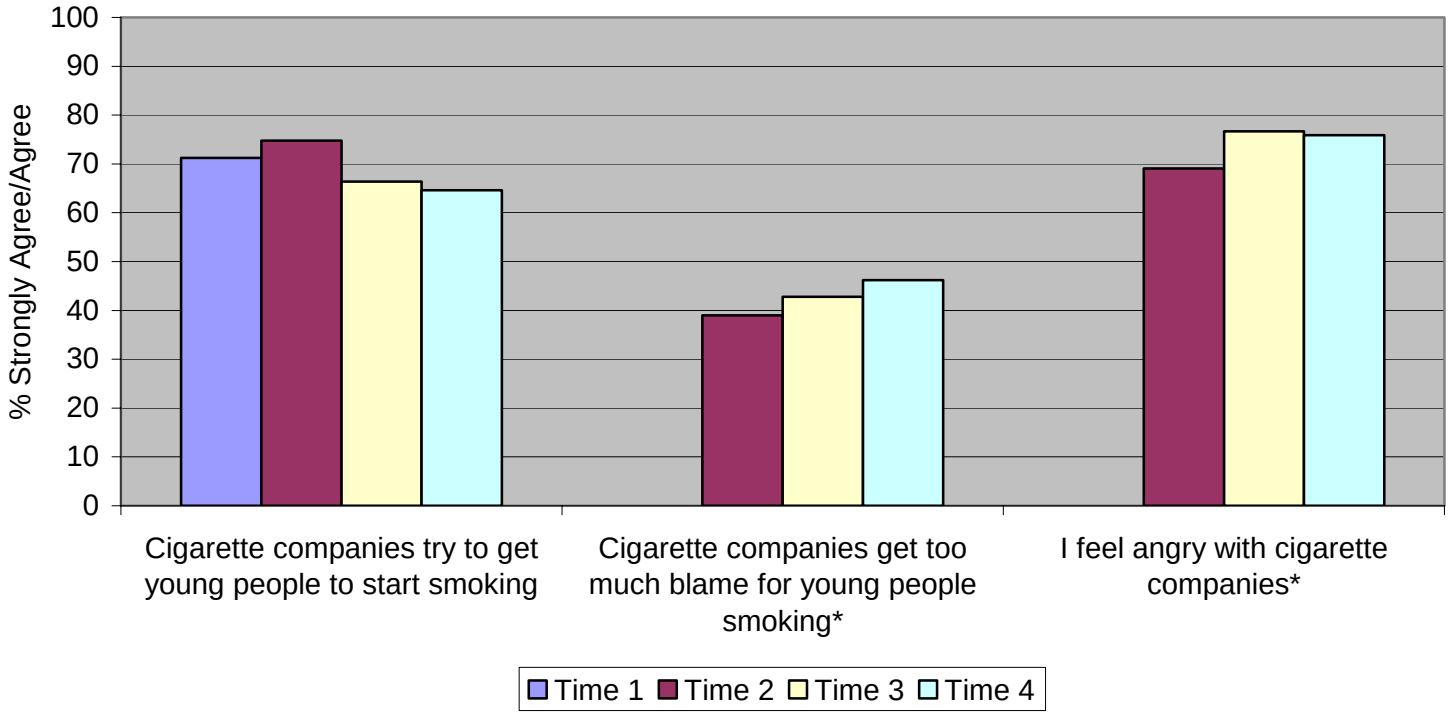
Figure 4D.3: NC youth's beliefs about likelihood of damaging health if start smoking (T1-T4)



4D.4 *Youth attitudes about tobacco industry and receptivity toward tobacco advertising*

A majority of youth continue to voice strong negative reactions to cigarette companies as they relate to youth smoking. As seen in Figure 4D.4a, nearly two-thirds of youth at T4 expressed beliefs that cigarette companies try to get young people to smoke, and three-fourths of youth at T4 expressed anger toward cigarette companies.

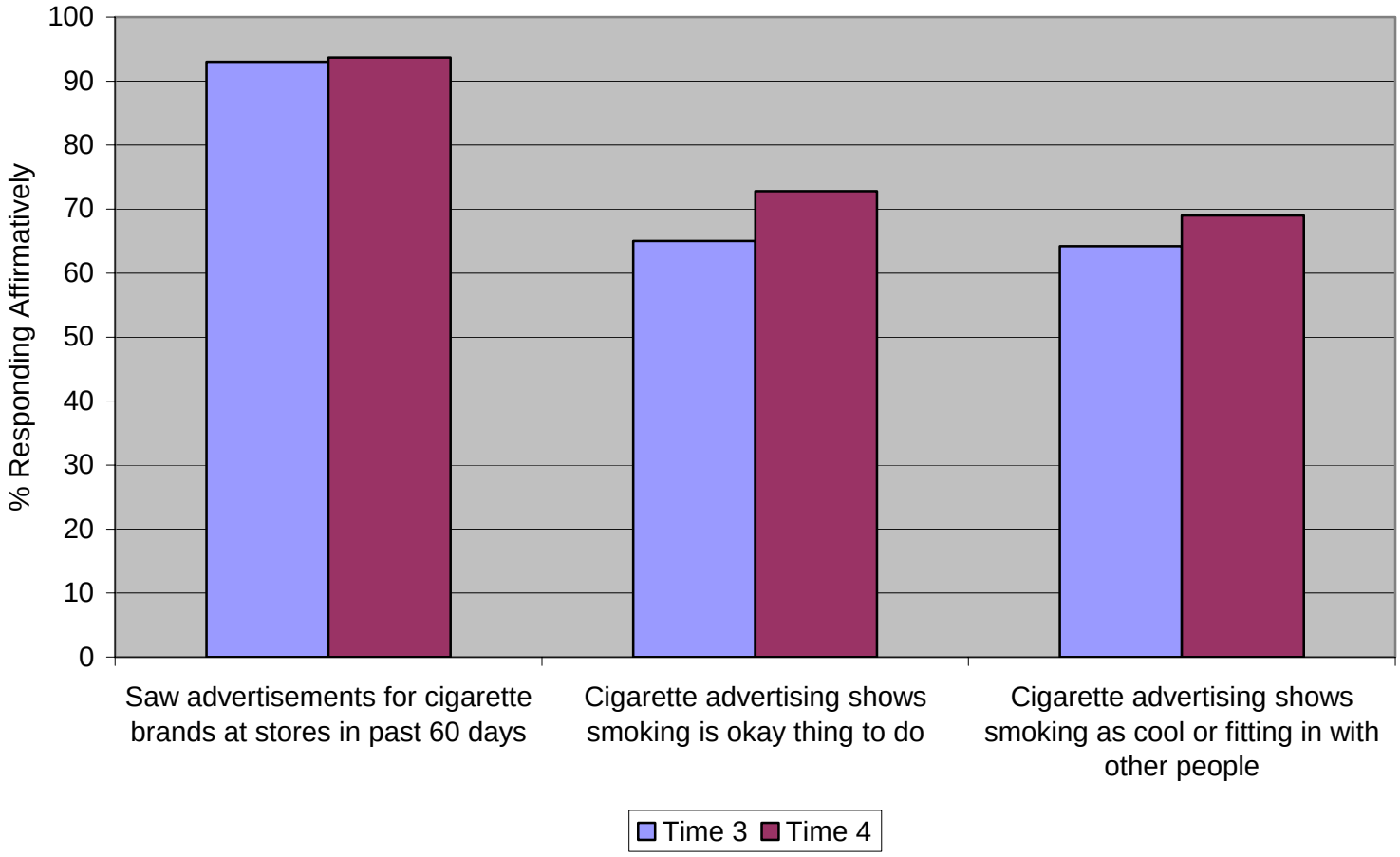
Figure 4D.4a: NC youth attitudes toward the tobacco industry (T1-T4)



*Not asked at T1

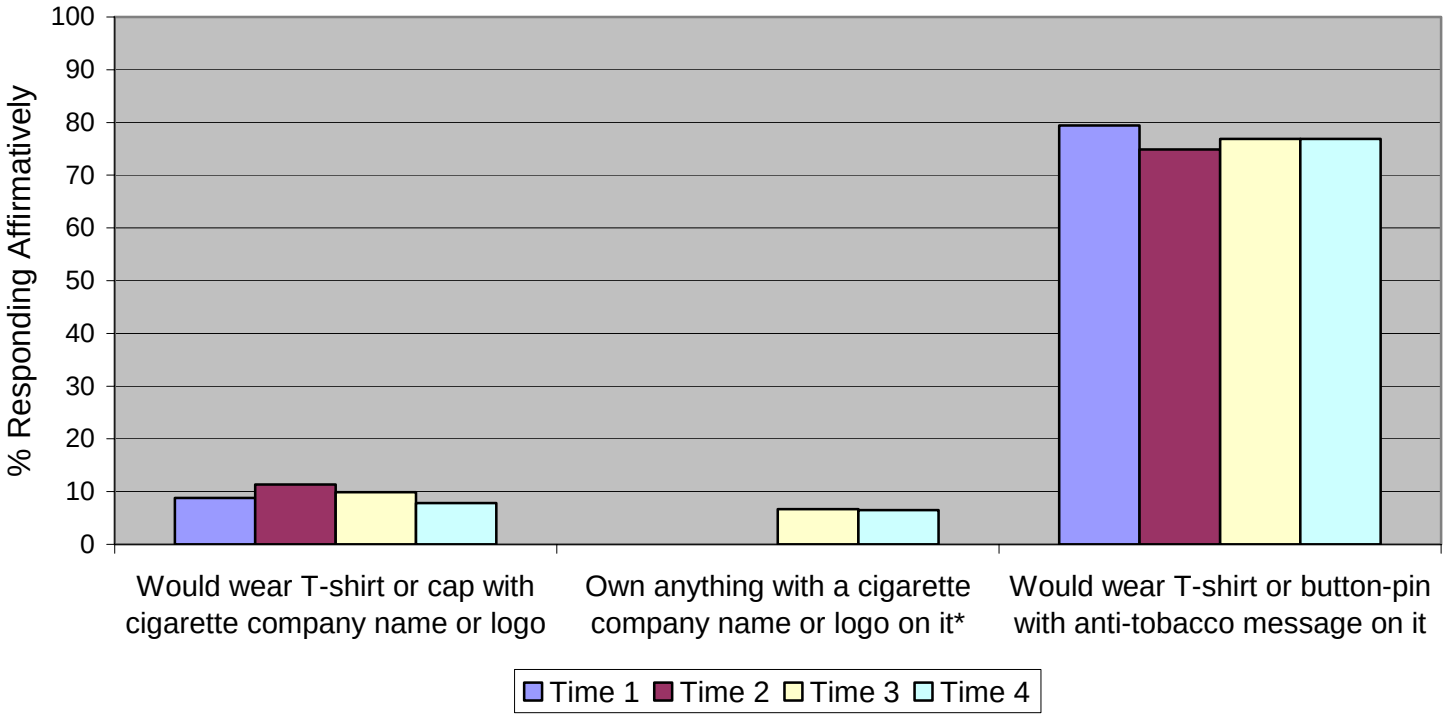
Cigarette promotions and advertisements continue to reach youth in North Carolina. As seen in Figure 4D.4b, over 90% of youth in the sample reported seeing advertisements for cigarette brands in nearby stores during the past 60 days. Approximately 70% think that cigarette advertising shows that smoking is okay or cool.

Figure 4D.4b: Exposure to tobacco advertising and message content (T3-T4)



While 8% of youth reported that they would wear a T-shirt or cap with a cigarette company name or logo, 77% of youth responded that they would wear something like a T-shirt or button-pin carrying an anti-tobacco message.

Figure 4D.4c: Tobacco and anti-tobacco merchandise (T1-T4)

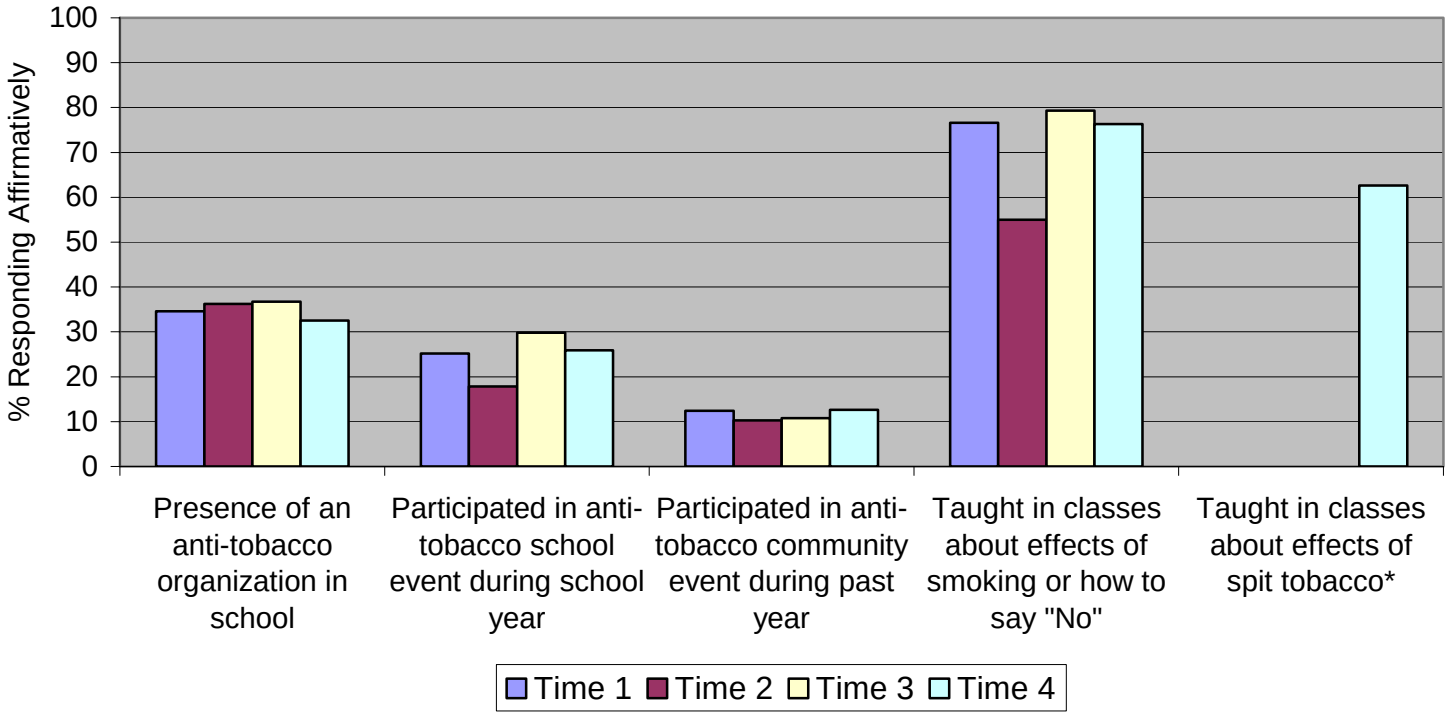


**Not asked at T1 or T2

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

Nearly one-third of the youth surveyed were aware of an anti-tobacco organization in their school and over one-fourth had participated in an anti-tobacco event at their school. About 13% had participated in an anti-tobacco community event. Over three-fourths of youth reported being taught about smoking or how to say “no” in classes, while fewer (63%) reported learning about spit tobacco.

Figure 4E: NC youth involvement in anti-tobacco organizations, classes, or events (T1-T4)

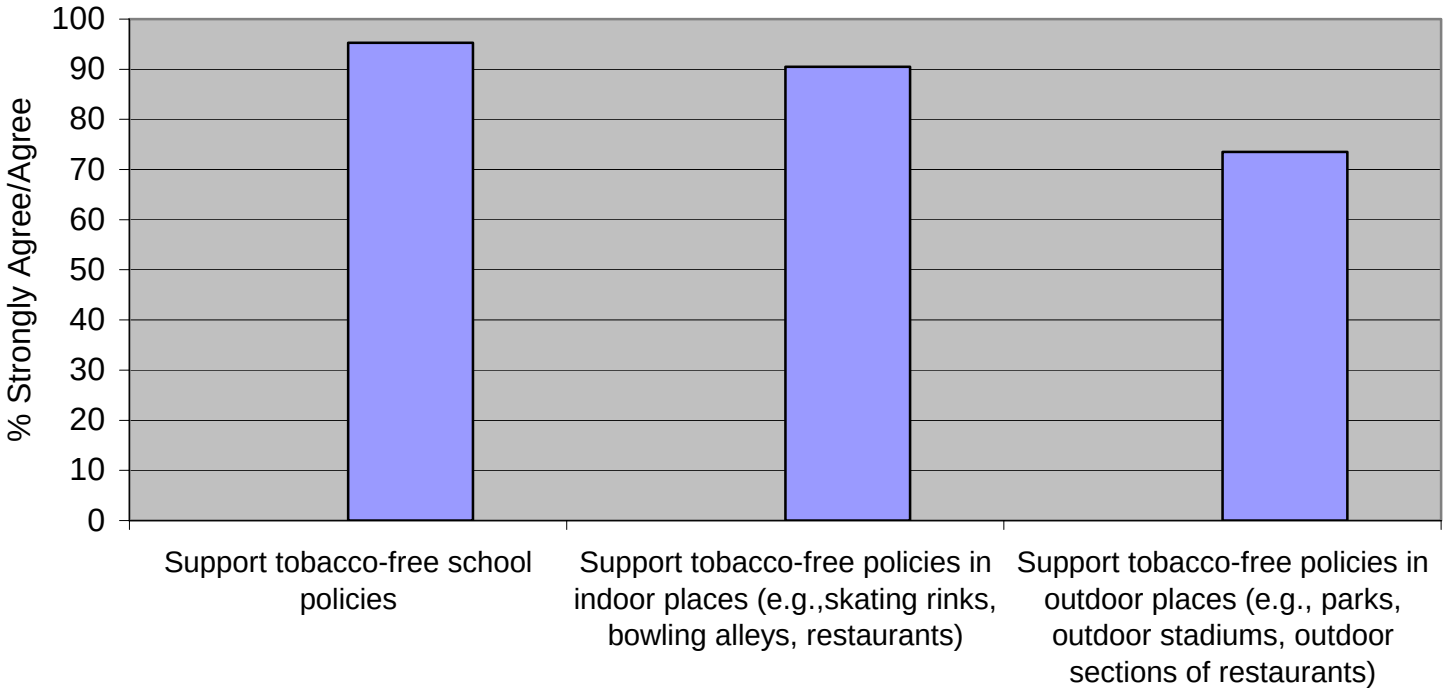


* Not asked at T1-T3

4F. Youth Support for Tobacco-Free Policies

Youth support for tobacco-free policies is very strong, with over 95% supporting tobacco-free policies in schools so that no one, not students, teachers, staff, or visitors, can smoke or use other tobacco products on school grounds at any time (Figure 4F). Ninety percent of youth support indoor places where they go, such as skating rinks, bowling alleys, or restaurants, being completely smoke-free, and nearly three-fourths support outdoor areas where they go (such as parks, outdoor stadiums, or the outdoor areas of restaurants) prohibiting all smoking.

Figure 4F: NC youth support for tobacco-free policies (T4)



5. Discussion

Current research continues to support inclusion of a well-funded, on-going mass media campaign as an important component of a comprehensive tobacco prevention and control program.[9] The TRU media campaign has an integral role alongside the community and school-based programs that form the Health and Wellness Trust Fund's Teen Tobacco Use Prevention and Cessation Initiative. The major, overarching goal of this statewide program is to reduce youth tobacco use. The 2005 NC Youth Tobacco Survey (YTS) demonstrated that the rate of decline for current smoking among youth was higher from 2003-2005 than it was from 2001-2003[4], and this change in rate of decline coincided with the comprehensive efforts launched by HWTF.

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

Youth awareness of the TRU campaign continues to grow. The current awareness rate of 71% translates to over 500,000 youth (11-17) in NC having seen and recognized the NC TRU campaign. While the increasing awareness rate is encouraging, a goal for the 2007-08 campaigns should be to increase awareness to over 80%, a rate that would approach levels seen in other successful state campaigns.[10, 11]

Ad receptivity among those who saw one or more TRU ads remains 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 use tobacco. While current ads are very well-received, they may have reached their maximum impact in terms of receptivity among NC youth, with some ads having played in NC for two years. New ads should be developed and aired more frequently in order to continue to capture youth attention.

Since a quarter of youth who saw the ads reported they had discussed them with their peers, the health information in the ads continues to have the capacity to spread to other youth through social networking. To increase this social networking, a second goal of the campaign should be to increase the current "chat value" (the percentage of youth who report talking to their friends about the ads) from 25% to 30% in 2008.

Youth knowledge about and attitudes against smoking have remained strong over time, with an overwhelming majority acknowledging that cigarettes are addictive and that youth can 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 with continued support of the TRU campaign and the teen initiative.

The social acceptability of cigarette smoking among NC youth remains mixed. Very few youth believe that smoking makes one look attractive or cool, and the majority of youth in this study said they do not approve of others their age using tobacco. Still, nearly half believe others their age think it is all right to smoke. This outcome may change with continued airing of the TRU Campaign and other programs of the initiative.

While awareness and receptivity to the TRU Campaign continue to increase, the long-term impact of the campaign on reducing consumption of tobacco products or susceptibility to using tobacco products among North Carolina youth is more difficult to pinpoint and should continue to be followed. It is important to recognize that campaign awareness reached higher levels only within this past year,

that the media campaign is part of a comprehensive approach that includes extensive coalition activities occurring statewide, and that the intensity of the dose is still less than what some other states have used.[12, 13] As part of the comprehensive statewide program to reduce and prevent tobacco use among youth in North Carolina, the TRU Campaign must continue to target at-risk youth. Since having best friends who smoke is a significant predictor of experimentation with tobacco products, decreases in tobacco use are likely to have a complementary effect on lessening experimentation among non-smokers. The overall reduction seen in tobacco use in the North Carolina Youth Tobacco Survey from 2003 to 2005 is ancillary evidence that the TRU Campaign may be having an additive effect to the other statewide efforts.

Youth exposure to secondhand 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 may be growing. While the percentage of youth reporting that smoking is not allowed in their homes remains constant, fewer youth report 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. Policy efforts to decrease secondhand smoke exposure among all youth remain a critically important outcome.

Youth overwhelmingly support smoke-free policies in areas they frequent, including their schools, indoor areas (such as recreational centers and restaurants), and even outdoor areas (such as parks and stadiums). Channeling this support into advocacy for tobacco-free policies has been a critical and successful component of the HWTF's school and community programs. It is possible that the TRU campaign can support this work.

Despite the removal of tobacco advertisements from many outdoor environments, including billboards, for many years, youth exposure to tobacco industry advertising remains too high, with the overwhelming majority of youth reporting exposure to cigarette ads in the previous two months. A majority of youth believe that cigarette advertising continues to portray smoking as making a person "look cool" or "fit 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 toward the tobacco industry. Evaluations of this national campaign, as well as of several state campaigns using an anti-industry theme, also indicate that youth respond well 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 remains unlikely for now. Instead, the data support grassroots approaches by the initiative to try and counter this influence on North Carolina youth.

Schools remain an important site for tobacco education and anti-tobacco activism, with nearly one-third of youth reporting the existence of an anti-tobacco organization at their school, approximately one-fourth involved in anti-tobacco school events, and over three-fourths reporting being taught about the effects of smoking in class. Participation in community anti-smoking events has remained stable over the past three years, with about one-tenth of youth statewide being involved in community events each year to decrease tobacco use. A cultural shift in anti-smoking attitudes and behaviors is likely underway and will be seen over time among youth. Comprehensive efforts by HWTF community and school grantees, as well as youth experiences with such school-based efforts, may contribute over time to substantive socio-normative behavior change.

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.[14] Despite the fact that several questions were included in the survey on whether the youth was alone when answering the questions and whether 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, might have been uncomfortable answering the questions, and thus under-reporting their behaviors. Therefore, this study may be conservative in the estimates of youth smoking behaviors. However, for the purposes of tracking the media campaign, a telephone survey is highly reliable and cost-effective.

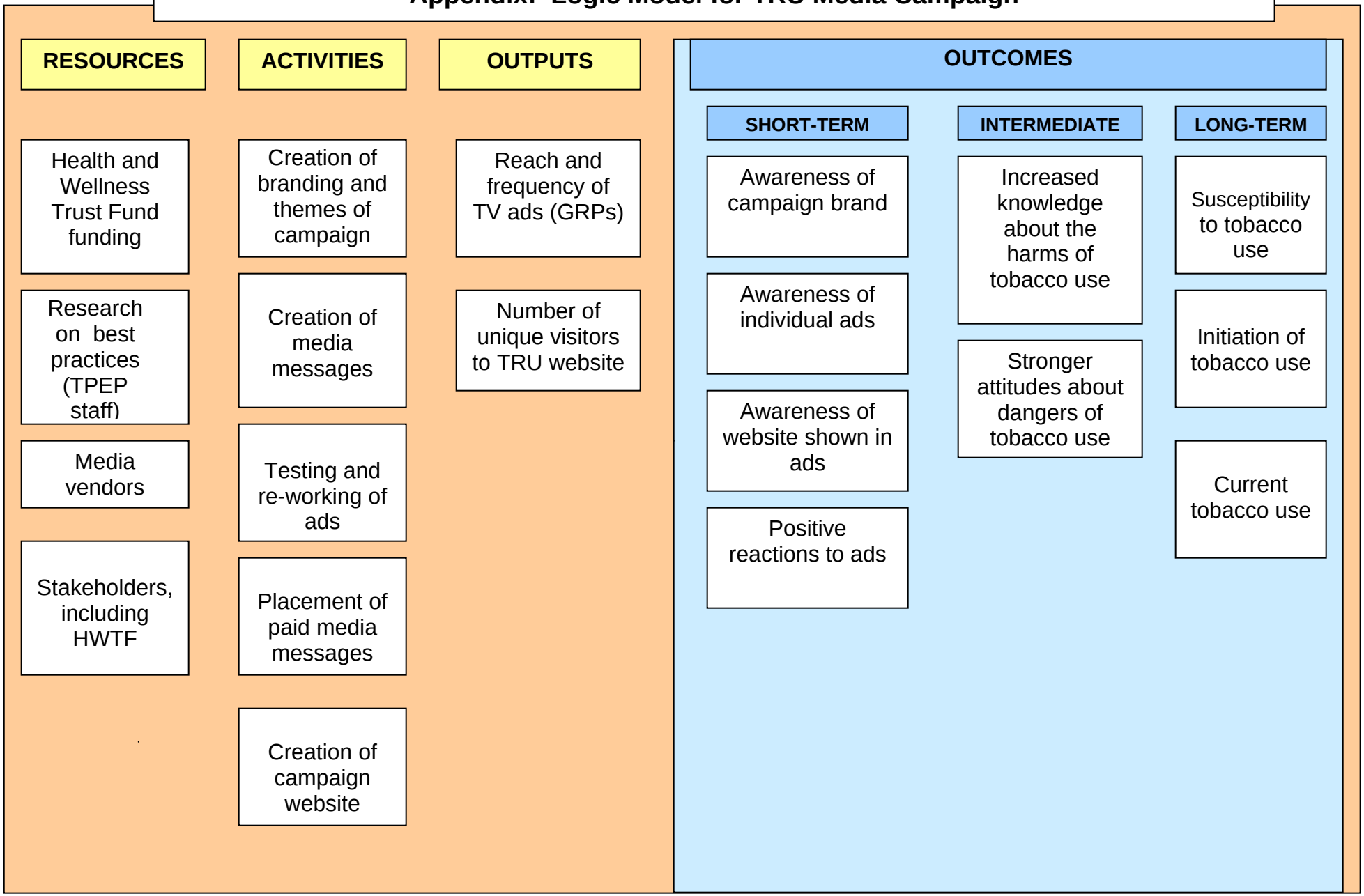
A second limitation is that the time between waves of data collection was unequal. The T2 survey occurred six months after T1, while T3 occurred 14 months later, and T4 13 months afterward, making it more difficult to model changes in attitudes or behaviors over time. Another limitation with modeling 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 would have to be a larger sample to capture substantial changes in tobacco use behavior. 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 longer term outcomes such as behavior change.

The TRU Media Campaign continues to use best practices guidelines for constructing, refining, and delivering effective messages. Youth awareness of this campaign is increasing, likely linked to the large increase in funding in 2006. While the campaign's impact on tobacco-related attitudes and behavior cannot be isolated from the larger teen tobacco prevention program in schools and communities statewide, findings of the 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. Continued evaluation of the campaign will complement program initiatives. Gains made in campaign and brand awareness would likely dissipate if frequency or intensity of campaign messages were lessened. To maximize campaign effectiveness, the TRU campaign should continue to integrate with statewide community and school programs to accomplish their common goal of reducing teen tobacco use in North Carolina.

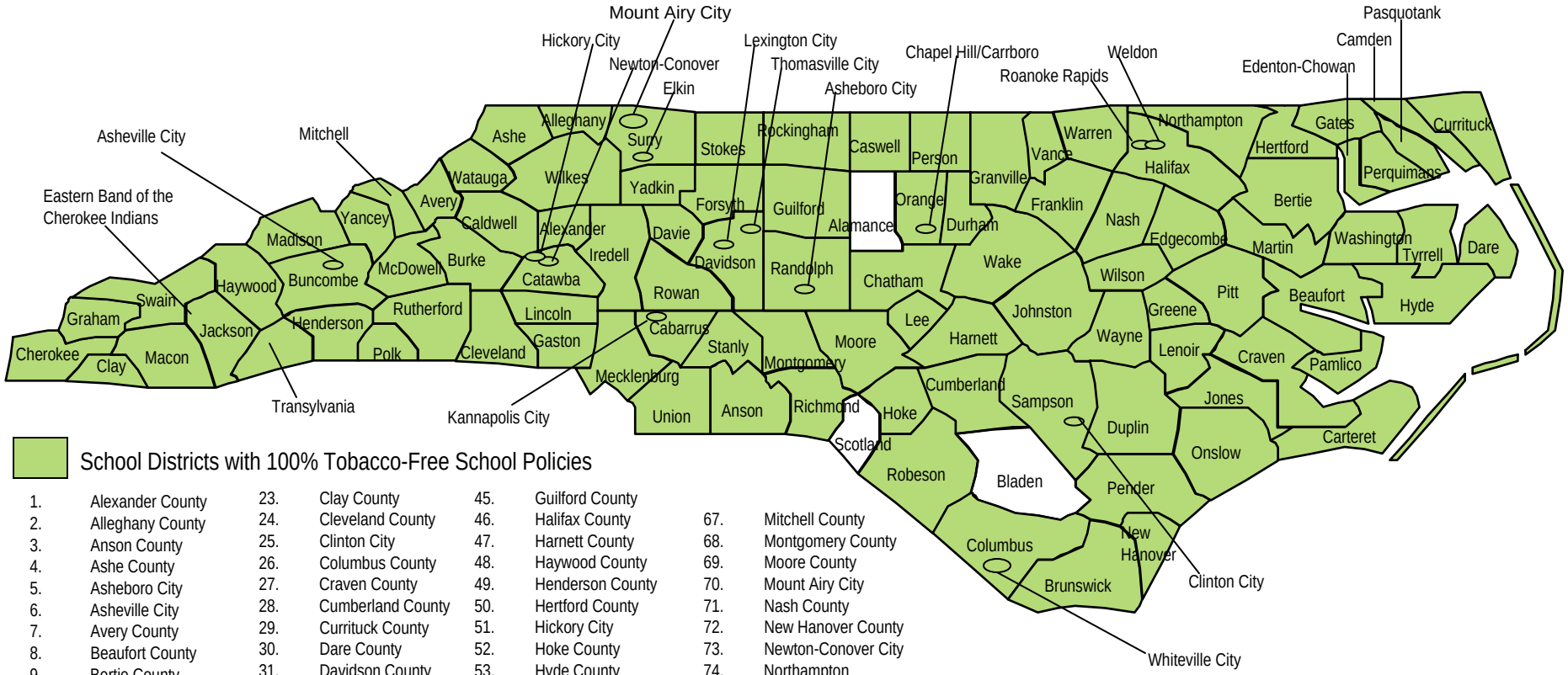
6. References

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*. Accessed July 1, 2005.
3. Johnston L, O'Malley, PM, Bachman, JG, Schulenberg, JE. *Monitoring the Future national results on adolescent drug use: Overview of key findings, 2006.* Bethesda, MD: National Institute on Drug Abuse; 2007.
4. Proescholdbell SK. *North Carolina Youth Tobacco Survey, 2005.* Raleigh, N.C.: N.C. Department of Health and Human Services; 2006.
5. North Carolina Health and Wellness Trust Fund. North Carolina Health and Wellness Trust Fund 2006 Annual Report. http://www.healthwellnc.com/hwtfc/htmfiles/annualreports.htm. Accessed August 2007.
6. CDC. Trends in cigarette smoking among high school students--United States, 1991-2001. *MMWR Morb Mortal Wkly Rep.* May 17 2002;51(19):409-412.
7. North Carolina Health and Wellness Trust Fund. Annual report to the joint legislative commission on governmental affairs and the joint legislative health care oversight committee.; 2006:277.
8. University of North Carolina School of Medicine Tobacco Prevention and Evaluation Program. Recommendations for 2004 North Carolina Youth Tobacco Use Prevention Media Campaign. http://fammed.unc.edu/TPEP/hwtfceval/reports/media_analysis03.pdf.
9. Farrelly MC, Niederdeppe J, Yarsevich J. Youth tobacco prevention mass media campaigns: past, present, and future directions. *Tob Control.* Jun 2003;12 Suppl 1:i35-47.
10. Sly DF, Heald GR, Ray S. The Florida "truth" anti-tobacco media evaluation: design, first year results, and implications for planning future state media evaluations. *Tob Control.* Mar 2001;10(1):9-15.
11. CDC. Effect of ending an antitobacco youth campaign on adolescent susceptibility to cigarette smoking--Minnesota, 2002-2003. *MMWR Morb Mortal Wkly Rep.* Apr 16 2004;53(14):301-304.
12. Hicks JJ. The strategy behind Florida's "truth" campaign. *Tob Control.* Mar 2001;10(1):3-5.
13. Balbach ED, Glantz SA. Tobacco control advocates must demand high-quality media campaigns: the California experience. *Tob Control.* Winter 1998;7(4):397-408.
14. Currivan DB, Nyman AL, Turner CF, Biener L. Does telephone audio computer-assisted self-interviewing improve the accuracy of prevalence estimates of youth smoking? Evidence from the UMass Tobacco Study. *Public Opinion Quarterly.* Win 2004;68(4):542-564.

Appendix: Logic Model for TRU Media Campaign



N.C. School Districts that Have Adopted a 100% Tobacco-Free School Policy: No Tobacco Use Anywhere, Anytime by Anyone – June 2008



School Districts with 100% Tobacco-Free School Policies

1. Alexander County
2. Alleghany County
3. Anson County
4. Ashe County
5. Asheboro City
6. Asheville City
7. Avery County
8. Beaufort County
9. Bertie County
10. Brunswick County
11. Buncombe County
12. Burke County
13. Cabarrus County
14. Caldwell County
15. Camden County
16. Carteret County
17. Caswell County
18. Catawba County
19. Chapel Hill-Carrboro
20. Charlotte-Mecklenburg
21. Chatham County
22. Cherokee County
23. Clay County
24. Cleveland County
25. Clinton City
26. Columbus County
27. Craven County
28. Cumberland County
29. Currituck County
30. Dare County
31. Davidson County
32. Davie County
33. Duplin County
34. Durham County
35. Edenton-Chowan
36. Edgecombe County
37. Elkin City
38. Franklin County
39. Forsyth County
40. Gaston County
41. Gates County
42. Graham County
43. Granville County
44. Greene County
45. Guilford County
46. Halifax County
47. Harnett County
48. Haywood County
49. Henderson County
50. Hertford County
51. Hickory City
52. Hoke County
53. Hyde County
54. Iredell-Statesville
55. Jackson County
56. Johnston County
57. Jones County
58. Kannapolis City
59. Lee County
60. Lenoir County
61. Lexington City
62. Lincoln County
63. Macon County
64. Madison County
65. Martin County
66. McDowell County
67. Mitchell County
68. Montgomery County
69. Moore County
70. Mount Airy City
71. Nash County
72. New Hanover County
73. Newton-Conover City
74. Northampton
75. Onslow County
76. Orange County
77. Pamlico County
78. Pasquotank County
79. Pender County
80. Perquimans County
81. Person County
82. Pitt County
83. Polk County
84. Randolph County
85. Richmond County
86. Robeson County
87. Rockingham County
88. Roanoke Rapids
89. Rowan-Salisbury
90. Rutherford County
91. Sampson County
92. Stanly County
93. Stokes County
94. Surry County
95. Swain County
96. Thomasville City
97. Transylvania County
98. Tyrell County
99. Union County
100. Vance County
101. Weldon City
102. Wake County
103. Warren County
104. Wayne County
105. Washington County
106. Watauga County
107. Whiteville City
108. Wilkes County
109. Wilson County
110. Yadkin County
111. Yancey County

*The Eastern Band of the Cherokee Indians, a federally funded Native American School District, has also adopted a 100% Tobacco-Free School Policy

Source: NCTobaccoFreeSchools.com

Updated June 9, 2008

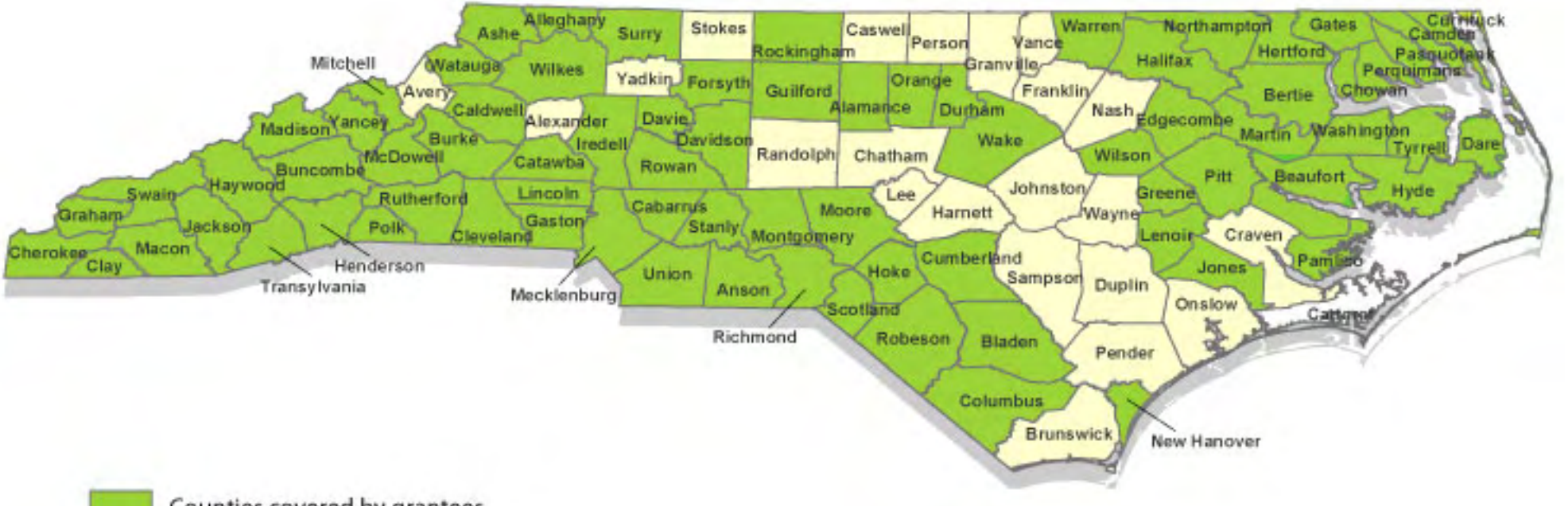
HWTF TOBACCO-FREE SCHOOLS

Signage Orders **July 2007 - January 2008**

School	**English**	**Spanish**	**Poly**	**Decal**	**Banner**	**Floor Stand**
Bertie 8/07	3	1	3	10	1	1
Brunswick 9/07	85	30	85	80	8	8
Dare 8/07	10	5	8	8	2	2
Davie 11/07	5	5	3	10	1	1
Franklin 10/07	65	25	66	70	7	7
Jackson 8/07					2	
Madison 11/07	30	10	27	20	2	2
Mt. Airy 8/07	15	5	15	20	2	2
Nash/Rocky Mt 1/08	120	40	120	100	10	10
Orange 1/08	15	5	15	30	3	3
Stokes 11/07	65	25	65	70	7	7
Wake 11/07	485	165	485	530	53	53
Whiteville City 1/08	25	10	7	30	3	3
Wilkes 1/08	15	5	15	40	4	4
	938	**331**	**914**	**1018**	**105**	**103**

NORTH CAROLINA Health Wellness TRUST FUND

Tobacco-Free Colleges Initiative
Counties Covered by Grantees

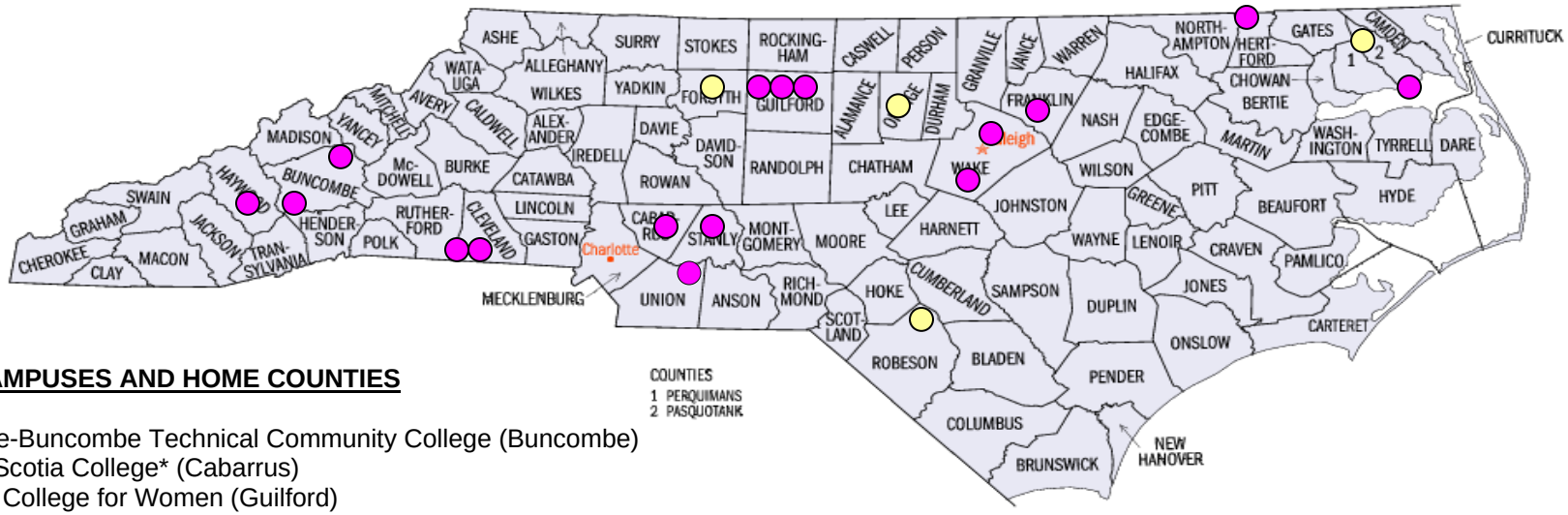


Counties covered by grantees

* SAVE of NC GASP (Survivors and Victims of Tobacco Empowerment) provides statewide coverage

Updated: 11-01-08

Map of 100% Tobacco-Free and Comprehensive Campus Policies Adopted in North Carolina



LIST OF CAMPUSES AND HOME COUNTIES

1. Asheville-Buncombe Technical Community College (Buncombe)
2. Barber-Scotia College* (Cabarrus)
3. Bennett College for Women (Guilford)
4. Cleveland Community College (Cleveland)
5. College of the Albemarle (Pasquotank)
6. Elizabeth City State University (Pasquotank)
7. Gardner-Webb University (Cleveland)
8. Greensboro College (Guilford)
9. Guilford Technical Community College (Guilford)
10. Haywood Community College (Haywood)
11. Louisburg College (Franklin)
12. Montreat College (Buncombe)
13. Peace College (Wake)
14. Roanoke-Chowan Community College (Hertford)
15. Stanly Community College (Stanly)
16. University of North Carolina at Chapel Hill (Orange)
17. University of North Carolina at Pembroke (Robeson)
18. Wake Technical Community College (Wake)
19. Wingate University (Union)
20. Winston-Salem State University (Forsyth)

LEGEND

Campuses with 100% Tobacco-Free Campus Policy

UNC System campuses with100ft Perimeter Policy

HWTF TOBACCO-FREE COLLEGES GRANT AWARDS

	ORGANIZATION	Counties	Campuses	Phase I	Phase II	Summary
1	Alamance Community College	Alamance			$74,967	ACC will provide a variety of incentives, services, educational activities, initiatives and public education efforts to assist students with smoking prevention or cessation.
2	Albemarle Regional Health Services	Beaufort Chowan Dare Edgecombe Halifax Hertford Martin Pasquotank	Seven (7) CCs Chowan College	$289,960		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.
3	American Lung Association of North Carolina	Cumberland Durham Forsyth Pasquotank Wake	Elizabeth City State Fayetteville State NCCU Shaw WSSU	$38,500		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.
4	Appalachian State University	Watauga			$75,000	ASU plans to promote, support and aid in the adoption of and compliance with a university-wide tobacco policy that will comply with North Carolina legislation.
5	Asheville-Buncombe Technical Community College	Buncombe Madison	ABTECH	$80,000		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.
6	Caldwell Community College and Technical Institute	Caldwell Watauga	Caldwell CC	$40,000		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.
7	Cleveland Community College	Cleveland Gaston Lincoln Rutherford	Cleveland CC	$40,000		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.
8	East Carolina University	Pitt	ECU	$79,930	$70,000	ECU will implement an expanded comprehensive tobacco use prevention and cessation program.
9	Elizabeth City State University	Pasquotank	Elizabeth City State	$39,996		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.
10	Fayetteville State University	Cumberland	Fayetteville State	$40,000		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.
11	First Health of the Carolinas	Hoke, Montgomery, Moore, Richmond, Scotland			$75,000	First Health will develop a regional community college task force to coordinate tobacco use prevention awareness activities, promote cessation services and conduct grassroots policy advocacy for tobacco-free campus environments.
12	Guilford County Department of Public Health	Alamance, Davidson, Forsyth, Guilford, Rockingham			$275,000	Guilford County DOH proposes to serve the Triad area, promoting tobacco-free policy and evidence-based cessation and prevention on 19 campuses. These campuses include three HMCUs (Bennett College, NC A&T University and Winston-Salem State University).
13	Lenoir County Health Department	Greene Jones Lenoir	Lenoir CC	$40,000		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.

HWTF TOBACCO-FREE COLLEGES GRANT AWARDS

	ORGANIZATION	Counties	Campuses	Phase I	Phase II	Summary
14	Mecklenburg County Health Department	Anson, Cabarrus, Catawba, Cleveland, Gaston, Jackson, Lincoln, Mecklenburg, Rowan, Stanly, Union	Twenty three (23) schools	$200,000	$275,000	The grant would allow the Mecklenburg County HD to continue to work in tobacco prevention, cessation and policy development with 17 colleges in an 11 county region.
15	Montreat College	Buncombe, Mecklenburg			$74,755	The College recognizes a responsibility to provide a healthy environment to all students and staff and requests funding for the implementation of a Tobacco Free Campus.
16	Moses Cone-Wesley Long Community Health Foundation	Guilford	Seven (7) public and private institutions in Guilford County	$61,310		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.
17	North Carolina Agricultural and Technical State University	Guilford	NC A&T	$80,000		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.
18	North Carolina Central University	Cumberland Durham Forsyth Guilford Mecklenburg Pasquotank Robeson Rowan Wake	NCCU other HMCUs	$164,153		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.
19	Pitt Community College	Pitt			$67,846	Pitt Community College will use grant funds to plan, design and implement effective measures to ensure a smoke-free campus.
20	Rowan Cabarrus Community College	Cabarrus, Rowan			$45,000	RCC plans to establish a formal smoking restrictions policy, eliminate second hand smoke exposure and promote cessation through literature and programming.
21	SAVE (Survivors and Victims of Tobacco Empowerment) of NC GASP	Statewide	n/a	$80,000		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.
22	Surry County Health and Nutrition Center	Surry	Surry CC	$39,000	$73,750	Funds will be used to prevent the initiation of tobacco, eliminate exposure to secondhand smoke, promote tobacco cessation resources and eliminate tobacco-related health disparities among young adults ages 18-24, on Surry Community College campuses.
23	UNC - Pembroke	Bladen, Columbus, Cumberland, Moore, Richmond, Robeson	UNC-Pembroke	$39,290	$75,000	UNCP, through its Counseling and Testing Center, developed a comprehensive tobacco prevention and control program plan with emphasis on policy, which also includes cessation, industry marketing/promotion and prevention education.
24	UNC - Chapel Hill	Orange	UNC-CH	$120,000		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.
25	University of North Carolina at Wilmington - CROSSROADS	New Hanover	UNC-Wilmington	$75,243		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.
26	Wake Tech Community College	Wake			$75,000	Wake Tech will initiate Tobacco-Free for the Community, an innovative program to transform all Wake Tech campuses into completely smoke-free environments.

HWTF TOBACCO-FREE COLLEGES GRANT AWARDS

	ORGANIZATION	Counties	Campuses	Phase I	Phase II	Summary
27	West Piedmont Community College	Burke			$75,000	WPCC proposes a comprehensive program plan that will involve campus and external organizations to tailor tobacco education and cessation tools to individual needs.
28	Wilkes Community College	Allegheny, Ashe, Wilkes	Wilkes CC	$80,000	$75,000	WCC plans to continue and expand the efforts, which began in Phase I to prevent initiation of tobacco use among its college age students, eliminate exposure to secondhand tobacco smoke on the college campus, educate students about tobacco prevention and cessation and eliminate tobacco related health disparities among college age students.
29	Wilson Technical Community College	Wilson	Wilson Tech CC	$60,000		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**	**$1,406,318**	

NORTH CAROLINA HEALTH AND WELLNESS TRUST FUND

UNC-ENTER TRAINING, TECHNICAL ASSISTANCE, & RESOURCE MANAGEMENT

Environmental Tobacco Smoke Training, Education, & Research (EnTER) Program
University of North Carolina School of Medicine
QUARTERLY REPORTS

REPORTING PERIOD: July 2007 –September 2007

Describe the objectives that were achieved during the past quarter:
During the past quarter (Jul-Sep, 2007), the EnTER Team assisted all grantees with the implementation of their proposals through training and technical assistance (TA). This phase involved participation in monthly program monitoring functions, providing technical assistance consultations, conducting a quarterly TA assessment, facilitating a grantee networking call, and scheduling 13 site visits and 5 trainings. Additionally, the EnTER team developed assessment tools to determine the needs of HWTF grantees and staff related to secondhand smoke.

1. **Monitoring and Technical Assistance to Tobacco-Free Colleges Initiative Grantees: Jul 1-Sep 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.
         b. Completed 56 technical assistance requests via phone and email.
         c. Developed and conducted Quarterly Grantee Training and Event Questionnaire.
         d. Scheduled 13 site visits with grantees to occur between October-December 2007.
         e. Scheduled 5 trainings with grantees to occur between October-December 2007.
         f. Reviewed one media approval request and facilitated five additional media requests between HWTF and grantees at the request of HWTF grants manager.
         g. Revised media guidelines for college grantees to reflect new grants management structure.
         h. Facilitated 1.5 hour grantee networking call on September 26.
         i. Revised trainings on priority populations, policy implementation, college tobacco basics, secondhand smoke science, and policy compliance based on results of grantee TA assessment.

      2. The EnTER Team:
         a. 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.
         b. Hired and trained new program coordinator for Tobacco-Free Colleges Initiative.
         c. Program coordinator attended orientation meetings with HWTF on August 16, August 23, and September 4.

d. Attended program monitoring meeting with HWTF on September 18.
e. Provided HWTF with cumulative program tracking scores from January 2006-August 2007 on September 19.
f. Provided HWTF with detailed information on performance history for one grantee, including correspondence logs, and summaries of activity and reporting patterns from June 2006-August 2007.
g. Provided monthly grantee progress tracking reports for June-August 2007.
h. Participated in weekly meetings and discussions on an as needed basis with project officer and grants managers 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. Conducted online evaluation of the June 25th grantee networking meeting and provided results to HWTF.
2. Created draft Phase II RFP and sent to HWTF on July 1.
3. Disseminated RFP to all NC 4 year colleges and local health departments on August 21.
4. Researched possible funding databases for RFP distribution and made recommendations to HWTF.
5. Hosted and participated in HWTF RFP applicant conference calls on August 21 and August 29.
6. Developed comprehensive Technical Assistance Manual and provided to HWTF on September 18.
7. Updated and developed tracking documents used to monitor grantee progress and efficacy of technical assistance.
8. Researched meeting facilities for RFP reverse site visits and made recommendations to HWTF.
9. Attended the UNC-CH tobacco-free campus forum on September 26.

3. **Secondhand Smoke Resource Management**

1. The EnTER Team:
   a. Contracted with personnel to develop and conduct grantee SHS needs assessment.

b. Began communicating with HWTF regarding needs assessment process, including scheduling meeting for October 12.
c. Developed timeline and workplan for the conduct of needs assessment.
d. Developed draft needs assessments for HWTF grantees, staff, and leadership.
e. Developed timeline and workplan for the development of SHS web-based training.
f. Researched web-based training modules from other public health programs.

4. **Describe any unanticipated problems. How were they addressed?**

The Lenoir County Health Department grantee has been largely unresponsive to multiple communications over the past several months, as documented in multiple monthly reports. A responsible coalition has not been established, marginal efforts have been made to gather information on policy change support at colleges, contact or involve media, promote the Quitline and reach the majority of other AAP goals.

The root cause appears to be high turnover in coordinator position. The coordinator present at the June 25th grantee conference subsequently asked not to work on the project. Angelique Williams is responsible for the position currently, but she has utilized ineffective and inconsistent communication strategies with EnTER, and her actions have implied apathy towards the project.

EnTER issued a Corrective Action Plan Worksheet at the September 18th monthly meeting. EnTER also provided HWTF with documentation of correspondence with Lenoir from June 2006-August 2007 on September 20, supplementing prior documentation provided in February 2007.

EnTER will await guidance from HWTF before attempting further communication with this grantee.

5. **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.
- Provide assistance to grantees in preparation for the Great American Smokeout.
- 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.
- Participate in reverse site visits at the request of HWTF.
- Participate in Phase II proposal review and reverse site visits at the request of HWTF.

- Make recommendations to HWTF regarding Phase II grant awards.
- Provide input on the development of the Quitline campaign at the request of HWTF.
- Meet with HWTF to review secondhand smoke needs assessments for grantees, grants managers, and HWTF leadership.
- Conduct secondhand smoke needs assessment and provide results and recommendations to HWTF.
- Begin the development of SHS resources based on results of needs assessment and input from HWTF.
- Ask HWTF to resolve Lenoir County HD grant status by end of October 2007.

REPORTING PERIOD: October 2007 –December 2007

Describe the objectives that were achieved during the past quarter:
During the past quarter (Oct-Dec, 2007), the EnTER Team assisted all grantees with the implementation of their proposals through training and technical assistance (TA). This phase involved participation in monthly program monitoring functions, providing technical assistance consultations, participating in three days of reverse site visits, orchestrating the development of a grantee orientation book, and conducting 17 site visits and 8 trainings. Additionally, the EnTER team conducted an assessment of all HWTF grantees and staff to determine their needs related to secondhand smoke, and provided recommendations to HWTF.

1. **Monitoring and Technical Assistance to Tobacco-Free Colleges Initiative Grantees: Oct. 1-Dec. 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.
         b. Worked with grantees largely on best practices for policy adoption, policy implementation, and positive policy compliance.
         c. Completed 68 technical assistance requests via phone and email.
         d. Conducted 17 site visits with grantees between October-December 2007.
         e. Conducted 8 trainings with grantees between October-December 2007.
         f. Assisted one grantee with 3 site visits, 1 training, and more than 10 phone calls.
         g. Facilitated 5 media requests.
         h. Conducted 3 closing interviews.
         i. Continued to revise/update trainings on priority populations, policy implementation, college tobacco basics, secondhand smoke science, and policy compliance.

      2. The EnTER Team:
         a. 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.
         b. Revised ECSU's new AAP with coordinator Regina McCoy-Davis.

c. Sent ECSU's revised AAP to Andre Stanley for approval.
d. Program coordinator attended monthly meetings with HWTF on November 13th and December 18th.
e. Orchestrated compilation and development of grantee orientation booklet.
f. Provided HWTF with site visit reports from each college/university visited.
g. Provided HWTF with closing interview from Cleveland CC.
h. Provided HWTF with cumulative program tracking scores from January 2006-Novemeber 2007.
i. Provided monthly grantee progress tracking reports for September-November 2007.
j. Participated in weekly meetings and discussions on an as needed basis with project officer and grants managers 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.
   d. Working with Evaluation Team to revise college needs assessment and baseline data collection tool to be released January 2008.

2. **Miscellaneous Activities in Support of the HWTF Tobacco-Free Colleges Initiative**

1. The EnTER Coordinator:
   a. Developed reverse site visit protocol outline at the request of HWTF.
   b. Reviewed 12 phase II grant applications for HWTF.
   c. Participated in 3 days of reverse site visits at HWTF for Phase II RFP applicants.
   d. Made recommendations to HWTF regarding Phase II grant awards.
   e. Updated policy table with all NC HWTF current tobacco policies for HWTF.
   f. Updated and disseminated contact information for all grantees to HWTF.
   g. Attended the Minneapolis conference on Tobacco or Health in October 2007.

3. **Secondhand Smoke Resource Management**

1. The EnTER Team:
   a. Met with HWTF staff on October 12 to review draft needs assessment.
   b. Conducted SHS needs assessments with HWTF grantees, grants managers, and leadership.
   c. Developed web based survey tool and disseminated to all HWTF grantees.
   d. Conducted conference call with grants managers on October 16 to discuss grantee needs.

e. Conducted individual interviews to college and disparities coordinators to further discuss grantee needs.
f. Analyzed needs assessment data and produced comprehensive report, including recommendations on resource development, for HWTF.
g. Met with HWTF Program Officers on December 5 to present needs assessment data and make formal recommendations on resource development.
h. Created draft of SHS web-based training.
i. Met with programmer to discuss format of web-based training.

4. **Describe any unanticipated problems. How were they addressed?**

North Carolina A&T appeared to be doing little programmatic work and Candice Justice believed that their financial reporting was inaccurate. Some of this was perceived as a result of disorganization at the university and within the structure of the grant. The coordinator (Schenita Davis Randolph) was not doing the financial reporting and varying amounts of money were being charged under "salary" from month to month.

Candice Justice and Bronwyn Charlton visited the campus in order to clarify the situation. It appears that programmatically the coalition has been doing some work (hanging Quitline posters in the school cafeteria, a GASO booth in the nursing dept, and Mary Gillet spoke to nursing students about using the fax referral system) but not enough to keep them in line with the AAP. Additionally, the financial ambiguity was not clarified completely.

These discrepancies were reported to HWTF by Candice Justice and communicated by Bronwyn Charlton prior to the final evaluation of Phase II applicants as well as at the December monthly meeting in a site visit report. NC A&T applied for Phase II funding but were not re-funded.

5. **What are the plans for the project/program for the next quarter?**

The EnTER Project Team will:

- Develop and distribute the final version of the grantee orientation booklet to Phase II grantees.
- Develop and conduct (with HWTF) a Phase II grantee orientation.
- Work with grantees to develop 6-month Annual Action Plans.
- Continue to conduct on-campus trainings with grantees based on need.
- Conduct site visits with grantees after the grantee orientation.
- Provide technical assistance to grantees as they establish new programs.
- Coordinate with HWTF to clarify roles and responsibilities for provision of TA.
- Develop additional grantee resources including fact sheets, petitions, model policies, and media materials as needed.
- 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 as needed 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.
- Participate in meetings at the request of HWTF.
- Provide input on the development of the Quitline campaign at the request of HWTF.
- Produce SHS resource materials as determined by grantee needs assessment.
- Finalize SHS web based training module.

REPORTING PERIOD: January 2008 – March 2008

Describe the objectives that were achieved during the past quarter:

During the past quarter (Jan-March, 2008), the EnTER Team assisted all grantees with their Annual Action Plans. Through meetings organized by HWTF, EnTER presented relevant information to grantees and helped many of them through one-on-one contact. EnTER participated in the February Grantee Orientation, presenting on 3 topics (EnTER TA, Policy Advocacy, and Policy Implementation) and developed and assembled the Grantee Orientation Handbook. These events were organized and implemented through multiple meetings with HWTF.

EnTER also provided information to UNC-TPEP for updating the Grantee Baseline Needs Assessment Survey and the indicators to meet changing program objectives and priorities of HWTF. EnTER also provided technical assistance and training to grantees. TA and resources were distributed as grantees began Phase II, and two trainings and site visits were completed in March.

Additionally, EnTER created multiple draft resources based upon the results of the needs assessment conducted last Fall.

1. **Monitoring and Technical Assistance to Tobacco-Free Colleges Initiative Grantees: Jan. – March, 2008**
   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.
         b. Worked with grantees largely on best practices for policy adoption, policy implementation, and positive policy compliance.
         c. Completed 43 technical assistance requests via phone and email.
         d. Conducted 2 site visits with grantees between January - March 2008.*
         e. Conducted 2 trainings with grantees between January - March 2008. *
         f. Conducted one telephone consultation/training with grantee between January – March 2008.
         g. Edited 2 AAP's after the AAP meetings and before grantees submitted them to HWTF.
         h. Continued to revise/update trainings on priority populations, policy implementation, college tobacco basics, secondhand smoke science, and policy compliance.

      Site visits and trainings were not scheduled during the Annual Action Planning process and orientation period of Phase II (Jan-Feb).

2. The EnTER Team:
    a. Communicated with grantees each month as needed to clarify information reported in the monthly progress reports; also provided verbal or written feedback about the reports as necessary.
    b. Program coordinator participated in several meetings with HWTF re: AAP planning.
    c. Orchestrated compilation and development of grantee orientation booklet.
    d. Provided HWTF with site visit reports from both college/universities visited.
    e. Provided HWTF with monthly reports from December 2007, January 2008, and February 2008 at March 27th 2008 TA Closeout Meeting. Monthly meetings for January, February, and March were cancelled by HWTF prior to meeting dates.
    f. Participated in weekly meetings and discussions on an as needed basis with project officer and grants managers 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.
    d. Providing information to Evaluation Team to revise college needs assessment and baseline data collection tool.
    e. Providing information to Evaluation Team to re-assess indicators as a response to changing HWTF program goals.

2. **Miscellaneous Activities in Support of the HWTF Tobacco-Free Colleges Initiative**

1. The EnTER Coordinator:
    a. Developed welcome letter for AAP meeting at request of HWTF.
    b. Updated contact lists for the Phase II initiative.
    c. Updated policy tables for the Phase II initiative.
    d. Provided HWTF employees with duplicate copies of all quarterly reports.
    e. Provided HWTF with materials from June 2007 Grantee Networking Meeting such as HWTF Power Points and attendance lists.
    f. Worked with HWTF to organize AAP meetings through multiple meetings and phone conferences.
    g. Attended both AAP meetings and orientation meeting.
    h. Developed framework, timeline and logistics for Grantee Orientation and reserved space in the Friday center (Mark Ezzel ultimately took over planning of this event).

3. **Secondhand Smoke Resource Development and Management**
    1. The EnTER Team in agreement with HWTF:
        a. Updated Case Study Survey used for 100% TFC Policy case study development.
        b. Submitted Case Study Surveys to Guilford County DPH coordinator, Mecklenburg coordinator, and AB Tech. Schools are currently very busy and unable to complete the case study surveys.
        c. Developed 1st draft Policy Advocacy Toolkit.
        d. Developed 1st draft of 4 new fact sheets on secondhand smoke
        e. Developed 1st draft of smoke-free business toolkit
        f. Developed 2nd draft of SHS training module
        g. Scheduled meeting with HWTF to finalize and plan dissemination of above materials.

4. **Describe any unanticipated problems. How were they addressed?**

Roles and responsibilities for AAP and Orientation planning were unclear. HWTF staff assumed many responsibilities that were previously carried out by EnTER in Phase I. Communication issues were discussed with HWTF.

After the EnTER College TA and Training Coordinator resigned her position with EnTER, the EnTER Scope of Work for College TA and Training for the last quarter was renegotiated. All technical assistance activities ended on 3/28/08 per agreement with HWTF, with no future TA, trainings, or site visits planned by EnTER staff. Resource management activities will continue.

5. **What are the plans for the project/program for the next quarter?**

The EnTER Project Team will:

- EnTER will no longer provide technical assistance to college grantees effective 3/28/08, per agreement with HWTF. EnTER's future work will focus exclusively on the development of secondhand smoke resources to support the needs of HWTF and their tobacco grantees, and any other mutually agreed upon activities by HWTF and EnTER.
- Present draft resources to Project Officer on 4/17/08.
- Revise resource content based on feedback from Project Officer.
- Finalize format, design, and dissemination of resources based on feedback and approval from Project Officer.
- Submit SOW for next fiscal year, and finalize based on feedback from Project Officer.

North Carolina
Health and Wellness Trust Fund
Tobacco-Free Colleges Initiative

Quarterly Report (Q3, Y2)
July - September 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 NC Health and Wellness Trust Fund Tobacco-Free Colleges Initiative Outcomes Evaluation, please contact:

Tobacco Prevention and Evaluation Program

University of North Carolina at Chapel Hill
School of Medicine
Department of Family Medicine
CB #7595, Manning Drive
Chapel Hill, NC 27599
T: 919-843-9751
F: 919-966-9435

Web: www.fammed.unc.edu/TPEP
Email: tpep@med.unc.edu

Table of Contents

A. Summary and Recommendations

A.1. Overview

The Health and Wellness Trust Fund (HWTF) Tobacco-Free Colleges Initiative began its second year of operation in January 2007. The initiative involves 20 grantees in activities to promote tobacco-free policy adoption and cessation on over 50 campuses across North Carolina.

This report highlights grantee outcomes and activities for Quarter 3 of Year 2 of the initiative (Q3,Y2: July-September 2007). General findings for Q3 are as follows:

- Grantees worked with a total of 59 college campuses across the state, including three new campuses working with grantees for the first time since the initiative began (i.e., Western Carolina University, St. Augustine's College, South College-Asheville).

- Grantees continue to make advancements in the areas of policy adoption and coalition development. During Q3, 13 new tobacco-related policy adoptions were adopted (including three 100% tobacco-free campus policies), five new policies underwent consideration, and three new campus coalitions were established with the support of grantees.

- Grantee activities in the areas of coalition recruitment, building support for policies, quitline promotion, and media showed increases coinciding with beginning of the school year activities.

A.2. Key Outcomes and Program Accomplishments

Policy Adoption

- Thirteen new tobacco-related policy adoptions occurred on eight campuses during Q3 with the direct and indirect support of grantees. These include three 100% tobacco-free policies adopted at Greensboro College, Roanoke-Chowan Community College, and Wake Technical Community College. Other policy adoptions included four perimeter policies, two policies prohibiting smoking inside all campus buildings, and two smoke-free dorm policies.

Building Support

- Five new tobacco-related policies underwent consideration by college officials during Q3, including four 100% tobacco-free campus policies under consideration at Surry Community College, High Point University, Guilford Technical Community College, and Belmont Abbey College. UNC-Chapel Hill also began considering the adoption of a comprehensive tobacco policy for their campus (i.e., 100 ft. perimeter policy) during this quarter.

- Over 100 college officials, campus organizations, and individuals (i.e., staff, faculty, student leaders) offered formal support for campus policy initiatives in Q3. Three grantees also collected 193 signatures showing support for campus policies.

- Grantees reported over 160 meetings/presentations and 45 media messages to build support for campus policy initiatives. The number of earned media messages published or aired by *non-campus based* media outlets (e.g., local newspapers) increased in Q3 compared to previous quarters.

Coalition Development

- Three new tobacco use prevention coalitions were established at Elizabeth City State University, Lenoir Community College, and Western Carolina University. One campus coalition (Lenoir-Rhyne College) disbanded. At the end of Q3, two Planning grantees were working to develop coalitions on nine remaining campuses.

- Grantees recruited 191 new coalition members in Q3, 77% of which were students.

Quitline Promotion

- Grantees conducted over 130 Quitline NC promotions (e.g., campus-wide events, presentations at meetings) during Q3, many of which occurred at campus events and freshman orientation sessions organized for the beginning of the school semester.

- Three grantees reported 11 meetings with campus-based health providers to promote Quitline NC fax referral service utilization.

A.3. Key Barriers to Program Activities

- Sixty percent (12) of all grantees reported difficulty scheduling meetings/events or establishing campus contacts due to summer schedules.

- Fifty percent (10) of all grantees reported administrative barriers, most of which were related to delays in approval processes for grantee activities.

- Other barriers reported include challenges hiring/training new staff, college systems-level issues (e.g., new leadership on campus unfamiliar with policies) and resistance to policy change on campus (e.g., non-compliance with new policy changes).

A.4. Recommendations for Program Development and Improvement

- The growing successes of the Tobacco-Free Colleges Initiative are likely to result in requests from other states for information from North Carolina. HWTF may want to proactively consider disseminating program accomplishments nationally.

- HWTF should continue to communicate grantee policy successes throughout NC via press releases, meetings, emails, etc.

- As policy adoptions on campuses increase, HWTF may want to further emphasize grantee efforts to promote smoke-free policies in off-campus areas frequented by young adults.

- Grantees should continue to provide ongoing follow-up and support to campuses with new policies, as well as campuses now considering 100% tobacco-free/comprehensive policies.

- HWTF should consider talking with grantees about ways to alter approval processes that would continue to meet reporting requirements but reduce grantee barrier reports.

B. Background

In January 2006, the North Carolina (NC) Health and Wellness Trust Fund (HWTF) awarded $1.6 million in grant funding to promote tobacco use prevention and cessation among young adults on NC college campuses. Grants were awarded to 20 organizations including colleges, community colleges, and health departments (See Appendix 1 for list of grantees, colleges, and counties covered). These organizations work towards developing coalitions, advocating for campus tobacco-free policies, and promoting Quitline NC on campuses across the state.

Two types of grants were originally awarded by the HWTF for the Tobacco-Free Colleges Initiative: Planning and Implementation grants. One Planning grant and one Implementation grant were later re-categorized as Special grants [i.e., Survivors and Victims of Tobacco Empowerment (SAVE) and the American Lung Association of NC (ALA)].

In total, ten Planning grants, eight Implementation grants, and two Special grants were awarded. Three of these grantees (2 Planning and 1 Implementation) work on multiple campuses. Primary short-term and intermediate outcomes for each type of grant are as follows:

- Planning grants aim to establish campus coalitions and build support for campus policy initiatives;

- Implementation grants aim to strengthen campus coalitions, build support for campus policies, and advocate for the adoption of tobacco-free policies on campus; and

- Special grants aim to assist other College grantees and non HWTF-supported campuses across the state in their areas of expertise (i.e., survivor advocacy, cessation).

All three types of Tobacco-Free College Initiative grantees also focus on promoting the use of Quitline NC to young adults on college campuses.

The UNC Tobacco Prevention and Evaluation Program (TPEP) conducts the outcomes evaluation for the NC Tobacco-Free Colleges Initiative. The purpose of this evaluation is to demonstrate the effectiveness of the initiative at reaching its desired outcomes and to make recommendations for program improvement. The evaluation team is responsible for collecting baseline and monthly progress data from grantees using a web-based tracking system, as well as analyzing and disseminating results.

C. Methods

The following quarterly report summarizes the outcomes, progress, and activities of Tobacco-Free College Initiative grantees during the period of July 1 – September 30, 2007 (Q3, Y2).

Data were collected from all Planning and Implementation grantees on a monthly basis using the Colleges Online Reporting and Evaluation System (CORES) developed by UNC TPEP. This system is a revised version of the online Interim Monthly Reporting System used by grantees during Year 1. The CORES was implemented with Planning and Implementation grantees in February 2007. Special grantees (i.e., SAVE and ALA) report directly to UNC TPEP on a quarterly basis using an individualized indicator and reporting system.

Data are collected and reported based on key focus areas and indicators developed by UNC TPEP in collaboration with the HWTF (See Appendix 2 for a list of indicators collected monthly). Indicators are divided into two areas:

- Outcome indicators include policy change and progress towards policy change indicators.
- Program indicators include coalition development, building support for campus policies, Quitline NC promotion, and administrative measures.

The indicators include program activities that lead towards desired short-term, intermediate, and long term outcomes for the initiative, as outlined in the logic models developed for Planning and Implementation grants (See Appendices 3 and 4).

Grantees report their data using established indicator change criteria and reporting procedures outlined in a monthly reporting codebook provided to all grantees. All policy changes (i.e., primary outcome indicators) and key program indicator changes are verified with grantees by UNC TPEP staff via phone or email.

This was the third quarter that Planning and Implementation grantees used CORES for reporting their monthly data. All grantees received training on how to use CORES during the first two months of Year 2. Ongoing technical support and training are also provided to individual grantees by UNC TPEP staff throughout the year.

D. Summary of Quarter Activities

Sections D.1 and D.2 summarize Q3 outcome and program development indicator data reported by ten Planning grantees and eight Implementation grantees. One Planning grantee did not submit data for the month of September. See Tables 2 and 3 for Q3 and cumulative Y2 indicator changes by type of grant (pages 10 and 16). See Section D.3 for data on Special grantees.

D.1. Outcomes

Highlights of Planning and Implementation grantee outcome achievement are reported below:

D.1.a. Policy Adoption

Seven Planning and Implementation grantees (39% of all Planning and Implementation grantees) reported a total of twelve tobacco-related policy changes on seven campuses in Q3, including two 100% tobacco-free policies adopted at Greensboro College and Roanoke-Chowan Community College. These policy changes occurred with either the direct or indirect support of grantees.

Figure 1 shows the types of policies adopted in Q3 with the support of Planning and Implementation grantees. No policy adoptions in off-campus areas frequented by young adults were reported this quarter. Table 1 includes a detailed list of policies, campuses, and grantees involved.

Figure 1. Types of tobacco-related policies adopted in Q3 (n=12)

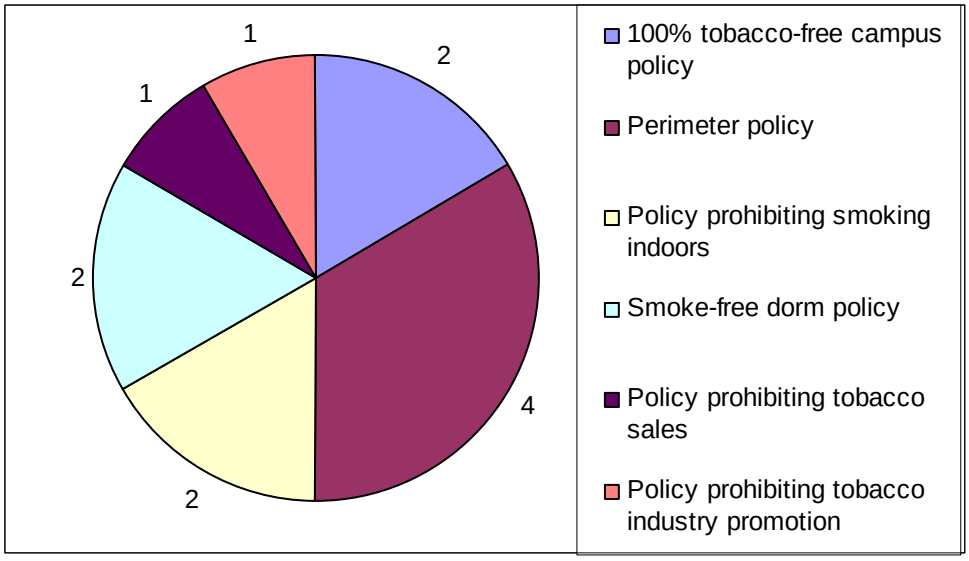


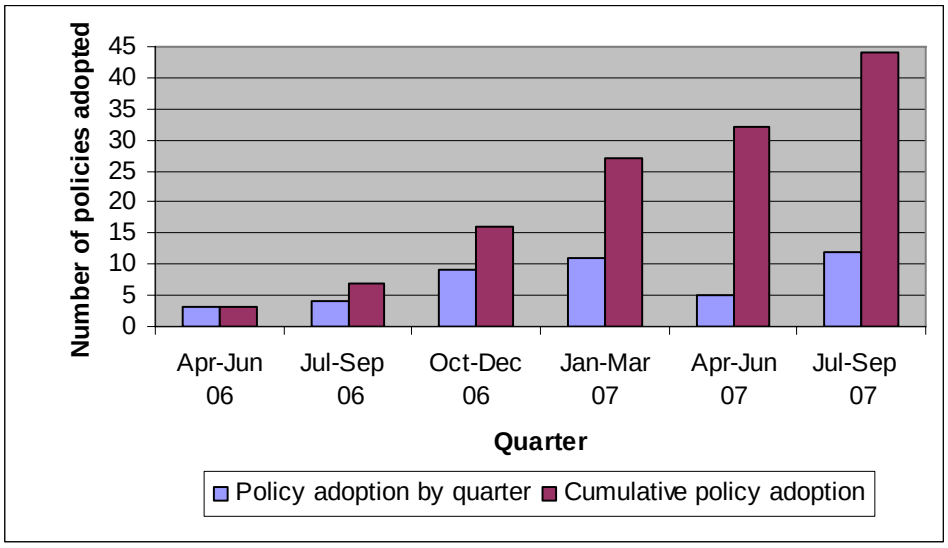
Table 1. List of tobacco-related policies adopted, campuses, and grantees involved in Q3 (n=11)

#	Type of Policy Adopted	Month Adopted	Campus	Grantee	Type of Involvement
1	**100% tobacco-free campus policy**	**August 2007**	**Greensboro College**	**Moses Cone – Wesley Long Community Health Foundation**	**Direct**
2	**100% tobacco-free campus policy**	**July 2007***	**Roanoke-Chowan Community College**	**Albemarle Regional Health Services**	**Indirect****
3	Policy prohibiting smoking at all building entrances, exterior areas surrounding entrances, and covered walkways	July 2007	Caldwell Community College	Caldwell Community College	Direct
4	25 foot perimeter policy	August 2007	East Carolina University	East Carolina University	Direct
5	25 foot perimeter policy	Sept. 2007	Belmont Abbey College	Mecklenburg County Health Department	Direct
6	25 foot perimeter policy	August 2007	Wilson Technical Community College	Wilson Technical Community College	Direct
7	Policy prohibiting smoking inside all campus buildings	July 2007	Caldwell Community College	Caldwell Community College	Direct
8	Policy prohibiting smoking inside all campus buildings	August 2007	Wilson Technical Community College	Wilson Technical Community College	Direct
9	Policy prohibiting smoking in all residence halls	Sept. 2007	Belmont Abbey College	Mecklenburg County Health Department	Direct
10	Policy prohibiting smoking in new residence hall	August 2007	UNC-Pembroke	UNC-Pembroke	Indirect
11	Policy prohibiting sale of all tobacco products on campus	July 2007	Caldwell Community College	Caldwell Community College	Direct
12	Policy prohibiting tobacco industry promotion on campus	July 2007	Caldwell Community College	Caldwell Community College	Direct

* Month policy was implemented (Policy adoption date was unavailable at the time of this report).
** New grant coordinator is unaware of previous grant coordinator's level of involvement in this policy change.

The number of tobacco-related policy adoptions occurring over time (by quarter and cumulatively) as a result of the direct or indirect efforts of grantees is shown below (Figure 2). In total, 44 policies have been adopted with the support of grantees since the beginning of the initiative.

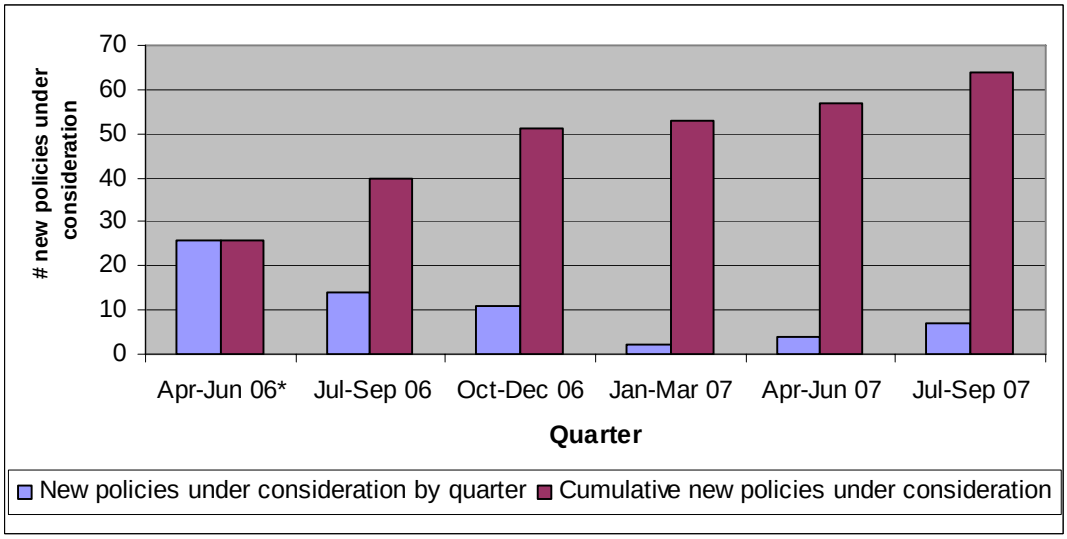
Figure 2. Number of tobacco-related policies adopted over time



D.1.b. Building Support for Policy Change

Five grantees reported seven *new* policies that formally underwent consideration by college officials during Q3. These include four 100% tobacco-free campus policies under consideration at Surry Community College, High Point University, Guilford Technical Community College, and Belmont Abbey College. UNC-Chapel Hill also began considering the adoption of a comprehensive tobacco-free policy. Figure 3 highlights new policies under consideration reported over time. It is expected that the number of new policies under consideration would decrease over time as the program is successful at promoting formal policy adoption by colleges.

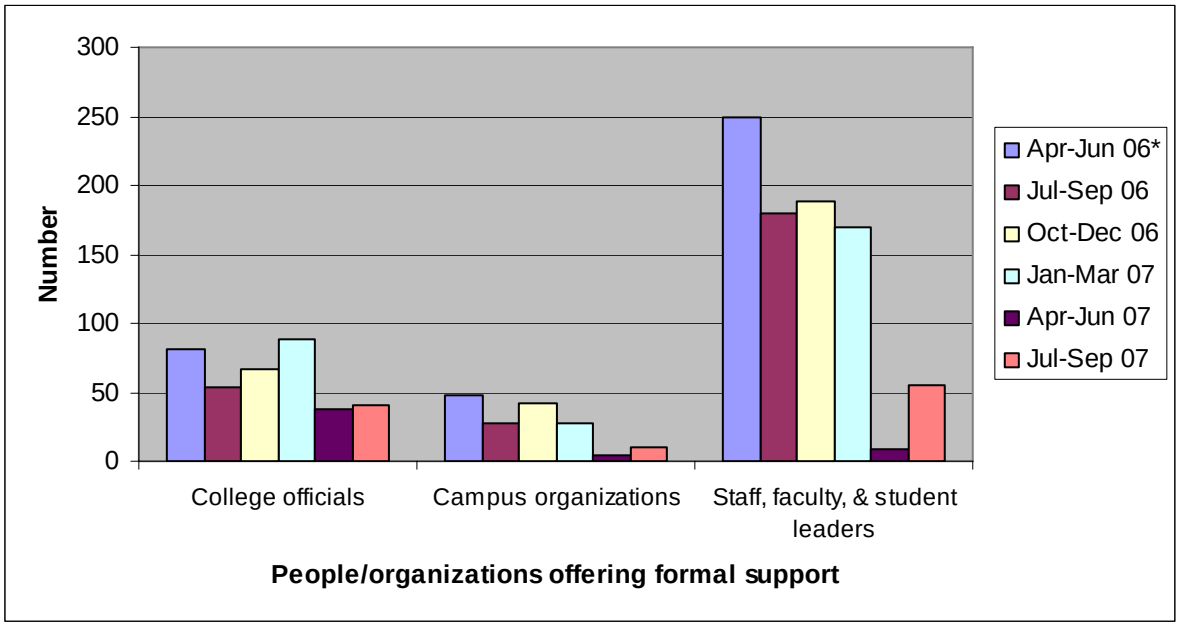
Figure 3. Number of *new* policies under consideration over time



* Includes some policies that underwent consideration in Jan-Mar 06.

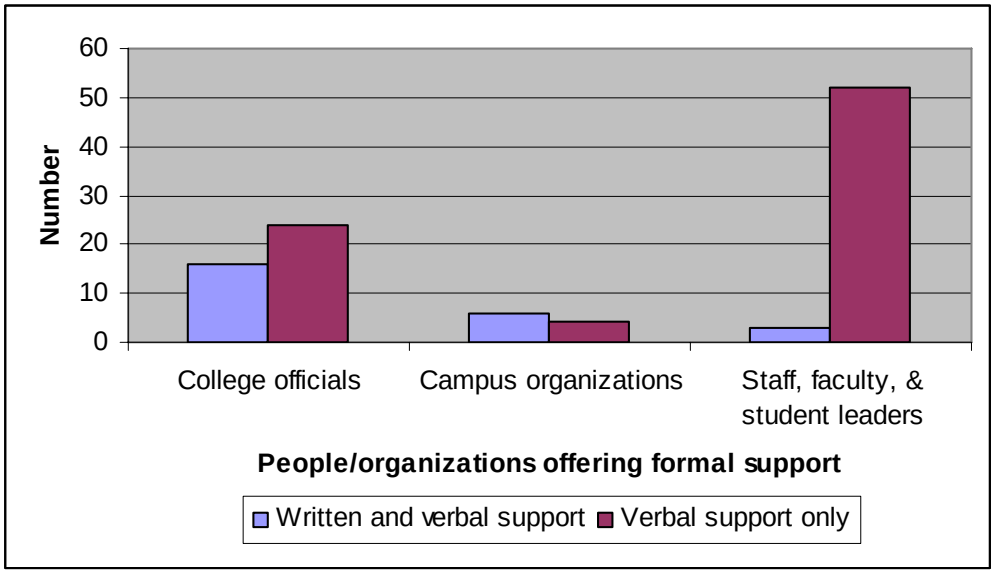
Figure 4 highlights the number of *new* college officials, campus organizations, and staff/faculty/ student leaders offering formal support for campus policy initiatives over time. In total, 105 campus individuals and organizations were reported in Q3, including 40 college officials, 10 campus organizations, and 55 staff/faculty/student leaders (see Table 2 for cumulative Y2 data). It is expected that these numbers would decrease over time as grantees have already reported support from key campus groups and individuals in previous months. Twenty-seven percent of all campus individuals and groups reported in Q3 provided both written and verbal support (Figure 5). In addition, three grantees collected 193 signatures showing support for campus policies.

Figure 4. Formal support offered for campus policy initiatives over time



* Includes some people/organizations offering formal support in Jan-Mar 06.

Figure 5. Type of formal support offered in Q3 (n=105)

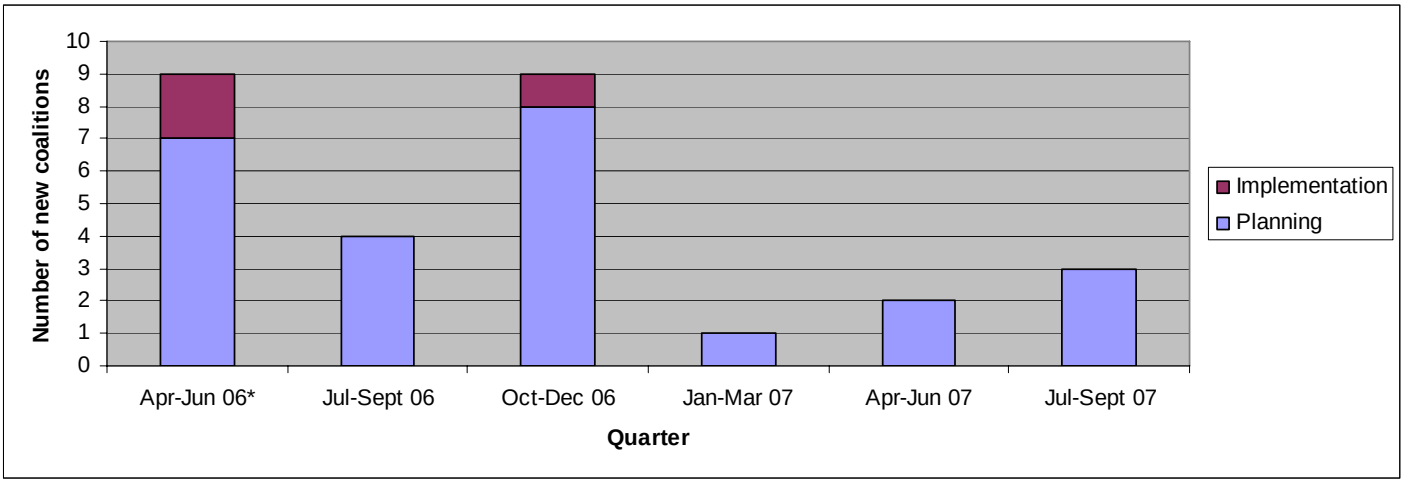


D.1.c. Coalition Development

Planning and Implementation grantees are currently working on 52 college campuses across the state (This number does not include seven additional campuses who worked with Special grantee, ALA of NC, in Q3 -- see page 17). The 52 campuses include one new campus (Western Carolina University) that began working with one multi-campus Planning grantee for the first time in Q3.

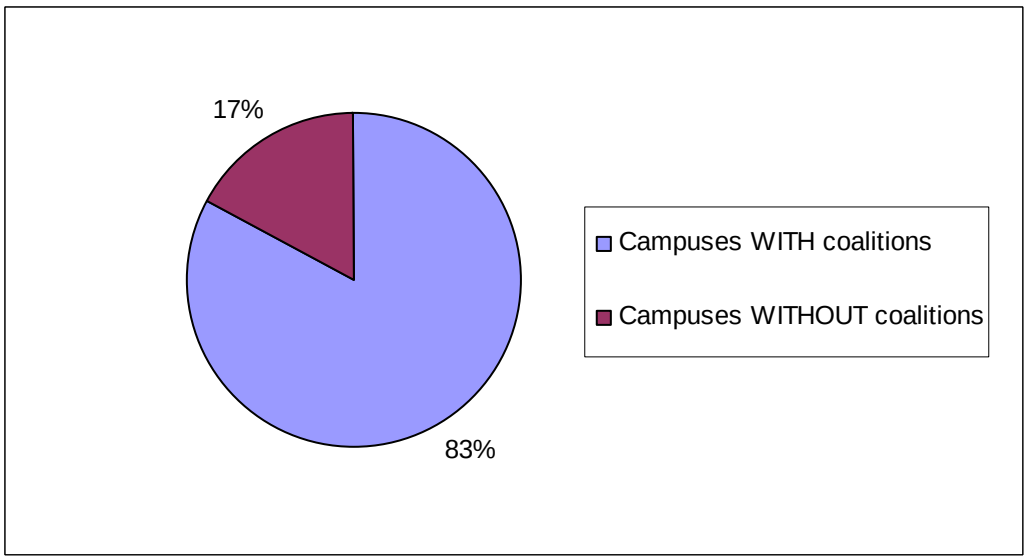
Three campuses (Elizabeth City State University, Lenoir Community College, Western Carolina University) established new tobacco use prevention coalitions on campus in Q3 (Figure 6). With the addition of these campuses, 83% of all Planning and Implementation grantee-supported campuses now have established coalitions to address tobacco issues on campus. One campus (Lenoir-Rhyne College) disbanded their coalition during this quarter. At the end of Q3, two multi-campus, Planning grantees were working to establish coalitions on nine campuses (Figure 7).

Figure 6. Number of new campus coalitions established over time



* Includes some new coalitions established in Jan-Mar 06

Figure 7. Coalition status of HWTF grantee campuses at the end of Q3 (n=52)



D.1.d. Summary of Outcome Indicators

The following table summarizes all outcome indicators changes reported monthly by Planning and Implementation grantees in Q3 (Table 2).

Table 2: Summary of Q3 Outcome Indicator Changes

Outcome Indicator	# of Q3 Planning grantees involved (n=10)*	# of Q3 Implem. grantees involved (n=8)	Total # of Q3 indicator changes	YTD indicator changes
Policy Adoption				
# of tobacco-free policies adopted by campus organizations	0	0	0	0
# of tobacco-free policies adopted in campus areas	5	2	9	15
# of tobacco-free policies adopted in off-campus areas frequented by young adults	0	0	0	7
# of policies adopted prohibiting the sale of tobacco products on campus	1	0	1	2
# of policies adopted prohibiting tobacco industry advertising, free sampling, & sponsorship on campus	1	0	1	3
Building Support for Policy Change				
# of signatures on petitions showing support for campus policy initiatives	1	2	193	2544
# of college officials offering formal support for campus policy initiatives	9	4	40	167
# of organizations offering formal support for campus policy initiatives	3	4	10	42
# of staff/faculty/student leaders offering formal support for campus policy initiatives	8	3	55	233
# of policy changes under consideration by college officials	3	2	7	13
Coalition Development				
# of new campus coalitions established	3	0	3	6

* One Planning grantee did not submit data for the month of September.

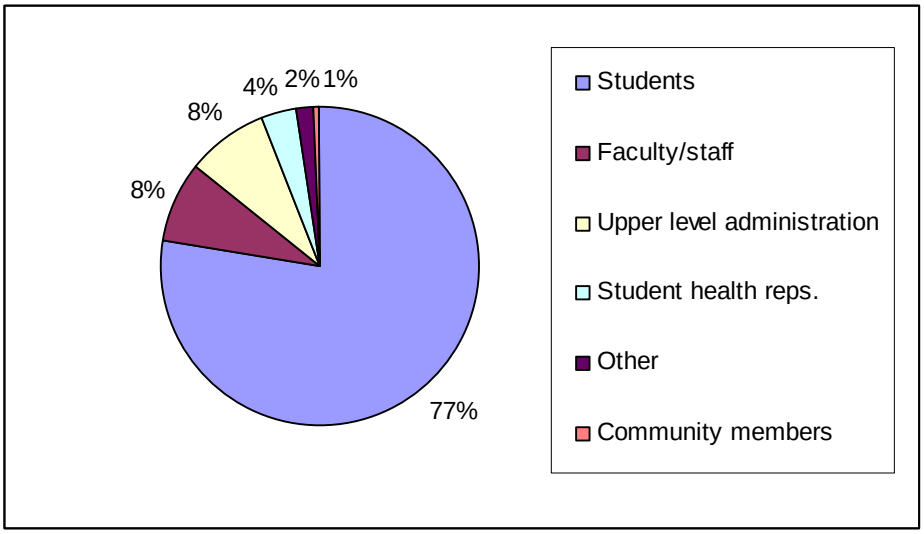
D.2. Program Development

This section describes process indicators reported by Planning and Implementation grantees in Q3.

D.2.a. Coalition Development

Grantees recruited 191 new coalition members during Q3, most (77%) of which were students (Figure 8). Thirty-five percent (66) represented priority population groups (e.g., fraternity members).

Figure 8. Type of new coalition members recruited in Q3 (n=191)



D.2.b. Building Support for Policy Change

Figure 9 highlights the number of surveys and petitions conducted by grantees over time.

Figure 9. Number of surveys and petitions over time

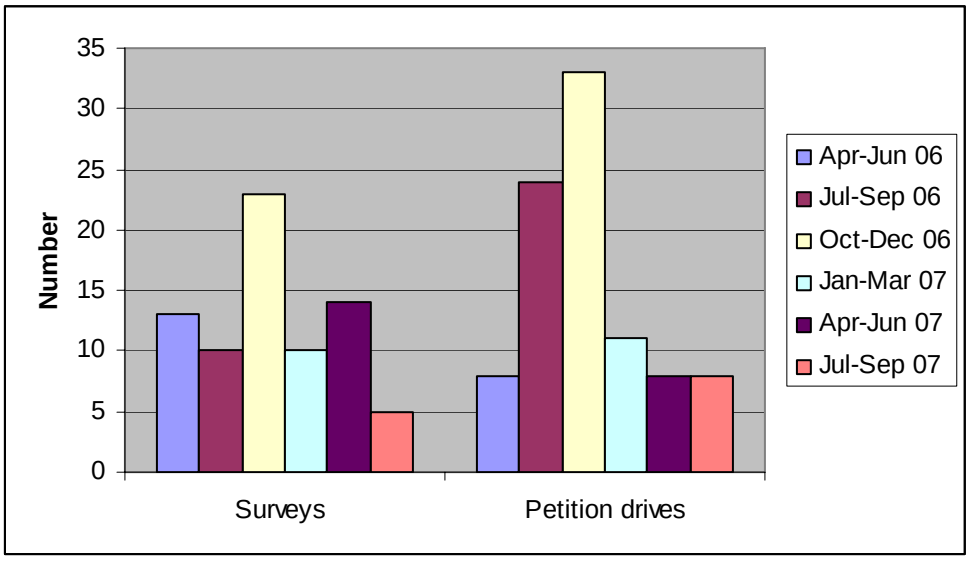


Figure 10 highlights the number of meetings/presentations to build support for campus policy initiatives over time (by quarter and cumulatively). In total, grantees reported participating in 879 meetings/presentations since the beginning of the initiative. All but two grantees reported participating in meetings/presentations to promote policies during Q3. Thirty percent of Q3 meetings/presentations were to obtain support for coalition activities and 26% were class presentations (Figure 11).

Figure 10. Number of meetings/presentations to build support for campus policies over time

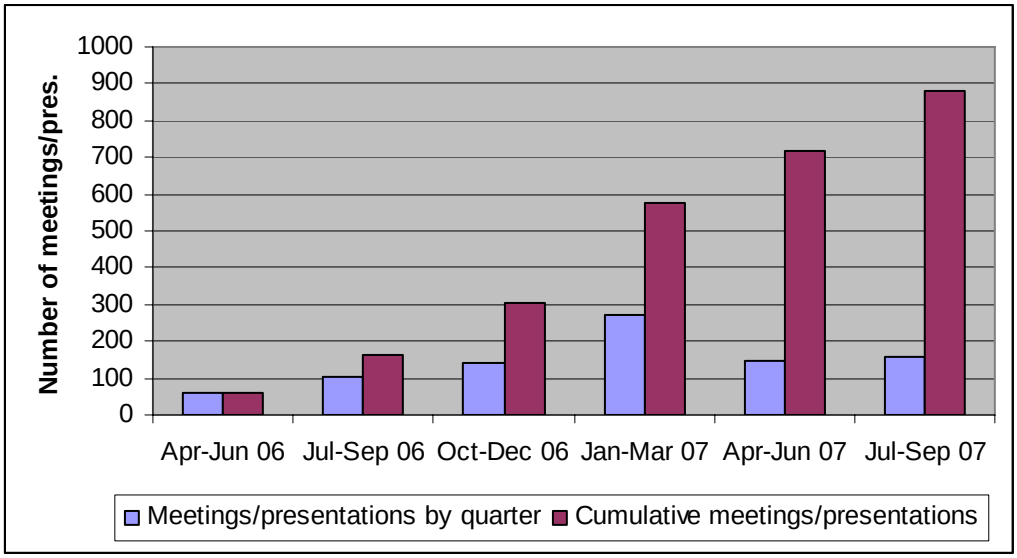
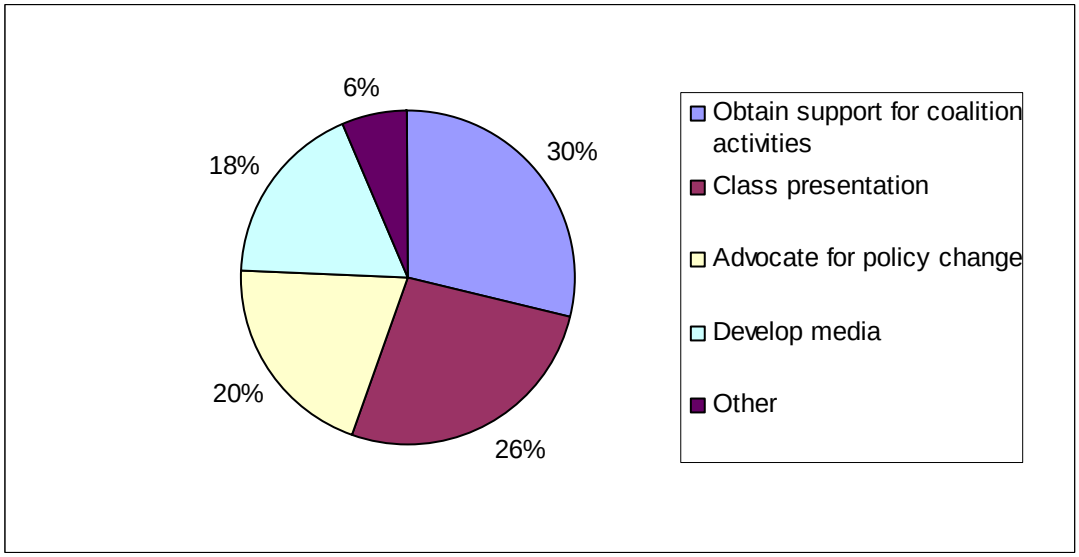


Figure 11. Type of meetings/presentations to advance campus policies held in Q3 (n=159)



The number of earned media messages (i.e., radio, TV, newspaper messages) to promote campus policies increased in Q3 compared to the previous quarter (Figure 12). The majority (96%) of media messages were earned messages published in newspapers (Figure 13). Forty-nine percent of the earned messages were published/aired via campus-based media outlets (e.g. campus newspaper) and 51% were published/aired via non campus-based media outlets (e.g., local newspaper). The number of earned policy messages in non campus-based media increased in Q3 compared to previous quarters.

Figure 12. Number of newspaper/radio/TV media messages promoting campus policies over time

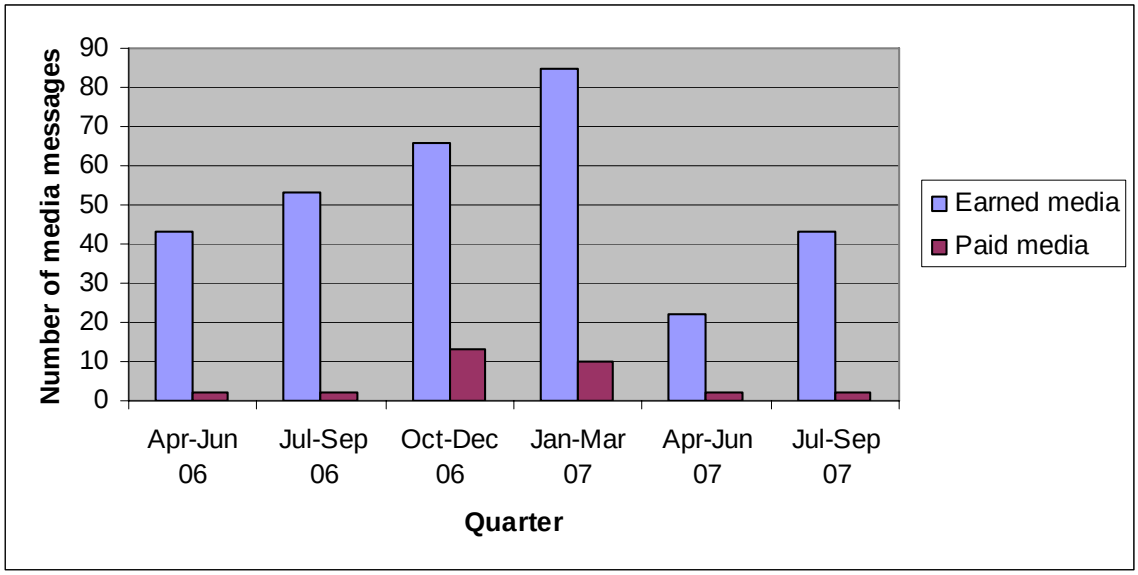
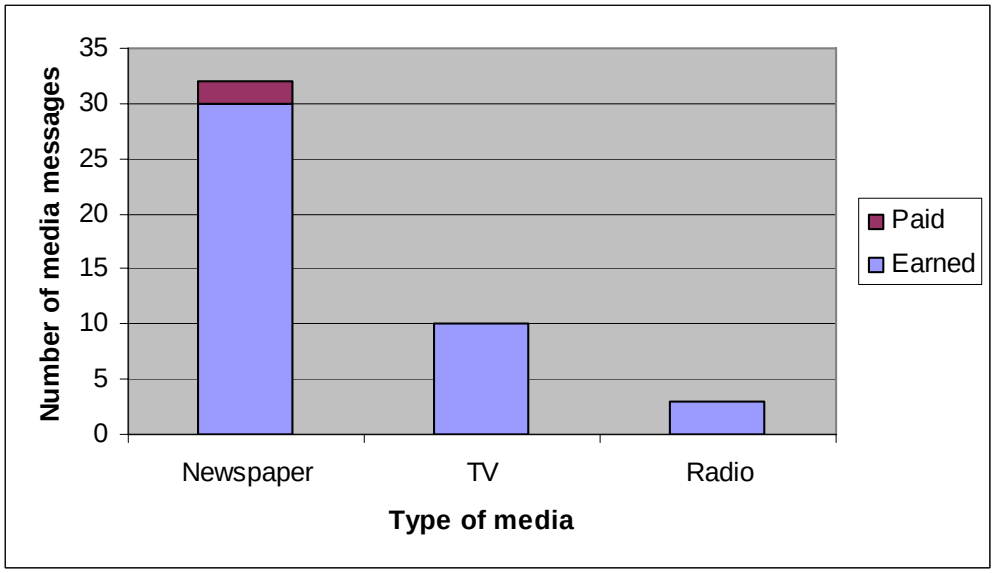


Figure 13. Type of media messages promoting campus policies in Q3 (n=45)

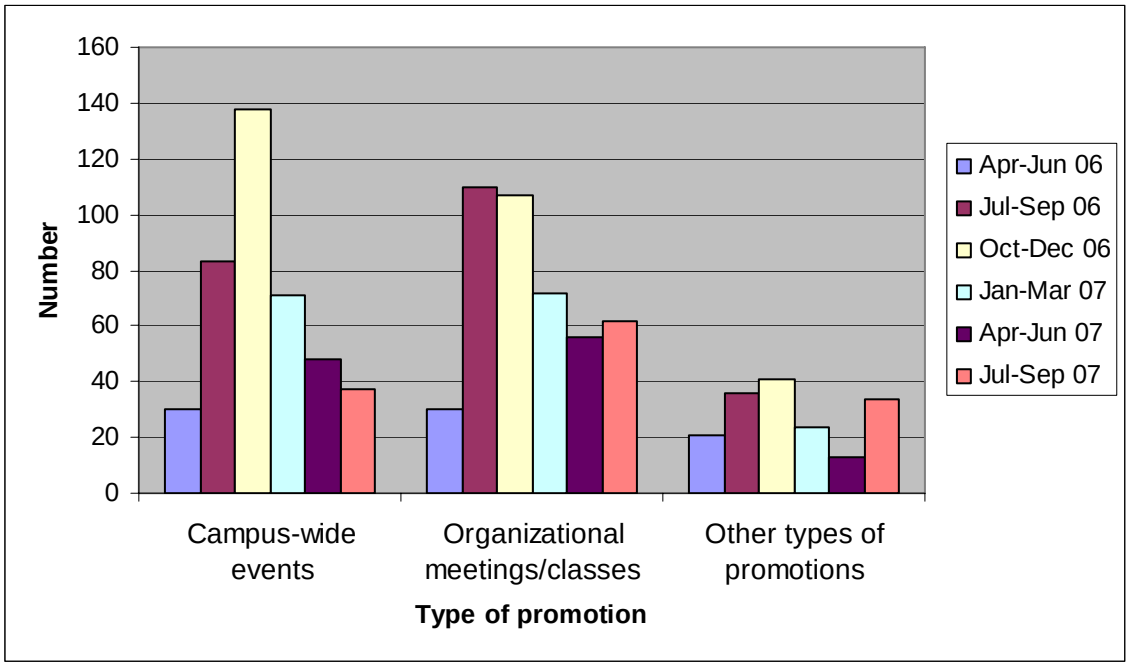


Note: 46% of earned media and 100% of paid media messages were published/aired by campus-based media outlets.

D.2.c. Quitline Promotion

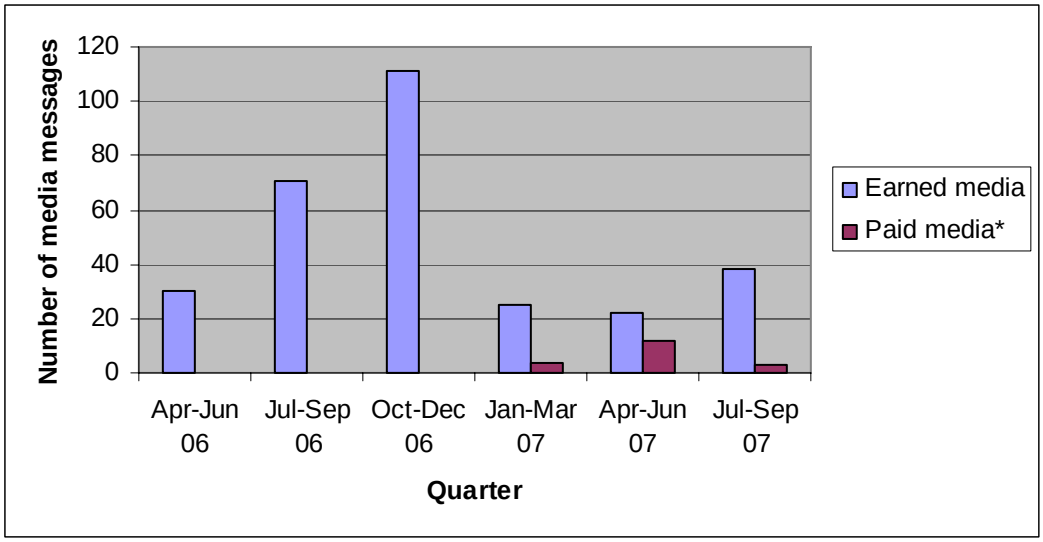
Figure 14 highlights the number and type of Quitline NC promotions conducted by grantees over time. In total, 15 grantees conducted 133 Quitline NC promotions during Q3 including campus-wide events, organizations meetings/classes, and other types of promotions (e.g., Quitline NC mouse pads distributed at freshmen orientation events, bulletin boards). Forty-four percent of all Quitline NC promotions specifically targeted a priority population on campus (e.g., freshmen, women, African Americans, fraternity/sorority members). Three grantees also reported 11 meetings with campus-based health providers to promote the Quitline NC fax referral service.

Figure 14. Number and type of quitline promotions over time



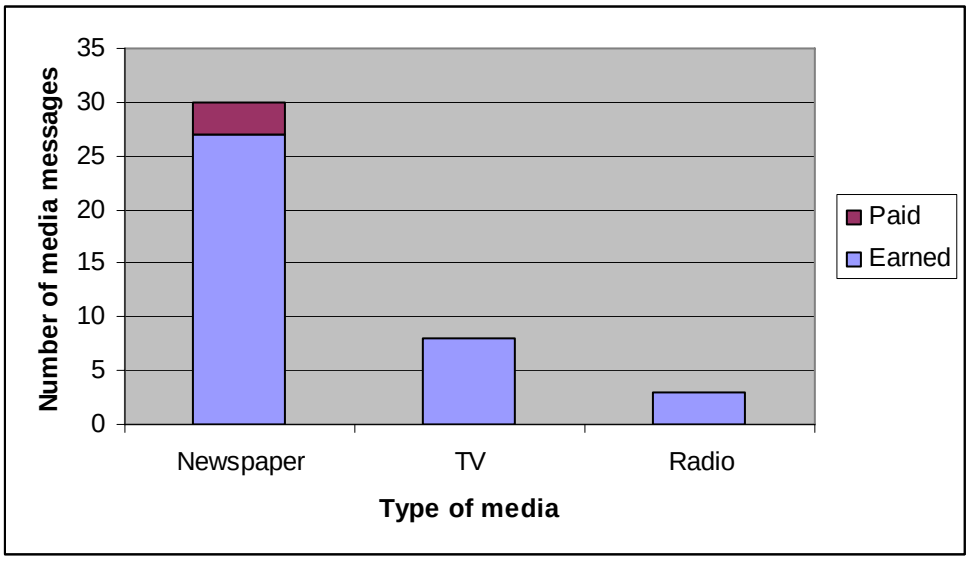
Grantees reported 41 media messages (i.e., radio, TV, newspaper messages) promoting Quitline NC on campuses during Q3, 93% of which were earned. The number of messages increased in Q3 compared to the previous two quarters (Figure 15). However, the total number of earned and paid messages is lower then the number of Quitline media messages reported at the same time last year. The majority of messages were distributed via newspapers (Figure 16). Twenty-two percent of all Quitline media messages were published/aired by non campus-based media outlets.

Figure 15. Number of newspaper/radio/TV media messages promoting Quitline NC over time



* Paid media indicator only included in Year 2.

Figure 16. Type of media messages promoting Quitline NC in Q3 (n=41)



Note: 79% of earned media and 67% of paid media messages were published/aired by campus-based media outlets.

D.2.b. Summary of Program Indicators

The following table summarizes all program indicators changes reported by Planning and Implementation grantees in Q3 (Table 3).

Table 3. Summary of Q3 Program Indicators

Program Indicator	# of Q3 Planning grantees involved (n=10)*	# of Q3 Implem. grantees involved (n=8)	Total # of Q3 indicator changes	YTD indicator changes
Coalition Development				
# of new coalition members recruited	7	6	191	407
# of trainings attended by staff/partners	3	1	7	43
Building Support for Policy Change				
# of surveys completed to assess student tobacco use & attitudes	1	2	5	29
# of petition drives completed to show support for campus policy initiatives	1	2	8	27
# of meetings/presentations to advance tobacco-related policies	10	8	159	577
# of earned newspaper/radio/TV messages promoting support for campus policy initiatives	4	5	43	150
# of paid newspaper/radio/TV messages promoting support for campus policy initiatives	0	1	2	14
Quitline Promotion				
# of Quitline promotions	8	7	133	417
# of earned newspaper/radio/TV messages promoting Quitline	4	3	38	85
# of paid newspaper/radio/TV messages promoting Quitline	1	2	3	19
# of meetings/presentations to promote Quitline fax referral system among health services providers	2	1	11	34
Administrative				
# of new staff hired with grant funds	2	3	8	13
# of meetings with elected state/government leaders to promote HWTF and coalition initiatives	1	0	4	12

* One Planning grantee did not submit data for the month of September.

D.3. Special Grants

The HWTF Tobacco-Free Colleges Initiative funds two Special grants: Survivors and Victims of Tobacco Empowerment (SAVE) and the American Lung Association of NC (ALA). Highlights of Special grantee activities during Q3 are summarized below:

D.3.a. Survivors and Victims of Tobacco Empowerment (SAVE)

SAVE provided services to one Planning grantee supported campus (Stanly Community College) during Q3. This included Quitline NC radio messages, involving SAVE survivors, that were aired by a Stanly County radio station. SAVE also met with a staff member at the Anson County Health Department to plan future distribution of tobacco prevention and quitline materials on college campuses in Anson County.

D.3.b. American Lung Association of North Carolina (ALA)

ALA reported providing services to the following eleven college campuses during Q3 (Table 6). ALA worked with three of these campuses for the first time since the start of the initiative (Wilson Technical Community College, St. Augustine's College, South College-Asheville):

Table 6. Colleges served by ALA in Q3

#	Colleges served	HBCU?	College supported by HWTF Planning or Implementation grantee?
1	Fayetteville State University	Yes	Yes -- Fayetteville State University
2	North Carolina Central University	Yes	Yes -- North Carolina Central University
3	Elizabeth City State University	Yes	Yes -- Elizabeth City State University
4	Wilson Technical Community College	No	Yes – Wilson Technical Community College
5	Winston-Salem State University	Yes	No
6	Shaw University	Yes	No
7	St. Augustine's College	Yes	No
8	Fayetteville Technical Community College	No	No
9	Forsyth Technical Community College	No	No
10	Wake Technical Community College	No	No
11	South College - Asheville	No	No

ALA also had indirect involvement in Wake Technical Community College's adoption of a 100% tobacco-free campus policy during Q3. Based on information provided by the ALA grant coordinator, ALA attended committee meetings concerning the college's tobacco education/policy initiative where they served as technical assistance advisors on cessation-related issues. This included offering *Freedom From Smoking* (FFS) trainings to staff and students, and providing ongoing technical assistance to trained facilitators.

In total, ALA reported the following activities during Q3:

- Nine meetings to provide technical assistance;
- Four meeting/presentations to advance campus tobacco policies;
- Three *Freedom From Smoking* (FFS) clinics held at Wake Technical Community College (Participant numbers unavailable at the time of their report);
- Distribution of self-help manuals and materials;
- Establishing self help link on college student health services website; and
- Three Quitline NC promotions.

D.4. Barriers

All HWTF Tobacco-Free College Initiative grantees are asked to report their top three barriers to effective program implementation. Planning, Implementation, and Special grantees provided the following responses in Q3:

- 60%(12) reported difficulty scheduling meetings/events or establishing campus contact, particularly during summer months;
- 50%(10) reported issues related to administrative or approval processes (e.g., challenges getting media, budget adjustments, contract, or signs approved, time spent preparing Phase II grant proposal);
- 40%(8) reported challenges hiring and/or training new staff;
- 15%(3) reported college systems-level issues (e.g., new leadership unfamiliar with ability to make policy, waiting for IRB approval for survey);
- 15%(3) reported resistance to policy change on campus (e.g., non-compliance or grumbling due to policy change, committee voting not to address tobacco policy at this time);
- 15%(3) reported some other type of barrier (e.g., no interest in cessation classes, deciding on type of policy, time spent on MAPH feasibility plan).

E. Appendix 1: List of grantees, colleges, and counties covered by Tobacco-Free Colleges Initiative

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	
	NC Community Colleges	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
Mecklenburg County Health Department	Belmont Abbey College Brookstone College of Business Carolinas College of Health Sciences	Mecklenburg	

GRANTEE	COLLEGE	COUNTY (campus locations)	COUNTY (populations served) Community Colleges Only
Mecklenburg County Health Department (continued)	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
	Western Carolina University (added August 2007)	Jackson	
	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	
	Other Historically Minority Colleges and Universities (HMCUs)	Cumberland, Forsyth, Rowan, Guilford, Wake, Mecklenburg, Pasquotank, Robeson	

GRANTEE	COLLEGE	COUNTY (campus locations)	COUNTY (populations served) Community Colleges Only
SAVE (Survivors and Victims of Tobacco Empowerment) of NC GASP	Statewide		
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

Appendix 2: Monthly Program and Outcome Indicators

1. Coalition Development
# of new coalitions established
# of new coalition members recruited
# of trainings attended by staff/partners
# of staff/partners attending one or more trainings
# of surveys completed to assess student tobacco use and attitudes
2. Building Support
# 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 earned newspaper/radio/TV messages promoting support for campus policy initiatives • Earned messages from campus-based media outlets • Earned messages from non-campus based media outlets
# of paid newspaper/radio/TV messages promoting support for campus policy initiatives • Paid messages from campus-based media outlets • Paid messages from non-campus based media outlets
# of college officials offering formal support for campus policy initiatives
# of organizations offering formal support for campus policy initiatives
# of staff/faculty/student leaders offering formal support for campus policy initiatives
# of policy changes under consideration by college officials
3. Policy Adoption
# of tobacco-free policies adopted by campus organizations • **Tobacco-free policies adopted by campus organizations representing priority populations**
# of tobacco-free policies adopted in campus areas
# of tobacco-free policies adopted in off-campus areas 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

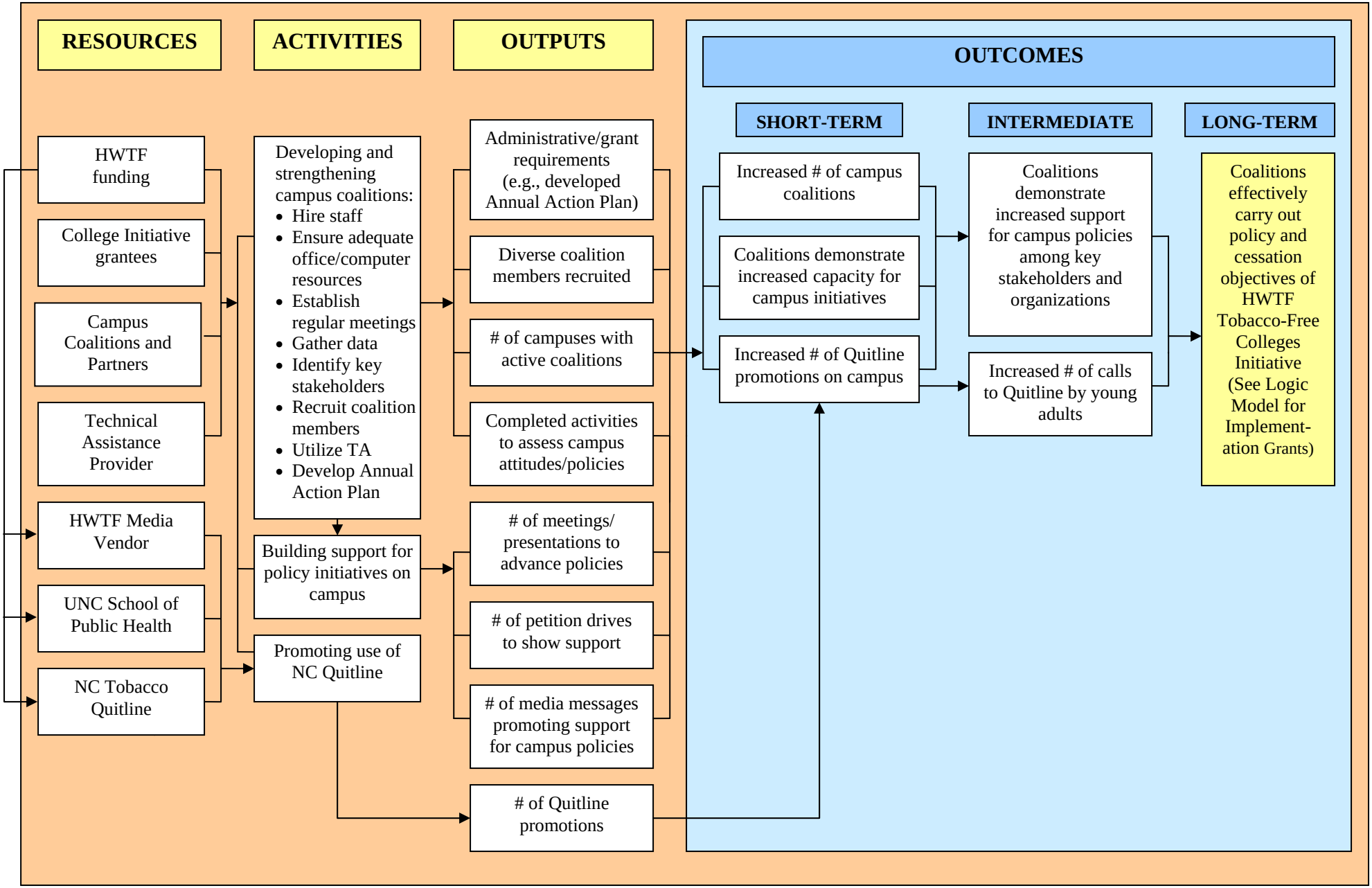
4. Quitline Promotion
# of Quitline promotions • Campus-wide events • Presentations at organizational meetings, classes, or events • Other types of promotional events • Quitline promotions targeting priority populations
# of earned newspaper/radio/TV messages promoting Quitline • Earned messages from campus-based media outlets • Earned messages from non-campus based media outlets • Earned messages promoting Quitline targeting priority populations
# of meetings/presentations to promote Quitline fax referral system among health services providers
5. Administrative Measures
# of new staff hired with grant funds
# of meetings with elected state/government leaders to promote HWTF and coalition initiatives

Notes:

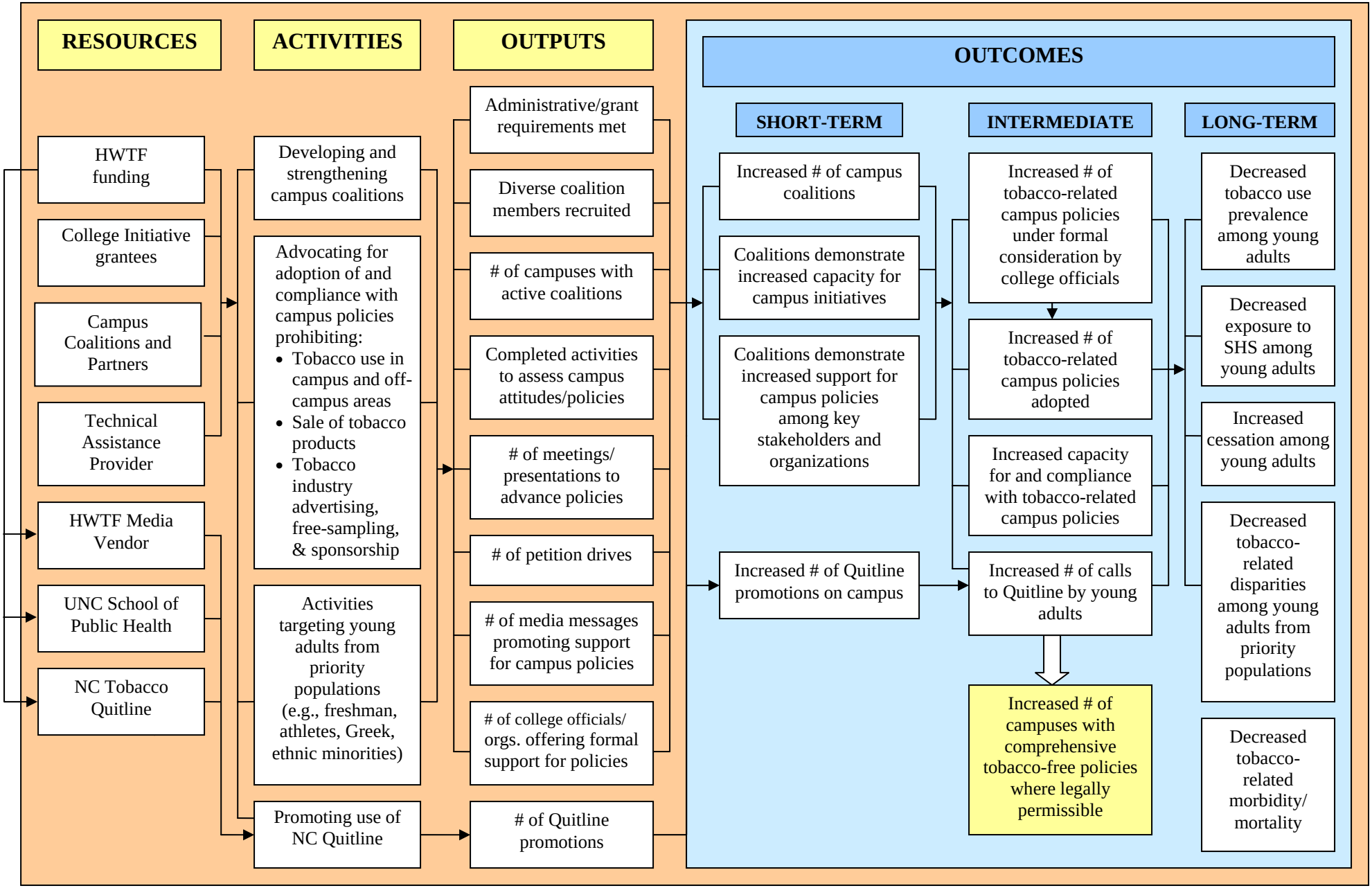
- Bolded indicators are outcome-oriented. Non-bolded indicators are process or program-oriented.

- The indicators listed above are those collected on a monthly basis using the web-based reporting system. Additional indicator data for evaluating this initiative are collected throughout the year using other sources (e.g., Annual College Initiative Grantee Assessment, BRFSS, Quitline data, conference call attendance sheets). For a comprehensive list of all HWTF Tobacco-Free Colleges Initiative indicators and desired outcomes, contact UNC TPEP.

Appendix 3: Logic Model for Tobacco-Free Colleges Initiative Planning Grants



Appendix 4: Logic Model for Tobacco-Free Colleges Initiative Implementation Grants



North Carolina
Health and Wellness Trust Fund

Tobacco-Free Colleges Initiative

Phase II Six Month Report
January – July 2008

Prepared for:
North Carolina Health & 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 Tobacco-Free Colleges Initiative Outcomes Evaluation, please contact:

Tobacco Prevention and Evaluation Program

University of North Carolina at Chapel Hill
School of Medicine
Department of Family Medicine
CB #7595, Manning Drive
Chapel Hill, NC 27599
T: 919-843-9751
F: 919-966-9435

Web: http://www.tpep.unc.edu
Email: tpep@med.unc.edu

Table of Contents

A. Summary and Recommendations

A.1. Overview

The North Carolina (NC) Health and Wellness Trust Fund (HWTF) Tobacco-Free Colleges Initiative was first launched in January 2006. The purpose of this initiative is to support efforts that prevent and reduce tobacco use among NC college students, age 18-24, through the promotion of tobacco-free policy adoption and cessation services on campus.

After two successful years (Phase I report available at: http://www.tpep.unc.edu), the HWTF expanded the Initiative with $1.4 million in Phase II grant funding beginning in January 2008. Phase II grants were awarded to 14 organizations working with 50 campuses in 33 counties across NC. Additional technical assistance services not covered in this evaluation expand the campaign state-wide. A special contract was also awarded to one Phase I grantee, extending their work through a portion of Phase II.

This report highlights grantee outcomes and activities for the first six months of Phase II (Q1, January-March 2008, and Q2, April-June 2008). General findings for this period are as follows:

- Grantees achieved several substantial outcomes in the first six months of Phase II, including the adoption of several tobacco-related policies limiting the use, sale, and distribution of tobacco products on campus. The initial groundwork for many of these policies was established prior to Phase II funding.

- Grantees made significant progress in building support for campus policy adoption and compliance, coalition development, and QuitlineNC promotion, despite time needed for Phase II grant start-up activities and the academic calendar limiting campus events.

A.2. Key Outcomes and Program Accomplishments

Policy Adoption

- Eighteen new tobacco-related policy adoptions occurred on seven campuses with the support of Phase II grantees. Key policy adoptions include two 100% Tobacco-Free Campus Policies adopted at Montreat College and Wingate University. As of June 2008, 18 campuses across NC have now adopted 100% Tobacco-Free Policies or Comprehensive Campus Tobacco Policies (i.e., 100' perimeter policies). Fourteen (78%) of these policies received assistance in adoption through the direct or indirect support of HWTF Tobacco-Free Colleges Initiative grantees since the beginning of Phase I.

- Two perimeter policies were adopted at Appalachian State University (50ft.) and Sandhills Community College (25ft.) in the first six months of Phase II. Surry Community College also adopted policies that substantially limited tobacco use, sales, and advertising on campus.

- Seven campus organizations on two campuses (Wilkes Community College and Western Piedmont Community College) adopted written tobacco-free policies. These organizations included a human services club, student government associations, nursing clubs, a dental club, and a respiratory therapy club.

Building Support

- Ten new tobacco-related campus policies underwent formal consideration by college officials during the first six months of Phase II. Key Phase II policies under consideration include Comprehensive Campus Tobacco Policies currently under consideration at Elizabeth City State University and Western Carolina University. In total, 69 new policies have undergone formal consideration by college officials since the beginning of Phase I.

- Over 170 college officials, campus organizations, and individuals (i.e., staff, faculty, student leaders) offered formal support for campus policy initiatives in Phase II. Four grantees also collected 241 petition signatures showing support for campus policies.

- Grantees reported a total of 184 meetings/presentations and 45 earned media messages to build support for policy adoption. Over half (55%) of the messages were in newspapers.

- Grantees reported a total of 126 meetings/presentations, 37 earned media messages, and 10 paid media messages building support for policy compliance. Seventy-seven percent of the messages were published in newspapers, mainly campus-based.

Quitline Promotion

- All 15 grantees promoted QuitlineNC on one or more of their campuses during the first six months of Phase II. At the beginning of Phase II, only 41% of the campuses completing the baseline survey reported promoting QuitlineNC on campus in the past six months. In total, 165 QuitlineNC promotions (e.g., campus-wide events, presentations at meetings) were reported in Phase II, 58% of which occurred at campus-wide events.

- Grantees reported a total of 64 media messages (80% earned) to promote QuitlineNC. Just over half were published in newspapers, 66% of which were campus-based.

- Eight grantees reported 22 meetings with campus-based health providers to promote QuitlineNC fax referral service utilization. In addition, seven grantees reported 22 meetings to promote 5As and other related cessation services.

Coalition Development

- Four grantees (Alamance Community College, Rowan-Cabarrus Community College, First Health of the Carolinas, Guilford County Health Dept.) established new tobacco use prevention coalitions for 11 campuses. At the end of June 2008, only four (8%) of the 50 HWTF Phase II grantee-supported campuses did not have coalitions.

- Grantees recruited 186 new coalition members in the first six months of Phase II, 64% of whom were upper level administrators, faculty, or staff members on campus.

A.3. Key Barriers to Program Activities

- Barriers differed by quarter, with more grantees reporting difficulty with administrative procedures in Q1 (6) and difficulty scheduling due to holidays in Q2 (12).

- The most commonly cited barrier in this report period was difficulty scheduling around the academic calendar, which was reported by 93% of grantees (14).

- Sixty percent (9) of all grantees reported a lack of interest or resistance to policy adoption and/or compliance on campus.

- Forty-seven percent (7) of grantees reported that staffing changes and hiring were barriers to program activities.

- Other commonly reported barriers include issues related to administrative or approval processes (47%), difficulty scheduling meetings due to schedule conflicts (40%), and lack of administration support and/or interest in policy change (40%)

A.4. Recommendations

- Continue to publicize multiple policy successes of the Tobacco-Free Colleges Initiative, including new 100% Tobacco-Free Policies and Comprehensive Campus Tobacco Policies adopted statewide, and the relationships to Phase I and Phase II funding. This may have added interest and impact, particularly following recent media coverage of Tobacco-Free Schools in NC.

- Encourage grantees to meet with an elected local or state government official to promote the HWTF and share successes of tobacco-free campus initiatives. (Only three grantees reported a total of ten meetings for this purpose in Q1 and Q2.)

- Encourage grantees to focus policy and cessation promotion efforts on campus around the beginning of the school year. This may include participating in freshman events with fraternities and sororities, scheduling meetings with college officials setting policy agendas for the upcoming year, and working with athletics officials and teams (e.g., soccer, football). Planning and preparation could occur during summer months when student activity is lower.

- Work with four remaining campuses to establish tobacco use prevention coalitions.

- Provide training and resources on efficient approaches to scheduling group meetings (for example, internet-based meeting schedulers such as Meeting Wizard). (Six [40%] grantees reporting difficulty scheduling throughout the course of the six month period, and 14 [93%] of the grantees reporting difficulty scheduling around the academic year.)

- Review procedures to ensure relevant data on technical assistance for non-funded campuses in the Smoke-Free Colleges Initiative are included in future quarterly reports to more fully capture the impact of the Initiative's role in policy change.

- Review composition of coalitions during technical assistance provision to encourage student representation on coalitions among those with few or no students.

B. Background

Young adults, aged 18-24, continue to have the highest rates of tobacco use among all age groups in NC, with 31.3% of this population identified as current smokers in 2007.[1] Nearly 60% of NC young adult smokers have made unsuccessful quit attempts in the last year. Among young adults attending college, the level of exposure to tobacco marketing and use are elevated.[2] Additionally, certain subpopulations (e.g., fraternities, sororities, athletes, freshmen) deemed "priority populations" are at additional risk for tobacco initiation and face barriers to cessation services.[3]

The HWTF Tobacco-Free Colleges Initiative began in January 2006 with $1.6 million in Phase I funding aimed at preventing and reducing tobacco use among NC college students through the promotion of tobacco-free policy adoption and QuitlineNC on campus. Twenty community and campus-based organizations received Phase I grants from the HWTF to carry out this work on 62 campuses. Prior to this initiative, only two campuses statewide were known to be 100% tobacco free (John Wesley College and Bennett College).

Phase I of the initiative demonstrated several successful outcomes, including the adoption of 15 100% Tobacco-Free Policies and Comprehensive Campus Tobacco Policies. 100% Tobacco-Free Policies prohibit the use of tobacco anywhere on campus grounds and in campus vehicles by anyone at anytime. The sale, advertisement, sponsorship and free sampling of tobacco products on campus are also prohibited. Comprehensive Campus Tobacco Policies are similar to 100% Tobacco-Free Policies; however, they technically only prohibit tobacco use within 100 ft. of campus buildings. Comprehensive Campus Tobacco Policies apply to UNC system schools, which are currently limited by state law to the adoption of a maximum 100 ft. perimeter policy.

Following the success of Phase I, the initiative was expanded in January 2008 with an additional $1.4 million in Phase II grant funding awarded to 14 community and campus-based organizations (See Appendix 1 for list of Phase II grantees). Six (43%) of these organizations also received Phase I grants. One additional grantee (Elizabeth State City University) received a special contract to extend their Phase I work through a portion of Phase II.

Phase II grantees promote tobacco-free policy adoption, policy compliance, QuitlineNC and other cessation services on public and private college, university, and community college campuses. In total, Phase II grantees work with 50 different campuses across NC. Three grantees work with multiple campuses (i.e., 39 campuses, or 78% of all campuses supported by Phase II grantees).

In addition to Phase II grantee efforts on these 50 campuses, the HWTF offers technical assistance to non-funded campuses across the state through a newly appointed 100% Tobacco-Free Campuses Director. The 100% Tobacco-Free Campuses Director supports Phase II grantees, as well as leaders on non-funded campuses seeking assistance with tobacco-related campus policy and cessation initiatives. This position and service to non-funded campuses is a new component of the HWTF Tobacco-Free Colleges Initiative offered in Phase II.

The UNC Tobacco Prevention and Evaluation Program (TPEP) conducts outcomes evaluation for the grantee-funded portion of the HWTF Tobacco-Free Colleges Initiative. The purpose of this

[1] North Carolina State Center for Health Statistics. BRFSS 2007. Available from: http://www.schs.state.nc.us/SCHS/brfss/2007/index.html

[2] Rigotti NA, Moran SE, Wechsler H. US college students' exposure to tobacco promotions: prevalence and association with tobacco use. Am J Public Health. 2005 Jan;95(1):138-44.

[3] American Legacy Foundation. Priority Populations. [Internet site.] Available from: http://www.americanlegacy.org/2165.aspx

evaluation is to demonstrate the effectiveness of the initiative at reaching its desired outcomes and to make recommendations for program improvement. The evaluation team is responsible for collecting baseline and monthly progress data from grantees using a customized, web-based tracking system, as well as analyzing data and disseminating results.

C. Methods

The following report highlights the outcomes and program activities of Phase II grantees during the six month period of January to June 2008, including data from quarter one (Q1, January-March 2008) and quarter two (Q2, April-July 2008). The new fiscal year (FY 08-09) for the HWTF Tobacco-Free Colleges Initiative will officially begin in July 2008. This shift will change the previous January-December Colleges Initiative fiscal year to a July-June fiscal year schedule, allowing the Initiative to be consistent with the fiscal years of other HWTF Tobacco Programs.

Outcome and program-oriented data were collected from all grantees on a monthly basis using the Colleges Online Reporting and Evaluation System (CORES) developed by UNC TPEP. Data from one Phase I contract grantee (ECSU) were also collected and included in this report, as they received a continuation of funds for Phase II. CORES data are reported based on key focus areas and indicators developed for the Tobacco-Free Colleges Initiative by UNC TPEP in collaboration with the HWTF (See Appendix 2 for a list of Phase II indicators collected monthly using CORES). Indicators are divided into two areas:

- Outcome indicators include policy change and progress towards policy change indicators.
- Program indicators include building support for adoption and compliance with campus policies, QuitlineNC promotion, coalition development, and administrative measures.

The indicators include program activities that lead towards desired short-term, intermediate, and long term outcomes for the initiative, as outlined in the Logic Model for Phase II Tobacco-Free Colleges Initiative Grants (See Appendix 3).

Grantees report their data using established indicator change criteria and reporting procedures outlined for all grantees in a CORES Codebook. Indicator definitions are also integrated in CORES via an easy-access, online help file. In addition, all grantees received training on how to use CORES via conference calls conducted in February 2008. Individual CORES training was also provided to grantees by phone, as required. Upon final receipt and compilation of grantee CORES data, all policy changes (i.e., primary outcome indicators) and key program indicator changes are verified with grantees by UNC TPEP staff via phone or email. Additional data cleaning is also conducted to improve data quality.

Baseline data were collected from all Tobacco-Free Colleges Initiative grantees at the beginning of Phase I and Phase II using an online survey. The Phase II baseline survey was designed to assess existing tobacco-related campus policies, coalitions, and cessation services on all grantee-supported campuses as of December 31, 2007, (i.e., prior to start of Phase II). Baseline data collection was included in the evaluation methodology to compare and assess grantee outcome achievement over time. Thirty-seven Phase II grantee-supported campuses (74%) had submitted Phase II baseline data at the time of this report.

A summary of key baseline data for Phase II campuses are highlighted in Table 1. Phase II baseline data include several policies that were achieved by Phase II grantees in Phase I (e.g., seven of the nine 100% tobacco-free campus policies reported at Phase II baseline were adopted with the support of grantees in Phase I).

Table 1. Baseline Phase II grantee information*

General Information	#
Number of Phase II grantees	14
Number of Phase II grantees who also received funding in Phase I	6 (43%)
Number of campuses supported by Phase II grantees • Community Colleges • Public Colleges/Universities (UNC campuses) • Private Colleges/Universities • Historically Black Colleges/Universities	50 19 (38%) 8 (16%) 23 (46%) 5 (10%)
Number of Phase II campuses who were also supported in Phase I	34 (68%)
Number of counties with campuses (home site) supported by Phase II grantees	33
Key Baseline Data for all Phase II grantee-supported campuses (n=50)	#
Number of campuses that have adopted 100% Tobacco-Free Campus Policies	9 (18%)
Number of UNC campuses that have adopted Comprehensive Campus Tobacco Policies	1 (2%)
Number of campuses with established campus coalitions	35 (70%)
Key Baseline Data for Phase II grantee-supported campuses completing baseline survey (n=37)	#
Number of campuses with written policy that regulates or controls the use of tobacco property on campus grounds and property	29 (78%)
Number of campuses with no tobacco use at least 25 feet from all buildings	16 (43%)
Number of campuses that prohibit the sale of tobacco products on campus	33 (89%)
Number of campuses that prohibit tobacco industry advertising on campus	22 (59%)
Number of campuses that prohibit free distribution of sample tobacco products on campus	19 (51%)
Number of campuses that prohibit tobacco industry sponsored events on campus	20 (54%)
Number of campuses that offer cessation counseling for students who wish to quit	16 (43%)
Number of campuses that have promoted QuitlineNC on campus in the past six months to completing the survey	22 (59%)
Number of campuses that have at least one college official offering formal support for tobacco use prevention policy initiatives on campus	21 (57%)

* Baseline summary does not include Phase I special contract grantee (ESCU)

D. Summary of Six Month Period Activities

Sections D.1 and D.2 summarize Q1 and Q2 outcome and program indicator data reported by 14 Phase II Colleges Initiative grantees and one Phase I special contract grantee (Elizabeth City State University) (n=15). See Tables 2 and 3 for a listing of cumulative indicator changes.

D.1. Outcomes

D.1.a. Policy Adoption

Seven grantees reported a total of 18 tobacco-related policy changes on seven campuses in Q1 and Q2, including 100% Tobacco-Free Policies adopted at Montreat College and Wingate University, one 50 ft. perimeter policy adopted at Appalachian State University, and one 25 ft. perimeter policy adopted at Sandhills Community College. Surry Community College also adopted a tobacco-related policy affecting several areas, including the prohibition of tobacco use in all campus buildings and vehicles, at all campus athletic events, and on all campus grounds except parking lots. Surry's policy is reported as four separate policy changes based on the four key areas targeted by the policy (i.e., campus areas, special events, tobacco sales, industry influence).

Since the beginning of Phase I, a total of 71 tobacco-related policies have been adopted on 33 campuses with the support of HWTF grantees. Three of the grantees who reported policies in Phase II (Wingate University, Surry County Health and Nutrition Center, Wilkes Community College) began building support and/or advocating for these policies during Phase I of the initiative.

Figure 1 shows the types of policies adopted in Q1 and Q2 with the direct or indirect support of Phase II grantees. Table 2 includes a detailed list of policies, campuses, and grantees involved.

Figure 1. Types of tobacco-related policies adopted in Q1 and Q2 (n=18)

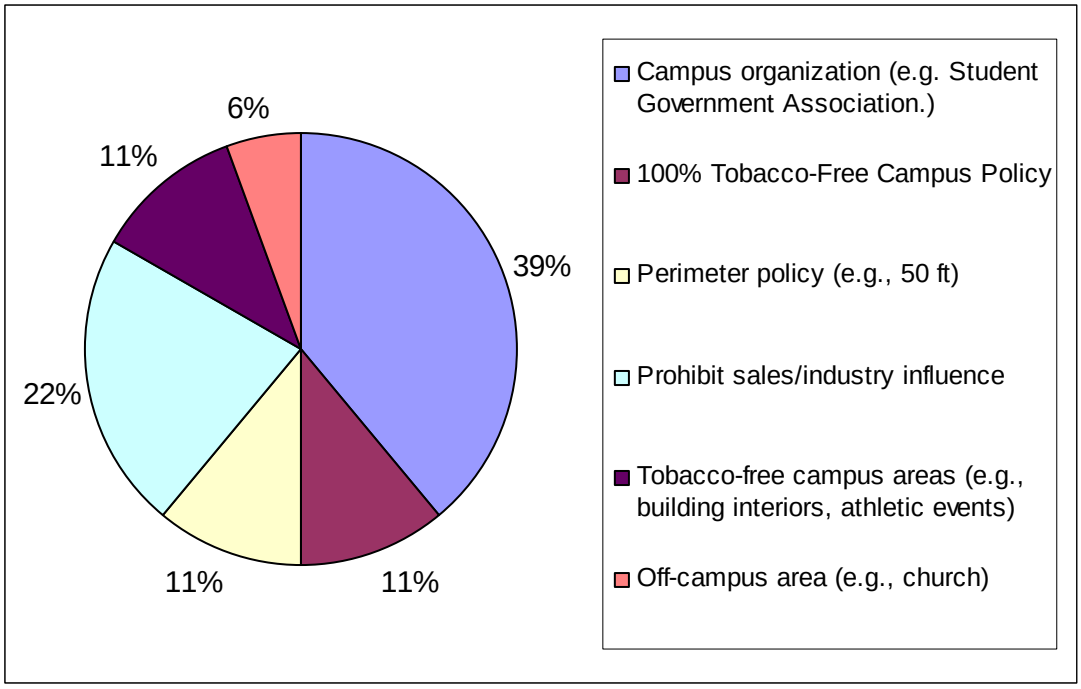


Table 2. List of tobacco-related policies adopted, campuses, and grantees involved in Q1 and Q2 (n=18)

#	Type of Policy Adopted	Month Adopted	Campus	Grantee	Type of Involvement
1	100% Tobacco-Free Campus Policy	January 2008	Montreat College	Montreat College	Direct
2	100% Tobacco-Free Campus Policy	January 2008	Wingate University*	Mecklenburg Co. Health Department	Direct
3	50 ft. perimeter policy	January 2008	Appalachian State University	Appalachian State University	Indirect
4	Tobacco-free policy adopted by off-campus area: Montreat Presbyterian Church	January 2008	Montreat College	Montreat College	Direct
5	25 ft. perimeter policy	February 2008	Sandhills Community College	First Health of the Carolinas	Direct
6	Policy prohibiting sale of tobacco products on campus	February 2008	Surry Community College*	Surry County Health and Nutrition Center	Direct
7	Policy prohibiting tobacco advertising, industry sponsorship, and free sampling on campus	February 2008	Surry Community College*	Surry County Health and Nutrition Center	Direct
8	Policy prohibiting tobacco use at all college athletic tournaments, events, and contests	February 2008	Surry Community College*	Surry County Health and Nutrition Center	Direct
9	Policy prohibiting tobacco use in all campus building, campus vehicles, and on all grounds (except parking lots)	February 2008	Surry Community College*	Surry County Health and Nutrition Center	Direct
10	Tobacco-free policy adopted by campus organization: Student Government Assoc.	February 2008	Wilkes Community College*	Wilkes Community College	Direct
11	Tobacco-free policy adopted by campus organization: 1st Year Nursing Club	March 2008	Wilkes Community College*	Wilkes Community College	Direct
12	Tobacco-free policy adopted by campus organization: 2nd Year Nursing Club	March 2008	Wilkes Community College*	Wilkes Community College	Direct
13	Tobacco-free policy adopted by campus organization: Dental Club	March 2008	Wilkes Community College*	Wilkes Community College	Direct
14	Tobacco-free policy adopted by campus organization: Human Services Club	March 2008	Wilkes Community College*	Wilkes Community College	Direct
15	Tobacco-free policy adopted by campus organization: Respiratory Therapy Club	March 2008	Wilkes Community College*	Wilkes Community College	Direct
16	Policy prohibiting sale of tobacco products by campus entities	April 2008	Montreat College	Montreat College	Direct
17	Policy prohibiting tobacco advertising, industry sponsorship, and free sampling on campus	April 2008	Montreat College	Montreat College	Direct
18	Tobacco-free policy adopted by campus organization: Student Government Assoc.	June 2008	Western Piedmont Community College	Western Piedmont Community College	Direct

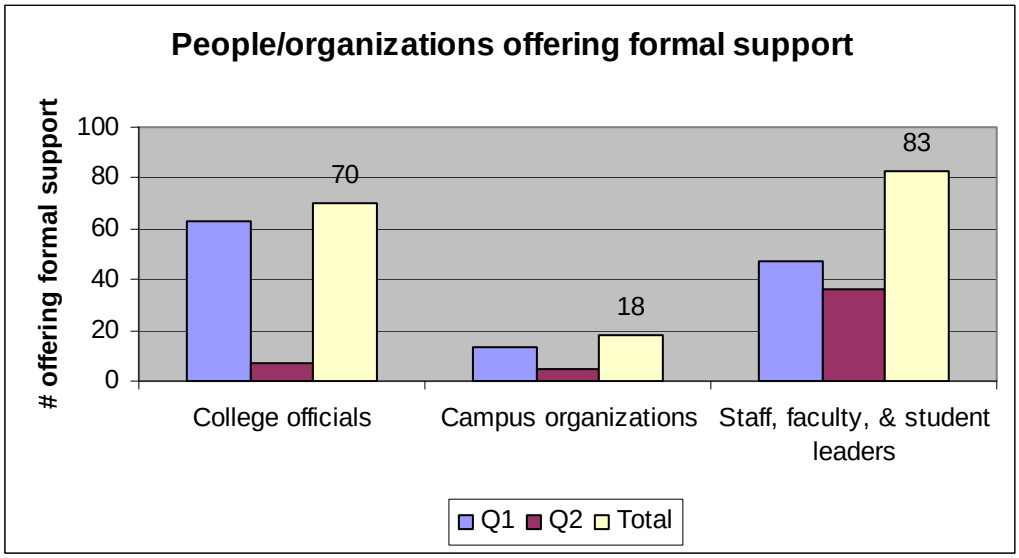
* Also received Phase I grant, or was supported by grantee that received Phase I grant.

D.1.b. Building Support for Policy Adoption

Six grantees reported 10 *new* policies that formally underwent consideration by college officials for the first time during Q1 and Q2. These include three Comprehensive Campus Tobacco Policies (i.e., 100 ft. perimeter policies) under consideration at Elizabeth City State University, Western Carolina University, and UNC-Pembroke. In April 2008, UNC-Pembroke changed their policy under consideration from a 100 ft. to a 25ft. perimeter policy.

Figure 2 highlights the number of *new* college officials, campus organizations, and staff/faculty/ student leaders offering formal support for campus policy initiatives in Q1 and Q2. In total, 171 campus individuals and organizations were reported offering support, including 70 college officials, 18 campus organizations, and 83 staff/faculty/student leaders. Forty-nine percent of all campus individuals and groups provided both written and verbal support. In addition, four grantees collected 241 petition signatures showing support for campus policies.

Figure 2. Type of formal support offered in Q1 and Q2 (n=171)



D.1.c. Coalition Development

Phase II grantees are currently supporting 50 campuses across the state. (This does not include Phase I special contract grantee campus, ECSU.) At Phase II baseline, 35 campuses (70%) had established tobacco use prevention coalitions. Coalition members assist grant coordinators in implementing activities on campus.

During Q1 and Q2, an additional eleven campuses established new tobacco use prevention coalitions with the support of four Phase II grantees (Alamance Community College, First Health of the Carolinas, Rowan-Cabarrus Community College, and Guilford County Health Department). All campuses supported by Guilford County Health Department use one centralized tobacco use prevention coalition. At the end of Q2, 92% (46) of all Phase II grantee-supported campuses have tobacco use prevention coalitions.

Over the course of Q1 and Q2, ten grantees have conducted 23 surveys to assess social norms around tobacco use and/or the prevalence of tobacco use among campus students. Grantees reported plans to use surveys for media campaigns, policy compliance, and advocacy.

Campuses without established tobacco use prevention coalitions include:

1. Catawba College
2. Gaston College
3. King's College
4. Livingstone College

D.1.d. Summary of Outcome Indicators

The following table summarizes all outcome indicators changes reported monthly by Phase II grantees in Q1 and Q2 (Table 3).

Table 3: Summary of Phase II Q1 and Q2 Outcome Indicator Changes

Outcome Indicator	# of grantees involved (n=15)*	Total Q1 indicator changes	Total Q2 indicator changes	Total Q1+Q2 indicator changes
Building Support for Policy Adoption				
# of signatures on petitions showing support for campus policy initiatives	4 (27%)	116	125	**241**
# of college officials offering formal support for campus policy initiatives	9 (60%)	63	7	**70**
# of organizations offering formal support for campus policy initiatives	6 (40%)	13	5	**18**
# of staff/faculty/student leaders offering formal support for campus policy initiatives	8 (53%)	47	36	**83**
# of policy changes under consideration by college officials	5 (33%)	8	2	**10**
Policy Adoption				
# of tobacco-free policies adopted by campus organizations	2 (13%)	6	1	**7**
# of tobacco-free policies adopted in campus areas	5 (33%)	6	0	**6**
# of tobacco-free policies adopted in off-campus areas frequented by young adults	1 (7%)	1	0	**1**
# of policies adopted prohibiting the sale of tobacco products on campus	2 (13%)	1	1	**2**
# of policies adopted prohibiting tobacco industry advertising, free sampling, & sponsorship on campus	2 (13%)	1	1	**2**
Coalition Development				
# of new campus coalitions established	4 (27%)	11	0	**11**

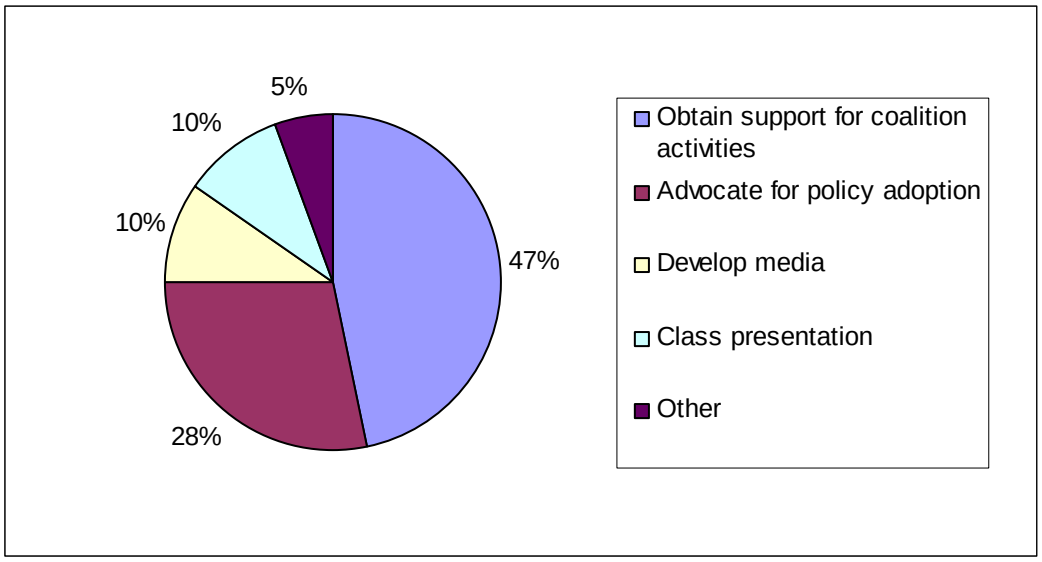
* Includes data from Phase I special contract grantee (ESCU)

D.2. Program Development

D.2.a. Building Support for Policy Adoption

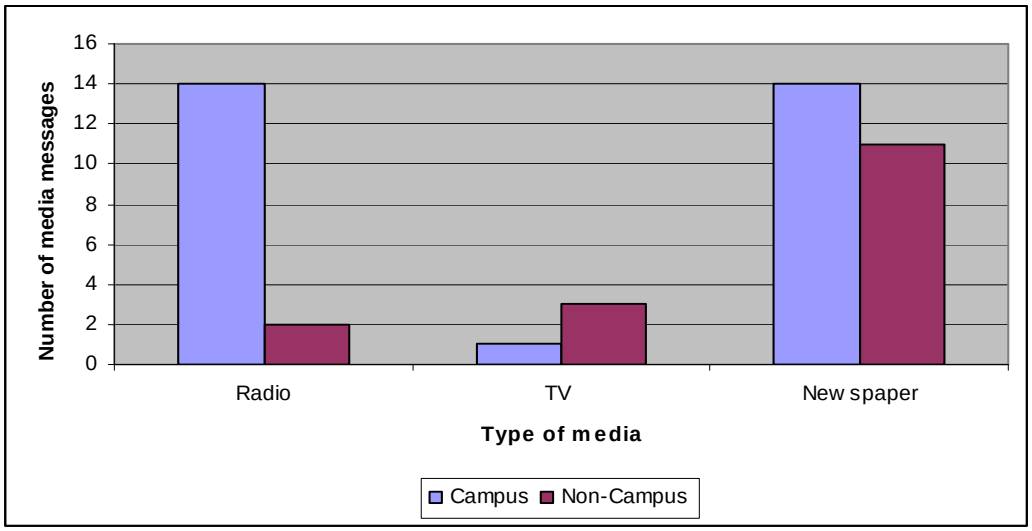
Ninety-three percent (14) of grantees participated in 184 meetings/presentations to build support for campus policy adoption in Q1 and Q2. Seventy-five percent of all the meetings/presentations were to obtain support for coalition activities and to advocate for policy adoption (Figure 3).

Figure 3. Type of meetings/presentations to promote campus policy adoption of Phase II (n=184)



Nine grantees reported a total of 45 earned media messages (no paid media) to promote policy adoption in Q1 and Q2. Fifty-six percent (25) of the messages were published in newspapers (Figure 4). Sixty-four percent were published/aired via campus-based media outlets.

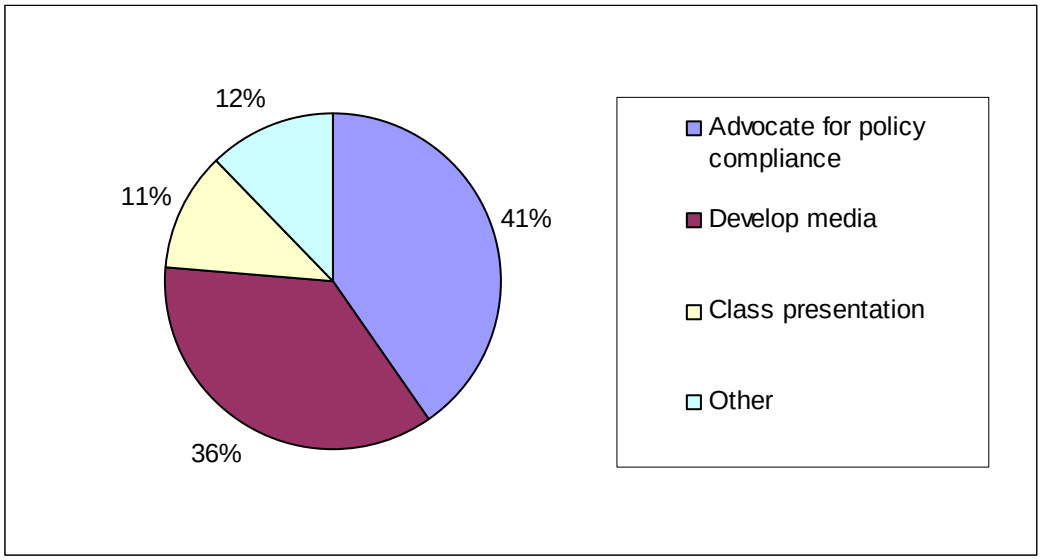
Figure 4. Type of earned media messages promoting campus policy adoption in Q1 and Q2 (n=45)



D.2.b. Building Support for Policy Compliance

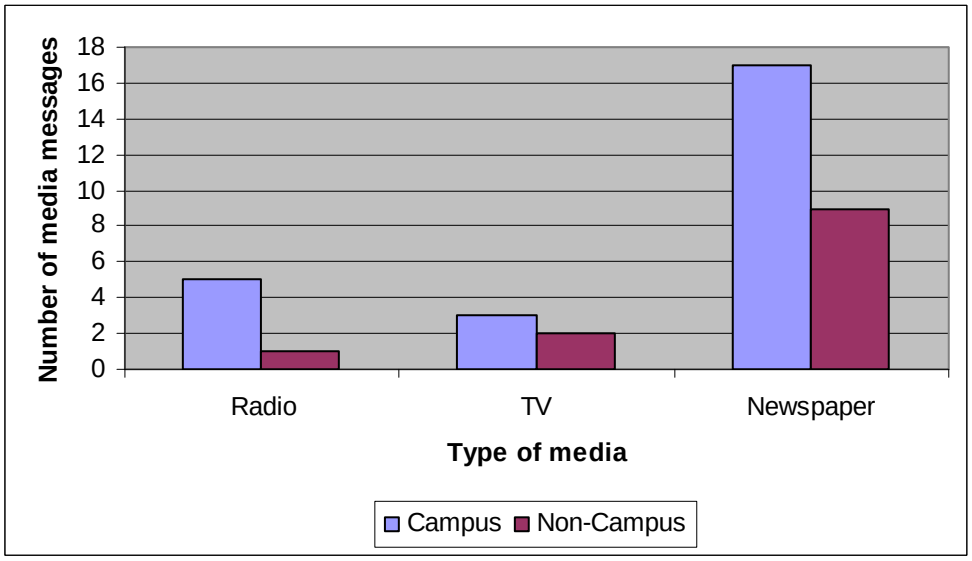
Eighty percent (12) of grantees participated in 114 meetings/presentations to build support for campus policy compliance in Q1 and Q2. Forty-one percent of the meetings were to specifically advocate for policy compliance on campus (Figure 5).

Figure 5. Type of meetings/presentations to promote campus policy compliance in Q1 and Q2 (n=114)



Eleven grantees reported a total of 37 earned media messages and 10 paid media messages to promote policy compliance. Seventy percent of the messages were published in newspapers (Figure 6). Sixty-eight percent were also published/aired via campus-based media outlets.

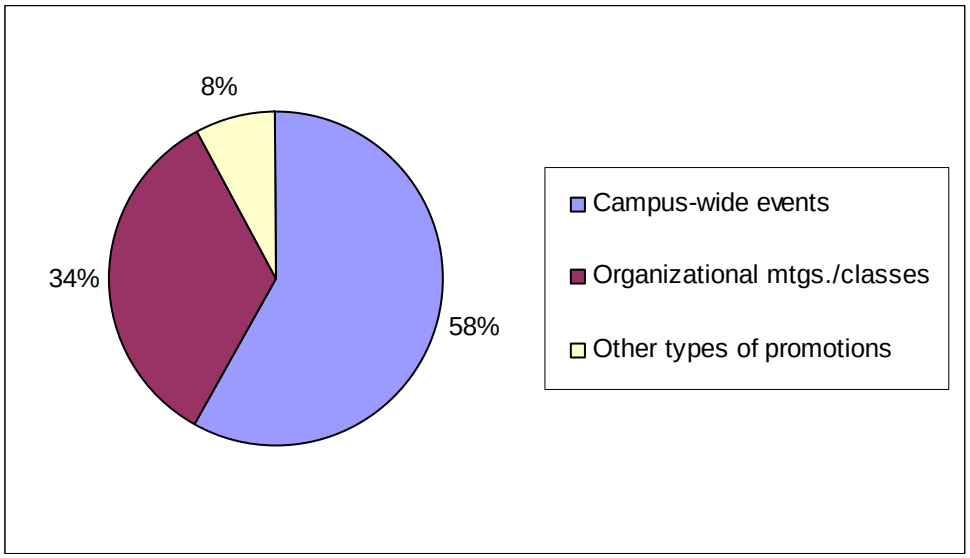
Figure 6. Type of earned media messages promoting campus policy compliance in Q1 and Q2 (n=37)



D.2.c. Quitline Promotion

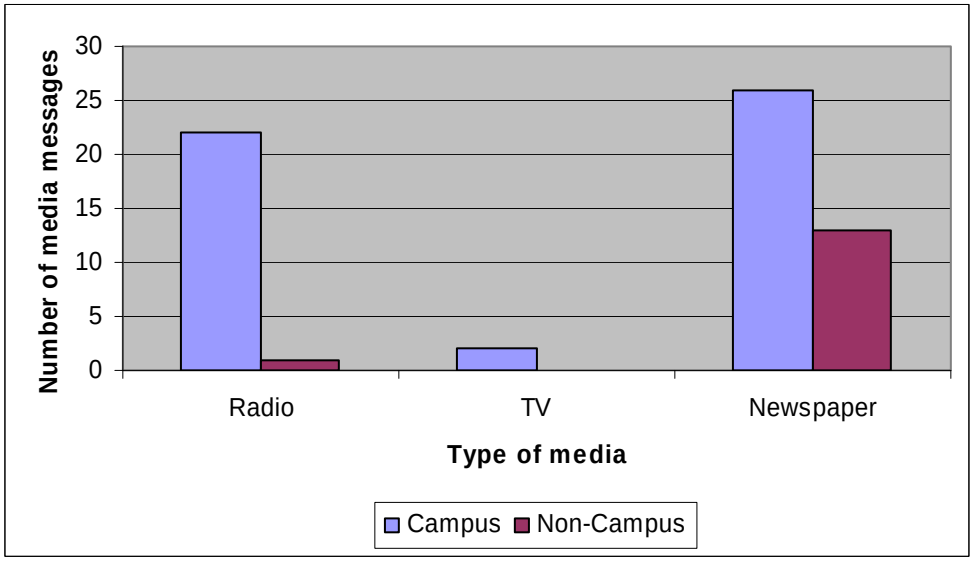
All 15 grantees conducted a total of 165 QuitlineNC promotions during Q1 and Q2 including campus-wide events, organizations meetings/classes, and other types of promotions (e.g., bulletin boards) (Figure 7). Nineteen percent of all promotions specifically targeted a priority population on campus (e.g., freshmen, athletes, fraternity/sorority members). Eight grantees also reported 22 meetings with campus-based health providers to promote the QuitlineNC fax referral service. Seven grantees reported 22 meetings to promote 5As and other related cessation services.

Figure 7. Type of QuitlineNC promotions in Q1 and Q2 (n=165)



Nine grantees reported 51 earned media messages and 13 paid media messages to promote QuitlineNC in Q1 and Q2. Just over 60% of the messages were published in newspapers (Figure 8). Most (78%) were published/aired via campus-based media outlets (e.g., campus newspaper).

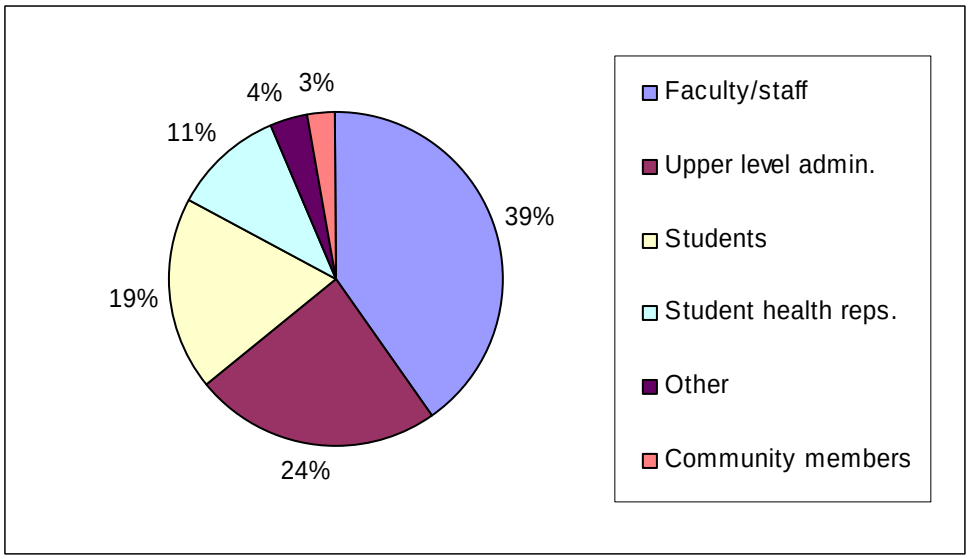
Figure 8. Type of earned and paid media messages promoting QuitlineNC in Q1 and Q2 (n=64)



D.2.d. Coalition Development

Thirteen grantees (87%) recruited 186 new coalition members during Q1 and Q2. The majority (63%) of new coalition members were upper level administrators, faculty, or staff. The proportion of new coalition members who are students declined from 65% in year two of Phase I to 19% in Q1 and Q2 of Phase II. Ten percent (19) of all new members represented priority population groups on campus (e.g., freshman, African Americans, Greek students, athletes).

Figure 9. Type of new coalition members recruited in Q1 and Q2 (n=186)



D.2.b. Summary of Program Indicators

The following table summarizes all program indicators changes reported by grantees in Q1 and Q2 (Table 3).

Table 3: Summary of Phase II Q1 and Q2 Program Indicator Changes

Program Indicator	# of grantees involved (n=15)*	Total Q1 indicator changes	Total Q2 indicator changes	Total Q1+Q2 indicator changes
Building Support for Policy Adoption				
# of petition drives completed to show support for campus policy adoption	4 (27%)	3	11	**14**
# of meetings/presentations to advance tobacco-related campus policy adoption	14 (93%)	108	76	**184**
# of earned newspaper/radio/TV messages promoting support for policy adoption	7 (47%)	33	12	**45**
# of paid newspaper/radio/TV messages promoting support for policy adoption	0	0	0	**0**
Building Support for Policy Compliance				
# of meetings/presentations to promote tobacco-related campus policy compliance	12 (80%)	53	73	**126**
# of earned newspaper/radio/TV messages promoting support for policy compliance	11 (73%)	27	10	**37**
# of paid newspaper/radio/TV messages promoting support for policy compliance	1 (7%)	0	10	**10**
Quitline Promotion				
# of Quitline promotions	15 (100%)	76	89	**165**
# of earned newspaper/radio/TV messages promoting Quitline	11 (73%)	25	26	**51**
# of paid newspaper/radio/TV messages promoting Quitline	3 (20%)	2	11	**13**
# of meetings/pres. to promote Quitline fax referral system among health providers	8 (53%)	7	15	**22**
# of meetings/pres to promote 5As/cessation services among health providers	7 (47%)	5	17	**22**
Coalition Development				
# of new coalition members recruited	13 (87%)	141	45	**186**
# of trainings attended by staff/partners	13 (87%)	26	32	**58**
# of surveys completed to assess student tobacco use and attitudes	10 (67%)	6	14	**20**

Administrative Measures				
# of new staff hired with grant funds	9 (60%)	9	3	**12**
# of meetings with elected state/government leaders to promote HWTF and tobacco-free campus initiatives	3 (20%)	4	6	**10**

* Includes data from Phase I special contract (ESCU)

D.3. Barriers

All grantees are asked to report their top three barriers to effective program implementation each month. Table 4 summarizes the number of grantees who reported a particular type of barrier in Q1 and Q2

Table 4: Summary of Q1 and Q2 Barriers

Q1: January – March 2008	Q2: April – June 2008
9 (60%) reported difficulty scheduling meetings/events or establishing campus contact.	12 (80%) reported difficulty because of end of classes and summer vacation limited meetings and student participation.
8 (53%) reported resistance to policy adoption and/or compliance on campus (e.g., students not remaining in designated smoking areas, disagreement on need for signage, committee voting against policy change as an issue of individual rights).	7 (47%) reported issues related to administrative or approval processes (e.g., delays in finalizing grant contract, budget and Annual Action Plan revisions, media approvals).
7 (47%) reported issues related to administrative or approval processes (e.g., delays in finalizing grant contract, budget and Annual Action Plan revisions, media approvals).	7 (47%) reported that tobacco use prevention/policies are not viewed as a priority on campus (e.g., policy adoption not on people's "agendas") or interim administrators delayed decisions until new leadership arrives.
7 (47%) reported challenges hiring and/or training new staff.	3 (20%) reported difficulties because other policies conflicted with desired policies or had reduced interest in additional policy change;
4 (27%) reported low attendance at trainings and/or coalition meetings.	3 (20%) reported difficulty scheduling meetings/events or establishing campus contact.
3 (20%) reported that tobacco use prevention/policies are not viewed as a priority on campus (e.g., policy adoption not on people's "agendas").	2 (13%) reported challenges hiring and/or training new staff.
5 (33%) reported some other type of barrier (e.g., lack of student interest in cessation resources (2), challenges recruiting coalition members (2), difficulty getting phone line/office set up, requests for tobacco education presentation for younger age groups).	4 (27%) reported other barriers including campus problems with litter (1), overspecialization of trainers for tobacco interventions among athletes (1), difficulty receiving baseline data from schools in multi-campus grants (1), and a lack of media outlets on small campuses (1).

E. Appendix 1: List of Phase II Tobacco-Free Colleges Initiative grantees

GRANTEE	COLLEGE	COUNTY (campus locations)	COUNTY (populations served) Community Colleges Only
Alamance Community College	Alamance Community College	Alamance	Alamance
Appalachian State University	Appalachian State University	Watauga	
East Carolina University	East Carolina University	Pitt	
First Health of the Carolinas	Montgomery County Community College	Montgomery	Montgomery
	Richmond County Community College	Richmond	Richmond (home county), Scotland
	Sandhills Community College	Moore	Moore (home county), Hoke
Guilford County Department of Public Health	Bennett College Greensboro College Guilford College Highpoint University John Wesley College Salem College	Guilford	
	Guilford Technical Community College	Guilford	Guilford
	UNC-Greensboro	Guilford, Cabarrus	
	ECPI College of Technology	Guilford, Cabarrus, Wake, Mecklenburg	
	Forsyth Technical Community College	Forsyth	Forsyth (home county), Guilford, Stokes
	Carolina Christian College NC School of the Arts Wake Forest University Winston-Salem State University	Forsyth	
	Rockingham Community College	Rockingham	Rockingham (home county)
	Elon University	Alamance	

GRANTEE	COLLEGE	COUNTY (campus locations)	COUNTY (populations served) Community Colleges Only
Guilford County Department of Public Health: **Technical Assistance Only**	North Carolina A & T University	Guilford	
	Davidson County Community College	Davidson, Davie	Davidson (home county), Davie
	Alamance Community College	Alamance	Alamance
Mecklenburg County Department of Public Health	Belmont Abbey College Davidson College Johnson and Wales University Kings College Queens University UNC-Charlotte	Mecklenburg	
	Barber-Scotia College	Cabarrus	
	Catawba Valley Community College	Catawba, Alexander	Catawba (home county), Alexander
	Catawba College Livingstone College	Rowan	
	Gardner-Webb University	Cleveland	
	Gaston College	Gaston, Lincoln	
	Mitchell Community College	Iredell	Iredell
	South Piedmont Community College	Union, Anson	Jointly chartered to Union & Anson
	Western Carolina University	Jackson	
	Wingate University	Union	
	Stanly Community College	Stanly	Stanly
	Cleveland Community College	Cleveland	Cleveland
Montreat College	Montreat College	Buncombe, Mecklenburg	

GRANTEE	COLLEGE	COUNTY (campus locations)	COUNTY (populations served) Community Colleges Only
Pitt Community College	Pitt Community College	Pitt	Pitt
Rowan-Cabarrus Community College	Rowan-Cabarrus Community College	Cabarrus, Rowan	Cabarrus, Rowan
Surry County Health and Nutrition Center	Surry Community College	Surry, Yadkin	Surry (home county), Yadkin
UNC-Pembroke	UNC-Pembroke	Robeson	
Wake Technical Community College	Wake Technical Community College	Wake	Wake
West Piedmont Community College	West Piedmont Community College	Burke	Burke
Wilkes Community College	Wilkes Community College	Wilkes, Ashe, Alleghany,	Wilkes (home county), Alleghany, Ashe

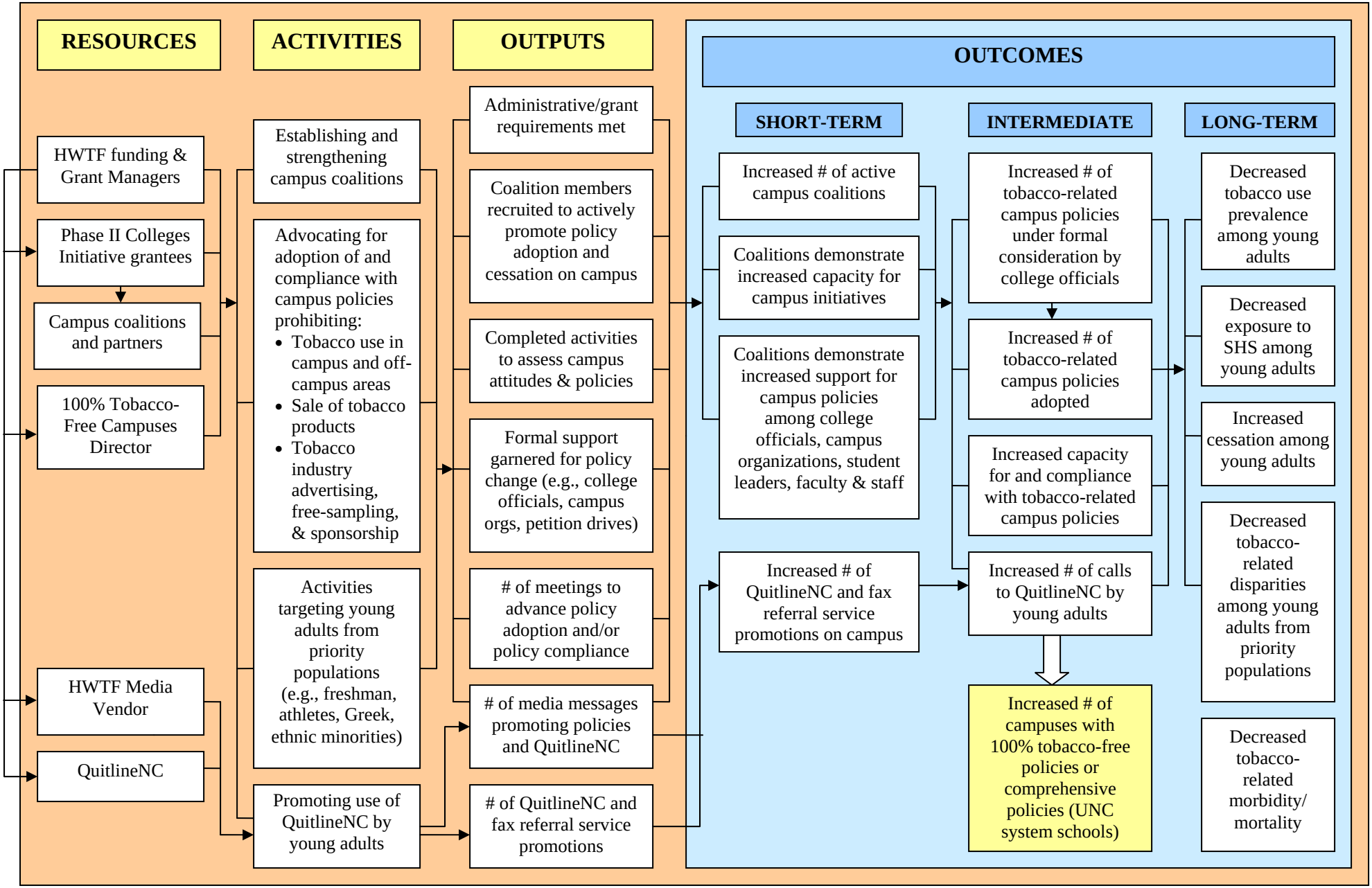
Appendix 2: Monthly Program and Outcome Indicators

CORES Monthly Report Indicators HWTF Tobacco-Free Colleges Initiative (Phase II)
1. Building Support For Policy Adoption
# of petition drives completed to show support for campus policy adoption
# of signatures on petitions showing support for campus policy adoption
# of meetings/presentations to advance tobacco-related campus policy adoption • Meetings/presentations to obtain support for coalition activities • Meetings with officials to advocate for policy adoption • Class presentations to promote policy adoption • Meetings to develop media promoting policy adoption
# of earned newspaper/radio/TV messages promoting support for campus policy adoption • Earned messages from campus-based media outlets • Earned messages from non-campus based media outlets
# of paid newspaper/radio/TV messages promoting support for campus policy adoption • Paid messages from campus-based media outlets • Paid messages from non-campus based media outlets
# of college officials offering formal support for campus policy adoption • Written and verbal support • Verbal support only
# of organizations offering formal support for campus policy adoption • Written and verbal support • Verbal support only
# of staff/faculty/student leaders offering formal support for campus policy adoption • Written and verbal support • Verbal support only
# of policy changes under formal consideration by college officials
2. Building Support For Policy Compliance
# of meetings/presentations to promote tobacco-related campus policy compliance • Meetings with officials to advocate for policy compliance • Class presentations to promote policy compliance • Meetings to develop media promoting policy compliance
# of earned newspaper/radio/TV messages promoting support for policy compliance • Earned messages from campus-based media outlets • Earned messages from non-campus based media outlets
# of paid newspaper/radio/TV messages promoting support for policy compliance • Paid messages from campus-based media outlets • Paid messages from non-campus based media outlets

3. Policy Adoption
# of tobacco-free policies adopted by campus organizations • **Tobacco-free policies adopted by campus organizations representing priority populations**
# of tobacco-free policies adopted in campus areas
# of tobacco-free policies adopted in off-campus areas 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
4. Quitline Promotion
# of Quitline promotions • Campus-wide events • Presentations at organizational meetings, classes, or events • Other types of promotional activities • Quitline promotions targeting priority populations
# of earned newspaper/radio/TV messages promoting Quitline • Earned messages from campus-based media outlets • Earned messages from non-campus based media outlets • Earned Quitline media messages targeting priority populations
# of paid newspaper/radio/TV messages promoting Quitline • Paid messages from campus-based media outlets • Paid messages from non-campus based media outlets • Paid Quitline media messages targeting priority populations
# of meetings/presentations to promote Quitline fax referral system among health services providers
# of meetings/presentations to promote 5As and related cessation services among health services providers
5. Coalition Development
# of new coalitions established
# of new coalition members recruited • Upper level administration, faculty, staff, community members, student health services representatives, students
# of trainings attended by staff/partners • Number of staff/partners attending one or more trainings
# of surveys completed to assess student tobacco use and attitudes
6. Administrative Measures
# of new staff hired with grant funds
# of meetings with elected state/government leaders to promote HWTF and tobacco-free campus initiatives • Meetings with elected local representatives • Meetings with elected state representatives

Bolded indicators are outcome-oriented. Non-bolded indicators are program-oriented.

Appendix 3: Logic Model for Phase II Tobacco-Free Colleges Initiative Grants



North Carolina Tobacco Use Quit Line Evaluation Report Year 03

Clinical & Behavioral Sciences Department

June 30, 2008

Table of Contents

Acknowledgements

The implementation evaluation and development of this Year 3 report involved complex coordination of efforts and could not have been accomplished without the collaboration and generous assistance of several individuals. In addition, we would like to acknowledge all staff who provided registration and tobacco treatment services to callers to the North Carolina Tobacco Use Quit Line, and the survey staff who assisted with data collection for the evaluation.

The following staff members are responsible for the implementation and execution of the survey, as well as the content of this report:

Patricia L Yepassis-Zembrou, MD, MPH, Senior Program Evaluator

Lisa Mahoney, MPH, Senior Data Analyst

Anne Perez-Cromwell, BASW, Senior Project Manager

Maja Hansen, BA, Senior Client Services Manager

Sara Smucker Barnwell, PhD, Associate Director of Evaluation

Susan M Zbikowski, PhD, Vice President Clinical and Behavioral Sciences

For additional copies of this report, please contact:

Maja Hansen

Free & Clear, Inc.

999 3rd Ave, Suite 2100

Seattle, Washington 98104

Telephone: 206.876.2247

Fax: 206.876.2101

Email: Maja.Hansen@freeclear.com

A. Executive Summary

Overview and Purpose

The North Carolina Tobacco Use Quit Line (NCQL) is a free statewide phone-based tobacco treatment program that became operational on November 1, 2005. The NCQL is now in its third year of operation. The NCQL offers a Quit Line call (one-call program) or a multi-call program with up to three intensive proactive follow-up calls. The one-call program consists of any or all of the following services: a single phone counseling session with a Quit Coach®, referrals to community resources, written educational material, and information on potential services offered through the callers' insurance. The multi-call program is an intensive proactive treatment that provides up to 3 follow-up calls in addition to the services provided with the initial Quit Line call. In addition to the phone counseling, the NCQL implemented the Web Coach™ program in April of 2007. Web Coach is Free & Clear, Inc.'s integrated phone and Web tobacco cessation program. Through Web Coach, participants can access online tools and exercises, receive tailored emails, access an extensive library of resources, and get support online from thousands of tobacco users using the program to quit. 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 three distinct parties. The North Carolina Health & Wellness Trust Fund (HWTF) funds provided services to youth (17 and younger), college-age youth (18-24), and adults (25 and older) who are the primary caregiver to a youth living in their home or who are employed in a K-12 school system or childcare facility. The North Carolina Tobacco Prevention & Control Branch (TPCB) funds provided services 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 of NC) also made a sizeable donation to the NCQL with the understanding that their members will receive tobacco cessation services through the NCQL, and that those members would be included in the outcome evaluation.

The state of North Carolina contracted with Free & Clear, Inc. (Free & Clear®) to conduct an evaluation of the Quit Line's third year of operation. A survey was conducted to measure satisfaction and tobacco related behaviors at 7 months post-registration in compliance with the North American Quit Line Consortium (NAQC) Minimal Data Set (MDS) requirements. Free & Clear survey staff administered the survey by telephone to 1000 participants. Participants who refused to complete the standard survey were invited to complete a shorter survey consisting of three key questions regarding their satisfaction and tobacco use. The purpose of this report is to summarize the results of the evaluation for Year 3 of the NCQL, fiscal year July 1, 2007 – June 30, 2008.

Results

Free & Clear attempted to survey 1000 individuals who called the NCQL between April 1, 2007 and October 31, 2007 and obtained 392 completed surveys; resulting in a survey completion rate of 39.2%.

Type of Survey Completed

- 392 participants participated in the outcomes evaluation
  - 342 (87.2%) completed the long survey comprised of the full questions in the instrument
  - 50 (12.8%) completed the short survey comprised of only three key questions

Respondents' Characteristics Reported at Enrollment or Assessment with the NCQL

- Respondents were 14 to 85 years of age (mean=42.8 ± 16.1)
- 58.4% were female
- 1.5% were Hispanic, 66.8% were White, 26.3% were Black or African American, 1.5% were Native American
- 58.2% reported education beyond high school
- 24.3% had no health insurance

- 26.0% received the one-call program, and 74.0% enrolled in the multi-call program
- 5.0% were enrolled through fax referral by their healthcare providers
- 39.5% were in the HWTF group, and 60.5% were in the TPCB group
- Participants were highly dependent upon tobacco: 60.1% had used tobacco for 20 or more years, 56.6% smoked 15 or more cigarettes per day, and 38.9% reported their first tobacco use of the day was within 5 minutes after waking up

Satisfaction with the NCQL

- 91.9% of respondents reported that, overall, they were satisfied with the NCQL: 94.3% for HWTF, 90.2% for TPCB, and 88.3% of BCBS of NC.
- 89.9% reported that the Quit Line met their expectations
- Participants who completed 3 or more calls were significantly more satisfied than those who completed less than 3 calls; 96.4% and 89.7% respectively.
- Participants who enrolled in the multi-call program (93.5%) were more likely to be satisfied than those enrolled in the one-call program (86.6%).

Quit Attempts and Abstinence Rates

- Among respondents making a serious quit attempt, 89.7% reported that their attempt lasted 24 hours or longer.
- 32.9% of respondents had not used tobacco in the last seven days: 36.8% of HWTF, 30.9% of TPCB, and 29.1% of BCBS of NC.
- 28.6% of respondents had not used tobacco for 30 days or more: 33.5% of HWTF, 25.3% of TPCB, 23.3% of BCBS of NC.
- 53.9% of the current smokers at 7 months reduced the amount of cigarettes smoked (per day) compared to the amount reported at enrollment, and they reduced the amount of cigarettes by an average of almost 12 cigarettes.
- Participants who completed 3 or more calls were significantly more likely to quit than those who completed less than 3 calls; 7-day responder quit rates were 42.9% and 28.6%, respectively.
- Participants who enrolled in the multi-call program reported higher 7-day responder quit rates (35.2%) than those enrolled in the one-call program (26.5%), but the difference was marginally significant (p=0.1). However, the 7-day intent-to-treat quit rates were significantly different.

Summary

Overall, findings indicate that the NCQL effectively provides tobacco treatment services to a wide array of North Carolina residents who seek assistance in quitting tobacco. Nearly 92% of callers were satisfied with NCQL services, and the vast majority of callers (89.9%) reported that NCQL met their expectations.

Nearly one-third of survey respondents were quit (32.9% for 7 days or more, and 28.6% were quit for 30 days or more). A little over half (53.9%) of the current smokers reduced the amount smoked compared to the initial amount reported at enrollment in the NCQL.

Program outcomes did not differ significantly by the population of interest. Participants funded by the HWTF had higher satisfaction rates and higher responder quit rates than TPCB. Satisfaction varied as a function of treatment intensity; multi-call program participants were more likely to report being satisfied than the one-call program participants. Multi-call participants also reported higher quit rates overall. The satisfaction and quit rates were associated with call completion rates. That is, participants who completed 3 or more calls were more likely to report higher satisfaction and quit rates compared to those who completed less than 3 calls. BCBS of NC respondents reported high satisfaction with the services received and nearly 30% were quit for 7 days or more. Among current tobacco users, over half reduced their tobacco consumption.

Relative to the previous year's evaluation, the survey response rate for the NCQL is lower this year (39.2% vs. 46.6%). Over half of the survey sample could not be surveyed due to invalid phone number or the number of attempts to reach the participant was exhausted.

Given the results of this year's evaluation, Free & Clear offers several recommendations to continue to grow and develop NCQL services. Increased outreach to young smokers, adult primary caregivers, and adult school employees could help expand the breadth of NCQL services. Continued support of provider education and the fax-referral program could also increase the numbers of referrals to NCQL. NCQL could benefit from providing NRT, which has been proven to be a cost-effective way to increase Quit Line usage and increase quit rates among Quit Line users.

B. Introduction

The North Carolina Tobacco Use Quit Line (NCQL) is a free statewide phone-based tobacco treatment program that 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.

NCQL services 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 as follows: callers in pre-contemplation or contemplation stage are mailed the Quit Guide 1, those in preparation are mailed the Quit Guide 2 and those who have 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 3 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 third report reviewing the comprehensive results of the outcome evaluation of the North Carolina Quit Line. The results are presented in seven sections to reflect the different populations of interest. 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 ages 0-17. The fourth section shows the survey results of the college-aged youth, ages 18-24. The fifth section shows the survey results of the adult caregivers or K-12 employees. 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 of NC).

C. Methodology

Methodology

Method: The Year 3 evaluation was designed to capture information regarding the five populations of interest to the state of North Carolina: 1) Youth (0-17), 2) College-aged Youth (18-24), 3) Adult School employees/Caregivers, 4) Adults not Employees/Caregivers, and 5) BCBS of NC members. In addition, NC sought to compare the program outcomes (satisfaction and quit rates) between its two main groups: the HWTF and TPCP populations. 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 50% response rate to the survey. We aimed to survey 1000 NCQL callers (482 HTWF and 518 TPCB) to obtain 540 completed surveys (270 per group). We utilized a mixed procedure to select the survey sample. A census was used to select the youth aged 0-17. Simple random sampling stratified by month of registration into the Quit Line was performed to select the remaining populations of interest: College-aged youth (18-24), Adult School Employees/Caregivers, Adults who were not School Employees or Caregivers, and BCBS of NC members. The entire sample size was then divided in 7 sub-samples of callers to allow monthly surveying over the evaluation period.

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, prank callers, or their call was for information only.

Participant and call information collected at the time of enrollment into the program, assessment data, and counseling call data were merged with the 7-month follow-up survey data for each sample participant. When assembling the survey sample, all possible attempts were made only to survey the respondent once, even if he or she contacted the NCQL more than one time. Efforts also were made to contact only one caller per household as people living in the same household might influence each other's responses.

For the sample, participants' characteristics collected at the time of program enrollment were extracted from the Free & Clear database and merged with the 7-month follow-up survey data. Enrollment data collected included participant demographics, tobacco history and tobacco use behaviors.

Survey Administration: The survey was administered by Free & Clear survey staff, composed of non-clinical staff specially trained to conduct research surveys. The independent survey 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 a participant refused to complete the survey instrument, they were invited to complete a shorter survey consisting of three key items pertaining to satisfaction and tobacco use. If the interviewer could not reach a caller after 11 attempts on various days and at various times, the survey was considered unanswered (i.e., located, unable to survey after 11 attempts).

The survey was administered by telephone between November 2, 2007 and May 31, 2008 to 1000 eligible callers who contacted the NCQL between April 1, 2007 and October 31, 2007 (see table C.1 below for the sampling specifications). The survey was conducted approximately 7 months after the callers registered for services. The purpose of the survey was to: 1) examine the characteristics of callers, 2) assess the callers' overall satisfaction with the services provided by the NCQL, 3) assess how many quit attempts the tobacco users made after receiving services from the NCQL, 4) determine the 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. A copy of the survey is included in the Appendix.

C.1 Survey Sampling Specifications

HWTF			TPCB	
Youth (0-17)	**Young Adult (18-42)**	**Adult (25+) Employee/ Caregiver**	**Adult (25+) NOT Employee/ Caregiver**	**BCBS of NC**
Census	Random by month of registration & Census of BCBS of NC Only	Random by month of registration & Census of BCBS of NC Only	Random by month of registration	Random by month of registration
Overall Sample				
Census = 83	Random = 199 Census BCBS of NC = 50	Random = 200 Census BCBS of NC = 49	Random = 419	Random = 99
HWTF Sub-Total N=482			**TPCB Sub-Total N=518**	
Grand Total N=1000				

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)
- Last tobacco use (last use, 7- and 30-day point prevalence)
- Current tobacco use frequency
- 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.

Statistical Analysis

Statistical Analysis: All analyses were conducted using SAS Version 9.1. This report provides a review of information regarding the entire survey sample, as well as separate, sub-reports regarding each of North Carolina's 5 populations of interest: 1) Youth (0-17), 2) College-Aged youth (18-24), 3) Adult School Employees/Caregivers, 4) Adult not Employees/Caregivers, 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.

Frequencies were generated for all survey sample characteristics, the survey sample disposition and survey responses. Univariate statistics were produced for continuous variables such as age, number of cigarettes smoked per day, and number of live calls completed. Chi square 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 3 calls, 3 calls and more). 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 at the time of the 7-month follow-up survey.

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. The intent-to-treat analysis assumed that survey non-respondents were continued tobacco users.

The overall satisfaction rate was defined as respondents being "somewhat" to "very" satisfied.

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 cigarettes per day), moderate smoker (15-20 cigarettes per day) and heavy smoker (more than 20 cigarettes per day).

We also calculated the reduction in the number of cigarettes smoked among those who used cigarettes. The amount smoked was calculated by subtracting the number of cigarettes smoked per day at initial contact with the NCQL and the number of cigarettes per day recorded at the 7-month follow-up survey. Tobacco reduction was reported in two ways: 1) by comparing the actual amount smoked with the baseline (fewer than baseline vs. as many or more than at baseline), and 2) by the mean number of cigarettes reduced.

Responses in the following categories were excluded from the respondents' analyses except the intent-to-treat analyses: "refused," "don't know," "not asked," "not collected," and "blank."

D. Results

D.1 Overall Results

Table D.1.1: Disposition of the Overall Sample for the North Carolina Evaluation

Disposition	N	%
Completed survey	392	39.2
Refused to participate in survey	58	5.8
Unable to locate caller (i.e., wrong or disconnected #)	255	25.5
Located; unable to survey after 11 attempts	274	27.4
Other (ill, deceased, incomplete survey)	21	2.1
Total	**1000**	**100.0**

The results of the survey call disposition are presented in Table D.1.1.

- We attempted to survey 1000 NCQL tobacco users, 392 completed the survey resulting in a survey response rate of 39.2%
- The majority of the callers (52.9%) could not be surveyed because they either had invalid phone numbers or could not be reached after 11 call attempts.

Table D.1.2: Characteristics of Survey Sample and Respondents (Source: Enrollment)

	Survey Sample		Survey Respondents	
	N=1000	%	N=392	%
Gender	**n=1000**		**n=392**	
Male	405	40.5	163	41.6
Female	595	59.5	229	58.4
Age at time of registration	**n=1000**		**n=392**	
Mean ± Standard Deviation	38.0 ± 15.9		42.8 ± 16.1	
Range	13 - 85		14 - 85	
Under 18 (0 -17)	83	8.3	19	4.8
18 – 24	208	20.8	61	15.6
25 – 40	261	26.1	83	21.2
41 – 60	360	36.0	176	44.9
> 60	88	8.8	53	13.5
Ethnicity	**n=994**		**n=388**	
Hispanic	25	2.5	6	1.5
Non-Hispanic	969	97.5	382	98.5
Race	**n=995**		**n=391**	
Native American	22	2.2	6	1.5
Asian	8	0.8	4	1.0
Black or African American	318	32.0	103	26.3
White	605	60.8	261	66.8
Other	42	4.2	17	4.3
Education	**n=712**		**n=313**	
Less than grade 9	28	3.9	7	2.2
Grade 9-11, no degree	97	13.6	35	11.2
GED	31	4.4	12	3.8
High school degree	184	25.8	77	24.6
Some College or University	218	30.6	96	30.7
College or University degree	154	21.6	86	27.5
Health insurance status	**n=907**		**n=366**	
Uninsured	270	29.8	89	24.3
Insured	637	70.2	277	75.7
Method of entry	**n=980**		**n=382**	
Phone Call	945	96.4	363	95.0
Fax Referral	35	3.6	19	5.0
Treatment intensity	**n=1000**		**n=392**	
One-Call	310	31.0	102	26.0
Multi-Call	690	69.0	290	74.0
Population of interest	**n=1000**		**n=392**	
HWTF	482	48.2	155	39.5
TPCB	518	51.8	237	60.5

Table D.1.2 presents the characteristics of the individuals we intended to survey and of those who responded to the survey.

- Gender distribution was comparable across the survey sample and the survey respondents; 58.4 to 59.5% were female
- Non-Hispanics, 41-60 years, White, insured, college or university degree, fax-referral, multi-callers, and TPCB sponsored groups responded to the survey in a greater proportion compared to their frequencies in the survey sample.

Table D.1.3: Additional Characteristics by Age of Survey Sample and Respondents (Source: Enrollment)

	Survey Sample		Survey Respondents	
	N=1000	%	N=392	%
Caller age 24 or less:	**n=291**		**n= 80**	
Currently in school				
Yes	289	99.3	79	98.8
No	2	0.7	1	1.3
Current grade level	**n=287**		**n= 79**	
Grade School	0	0.0	0	0.0
Middle School	38	13.2	5	6.3
High School	161	56.1	45	57.0
College	88	30.7	29	36.7
Currently working	**n=291**		**n= 80**	
Yes	162	55.7	47	58.8
No	129	44.3	33	41.3
Working full or part-time	**n=162**		**n= 47**	
Part-time	55	34.0	15	31.9
Full-time	107	66.0	32	68.1
Caller age 25 and older:				
Live with child under 18 as their primary caregiver	**n=659**		**n=295**	
Yes	190	28.8	73	24.7
No	469	71.2	222	75.3
Employed in a K-12 school or childcare facility	**n=649**		**n= 290**	
Yes	31	4.8	14	4.8
No	618	95.2	276	95.2
Last education level completed	**n=706**		**n=217**	
Less than grade 9	27	3.8	7	2.2
Grade 9-11, no degree	97	13.7	35	11.2
GED	31	4.4	12	3.9
High school degree	184	26.1	77	24.7
Some College or University	214	30.3	0	0.0
College or University degree	153	21.7	86	27.6

Table D.1.3 shows additional characteristics specific to the HWTF sponsored callers age 24 or less and callers age 25 and older.

- Overall, there was no variation between the survey sample and the respondents.
- Almost all callers age 24 or less were currently in school at the time they enrolled in the NCQL program and the majority was in High School.
- Over half of the callers age 24 or less reported working currently, either part- or full-time.
- Among callers age 25 and older, less than 30% lived with a child under 18 years of age and were their primary caregiver and less than 5% were K-12 school or childcare facility employees.

Table D.1.4: Tobacco History and Behaviors of Survey Respondents (Source: Enrollment)

	Survey Respondents	
	N= 392	%
Tobacco type reported at enrollment[1] (n=392)		
Cigarette	369	94.1
Cigar	18	4.6
Pipe	3	0.8
Smokeless tobacco (SLT)	24	6.1
Tobacco use frequency (n=371)		
Every day	330	88.9
Some days	16	4.3
Not at all	25	6.7
Cigarette use per day (cpd) (n= 390)		
Mean ± Standard Deviation	17.0 ± 12.5	
Range	0 - 60	
Smoking level (n=390)		
Light (0-14 cpd)	169	43.3
Moderate (15-20 cpd)	137	35.1
Heavy (21 + cpd)	84	21.5
Number of years used tobacco (n=298)		
Less than 1 year	4	1.3
1-5 years	32	10.7
6-19 years	83	27.9
20 + years	179	60.1
Dependence level (first tobacco use after waking) (n=373)		
5 minutes	145	38.9
6-30 minutes	111	29.8
31-60 minutes	52	13.9
More than 60 minutes	65	17.4

[1] Not mutually exclusive. Participants may have selected more than one.

Tobacco history and behaviors of the survey respondents collected at the time they enrolled in the North Carolina Tobacco Use Quit Line are portrayed in Table D.1.4.

- The vast majority of the survey respondents reported using cigarettes during the assessment call and 6.1% used smokeless tobacco.
- Daily used of cigarettes was high; 88.9% reported using cigarettes every day and reported using an average of 17 cigarettes a day.
- Tobacco addiction and dependence were prominent among the participants: 60.1% had used tobacco for 20 or more years, 38.9% smoked their first cigarettes within 5 minutes after waking up and 21.5% smoked more than 20 cigarettes a day.

Table D.1.5: Quit History and Motivation (Source: Assessment Call)

	Survey Respondents	
	N=392	%
Number of previous quit attempts (n=292)		
0	22	7.5
1	48	16.4
2-5	162	55.5
6+	60	20.5
Longest period of time tobacco-free (n=273)		
Less than 24 hours	28	10.3
24 hours-1 month	103	37.7
1- 6 months	62	22.7
More than 6 months	80	29.3
Reasons for quitting[1] (n=289)		
Health	270	93.4
Family	84	29.1
Finances	56	19.4
Socially unacceptable	25	8.7
Other	57	19.7
Smoke environment (n=391)		
No	165	42.2
Yes, both at home and work	226	57.8
Readiness to quit (stage of readiness) (n=390)		
Pre- or Contemplation	20	5.1
Preparation	319	81.8
Action	51	13.1
Maintenance	0	0.0
Motivation to quit (i.e., 1 = low, 10 = high) (n=250)		
1-5	15	6.0
6-8	99	39.6
9-10	136	54.4
Confidence in quitting (i.e., 1 = low, 10 = high) (n=209)		
1-5	49	23.4
6-8	84	40.2
9-10	76	36.4

[1] Not mutually exclusive. Participants may select more than one.

Table D.1.5 illustrates the quit history and motivation of respondents reported at the assessment call with the Quit Coach.

- Prior to enrolling in the NCQL, 55.4% of the callers made 2 to 5 attempts to quit tobacco. The main reason reported for seeking tobacco treatment at assessment was health (93.4%) followed by family (29.1%).
- The majority (57.8%) indicated they had other tobacco users both at home and work.
- A large proportion of survey respondents (81.8%) were in the preparation stage at the time of enrollment and 13.1% had just quit and wanted support to stay quit.
- A little over half of the respondents reported high motivation to quit tobacco, but the confidence in quitting was lower; only 36.4% reported a high level of confidence.

Table D.1.6: Key Program Components (Source: Intervention Calls)

	Survey Respondents	
	N=392	**%**
Set a quit date (n=392)		
Yes	261	66.6
No	131	33.4
Material sent (i.e., "Quit Guides") (n=392)		
Yes	373	95.2
No	19	4.8
Average number of calls completed (n=392)		
Mean ± Standard Deviation	2.1 ± 2.2	
Range	0 - 33	
Total number of calls completed (n=358)		
1 call	152	42.5
2 calls	87	24.3
3 calls	61	17.0
4 calls or more	58	16.2
Call completion rate[1] (n=358)		
1 or more calls	358	91.3
2 or more calls	206	52.6
3 or more calls	119	30.4
4 or more calls	58	14.8

[1] Not mutually exclusive. Participants can be included in more than one category.

Table D.1.6 shows key components of the NCQL program.

- Most of the respondents (66.6%) set a quit date, a critical step toward quitting.
- 95.2% were sent the Quit Guide(s), which are the roadmap to successful quitting.
- The average call completed by the respondents was 2.1 calls; this included the scheduled and ad hoc calls.

Table D.1.7: Program Outcomes: Satisfaction and Quit Rates (Source: Follow-up Survey)

	N	%
Satisfaction rate (N=344)		
Satisfied	316	91.9
Not Satisfied	28	8.1
7-day point prevalence tobacco abstinence rates		
Respondent 7-day quit rate (N=392)	129	32.9
Intent-to-treat 7-day quit rate (N=1000)	129	12.9
30-day point prevalence tobacco abstinence rates		
Respondent 30-day quit rate (N=392)	112	28.6
Intent-to-treat 30-day quit rate (N=1000)	112	11.2

Tables D.1.7 through D.1.12 present the results of the seven-month follow-up survey. Table D.1.7 summarizes the program outcomes across all groups (i.e., HWTF, TPCB, BCBS of NC).

- 91.9% of the callers were satisfied overall with the services provided by the NCQL.
- 32.9% of the respondents were quit for 7 days or more and 28.6% were quit for 30 days or more.

Table D.1.8: Satisfaction (Source: Follow-up Survey)

	N=392	%
Overall satisfaction (n=344)		
Very satisfied	169	49.1
Mostly satisfied	93	27.0
Somewhat satisfied	54	15.7
Not at all satisfied	28	8.1
Did the program meet callers' expectations (n=307)		
Yes	276	89.9
No	31	10.1
Reasons expectations were met in themes (n=276)		
Felt supported by the Quit Coach	83	30.1
Having access to Quit Line when needed	19	6.9
Helped me quit smoking	11	4.0
Provided good ideas to help with quitting/cravings	63	22.8
Receiving calls and getting support	43	15.6
The materials and information on quitting were helpful	19	6.9
The medication and support were helpful	6	2.2
Other	32	11.6
Reasons expectations were not met in themes (n=31)		
Did not get medication as expected	3	9.7
Didn't call me back	3	9.7
Information/support was not helpful	7	22.6
Never received calls	2	6.5
Not available when calling in	2	6.5
Not enough calls	9	29.0
Phone support was not a good fit for needs	2	6.5
Other	2	6.5
Don't know	1	3.2

- Close to 90% of the respondents reported that the NCQL met their expectations.
- Respondents who reported the Quit Line met their expectations stated that their top three reasons were that they felt supported by the Quit Coach, the Quit Coach provided good ideas to help with quitting/cravings, and receiving calls and getting support.
- Respondents who reported that the Quit Line did not meet their expectations stated that there were not enough calls, and the information or support was not helpful.

Table D.1.9: Respondents' Quit Attempts and Quit Status (Source: Follow-up Survey)

	N=392	%
Number of serious quit attempts lasting > 24 hours (n=301)		
0 time	38	12.6
1 time	81	26.9
2 times	78	25.9
3 times	51	16.9
4 or more	53	17.6
Longest time quit smoking on purpose (in days) (n=328)		
Mean ± Standard Deviation	55.7 ± 75.9	
Range	0 - 360	
Current smoking frequency (n=118)		
Every day	177	52.7
Some days	41	12.2
Not at all	118	35.1
When last used tobacco or smoked a cigarette even a puff (n=379)		
Within the last 24 hours	237	62.5
More than 24 hours ago, but less than 7 days	13	3.4
7 days but less than 1 month	17	4.5
1 month but less than 3 months	26	6.9
3 months but less than 6 months	38	10.0
6 months but less than 9 months	43	11.3
9 months but less than 12 months	4	1.1
12 months or longer	1	0.3

- Since calling the NCQL, 87.4% of the respondents had made at least one serious quit attempt that lasted more than 24 hours.
- The longest time they stayed quit was, on average, 55.7 days.
- 32.9% of respondents were quit at follow-up (i.e., for 7 days or more). Of those who quit, 67% were quit for 3 months or more.

Table D.1.10: Respondents - Current Tobacco Users: Tobacco Behaviors and Reduction (Source: Follow-up Survey)

	N=267	%
Tobacco type used in the last 30 days[1] (n=266)		
Cigarette	236	88.7
Cigar	22	8.3
Pipe	21	7.9
Smokeless tobacco (SLT)	30	11.3
Amount of cigarette used per day (n=207)		
Mean ± Standard Deviation	14.0 ± 8.3	
Range	0 - 40	
Dependence level (first tobacco use after waking) (n=219)		
Within 5 minutes	59	26.9
6-30 minutes	62	28.3
31-60 minutes	37	16.9
> 61 minutes	61	27.9
Already quit	0	0.0
Tobacco use reduction (n=206)		
As many or more than baseline	95	46.1
Less than baseline	111	53.9
Tobacco mean reduction (only for those who reduced tobacco use) (n=111)		
Mean ± Standard Deviation	11.5 ± 9.1	
Range	1 - 50	
Intentions regarding tobacco use at this time (n=222)		
Planning to quit in the next 30 days	94	42.3
Planning to quit in the next 6 months	62	27.9
Planning to quit sometime in the future but not in the next 6 mos.	31	14.0
Not planning to quit or cut down	5	2.3
Have quit	16	7.2
Other	14	6.3

[1] Not mutually exclusive. Participants can select more than one tobacco type.

- 53.9% 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, the average number of cigarettes was reduced by nearly 12.

Table D.1.11: Respondents' Use of Other Resources to Help Quit and Intentions toward Tobacco Use (Source: Follow-up Survey)

	N=336	%
Use other resources (n=336)		
Yes	180	53.6
No	156	46.4
Use medication (n=180)		
Yes	154	85.6
No	26	14.4
Kind of treatments or health professionals[1] (n=180)		
Medication:		
Zyban/Bupropion	8	4.4
NRT patches	58	32.2
NRT gum	40	22.2
NRT lozenges	8	4.4
Chantix (Varenicline)	62	34.4
Other medications	3	1.7
Advice from:		
Physician	32	17.8
Pharmacist	0	0.0
Nurse	0	0.0
Group cessation program	1	0.6
Self-help materials	9	5.0
Other	19	10.6

[1] Not mutually exclusive. Participants can select more than one.

- Since calling the NCQL 7 months ago, 53.6% of the respondents reported use of other resources to help them quit besides the NCQL.
- Of those who used other resources, 55.6% reported using medications and 17.8% reported advice from the physician.
- Medications were reported as the main resources the respondents used besides the Quit Line: 34.4% used Chantix, 32.2% used NRT patch and 22.2% used NRT gum. Only 4.4% used Zyban.

Table D.1.12A: Seven-Day Quit Rates by Key Variables of Interest (Source: Follow-up Survey)

Key Variables of Interest	Seven-day Quit Rates					
	Responder Quit Rate			Intent-To-Treat Quit Rate		
	N	Rate	p-value	N	Rate	p-value
Population of interest (n=392; ITT n=1000)						
TPCB (Responder n=237; ITT n=482)	72	30.4	0.19	72	13.9	0.3
HWTF (Responder n=155; ITT n=518)	57	36.8		57	11.8	
Health insurance (n=366; ITT n=907)						
Insured (Responder n=227; ITT n=637)	87	31.4	0.7	87	13.7	0.093
Uninsured (Responder n=89; ITT n=270)	26	29.2		26	9.6	
Treatment intensity (n=392; ITT n=1000)						
One-call (Responder n=102; ITT n=310)	27	26.5	0.11	27	8.7	0.0081
Multi-call (Responder n=290; ITT n=690)	102	35.2		102	14.8	
Live call completion (n=392; ITT n=1000)						
Less than 3 calls (Responder n=119; ITT n=792)	78	28.6	0.006	78	9.9	<0.001
3 calls and more (Responder n=273; ITT n=208)	51	42.9		51	24.5	

- HWTF respondents were more likely, but not significantly, to report being quit for 7 days or more than TPCB respondents. The seven-day respondent quit rates were 36.8% for HWTF and 30.4% for TPCB.
- 31.4% of the insured respondents were quit for 7 days or more compared to 29.2% of the uninsured respondents. The difference was not significant for the respondent 7-day quit rates. The difference in the intent-to-treat quit rates was marginally significant; 13.7% for the insured group and 9.6% for the uninsured group.
- 35.2% of respondents enrolled in the multi-call program reported being quit for 7 days or more compared to 26.5% who enrolled in the one-call program. The difference was not significant. However, the intent-to-treat quit rates were significantly different; 14.8% for multi-call and 8.7% for one-call.
- Respondents completing 3 calls or more were significantly more likely to quit than those who completed less than 3 calls. 7-day responder quit rates were 42.9% for respondents completing 3 calls or more and 28.6% for those completing the less than 3 calls.

Table D.1.12B: Thirty-Day Quit Rates by Key Variables of Interest (Source: Follow-up Survey)

Key Variables of Interest	Thirty-day Quit Rates					
	Responder Quit Rate			Intent-To-Treat Quit Rate		
	N	Rate	p-value	N	Rate	p-value
Population of interest (n=392; ITT n=1000)						
TPCB (Responder n=237; ITT n=482)	60	25.3	0.0777	60	11.6	0.6905
HWTF (Responder n=155; ITT Nn518)	52	33.6		52	10.8	
Health insurance (n=366; ITT n=907)						
Insured (Responder n=227; ITT n=637)	72	26.0	0.8559	72	11.3	0.2799
Uninsured (Responder n=89; ITT n=270)	24	27.0		24	8.9	
Treatment intensity (n=392; ITT n=1000)						
One-call (Responder n=102; ITT n=310)	25	24.5	0.2911	25	8.1	0.0351
Multi-call (Responder n=290; ITT n=690)	87	30.0		87	12.6	
Live call completion (n=392; ITT n=1000)						
Less than 3 calls (Responder n=119; ITT n=792)	68	24.9	0.015	68	8.6	<.0001
3 calls and more (Responder n=273; ITT n=208)	44	37.0		44	21.2	

- The 30-day respondent quit rates were 25.3% for TPCB compared to 33.6% for HWTF. The difference was marginally significant.
- 24.5% of those who enrolled in the one-call program reported being quit for 30 days or more compared to 30.0% who enrolled in the multi-call program. The difference was not significant. The intent-to-treat quit rates differed significantly between the treatment groups.
- 26.0% of the insured respondents were quit for 30 days or more compared to 27.0% of the uninsured.
- 30-day responder quit rates were significantly higher among participants who completed 3 calls or more than those who completed less than 3 calls; quit rates were 37.0% and 24.9%, respectively.

Table D.1.12C: Respondents' Satisfaction Rates by Key Variables of Interest (Source: Follow-up Survey)

Key Variables of Interest		Satisfaction Rates		
		N	Rate (% Satisfied)	p-value
Population of interest	**(n=344)**			
TPCB	(n=204)	184	90.2	0.173
HWTF	(n=140)	132	94.3	
Health insurance	**(n=320)**			
Insured	(n=242)	220	90.9	0.7038
Uninsured	(n=78)	72	92.3	
Live call completion	**(n=344)**			
Less than 3 calls	(n=234)	210	89.7	0.0362
3 calls and more	(n=110)	106	96.4	
Treatment intensity	**(n=344)**			
One-call	(n=82)	71	86.6	0.0453
Multiple-call	(n=262)	245	93.5	

- 94.3% of the HWTF reported being satisfied with the NCQL compared to 90.2% of TPCB.
- Participants enrolled in the multi-call program (93.5%) were more likely to be satisfied than those enrolled in the one-call program (86.6%).
- Participants completing 3 calls or more were significantly more satisfied than those with less than 3 calls; 96.4% versus 89.7%, respectively.

D.2: Health and Wellness Trust Fund Results

D.2 Health and Wellness Trust Fund Results

Table D.2.1: Disposition of Health and Wellness Trust Fund Participants

Disposition	N	%
Completed survey	**155**	**32.2**
Refused to participate in survey	31	6.4
Unable to locate caller (i.e., wrong or disconnected #)	152	31.5
Located; unable to survey after 11 attempts	137	28.4
Other (ill, deceased, incomplete survey)	7	1.5
Total	482	100.0

- The survey completion rate for the HWTF sponsored tobacco users was 32.2%.
- The majority of the individuals (59.9%) could not be surveyed due to invalid telephone numbers or inability to be reached after 11 call attempts.

Table D.2.2: Program Outcomes - Satisfaction and Quit Rates (Source: Follow-up Survey)

	N	%
Satisfaction rate (n=140)		
Satisfied	132	94.3
Not satisfied	8	5.7
7-day point prevalence tobacco abstinence rates		
Respondent 7-day quit rate (n=155)	57	36.8
Intent-to-treat 7-day quit rate (n=482)	57	11.8
30-day point prevalence tobacco abstinence rates		
Respondent 30-day quit rate (n=155)	52	33.5
Intent-to-treat 30-day quit rate (n=482)	52	10.8

- Overall satisfaction with the services provided by the NCQL was high among the HWTF sponsored participants; 94.3% were satisfied.
- 36.8% of the respondents reported being quit for 7 days or more and 33.5% were quit for 30 days or more.

Table D.2.3: Satisfaction (Source: Follow-up Survey)

	N=155	%
Overall satisfaction (n=140)		
Very satisfied	61	43.6
Mostly satisfied	39	27.9
Somewhat satisfied	32	22.9
Not at all satisfied	8	5.7
Did the program meet callers' expectations (n=122)		
Yes	109	89.3
No	13	10.7
Reasons expectations were met in themes (n=109)		
Felt supported by the Quit Coach	36	33.0
Having access to quitline when needed	4	3.7
Helped me quit smoking	4	3.7
Provided good ideas to help with quitting/cravings	28	25.7
Receiving calls and getting support	14	12.8
The materials and information on quitting were helpful	10	9.2
The medication and support were helpful	4	3.7
Other	9	8.3
Reasons expectations were not met in themes (n=13)		
Didn't call me back	2	15.4
Information/support was not helpful	4	30.8
Never received calls	1	7.7
Not enough calls	3	23.1
Phone support was not a good fit for needs	1	7.7
Other	1	7.7
Don't know	1	7.7

- 89.3% of the HWTF sponsored participants indicated that the NCQL met their expectations.
- The main reasons the NCQL met their expectations were that the participants felt supported by the Quit Coach and the Quit Coach provided good ideas to help them with quitting and cravings.
- Of the 13 who reported the NCQL did not meet their expectations, four participants indicated the information or support was not helpful.

Table D.2.4: Respondents' Quit Attempts and Quit Status (Source: Follow-up Survey)

	N=155	%
Number of serious quit attempts lasting > 24 hours (n=125)		
0 time	13	10.4
1 time	26	20.8
2 times	39	31.2
3 times	24	19.2
4 or more	23	18.4
Longest time quit smoking on purpose (in days) (n=130)		
Mean ± Standard Deviation	54.5 ± 74.7	
Range	0 – 360	
Current smoking frequency (n=132)		
Every day	67	50.8
Some days	15	11.4
Not at all	50	37.9
When last used tobacco or smoked a cigarette even a puff (n=150)		
Within the last 24 hours	86	57.3
More than 24 hours ago, but less than 7 days	7	4.7
7 days but less than 1 month	5	3.3
1 month but less than 3 months	14	9.3
3 months but less than 6 months	21	14.0
6 months but less than 9 months	16	10.7
9 months but less than 12 months	1	0.7
12 months or longer	0	0.0

- Since enrolling in the NCQL, 89.6% of HWTF participants had made at least one serious quit attempt that lasted more than 24 hours.
- The longest time they stayed quit was, on average, 54 days.
- 36.8% of respondents were quit at follow-up (i.e., for 7 days or more). Of those who quit, 66.7% were quit for 3 months or more.

Table D.2.5: Respondents - Current Tobacco Users: Tobacco Behaviors and Reduction (Source: Follow-up Survey)

	N=98	%
Tobacco type used in the last 30 days (n=98)		
Cigarette	85	86.7
Cigar	9	9.2
Pipe	3	9.2
Smokeless tobacco (SLT)	13	13.3
Amount of cigarette used per day (N=78)		
Mean ± Standard Deviation	13.3 ± 8.3	
Range	0 - 40	
Dependence level (first tobacco use after waking) (n=85)		
Within 5 minutes	26	30.6
6-30 minutes	23	27.1
31-60 minutes	16	18.8
> 61 minutes	20	23.5
Already quit	0	0.0
Tobacco use reduction (n=78)		
As many or more than baseline	38	48.7
Less than baseline	40	51.3
Tobacco mean reduction (only for those who reduced tobacco use) (N=40)		
Mean ± Standard Deviation	12.0 ± 9.4	
Range	1 – 50	
Intentions regarding tobacco use at this time (n=84)		
Planning to quit in the next 30 days	30	35.7
Planning to quit in the next 6 months	27	32.1
Planning to quit sometime in the future but not in the next 6 mos.	16	19.0
Not planning to quit or cut down	1	1.2
Have quit	6	7.1
Other	4	4.8

- 13.3% of the HWTF participants used smokeless tobacco.
- One half of the HWTF current smokers reduced their tobacco use compared to the amount they reported at enrollment.
- The average number of cigarettes they reduced by was 12; this was a reduction of a little over half a pack of cigarettes.

Table D.2.6: Respondents' Use of Other Resources to Help Quit and Intentions Toward Tobacco Use (Source: Follow-up Survey)

	N=134	%
Use other resources (n=134)		
Yes	63	47.0
No	71	53.0
Use medication (n=63)		
Yes	52	82.5
No	11	17.5
Kind of treatments or health professionals[1] (n=63)		
Medication:		
Zyban/Bupropion	2	3.2
NRT patches	22	34.9
NRT gum	18	28.6
NRT lozenges	3	4.8
Chantix (Varenicline)	15	23.8
Other medications	1	1.6
Advice from:		
Physician	10	15.9
Pharmacist	0	0.0
Nurse	0	0.0
Group cessation program	0	0.0
Self-help materials	6	6.4
Other	9	14.3

[1] Not mutually exclusive. Participants can select more than one.

- 47.0% of the HWTF participants used other resources besides the Quit Line to help them quit.
- Of those who used other resources, 61.9% used medications. The main tobacco cessation medications used were nicotine patch (34.9%), nicotine gum (28.6%), and Chantix (23.8%).
- 15.9% reported receiving advice from their physicians.

D.3 Youth's (0-17) Results

D.3 Youth's (0-17) Results

Table D.3.1: Disposition of Youth (0-17) Participants

Disposition	N	%
Completed survey	**19**	**22.9**
Refused to participate in survey	6	7.2
Unable to locate caller (i.e., wrong or disconnected #)	27	32.5
Located; unable to survey after 11 attempts	30	36.1
Other (ill, deceased, incomplete survey)	1	1.2
Total	**83**	**100.0**

- 83 Youth participants were sampled; only 19 (22.9%) completed the survey.
- 68.6% could not be surveyed due to invalid phone numbers or inability to be reached after 11 call attempts.
- Due to the small number of survey respondents in this group, cautious interpretation of the results is advised.

Table D.3.2: Program Outcomes: Satisfaction and Quit Rates (Source: Follow-up Survey)

	N	%
Satisfaction rate (n=17)		
Satisfied	17	100.0
Not satisfied	0	0.0
7-day point prevalence tobacco abstinence rates		
Respondent 7-day quit rate (n=19)	12	63.2
Intent-to-treat 7-day quit rate (n=83)	12	14.5
30-day point prevalence tobacco abstinence rates		
Respondent 30-day quit rate (n=19)	12	63.2
Intent-to-treat 30-day quit rate (n=83)	12	14.5

- All Youth participants were satisfied overall with the services provided by the NCQL.
- Of the 19 Youth who responded to the survey, 12 (63.3%) reported being quit for 7 days or more and 30 days or more. The intent-to-treat quit rates were 14.5% due to the high loss to follow-up.

Table D.3.3: Satisfaction (Source: Follow-up Survey)

	N=19	%
Overall satisfaction (n=17)		
Very satisfied	9	52.9
Mostly satisfied	6	35.3
Somewhat satisfied	2	11.8
Not at all satisfied	0	0.0
Did the program meet callers' expectations (n=14)		
Yes	14	100.0
No	0	0.0
Reasons expectations were met in themes (n=14)		
Felt supported by the Quit Coach	6	42.9
Having access to Quit Line when needed	1	7.1
Provided good ideas to help with quitting/cravings	5	35.7
Other	2	14.3
Reasons expectations were not met in themes		
None to report	N/A	N/A

- All Youth (0-17) participants reported that the NCQL met their expectations.
- The majority of Youth respondents felt supported by the Quit Coach and reported receiving good ideas to help them with the quitting and/or cravings.

Table D.3.4: Respondents' Quit Attempts and Quit Status (Source: Follow-up Survey)

	N=19	%
Number of serious quit attempts lasting > 24 hours (n=14)		
0 time		
1 time	4	28.6
2 times	4	28.6
3 times	5	35.7
4 or more	1	7.1
Longest time quit smoking on purpose (in days) (n=15)		
Mean ± Standard Deviation	52.1 ± 52.6	
Range	1 - 210	
Current smoking frequency (n=15)		
Every day	3	20.0
Some days	2	13.3
Not at all	10	66.7
When last used tobacco or smoked a cigarette even a puff (n=18)		
Within the last 24 hours	4	22.2
More than 24 hours ago, but less than 7 days	2	11.1
7 days but less than 1month	0	0.0
1 month but less than 3 months	5	27.8
3 months but less than 6 months	6	33.3
6 months but less than 9 months	1	5.6
9 months but less than 12 months	0	0.0
12 months or longer	0	0.0

- Since enrolling in the NCQL, all Youth (0-17) participants had made at least one serious quit attempt that lasted more than 24 hours.
- The average length they stayed quit was 52 days.
- 63.2% of respondents were quit at follow-up (i.e., for 7 days or more). Of those who quit, 50.0% were quit for 3 months or more.

Table D.3.5: Respondents - Current Tobacco Users: Tobacco Behaviors and Reduction (Source: Follow-up Survey)

	N=6	%
Tobacco type used in the last 30 days[1] (n=6)		
Cigarette	6	100.0
Cigar	0	0.0
Pipe	0	0.0
Smokeless tobacco (SLT)	0	0.0
Amount of cigarette used per day (n=5)		
Mean ± Standard Deviation	7.6 ± 8.1	
Range	0 - 20	
Dependence level (first tobacco use after waking) (n=5)		
Within 5 minutes	2	40.0
6-30 minutes	2	40.0
31-60 minutes	1	20.0
> 61 minutes	0	0.0
Already quit	0	0.0
Tobacco use reduction (n=5)		
As many or more than baseline	2	40.0
Less than baseline	3	60.0
Tobacco mean reduction (only for those who reduced tobacco use) (n=3)		
Mean ± Standard Deviation	3.0 ± 3.5	
Range	1 - 7	
Intentions regarding tobacco use at this time (n=4)		
Planning to quit in the next 30 days	3	75.0
Planning to quit in the next 6 months	0	0.0
Planning to quit sometime in the future but not in the next 6 months	1	25.0
Not planning to quit or cut down	0	0.0
You have quit	0	0.0
Other	0	0.0

[1] Not mutually exclusive. Participants can select more than one tobacco type.

- Of the Youth who reported that they are currently smoking, all used cigarettes in the last 30 days. None reported cigar, pipe or smokeless tobacco use.
- 3 out of 5 Youth respondents reduced their tobacco use compared to what they reported at registration. On average, they reduced by 3 cigarettes.

Table D.3.6: Respondents' Use of Other Resources to Help Quit and Intentions Toward Tobacco Use (Source: Follow-up Survey)

	N=16	%
Use other resources (n=16)		
Yes	7	43.8
No	9	56.3
Use medication (n=7)		
Yes	3	42.9
No	4	57.1
Kind of treatments or health professionals[1] (n=7)		
Medication:		
Zyban/Bupropion	0	0.0
NRT patches	2	28.6
NRT gum	1	14.3
NRT lozenges	0	0.0
Chantix (Varenicline)	0	0.0
Other medications	0	0.0
Advice from:		
Physician	0	0.0
Pharmacist	0	0.0
Nurse	0	0.0
Group cessation program	0	0.0
Self-help materials	1	14.3
Other	3	42.7

[1] Not mutually exclusive. Participants can select more than one.

- 43.8% of the Youth used other resources to help them quit.
- Of the 7 who used other resources, 3 reported using medications (nicotine patch or gum).

D.4 College-Aged Youth's (18-24) Results

D.4 College-Aged Youth's (18-24) Results

Table D.4.1: Disposition of College-Aged Youth (18-24) Participants

Disposition	N	%
Completed survey	**58**	**29.1**
Refused to participate in survey	10	5.0
Unable to locate caller (i.e., wrong or disconnected #)	73	36.7
Located; unable to survey after 11 attempts	56	28.1
Other (ill, deceased, incomplete survey)	2	1.0
Total	**199**	**100.0**

- 199 College-Aged Youth participants were sampled; 58 completed the survey resulting in a survey response of 29.1%.
- 64.8% could not be surveyed due to invalid phone numbers or inability to be reached after 11 call attempts.

Table D.4.2: Program Outcomes: Satisfaction and Quit Rates (Source: Follow-up Survey)

	N	%
Satisfaction rate (n=51)		
Satisfied	47	92.2
Not satisfied	4	7.8
7-day point prevalence tobacco abstinence rates		
Respondent 7-day quit rate (n=58)	18	31.0
Intent-to-treat 7-day quit rate (n=199)	18	9.0
30- day point prevalence tobacco abstinence rates		
Respondent 30-day quit rate (n=58)	15	25.9
Intent-to-treat 30-day quit rate (n=199)	15	7.5

- 92.2% of the College-Aged Youth participants were satisfied overall with the services provided by the NCQL.
- 31.0% of the respondents were quit for 7 days or more and 25.9% reported being quit for 30 days or more.

Table D.4.3: Satisfaction (Source: Follow-up Survey)

	N=58	%
Overall satisfaction (n=51)		
Very satisfied	22	43.1
Mostly satisfied	11	21.6
Somewhat satisfied	14	27.5
Not at all satisfied	4	7.8
Did the program meet callers' expectations (n=45)		
Yes	39	86.7
No	6	13.3
Reasons expectations were met in themes (n=39)		
Felt supported by the Quit Coach	11	28.2
Helped in getting ready to quit	2	5.1
Provided good ideas to help with quitting/cravings	12	30.8
Receiving calls and getting support	6	15.4
The materials and information on quitting were helpful	6	15.4
Other	2	5.1
Reasons expectations were not met in themes (n=6)		
Didn't call me back	2	33.3
Never received calls	1	16.7
Not enough calls	2	33.3
Don't know	1	16.7

- 86.7% of the College-Aged Youth participants reported that the NCQL met their expectations.
- Most of them felt supported by the Quit Coach and received good ideas to help them with quitting and craving.
- Of the 6 whose expectations were not met, the majority indicated there were not enough calls.

Table D.4.4: Respondents' Quit Attempts and Quit Status (Sources: Follow-up Survey)

	N=58	%
Number of serious quit attempts lasting > 24 hours (n=45)		
0 time	4	8.9
1 time	10	22.2
2 times	15	33.3
3 times	7	15.6
4 or more	9	20.0
Longest time quit smoking on purpose (in days) (n=48)		
Mean ± Standard Deviation	49.1 ± 77.9	
Range	0 - 360	
Current smoking frequency (n=48)		
Every day	27	56.3
Some days	4	8.3
Not at all	17	35.4
When last used tobacco or smoked a cigarette even a puff (n=56)		
Within the last 24 hours	34	60.71
More than 24 hours ago, but less than 7 days	4	7.14
7 days but less than 1month	3	5.36
1 month but less than 3 months	2	3.57
3 months but less than 6 months	6	10.71
6 months but less than 9 months	6	10.71
9 months but less than 12 months	1	1.79
12 months or longer	0	0.0

- Since enrolling in the NCQL, 91.1% of the College-Aged Youth participants had made at least one serious quit attempt that lasted more than 24 hours.
- The average time they stayed quit was 49 days.
- 31% of respondents were quit at follow-up (i.e., for 7 days or more). Of those who quit, 72.2% were quit for 3 months or more.

Table D.4.5: Respondents - Current Tobacco Users: Tobacco Behaviors and Reduction (Source: Follow-up Survey)

	N=41	%
Tobacco type used in the last 30 days[1] (n=41)		
Cigarette	33	80.5
Cigar	5	12.2
Pipe	6	14.6
Smokeless tobacco (SLT)	7	17.1
Amount of cigarette used per day (n=31)		
Mean ± Standard Deviation	13.1 ± 6.4	
Range	4 - 30	
Dependence level (first tobacco use after waking) (n=35)		
Within 5 minutes	9	25.7
6-30 minutes	8	22.9
31-60 minutes	6	17.1
> 61 minutes	12	34.3
Already quit	0	0.0
Tobacco use reduction (n=31)		
As many or more than baseline	15	48.4
Less than baseline	16	51.6
Tobacco mean reduction (only for those who reduced tobacco use) (n=16)		
Mean ± Standard deviation	11.7 ± 9.0	
Range	1 - 36	
Intentions regarding tobacco use at this time (n=36)		
Planning to quit in the next 30 days	10	27.8
Planning to quit in the next 6 months	11	30.6
Planning to quit sometime in the future but not in the next 6 months	8	22.2
Not planning to quit or cut down	1	2.8
You have quit	4	11.1
Other	2	5.6

[1] Not mutually exclusive. Participants can select more than one tobacco type.

- Of the College-Aged Youth who reported being current tobacco users at the follow-up, 17.1% used smokeless tobacco.
- A little over a half (51.6%) of the College-Aged Youth who reported that they are currently smoking reduced their tobacco use compared to the initial use reported at registration; the average cigarette reduction was by nearly 12 cigarettes.

Table D.4.6: Respondents' Use of Other Resources to Help Quit and Intentions Toward Tobacco Use (Source: Follow-up Survey)

	N=49	%
Use other resources (n=49)		
Yes	20	40.8
No	29	59.2
Use medication (n=20)		
Yes	15	75.0
No	5	25.0
Kind of treatments or health professionals[1] (n=20)		
Medication:		
Zyban/Bupropion	0	0.0
NRT patches	3	15.0
NRT gum	9	45.0
NRT lozenges	1	5.0
Chantix (Varenicline)	2	10.0
Other medications	0	0.0
Advice from:		
Physician	5	25.0
Pharmacist	0	0.0
Nurse	0	0.0
Group cessation program	0	0.0
Self-help materials	0	0.0
Other	2	10.0

[1] Not mutually exclusive. Participants can select more than one.

- 40.8% of the College-Aged Youth used other resources to help them quit.
- Of those who used other resources, 65.0% used medications; 3 reported using nicotine patches, 9 reported using nicotine gum, and 2 reported using Chantix.

D.5 Adult (25 and older) K-12 Employees/Caregivers' Results

D.5 Adult (25 and older) K-12 Employees/Caregivers' Results

Table D.5.1: Disposition of Adult (25 and older) K-12 Employees/Caregivers

Disposition	N	%
Completed survey	**78**	**39.0**
Refused to participate in survey	15	7.5
Unable to locate caller (i.e., wrong or disconnected #)	52	26.0
Located; unable to survey after 11 attempts	51	25.5
Other (ill, deceased, incomplete survey)	4	2.0
Total	**200**	**100.0**

- 200 Employee/Caregiver participants were sampled; 78 completed the survey resulting in a survey response of 39.0%.
- 51.5% could not be surveyed due to invalid phone numbers or inability to be reached after 11 call attempts.

Table D.5.2: Program Outcomes: Satisfaction and Quit Rates (Source: Follow-up Survey)

	N	%
Satisfaction rate (n=72)		
Satisfied	68	94.4
Not satisfied	4	5.6
7-day point prevalence tobacco abstinence rates		
Respondent 7-day quit rate (n=78)	27	34.6
Intent-to-treat 7-day quit rate (n=200)	27	13.5
30-day point prevalence tobacco abstinence rates		
Respondent 30-day quit rate (n=78)	25	32.1
Intent-to-treat 30-day quit rate (n=200)	25	12.5

- 94.4% of the Employee/Caregiver respondents were satisfied overall with the services provided by the NCQL.
- 34.6% of the respondents were quit for 7 days or more and 32.1% reported being quit for 30 days or more.

Table D.5.3: Satisfaction (Source: Follow-up Survey)

	N=72	%
Overall satisfaction (n=72)		
Very satisfied	30	41.7
Mostly satisfied	22	30.6
Somewhat satisfied	16	22.2
Not at all satisfied	4	5.6
Did the program meet callers' expectations (n=63)		
Yes	56	88.9
No	7	11.1
Reasons expectations were met in themes (n=56)		
Felt supported by the Quit Coach	19	33.9
Having access to Quit Line when needed	3	5.4
Helped me quit smoking	2	3.6
Provided good ideas to help with quitting/cravings	11	19.6
Receiving calls and getting support	8	14.3
The materials and information on quitting were helpful	5	8.9
The medication and support were helpful	3	5.4
Other	5	8.9
Reasons expectations were not met in themes (n=7)		
Information/support was not helpful	4	57.1
Not enough calls	1	14.3
Phone support was not a good fit for needs	1	14.3
Other	1	14.3

- 88.9% of the Employee/Caregiver participants reported that the NCQL met their expectations.
- The majority felt supported by the Quit Coach and reported receiving good ideas to help with quitting/craving.
- Those whose expectations were not met stated that the information or support was not helpful.

Table D.5.4: Respondents' Quit Attempts and Quit Status (Source: Follow-up Survey)

	N=78	%
Number of serious quit attempts lasting > 24 hours (n=66)		
0 time	9	13.6
1 time	12	18.2
2 times	20	30.3
3 times	12	18.2
4 or more	13	19.7
Longest time quit smoking on purpose (in days) (n=67)		
Mean ± Standard Deviation	59.0 ± 77.2	
Range	0 - 360	
Current smoking frequency (n=69)		
Every day	37	53.6
Some days	9	13.0
Not at all	23	33.3
When last used tobacco or smoked a cigarette even a puff (n=76)		
Within the last 24 hours	48	63.2
More than 24 hours ago, but less than 7 days	1	1.3
7 days but less than 1month	2	2.6
1 month but less than 3 months	7	9.2
3 months but less than 6 months	9	11.8
6 months but less than 9 months	9	11.8
9 months but less than 12 months	0	0.0
12 months or longer	0	0.0

- Since enrolling in the NCQL, 86.4% of the Employee/Caregiver participants had made at least one serious quit attempt that lasted more than 24 hours.
- The longest time they stayed quit was 59 days.
- 34.6% of respondents were quit at follow-up (i.e., for 7 days or more). Of those who quit, 66.7% were quit for 3 months or more.

Table D.5.5: Respondents - Current Tobacco Users: Tobacco Behaviors and Reduction (Source: Follow-up Survey)

	N=51	%
Tobacco type used in the last 30 days[1] (n=51)		
Cigarette	46	90.2
Cigar	4	7.8
Pipe	3	5.9
Smokeless tobacco (SLT)	6	11.8
Amount of cigarette used per day (n=42)		
Mean ± Standard Deviation	14.1 ± 9.4	
Range	3 - 40	
Addiction level (first tobacco use after waking) (n=45)		
Within 5 minutes	15	33.3
6-30 minutes	13	28.9
31-60 minutes	9	20.0
> 61 minutes	8	17.8
Already quit	0	0.0
Tobacco use reduction (n=42)		
As many or more than baseline	21	50.0
Less than baseline	21	50.0
Tobacco mean reduction (only for those who reduced tobacco use) (n=21)		
Mean ± Standard Deviation	13.6 ± 9.9	
Range	5 - 50	
Intentions regarding tobacco use at this time (n=44)		
Planning to quit in the next 30 days	17	38.6
Planning to quit in the next 6 months	16	36.4
Planning to quit sometime in the future but not in the next 6 months	7	15.9
Not planning to quit or cut down	0	0.0
You have quit	2	4.5
Other	2	4.5

[1] Not mutually exclusive. Participants can select more than one tobacco type.

- 11.8% of the Employee/Caregiver participants reported using smokeless tobacco at the follow-up survey.
- Half of the Employee/Caregiver participants reduced their tobacco use compared to the initial use reported at enrollment.
- The average cigarette reduction was by nearly 14.

Table D.5.6: Respondents' Use of Other Resources to Help Quit and Intentions Toward Tobacco Use (Source: Follow-up Survey)

	N=69	%
Use other resources (n=69)		
Yes	36	52.2
No	33	47.8
Use medication (n=36)		
Yes	34	94.4
No	2	5.6
Kind of treatments or health professionals[1] (n=36)		
Medication:		
Zyban/Bupropion	2	5.6
NRT patches	17	47.2
NRT gum	8	22.2
NRT lozenges	2	5.6
Chantix (Varenicline)	13	36.1
Other medications	1	2.8
Advice from:		
Physician	5	13.9
Pharmacist	0	0.0
Nurse	0	0.0
Group cessation program	0	0.0
Self-help materials	3	8.3
Other	4	11.1

[1] Not mutually exclusive. Participants can select more than one.

- 52.2% of the Employee/Caregiver participants used other resources to help them quit.
- Of those who used other resources, 63.9% used medications.
- The main tobacco cessation medications used were nicotine patches (47.2%), Chantix (36.1%), and nicotine gum (22.2%).
- 13.9% of the respondents used physician advice.

D.6 Tobacco Prevention and Control Branch Adults' (who are 25 and older and *not* Employees/Caregivers) Results

D.6 Tobacco Prevention & Control Branch Adults (25 and older *not* Employee/Caregiver) Results

Table D.6.1: Disposition of Tobacco Prevention & Control Branch Adults (25 and older *not* Employee/Caregiver)

Disposition	N	%
Completed survey	**237**	**45.8**
Refused to participate in survey	27	5.2
Unable to locate caller (i.e., wrong or disconnected #)	103	19.9
Located; unable to survey after 11 attempts	137	26.4
Other (ill, deceased, incomplete survey)	14	2.7
Total	**518**	**100.0**

- 518 TPCB participants were sampled; the survey response rate was 45.8%, higher than the HWTF survey response rate.
- 46.3% could not be surveyed due to invalid phone numbers or inability to be reached after 11 call attempts.

Table D.6.2: Program Outcomes: Satisfaction and Quit Rates (Source: Follow-up Survey)

	N	%
Satisfaction rate (n=204)		
Satisfied	184	90.2
Not satisfied	20	9.8
7-day point prevalence tobacco abstinence rates		
Respondent 7-day quit rate (n=237)	72	30.4
Intent-to-treat 7- day quit rate (n=518)	72	13.9
30- day point prevalence tobacco abstinence rates		
Respondent 30- day quit rate (n=237)	60	25.3
Intent-to-treat 30- day quit rate (n=518)	60	11.6

- 90.2% of the TPCB participants were satisfied with the overall services provided by the NCQL.
- 30.4% of the respondents reported being quit for 7 days or more, and 25.3% reported being quit for 30 days or more.

Table D.6.3: Satisfaction (Source: Follow-up Survey)

	N=204	%
Overall satisfaction (n=204)		
Very satisfied	108	52.9
Mostly satisfied	54	26.5
Somewhat satisfied	22	10.8
Not at all satisfied	20	9.8
Did the program meet callers' expectations		
Yes	167	90.3
No	18	9.7
Reasons expectations were met in themes (n=167)		
Felt supported by the Quit Coach	47	28.1
Having access to quitline when needed	15	9.0
Helped in getting ready to quit	7	4.2
Provided good ideas to help with quitting/cravings	35	21.0
Receiving calls and getting support	29	17.4
The materials and information on quitting were helpful	9	5.4
The medication and support were helpful	2	1.2
Other	23	13.8
Reasons expectations were not met in themes (n=18)		
Did not get medication as expected	3	16.7
Didn't call me back	1	5.6
Information/support was not helpful	3	16.7
Never received calls	1	5.6
Not available when calling in	2	11.1
Not enough calls	6	33.3
Phone support was not a good fit for needs	1	5.6
Other	1	5.6

- 90.3% of the TPCB participants reported that the NCQL met their expectations.
- The main reasons the NCQL met their expectations were that the participants felt supported by the Quit Coach and the Quit Coach provided good ideas to help them with quitting and cravings.
- Of the 18 who reported the NCQL did not meet their expectations, 6 stated there were not enough calls, 3 indicated they did not get the medication as expected, and another 3 said the information or support was not helpful.

Table D.6.4: Respondents' Quit Attempts and Quit Status (Source: Follow-up Survey)

	N=176	%
Number of serious quit attempts lasting > 24 hours		
0 time	25	14.2
1 time	55	31.3
2 times	39	22.2
3 times	27	15.3
4 or more	30	17.0
Longest time quit smoking on purpose (in days) (n=198)		
Mean ± Standard Deviation	56.5 ± 76.8	
Range	0 -360	
Current smoking frequency (n=206)		
Every day	110	53.9
Some days	26	12.7
Not at all	68	33.3
When last used tobacco or smoked a cigarette even a puff (n=229)		
Within the last 24 hours	151	65.9
More than 24 hours ago, but less than 7 days	6	2.6
7 days but less than 1month	12	5.2
1 month but less than 3 months	12	5.2
3 months but less than 6 months	17	7.4
6 months but less than 9 months	27	11.8
9 months but less than 12 months	3	1.3
12 months or longer	1	0.4

- Since enrolling in the NCQL, 85.8% of TPCB participants had made at least one serious quit attempt that lasted more than 24 hours.
- The longest time they stayed quit was 56.5 days.
- 30.4% of respondents were quit at follow-up (i.e., for 7 days or more). Of those who quit, 66.7% were quit for 3 months or more.

Table D.6.5: Respondents Current Tobacco Users: Tobacco Behaviors and Reduction (Source: Follow-up Survey)

	N=169	%
Tobacco type used in the last 30 days[1] (n=168)		
Cigarette	151	89.9
Cigar	13	7.7
Pipe	12	7.1
Smokeless tobacco (SLT)	17	10.1
Amount of cigarette used per day (n=129)		
Mean ± Standard Deviation	14.4 ± 8.3	
Range	0 - 40	
Dependence level (first tobacco use after waking) (n=134)		
Within 5 minutes	33	24.6
6-30 minutes	39	29.1
31-60 minutes	21	15.7
> 61 minutes	41	30.6
Already quit	0	0.0
Tobacco use reduction (n=128)		
As many or more than baseline	57	44.5
Less than baseline	71	55.5
Tobacco mean reduction (only for those who reduced tobacco use) (n=71)		
Mean ± Standard Deviation	11.1 ± 9.0	
Range	1 - 40	
Intentions regarding tobacco use at this time (n=138)		
Planning to quit in the next 30 days	64	46.4
Planning to quit in the next 6 months	35	25.4
Planning to quit sometime in the future but not in the next 6 months	15	10.9
Not planning to quit or cut down	4	2.9
You have quit	10	7.2
Other	10	7.2

[1] Not mutually exclusive. Participants can select more than one tobacco type.

- 10.1% of TPCB current smokers used smokeless tobacco in the past 30 days
- 55.5% of TPCB current smokers reduced their tobacco use compared to the initial use reported at enrollment
- The average cigarette reduction was by 11.

Table D.6.6: Respondents' Use of Other Resources to Help Quit and Intentions Toward Tobacco Use (Source: Follow-up Survey)

	N=202	%
Use other resources (n=202)		
Yes	117	57.9
No	85	42.1
Use medication (n=117)		
Yes	102	87.2
No	15	12.8
Kind of treatments or health professionals[1] (n=117)		
Medication:		
Zyban/Bupropion	6	5.1
NRT patches	36	30.8
NRT gum	22	18.8
NRT lozenges	5	4.3
Chantix (Varenicline)	47	40.2
Other medications	2	1.7
Advice from:		
Physician	22	18.8
Pharmacist	0	0.0
Nurse	0	0.0
Group cessation program	1	0.9
Self-help materials	5	4.3
Other	10	8.5

[1] Not mutually exclusive. Participants can select more than one.

- 57.9% of the TPCB used other resources to help them quit.
- Of those who used other resources, 52.1% used medications.
- The main tobacco cessation medications used were Chantix (40.2%), nicotine patches (30.8%), and nicotine gum (18.8%).
- 18.8% reported using physician advice.

D.7 Blue Cross Blue Shield of North Carolina's Results

D.7 Blue Cross Blue Shield of North Carolina's Results

Table D.7.1: BCBS of NC Program Outcomes: Satisfaction, Quit Rates and Reduction in Cigarette Use (Source: Follow-up Survey)

	N	%
Satisfaction rate (n=77)		
Satisfied	68	88.3
Not satisfied	9	11.7
7-day point prevalence tobacco abstinence rates		
Respondent 7-day quit rate (n=86)	25	29.1
Intent-to-treat 7-day quit rate (n=198)	25	12.6
30-day point prevalence tobacco abstinence rates		
Respondent 30-day quit rate (n=86)	20	23.3
Intent-to-treat 30-day quit rate (n=198)	20	10.1
Tobacco use reduction (n=49)		
As many or more than baseline	20	40.8
Less than baseline	29	59.2
Tobacco mean reduction (only for those who reduced tobacco use) (n=29)		
Mean ± Standard Deviation	11.6 ± 9.1	
Range	1 - 40	

- 88.3% of the BCBS of NC members reported being satisfied with the services provided by the NCQL.
- 29.1% of the respondents had quit for 7 days or more and 23.3% reported being tobacco abstinent for 30 days or more.
- Among current smokers at the time of the survey, 59.2% reduced the amount of cigarettes they used compared to the amount they reported at enrollment.
- The average cigarette reduction was nearly 12.

Table D.7.2: Use of Other Resources to Help Quit and Intentions Toward Tobacco Use (Source: Follow-up Survey)

	N=73	%
Use other resources (n=73)		
Yes	42	57.5
No	31	42.5
Use medication (n=42)		
Yes	35	83.3
No	7	16.7
Kind of treatments or health professionals[1] (n=42)		
Medication:		
Zyban/Bupropion	1	2.4
NRT patches	11	26.2
NRT gum	7	16.7
NRT lozenges	2	4.8
Chantix (Varenicline)	16	38.1
Other medications	0	0.0
Advice from:		
Physician	7	16.7
Pharmacist	0	0.0
Nurse	0	0.0
Group cessation program	0	0.0
Self-help materials	1	2.4
Other	3	7.1

[1] Not mutually exclusive. Participants can select more than one.

- 57.5% of the BCBS of NC members have used other methods or aids besides the NCQL to help them quit.
- Of those who used other resources, 45.2% used medications.
- The main tobacco cessation medications used were Chantix (38.1%), nicotine patches (26.2%), and nicotine gum (16.7%).
- 16.7% reported using physician advice.

Table D.7.3: Smoking Status at Initial Call vs. Follow-up Call

	Initial Call		Follow-Up Call	
	N=66	%	N= 66	%
Current smoking frequencies				
Every day	59	89.4	38	57.6
Some days	5	7.6	7	10.6
Not at all	2	3.0	21	31.8

- At the initial assessment call, 89.4% of BCBS of NC members smoked cigarettes every day; at the follow-up only 57.6% smoked every day, a 31.8% crude reduction in the smoking frequencies.

E. Summary and Recommendations

The present report summarizes the findings of the third year evaluation of the North Carolina Tobacco Use Quit Line (NCQL). Relative to the previous year's evaluation, the survey response rate for the NCQL is lower this year (39.2% vs. 46.6%). Over half of the survey sample could not be surveyed due to an invalid phone number or the number of attempts to reach the participant was exhausted.

Demographic characteristics were comparable across the Quit Line callers selected for the survey sample and callers who completed the survey. More than half (58.4%) of survey respondents were female and only 1.5% were Hispanic. Almost a quarter of survey respondents were uninsured (24.3%). Survey respondents were highly dependent upon tobacco: 60.1% had used tobacco for 20 or more years, 56.6% smoked 15 or more cigarettes per day, and 38.9% reported their first tobacco use of the day within 5 minutes after waking up. The majority of the callers (74%) enrolled in the multi-call program and only a small number (5.0%) enrolled with the NCQL through fax referral. Thus, the Quit Line tended to serve a population that was female, Caucasian or African American and highly dependent on tobacco.

Some key program components were examined. Two-third of the respondents set a quit date while they were in the program. The vast majority (95.2%) were mailed a Quit Guide (stage-based written material). On average, respondents completed 2.1 counseling calls, with 30.4% completing less than 3 calls, and 69.6% completing 3 or more calls.

The evaluation examined several program outcomes, including caller satisfaction, expectations, tobacco cessation rates and reduction. Overall satisfaction with the services provided by the NCQL was high (91.9%), and the majority (89.9%) indicated that the Quit Line met their expectations. The main reasons mentioned among those whose expectations were met included feeling supported by the Quit Coach, receiving good ideas to help with quitting and/or cravings, and just the fact of receiving calls and support. Among those whose expectations were not met (10.1%), the foremost reasons they stated were not receiving enough calls and the information or support was not helpful.

The point prevalence tobacco abstinence rates at the 7-month follow-up were 32.9% for the 7-day respondent quit rate and 28.6% for the 30-day respondent quit rate. The 7-day and 30-day intent-to-treat quit rates were 12.9% and 11.2%, respectively. Half of the current smokers reduced the amount smoked compared to the initial amount reported at their enrollment in the NCQL. More than half (53.6%) reported using other resources to help them quit; among those, over a half used tobacco cessation medications. The primary medications used were Chantix (34.4%), nicotine patch (32.2%), and nicotine gum (22.2%). Very few participants reported using Zyban.

Results from the bivariate analyses showed a significant association between the program outcomes and live call completion. Participants who completed 3 or more calls were more likely to be satisfied with the NCQL services and reported higher quit rates than those who completed less than 3 calls. The Health and Wellness Trust Fund (HWTF) population survey respondent quit rates were slightly higher compared to the Tobacco Prevention and Control Branch (TPCB) population (7-day: 36.8% vs. 30.9%, respectively; 30-day: 33.6% vs. 25.3%, respectively), but the difference was not statistically significant.

Satisfaction and intent-to-treat quit rates significantly differed as a function of treatment intensity. 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%). 7- and 30-day intent-to-treat quit rates were higher for the multi-call participants compared to the one-call participants. The responder quit rates, though higher among multi-call participants, did not differ from the one-call participants; 7-day quit rates were 35.2% vs. 26.5% and 30-day quit rates were 30.0% vs. 24.5%, respectively. The respondent 7-day quit rates were comparable among insured (31.4%) and uninsured participants (29.2%), but the 7-day intent-to-treat quit rates were significantly different (13.7% vs. 9.6%). Insurance status was not associated with satisfaction. Number of live calls completed and treatment intensity were significant predictors of successful cessation through the NCQL program.

Blue Cross Blue Shield of North Carolina (BCBS of NC) represented 21.9% of the survey respondents. BCBS of NC reported high satisfaction with the NCQL (88.3%). A little less than one-third of survey respondents reported being quit for 7 days or more, and almost a fourth of survey respondents reported being quit for 30 days or more. Over half reported that they reduced their tobacco use compared to what

they reported at enrollment. Over half reported using other resources to help them quit, with 38.1% using Chantix and 26.2% using nicotine patches.

Overall, the results of the third year evaluation of the NCQL were consistent with the previous year results and demonstrated the impact of the Quitline on different segments of the population. Seven- and 30-day responder quit rates were slightly higher this year compared to last year; 32.9% vs. 26.9% and 28.6% vs. 23.6%, respectively. Satisfaction results were similar. The proportion of participants who received physicians' advice to help them quit increased from 14.6% last year to 17.8% this year. Tobacco reduction rates among current tobacco users was higher; 53.6% vs. 41.3%. The use of Zyban dropped from 11.9% last year to 4.4% this year due to the availability of Chantix. There were enhanced quit rates among the priority populations. The HWTF 7-day responder quit rates were 36.8% vs. 33.0% last year; the 30-day responder quit rates were 33.5% vs. 30.0%. The TPCB 7-day responder quit rates were 30.4% vs. 23.0% last year; the 30-day responder quit rates were 25.3% vs. 18.0%.

Surprisingly, the program outcomes among the BCBS of NC members were somewhat lower compared to the previous years. We endeavored to equally select the BCBS of NC members for the survey across the two populations of interest; HWTF and TPCB. In order to have sufficient number of participants in the younger HWTF group, we conducted a census, which might have affected the overall outcomes of the BCBS of NC.

This year, the evaluation for the NCQL experienced a high proportion of participants that could not be surveyed due to either invalid telephone numbers or inability to be reached after all attempts were exhausted. Free & Clear has been diligently exploring cost-effective approaches to increase survey response rates, and has already implemented strategies to improve survey response rates in general. These include methods such as reverse phone number look-up for wrong or invalid telephone numbers and recycling the participants we were unable to reach after 11 attempts by extending their survey windows for additional attempts. In the future, we recommend considering a pre-notification letter with or without incentives, and on-line surveys as a strategy to increase survey completion rates, especially among younger participants.

As observed in previous years, relatively fewer survey sample members and respondents were referred to the NCQL through fax (~5%). Similarly, among callers aged 25 and older, less than 30% lived with a child under 18 and were their primary caregivers and less than 5% were K-12 school or childcare facility employees. Whereas NCQL stakeholders already demonstrate a strong commitment to provider education, use of the fax referral program and reaching youth primary caregivers and school employees, these data suggest that continued support of the fax referral program and outreach are important. Empirical studies have shown that participants who enrolled in the Quit Line through fax referral experienced an increased likelihood of being quit.[1] [2]

Given the relatively low representation of younger Quit Line callers, Free & Clear suggests that the NCQL 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, among survey respondents who were not satisfied or whose expectations were not met, some indicated that they would have liked more counseling calls or would benefit from more helpful information. Given the high utilization of the multi-call service benefit, these findings are somewhat unclear. 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.

---

[1] Perry, R. J., Keller, P. A., Fraser, D., & Fiore, M. C. (2005). Fax to quit: A model for service delivery of tobacco cessation services to Wisconsin residents. *Wisconsin Medical Journal, 104,* 37-44.

[2] Yepassis-Zembrou, P.L. (2007). Wisconsin Tobacco Quit Line Referral and Disparate Populations 3-Month Follow-up Evaluation 2007. Seattle: Free & Clear, Inc.

F. Appendix

F.1 In the Words of North Carolina Callers

Below are some quotes from the residents of the State of North Carolina about how the Quit Line met their expectations.

- I never had anyone to talk to about the cigarettes (before).
- Good! The service and the people were nice and supportive.
- They don't judge, they are there when I need them, they have offered some really good suggestions.
- If it wasn't for the Quit Line I wouldn't have anyone to help me or encourage me.
- It was someone to keep me going & they gave me different ways to overcome the stressful moments.
- They're very informative. They're very concerned with helping you quit, for another, they're not judgmental, very supportive as far as giving you things to try and help you with quitting. Stuff like that.
- They were a good reinforcement for me when I had an urge for a cigarette.
- Well I was able to talk to a gentleman the first day I called that really listened to me and didn't judge me. He was just there to listen to my smoking story and try to give me some good advice about stopping cigarettes.
- It was very helpful to speak with someone who had been through the same thing. It helped me to gain the strength to believe in myself.
- Just the encouragement, it's a battle every day.
- I was very happy to know that almost all of the people I talked to were ex-smokers themselves.
- They listened, seem to be concerned. I have to talk to somebody that's been through it, knows what I'm going through. I quit smoking because I got 3 grandkids, if I didn't quit I wouldn't see them grow up, the 2nd reason: it stinks!
- They exceeded my expectations. I needed to get a documentation that I was trying to quit & didn't expect it to happen, but it worked for me.
- They're just very supportive, in whatever method you choose. They are very open and supportive to whatever method you are going to try.
- I thought I wasn't going to talk to someone that's down to earth, and they were, and that help me quit more.
- They were supportive and I had the coach to speak with.
- It was really personal. They could talk to me like I was one individual person, They related to me and talked to me like I was an actual human being. It wasn't talking to a robot, it was a real person. .They gave me a lot of motivations and (it) was very nice.
- They were there for me to talk to and help me self-realize what was the true reason behind my smoking habit.
- Well, they helped me. People would call me and give me encouragement and tips on things to do when I had cravings. Helped me to recognize my triggers. Support was the main thing.
- They were just very helpful, I just knew that I could talk to somebody on the telephone and I appreciate it and you all care, you actually care and you were sincere and you took your time and talked to me.
- I thought it was very informative and offered a lot of support. They seamed to care a lot about your health.

- It gave you a little bit of confidence and just knowing there's somebody out there if you need someone to give you suggestions on quitting and just knowing someone cares.
- Just when I really didn't know what to do, every time I called, they successfully helped me fight craving; they gave me hints & suggestions to get past the craving.
- First time II talked to them they were very encouraging and showed me that they cared about my health and when you see that somebody else cares you start believing in yourself.
- They were really personable. They communicated well, they got down to my level and they didn't act like machines. I always got a real person and they were on time and followed through on what they were going to do and I received information like I was supposed to.
- It gave me someone to be accountable to.
- It was very helpful, it gave me someone to talk to and gauge my progress.
- The program gave me more confidence (to quit).
- Acted as an outlet, I could always call in and talk to a Quit Coach.
- It allowed me to talk to people to try to get through smoking urges.
- Talking to me about the cigarettes... About quitting... Just the conversation...
- Just talking about it over the phone helped.
- Just someone to talk to about my addiction.
- I wasn't really expecting all that much, it was helpful to have somebody to talk to.
- Y'all was there when II wanted to talk to ya.
- They were there, they talked me out of starting again, they (were) very helpful.
- Someone to talk to and they understand w/o condemning if you fall back again.
- Somebody to talk to. Offer different types of suggestions... Replacement options...
- It is good to have someone to talk to ... Most people don't really understand ...they criticize you. They don't understand this is an addiction.
- By helping me quit.
- It was just good to talk to someone and have some ideas to try.
- It was nice to have somebody that was sort of a real person with a situation, understood what you were going through.
- It was very comforting to have someone to talk to when I needed, I don't have that.
- It was nice to be able to talk to someone, and they gave me advice to quit, and tips to help me continue.
- If I was craving anything, all I had to do is call and they talked me out of it.
- In terms of just having support, having someone to talk to.
- They were there when I needed them and when I first started calling, I would call every day... and then I called about once a week and then I quit calling when I got all my answers. They were very supportive.
- They offered me more calls if I needed them, and they signed me up for them, and they helped a lot. It's good now to say "Yes - I quit", and each time you say it, it reinforces it even more.
- Because they were available if I needed to talk to somebody. Sometimes when you get weak, you just need to talk to somebody.

- They helped me stay off cigarettes.
- Gave me the initiative to want to quit...
- It helped me to quit...
- They helped me to stop smoking and so I could have a healthy baby.
- They encouraged me to quit, in the past, I tried several times and did not have any success, 4 days (were) the most II was able to quit. It was unreal to think about quitting and with the Quit Line and patches together, finally I got it done, it was much easier this time.
- Very good – I did quit; I have more energy, better appetite; I feel great.
- I asked about the nicotine gum and patches.
- They told me how to quit.
- They helped set short goals and then it went for longer periods. Such as don't smoke until next call. Then, it became permanent.
- They are really helpful with suggestions. And sending information... They gave me a lot of support
- Quit date & things to do instead of dipping was helpful.
- They helped me do stuff like doing substitute things with your hands like eating celery instead of smoking.
- Well, ya'll sent me this thing via mail re: being pregnant & smoking, It told me to keep hands busy, so II started crocheting a blanket for my unborn child and that motivated me to finally quit smoking.
- They had a lot of helpful tips. They were nice, they didn't rush me off the phone and they had a lot of info for me to quit.
- Well they just helped me a lot when I was having a craving for cigarettes, making you think about what you do before you did it.
- They just gave me the options of things I could do besides smoking, they informed me and educated me more.
- Just by answering my questions leading me to different places where I could find information about tobacco and what it does.
- There was a good counselor that offered me lots of options, I was pleased with that.
- I you were there when I called and you gave me ideas, and were very resourceful. You all called (and) checked on me to see how things were going.
- As far as trying to show me the benefits and disadvantages of using some type of system...
- Checking in on you & they're there if you need them & any information that they can give you.
- They called and checked regularly like they promised they would.
- They answered all my questions & each time I called in, they were always there at beck & call & that was my only support outside of the Lord.
- You called me and gave me encouragement to quit, it lets me know someone cares.
- Consistent. Because y'all are cool. You kept up with the phone calls, and you remembered everything about me from the last call. You gave me advice.
- They were very polite and friendly and followed up with what they said they would.
- A lot of regular persistence. They were there for me and they called me and everything and did what said they were going to do.

- The overall understanding, courtesy, constant calls; I didn't realize how hard it was on my body to be smoking.
- A lot of people checking up on me and showing that they care.
- With the quit coach calling me consistently, that did help me out a lot.
- You all really help me out a lot. I got a lot of information on quitting smoking.
- They are helpful and they have good resources and materials and a network set in place for support.
- The info was very helpful and follow up was good.
- They just provided you with so much information that you wouldn't normally have.
- Well it got me started, helped me out a lot, I kept reading the material, and doing what it said.
- The documents they sent me with different suggestions were very helpful.
- Just with the support with the reading material and everything and I knew I could call and talk to somebody if I needed to.
- The info I was reading was very helpful, when I had time.

Below are some quotes from the residents of the State of North Carolina about how the <u>Quit Line did not meet their expectations</u>.

- I expected them to be more helpful; I thought I could get RX or NRT but was told, no.
- Called back, called back. I don't (like) your customer support, not at all there for me. I called when I had cravings and it just seemed like they told me 'just don't think about it, do something else'.
- Well, when I wanted to discuss their life and opinions, that was never discussed, people who have successfully quit. The lady said, "It's not about me". It would be nice if you guys were open about the things that you were successful. The way they quit and how they went about it.
- Stayed more on a personal contact on a daily basis, it was like once every couple weeks, it really wasn't enough contact so I could enough moral support in other words.
- I'm not sure if there is anything else they can do. I was hoping there would be some magic word that could be spoken to me that would give me more incentive. I want to keep on trying.
- Send somebody to my house to take them out of my hands. It's just not realistic to me to have someone supporting me over the phone; it would have to be face to face for me.
- Being able to speak to somebody one on one.

NORTH CAROLINA TOBACCO USE QUIT LINE COMBINED SATISFACTION AND QUIT SURVEY

YEAR 03

Customized End Of Program (EOP) Survey (DRAFT- xx item) 11.01.07

Note: Used for NC Survey FY03 (2007-2008)

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 mm

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 North Carolina Tobacco Use 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 your with 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 Use 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-QUITNOW)."

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
10) Other (Specify _____)

Proceed to Section A

Section A

Quality of Quit Line as Measured by Respondents' Satisfaction and Respondents' Quit Attempts and Quit Status

"The following questions ask about your experience and satisfaction 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 Free & Clear (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 CACULATED 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
2) More than 24 hours ago, but less than 7 day — **PROCEED TO QA7**
3) 7 days but less than 1month
4) 1 month but less than 3 months
5) 3 months but less than 6
6) 6 months but less than 9 months — **PROCEED TO MDS11**
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 <u>intentions</u> regarding your tobacco use at this time*? Would you say you are…*
<u>NOTE:</u> 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,* 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 1-800-784-8669 (1-800-QUITNOW)."

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

Quitline NC Evaluation
July 2007 – June 2008

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 Quitline NC Outcomes Evaluation, please contact:

Tobacco Prevention and Evaluation Program

University of North Carolina at Chapel Hill
School of Medicine
Department of Family Medicine
CB #7595, Manning Drive
Chapel Hill, NC 27599
T: 919-843-9751
F: 919-966-9435

Web: www.fammed.unc.edu/TPEP
Email: tpep@med.unc.edu

Table of Contents

A. EXECUTIVE SUMMARY

A.1. Overview

The North Carolina Tobacco Quitline (Quitline NC) is a telephone-based, tobacco cessation service that provides free support to all NC residents who want to quit their tobacco use. Research shows that quitlines are an effective and evidence-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 started operations in North Carolina in 2005 and is jointly funded by the NC Health and Wellness Trust Fund (HWTF) and the NC Department of Health and Human Services (DHHS). The HWTF funds services for callers ages 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. DHHS funds all other callers. Based on Centers for Disease Control and Prevention (CDC) guidelines for state quitlines, Quitline NC aims to provide services for up to 2.0% of North Carolina's adult smoking population each year. [2]

The University of North Carolina School of Medicine Tobacco Prevention and Evaluation Program (UNC TPEP) evaluates the outcomes of the HWTF-funded portion of Quitline NC. A framework for this evaluation is outlined in the HWTF Quitline logic model developed by UNC TPEP in collaboration with the HWTF and DHHS and updated yearly as appropriate (Appendix A).

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, the eight month period between November 2006 and June 2007 constituted Year 2. Year 3 of Quitline NC encompassed July 2007 through June 2008. This report summarizes findings from UNC TPEP's analysis of HWTF-funded caller data for Quitline NC Year 3.

The HWTF funded Quitline NC at $3.02 million in Year 3 (approximately $2.2 million was directed towards promotion, and approximately $829,000 towards direct program services). Overall HWTF funding for Quitline NC increased 100% in Year 3 (compared to the first 20 months of operation in which $2.03 million was allocated to the Quitline, and only $430,000 on promotion).

In September 2007, the HWTF launched "Call it Quits," a multimedia, statewide Quitline NC promotional campaign targeted to young adults. The campaign combined TV, radio, print, and online Quitline NC promotions that featured simulated calls between a young adult smoker and a quitline coach. The "Call it Quits" campaign and a fax referral promotion were the only Quitline NC promotions run by the HWTF and other state agencies during Year 3.

The following section highlights key outcomes of the HWTF-funded portion of Quitline NC in Year 3 and makes recommendations for Year 4.

A.2. Summary of Key Findings and Outcomes

Quitline Operation and Call Volume

- In total, Quitline NC received 7,332 calls during Year 3, an average of 611 calls per month. Average monthly call volume in Year 3 increased by 56% compared to the first 20 months of operation (392 calls/month).

- The majority of calls (87%) to Quitline NC in Year 3 were from tobacco users (average 530 calls/month); other calls were from providers, family members, etc. Fifty-four percent (3,448) of callers who used tobacco were youth, young adults, or primary caregivers/school employees funded by the HWTF (average 287 calls/month). In Year 3, all HWTF funded callers were tobacco users.

- In Year 3, Quitline NC provided services to approximately 0.36% of North Carolina's adult smoking population. Quitline NC was successful in reaching a greater percentage of youth and young adult smokers in Year 3 compared with the first 20 months of operation.

- At least one HWTF-funded caller from every county in North Carolina called Quitline NC during Year 3.

- Quitline NC call volumes peaked and remained higher during the five months in which television and radio ads from the HWTF-funded "Call it Quits" promotional campaign were aired. Sixty-six percent of all HWTF calls were received during these months.

HWTF Target Populations

- Three percent (217) of all callers who use tobacco were youth (ages 12-17) and 22% (1,414) were young adults (ages 18-24). In Year 3, Quitline NC reached 0.22% of North Carolina high school aged smokers and 0.45% of North Carolina young adult smokers.

- The total number of callers from HWTF target populations increased by 15% in Year 3. Youth calls increased by 31.5% and young adult calls increased by 63%.

- Young adult callers to Quitline NC came predominately from targeted, at risk populations. Most (63%) young adult callers did not attend school. Young adult callers who were not currently in college were more likely to report Hispanic ethnicity, have no health insurance, have Medicaid coverage, and use multiple forms of tobacco compared to young adult callers in college.

- Quitline NC also reached a substantial number of youth, young adults, and primary caregivers/school employees from populations that experience disparities in tobacco use, effects of tobacco-related diseases, and access to healthcare or other cessation resources.

- In Year 3, Quitline NC reached many adults who are caretakers and role models for children and youth in their home and school environments. Twenty-nine percent (1,817) of all callers who used tobacco were primary caregivers and/or childcare/school employees supported by HWTF funds.

- Six percent (218) of all female, HWTF-funded callers were either planning a pregnancy, pregnant, or breastfeeding (58% of these callers were young adults and 4% were youth).

- At registration, 64% of HWTF-funded callers enrolled in the Multi-Call Program and 33% enrolled in the One-Call Program.

- The majority of HWTF-funded callers (89%) were in the preparation stage of quitting, indicating they were ready to quit, and most (87%) smoked cigarettes each day, suggesting that Quitline NC successfully reached everyday smokers who are ready to quit in the next 30 days.

Promotion

- Call volumes for all HWTF-funded target populations increased during months in which “Call it Quits” ads aired, suggesting that the campaign reached its young adult target audience and also had spillover influence on youth and adult callers.

- HWTF-funded callers reported that they most frequently heard about Quitline NC via TV, radio, health professionals, and a family member or friend. Youth and young adults were more likely to hear about the quitline from a family member or friend than from a health professional. In the absence of TV and/or radio ads, youth call volume was low (fewer than 10 calls per month).

Fax Referral Service

- The HWTF promoted the fax referral service statewide through a campaign that began in March 2008 and continued through the end of Year 3. The number of Quitline callers (both HWTF and DHHS-funded callers) who were referred by fax increased from 27 in March to 42 in April and remained at higher levels through the end of Year 3.

- Utilization of the fax referral service was relatively low, with a total of 265 (4%) of all tobacco-using callers referred by fax during Year 3. Among HWTF-funded callers, 122 (3.5%) were referred by fax, of whom 86% were primary caregivers or school employees.

Satisfaction and Quit Rates

- Analysis by Quitline NC vendor, Free & Clear, Inc., provides estimates of intent-to-treat 30-day quit rates, based on the number of callers who responded to a follow up survey and reported being tobacco free for 30 days. Among all HWTF-funded callers who responded to the survey (n=155), there was an estimated 10.8% intent-to-treat 30-day quit rate, comparable to the 11.1% quit rate reported for the first 20 months of operation.[3] (Intent-to-treat quit rates assume that all survey non-respondents are continued smokers, and thus may underestimate the number of Quitline NC callers who quit tobacco).

- Estimated intent-to-treat 30-day quit rates were 7.5% for young adults (n=58) and 14.5% for youth (n=19) who responded to the follow up survey,[3] compared to 13.2% and 10.3%, respectively, for the first 20 months of operation.

- Ninety percent of HWTF survey respondents reported satisfaction with Quitline NC services. Overall, 92% of young adults and 100% of youth reported satisfaction with Quitline NC services. Few youth callers completed the survey.[3]

A.3. Recommendations

With continued quitline promotion, increases in secondhand smoke policy adoption and legislation, new research in cessation agents, and hospital efforts to promote cessation, the demand for Quitline NC services will likely increase over the next few years. The following recommendations are offered to guide future planning and provision of Quitline NC services to HWTF target populations:

- Establish annual objectives for the target number of HWTF-funded callers and fax referrals to better link call volumes and program budgets.

- Build on the success of the “Call it Quits” campaign with ongoing promotional campaigns targeted to HWTF target populations to maintain steady call volumes from month to month.

- Continue targeted promotion to young adults who use tobacco through a variety of outlets to capture the large proportion of this population who are not enrolled in college.

- Continue to seek innovative ways to promote the quitline and its fax referral service to health professionals, who remain a top source of information about Quitline NC.

- Consider a more detailed evaluation of media and fax referral promotions to pinpoint campaign successes and identify ways to improve campaign effectiveness.

- Emphasize Quitline NC promotion as a part of the Teen Tobacco Use Prevention and Cessation and the Tobacco Free College Initiatives to build on the influence of family and friends as a top source of Quitline NC information for youth and young adults.

- Examine the cost-effectiveness of Quitline NC in terms of reach and success of its outcomes compared to other state quitlines.

- Examine reported 30-day quit rate data in more detail and work with Free & Clear to achieve survey response rates above 50% to more accurately measure the impact of Quitline NC services on smoking cessation.

B. BACKGROUND

Tobacco use continues to be the leading cause of preventable death and disability in North Carolina. Approximately 12,000 North Carolina adults die from smoking each year, and an estimated 193,000 youth currently under age 18 will die prematurely from smoking. Thousands more survive with chronic, tobacco-related illnesses. Each year, North Carolina spends $2.5 billion in health care costs directly related to smoking and loses an estimated $3.3 billion in smoking-caused productivity losses.[4]

In North Carolina, approximately 1.5 million (22.9%) adults over age 18 smoke;[5] 19% of NC high school students smoke, and 4.5% of NC middle school students smoke.[6] About 40% of youth live in homes where others smoke.[6] Smoking rates are highest among young adults, ages 18-24 years old, at 27.8%.[5] The need for policies and programs that encourage quitting and improve access to proven cessation resources has increased as declines in smoking rates have slowed in the past decade.

Helping tobacco users quit is a critical step to improving public health and reducing tobacco-related morbidity and mortality in North Carolina. More than half of all North Carolina youth, young adult, and adult smokers have attempted to quit in the past year.[5,6] While many studies show that most tobacco users want to quit, many are unable to successfully quit without support.

B.1. The North Carolina Tobacco Quitline (Quitline NC)

In October 2005, the NC Health and Wellness Trust Fund 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 tobacco use 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. A recent meta-analysis of 13 studies reported that proactive quitlines 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.[2,7] Quitline NC does not provide pharmacotherapy as part of its cessation support services. Research has also shown that marketing campaigns promoting quitlines effectively increase utilization.[2,8,9] One study reported that young adults respond to mass media quitline promotion, even when it does not target them.[10] Recently updated clinical guidelines from the US Department of Health and Human Services highlight quitlines as an effective support in quitting.[11]

Call volume varies widely among state quitlines. The expected number of calls, often referred to as the reach of a quitline, is associated with several factors including state population, tobacco prevalence rates, quitline resources, years in operation, and level of promotion. Recent data collected by researchers at the North American Quitline Consortium (NAQC) showed that the reach of quitlines to adult smokers averaged around 1% in the United States in 2005, with a range among quitlines from 0.01% to 4.28%.[12] This study included new state quitlines as well as quitlines that had been in operation for several years.

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 Smoker's Helpline (one of the most established quitlines in the U.S.) in proportion to their numbers in the state. Young adults from populations that experience disparities in tobacco use, the effects of tobacco-related disease, and access to healthcare resources (e.g. racial and ethnic minorities, low income groups) were also well represented among young adult callers.

The effectiveness of quitlines for youth populations has not been established in the literature. However, empirical studies on youth-focused quitlines in Utah and California have shown promising results. An evaluation of the Utah Youth Tobacco Quitline demonstrated an overall 43%, 30-day smoking abstinence rate among youth callers who responded to a follow up survey.[13] The 2008 Clinical Practice Guidelines identify the kind of support provided through quitlines as an appropriate resource for assisting youth smokers in quitting.[11]

Quitline NC is the first state-funded quitline in North Carolina. Prior to the launch of Quitline NC in November 2005, North Carolina residents could access a national tobacco cessation quitline provided through the National Cancer Institute (NCI) at 1-800-44U-QUIT. Callers to Quitline NC are routed to Seattle-based quitline vendor, Free & Clear, Inc. for 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. The company currently operates several state quitlines in the U.S. including Utah, Oregon, and South Carolina. Free & Clear has 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. Among callers who responded to a follow-up survey, 34% reported being quit for more than 30 days.[14] All quitlines included in this study offered only the Multi-Call Program; Quitline NC offers both a single and multi-call program. Quit rates for commercial quitlines (i.e. those sponsored by an employer) are typically higher than state quitlines due to differences in the types of callers and available services (i.e. pharmacotherapy).

The HWTF funds two statewide prevention and cessation initiatives targeting teens and college students in North Carolina: the Teen Tobacco Use Prevention and Cessation Initiative (begun in 2003) and the Tobacco-Free Colleges Initiative (begun in 2006). In an effort to supplement these initiatives, the HWTF funds Quitline NC research and provision of services to the following three populations:

1) All callers ages 24 years and younger

2) All callers who are identified as school or childcare employees

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. low

income populations). In fiscal year 2007-2008, HWTF provided one time funding for adult callers to match the BCBS contribution.

B.2. Quitline NC Services

Quitline NC was officially launched on November 1, 2005. All interested tobacco users, providers, and proxies (e.g. family members) are eligible for free telephone assistance from one of Free & Clear's expert tobacco treatment specialists, or quit coaches. Services are provided in English and Spanish (as well as many other languages), seven days a week between 8:00 am and midnight.

Callers may request information about quitting for themselves, a friend, or a 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 receive printed cessation support materials and a referral to local programs.

Quitline NC is a proactive quitline service. As a proactive service, quit coaches can initiate calls to tobacco users to answer questions and offer program services. Following the first call of the Multi-Call Program, tobacco users are offered an additional three proactive calls. Research has demonstrated that quitline callers who participate in multi-call interventions are more likely to succeed at quitting than callers who participate in single-call interventions.[1]

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 services. This service is designed to assist health professionals in connecting their patients to Quitline NC using a special fax referral form. When Quitline NC receives the fax referral, a quit coach initiates 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 (TPEP) conducts 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 the third year of operation (fiscal year 2007-2008), particularly in relation to the goal of reaching tobacco-using youth and young adult populations in North Carolina, and to comment on overall trends in quitline usage over the first three years of operation.

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 (Appendix A). This model outlines the resources, activities, outputs, and short-term, intermediate, and long-term outcomes for the HWTF-funded portion of Quitline NC, and is updated yearly as appropriate.

The Quitline NC vendor, Free & Clear, collects, cleans, and manages all Quitline NC caller intake data, call utilization data, and end-of-program survey data. Intake data collection includes Minimal 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 data necessary for the evaluation are collected.

Free & Clear sends raw data extracts for each month to UNC TPEP. The extracts include data on callers, demographic information, tobacco use, and use of various quitline services. The data sets sent by Free & Clear contain information on every call made to the quitline; TPEP extracts records for each unique caller for analysis for this evaluation. TPEP analyzes data using SPSS with a specific focus on data for callers who use tobacco from populations supported by HWTF funding (i.e. youth, young adults, primary caregivers, and school/childcare employees). Analysis of program utilization data (i.e. how many callers who registered for the Multi-Call Program completed all calls) is not feasible with the existing data set structure.

D. SUMMARY OF FINDINGS

D.1. Call Volume

Quitline NC completed its third year of operation between July 1, 2007 and June 30, 2008. During this period, 7,332 people called Quitline NC (Table 1). The majority of callers (6,632, or 87%) were tobacco users. On average, 530 tobacco users called each month.

Callers from HWTF target populations accounted for 46% (3,448) of all Quitline NC callers and 54% (3,448) of all tobacco-using callers in Year 3. One hundred percent of all HWTF-funded callers were tobacco users. Seventy-five percent of DHHS-funded callers were tobacco users. Ninety-seven percent (6,145) of all tobacco users were adults (18 years old and older) and 3% (217) were youth (12-17 years old). Ninety-three percent (5,891) of all tobacco users smoked cigarettes exclusively or in conjunction with use of another tobacco product.

Table 1. Total Callers by Type of Caller and Funding Source, Nov 05-Jun 07 (n=7332)

	Funding Source				Total	
	HWTF		DHHS			
Type of Caller	#	%	#	%	#	%
Tobacco User	3448	100.0	2914	75.2	6362	86.9
General Public	-	-	692	17.9	692	9.5
Proxy	-	-	151	3.9	151	2.1
Provider	-	-	117	3.0	117	1.6
Total	3448	100.0	3874	100.0	7322	100.0

Call Volume Increases During Year 3

Quitline NC provided services to more callers from HWTF-funded populations during Year 3 (3,448) than during the first 20 months of operation combined (2,988). An average of 287 HWTF-funded callers called Quitline NC per month during Year 3, a marked increase from an average of 214 HWTF-funded calls per month during Year 2. Young adults experienced the largest increase in average monthly call volume, from 69.1 calls per month in Year 2 to 117.8 calls per month in Year 3 (70.5% increase). Average monthly call volume for youth increased by 56%, from 11.6 calls per month in Year 2 to 18.1 calls per month in Year 3. Primary caregivers and school employee calls increased by 13.5%, from 133 calls per month in Year 2 to 151.4 calls per month in Year 3.

Figure 1 shows the total number of callers from HWTF-funded populations; figure 2 shows trends in monthly call volume since the inception of Quitline NC.

Figure 1. Number of HWTF Callers by Year 3 and First 20 Months (Tobacco Users Only, n=6436)

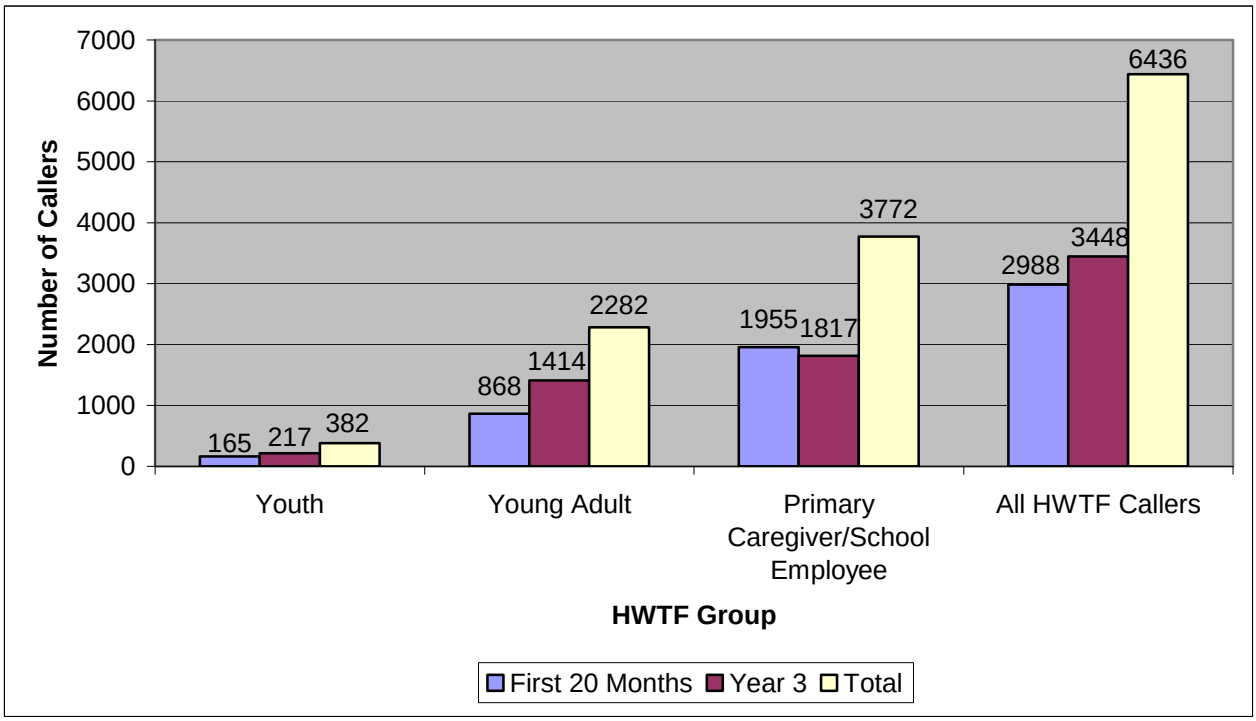


Figure 2. Total Monthly HWTF Call Volume, Year 1 – Year 3 (n=6436)

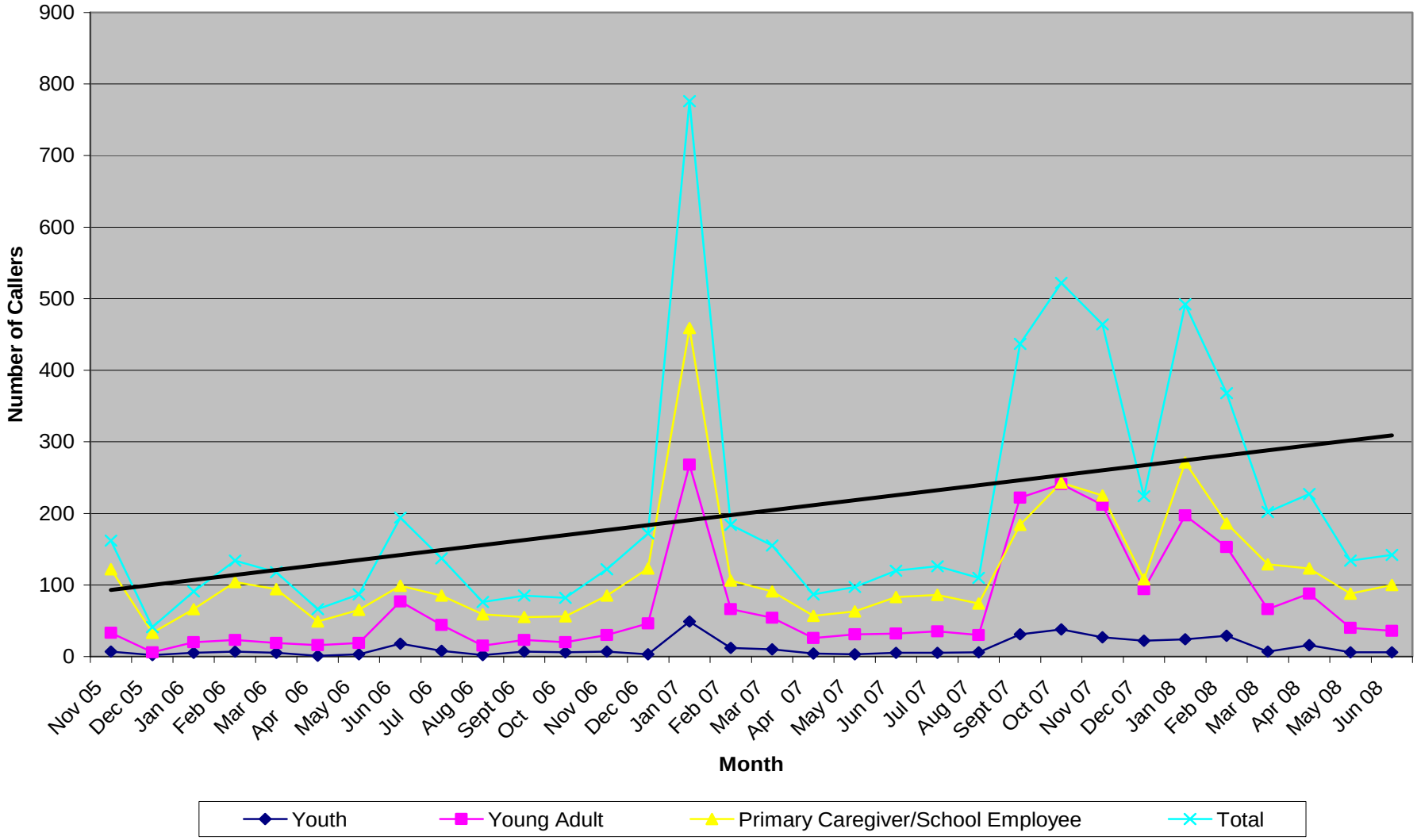


Figure 3 highlights the breakdown of HWTF-funded callers among all Quitline NC callers during Year 3. Overall, HWTF funded over half (54%) of all callers who use tobacco, 22% of whom were young adults and 3% of whom were youth. This was an increase from the first 20 months of quitline operation, during which HWTF funded callers accounted for 46% of all callers who used tobacco.

Figure 4 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 adult primary caregivers and school employees (1817 or 54%)*, followed by young adults (1,414 or 41%), and youth (217 or 6%). The proportion of HWTF-funded callers that were young adults increased from 29% in the first 20 months to 41% in Year 3.

Figure 3. Percentage of HWTF Callers Among All Callers, Year 3 (Tobacco Users Only, n=6362)

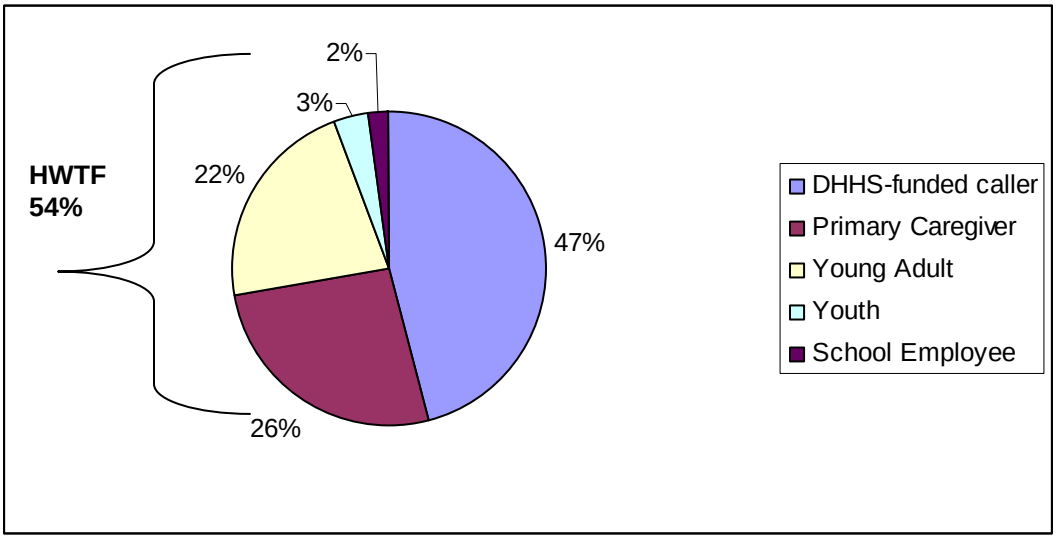
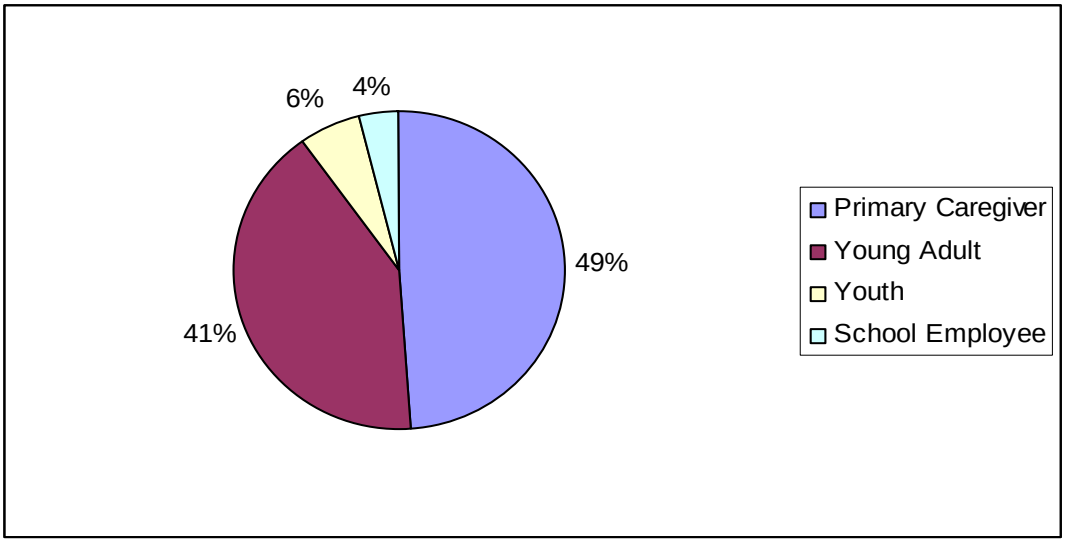


Figure 4. Percentage of Target Populations Among HWTF Callers, Year 3 (Tobacco Users Only, n=3448)



* 4.6% (159) of HWTF-funded, tobacco-using 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

Quitline Promotion Drives Increased Calls

Figure 5 shows the total number of calls to Quitline NC by HWTF-funded callers during each month of Year 3. Figure 6 shows the total number of calls to Quitline NC by all tobacco using callers during Year 3. Call volumes peaked and remained higher during months in which both television and radio ads from the “Call it Quits” campaign were aired. Call volumes were not as high during months in which only radio ads and online promotion occurred. Section D.4 contains more detailed information about Quitline NC promotions and associated changes in call volume.

Figure 5. HWTF Call Volume Over Time (n=3448)
July 2007 – June 2008

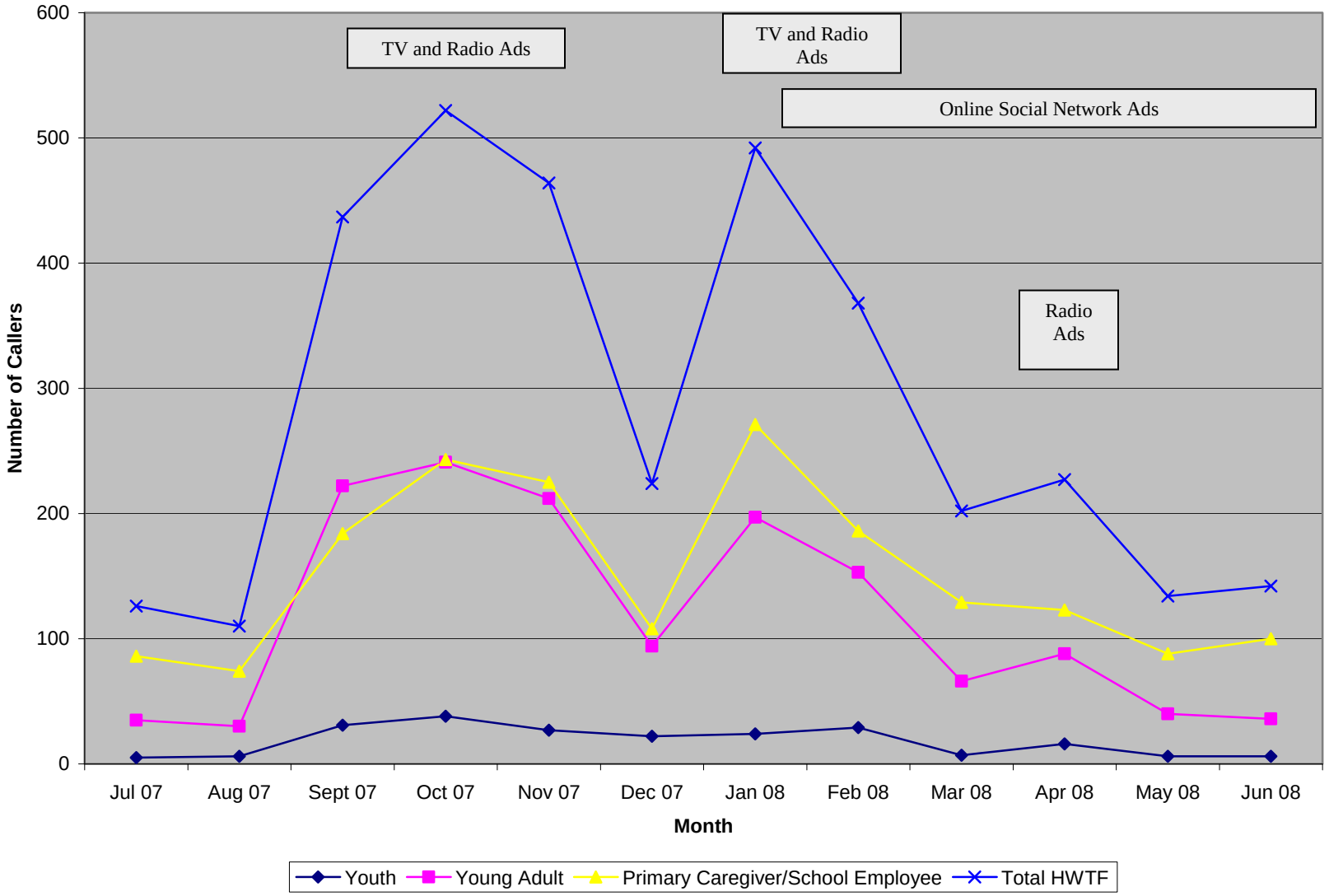
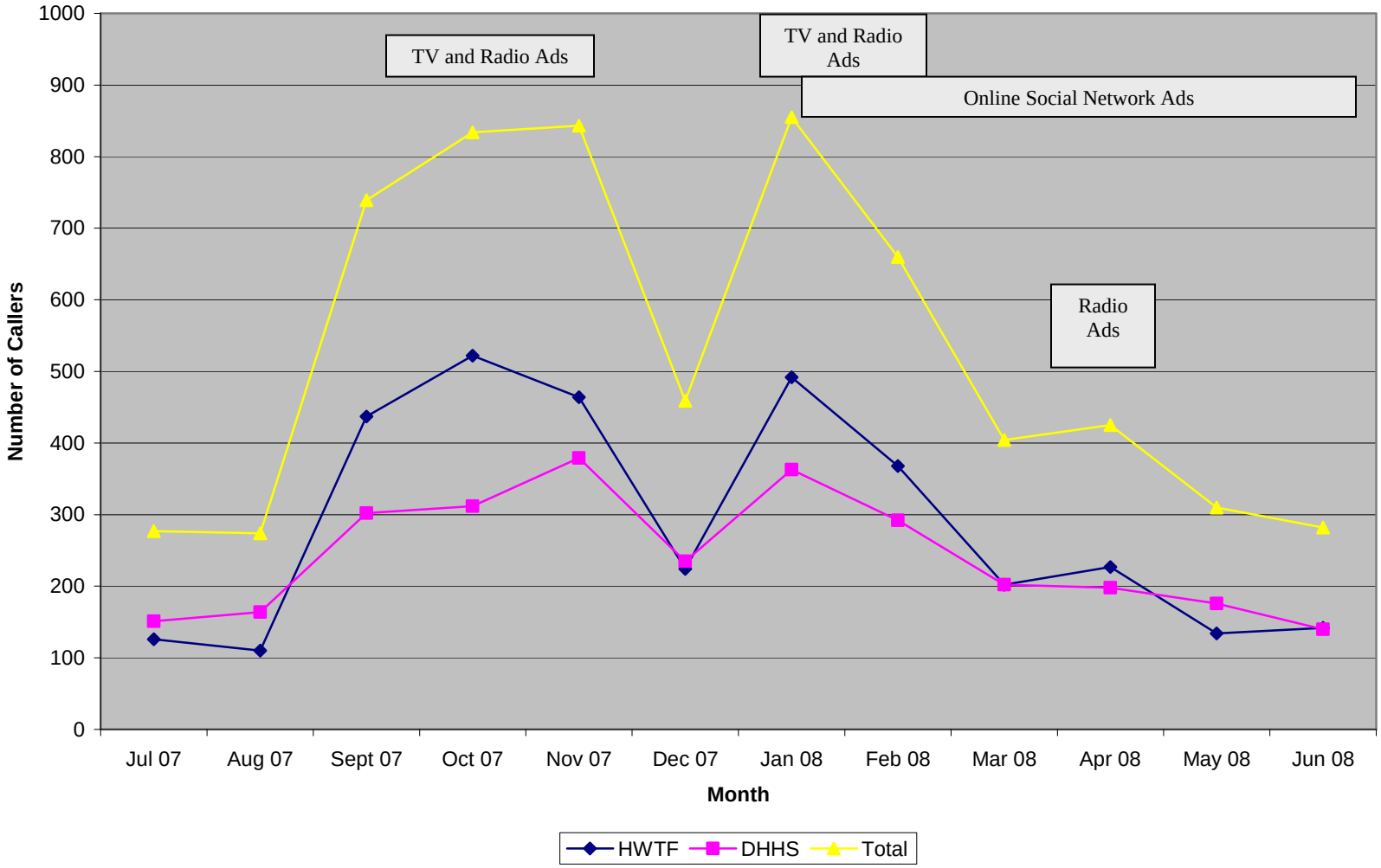


Figure 6. HWTF and DHHS Call Volume Over Time (Tobacco users only, n =6362)
July 2007 –June 2008



Quitline Reaches More Youth and Young Adult Smokers

Based on CDC guidelines, Quitline NC ultimately aims to provide services to 2% of NC tobacco users each year.[2] The most recent data in the literature indicates that, on average, state quitlines reach approximately 1% of smokers in their state.[9] Quitline NC's reach is calculated based on the number of unique callers to Quitline NC as a percentage of the total smoking population of North Carolina. (Smoking data are used as overall tobacco-use prevalence rates are not available.)

In Year 3, Quitline NC served approximately 0.36% of North Carolina's adult smoking population, 0.45% of NC young adult smokers, and 0.22% of NC youth smokers. Year 3 showed marked success in increasing the reach of Quitline NC to both young adult and youth smokers. The percentage of young adult smokers ages 18-24 served by Quitline NC increased from 0.31% in the first 20 months to 0.45% during Year 3. Youth ages 14-17 served by Quitline NC increased from 0.15% in the first 20 months to 0.22% during Year 3. Quitline NC reach to adult smokers in Year 3 was similar to its reach (0.39%) in the first 20 months of operation.

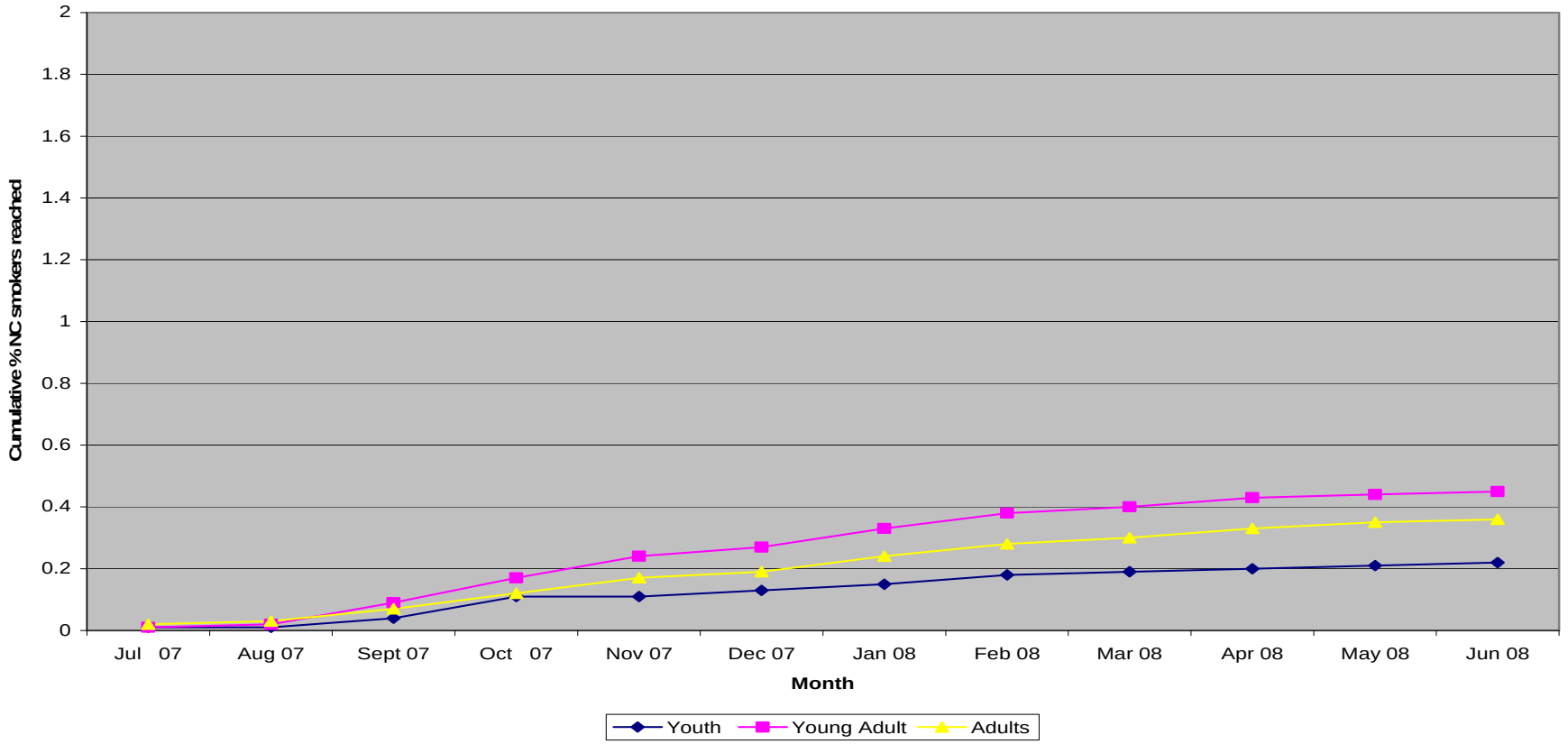
Figure 7 highlights the cumulative percentage of NC adult, young adult, and youth smokers reached by Quitline NC over time in Year 3.

Table 2. Cumulative Percentage of NC Smokers Reached by Quitline NC, July 07 – June 08

NC Population*	Prevalence of Current Smoking**	# of Callers Who Smoke	% Cumulative Reach	Target % Annual Reach
Adults, 18 & older (6,668,948)	22.9% (1,567,127)	5,684	0.36	2.0
Young Adults, 18-24 (918,787)	31.3% (295,581)	1,334	0.45	--
High School Aged Youth, 14-17 (483,189)	19.0% (93,865)	204	0.22	--

* US Census Bureau (2007) and NC State Data Center (2007); ** BRFSS (2007) and NC YTS (2007).
Note: Targets for youth and young adult smokers have not yet been established.

Figure 7. Cumulative Percentage of North Carolina Smokers Reached by Quitline NC, July 07 – June 08



D.2. Characteristics of HWTF Callers

The following section highlights the characteristics of tobacco users from HWTF supported populations that called Quitline NC between July 2007 and June 2008. During Year 3, the HWTF-funded portion of Quitline NC reached a substantial number of callers from populations who experience disparities in tobacco use, effects of tobacco-related diseases, and limited access to healthcare or other cessation resources (e.g., racial and ethnic minority groups, people with low socio-economic status).

Table 3 shows selected demographic characteristics, tobacco-use behaviors, and Quitline use for each of the three HWTF target populations. Sections D.2.a through D.2.c describe each population in greater detail. Additional data tables to accompany this section are included in Appendix B.

Table 3. Selected Characteristics of HWTF-Funded Callers (n=3448)*

Demographic & Tobacco-Use Information		Youth (% of total, n=217)	Young Adult (% of total, n=1414)	Primary Caregiver/School Employee (% of total, n=1817)
Gender	Female	47.0	48.9	65.9
	Male	53.0	51.1	34.1
Language	English	99.5	96.7	95.0
	Spanish	0.5	3.3	5.0
Ethnicity	Non-Hispanic	88.5	88.7	90.1
	Hispanic	7.4	7.1	7.9
Race	White	65.0	57.6	48.3
	Black/African American	22.1	26.2	35.8
	American Indian	1.8	1.9	2.6
	Other Race	6.4	9.8	8.8
Health Insurance	Commercial Insurance	0.0	19.0	32.5
	Medicaid	0.9	15.0	16.3
	Medicare	0.0	1.0	4.4
	No Insurance	0.0	48.0	31.8
Pregnancy Status (% of female callers)	Planning Pregnancy	2.9	6.2	1.8
	Currently Pregnant	5.9	11.3	2.1
	Breastfeeding	0.0	0.9	0.6
Tobacco Use	Cigarettes Exclusively	80.6	85.1	94.0
	Smokeless	2.3	1.3	1.8
	Cigar	0.0	0.8	0.8
	Multiple	13.4	9.3	2.1
Stage of Change	Preparation	90.3	88.4	88.9
	Action	2.8	4.4	7.2
Method of Entry to Quitline NC	Inbound English Call	97.2	96.1	89.0
	Inbound Spanish Call	0.0	2.0	3.6
	Fax Referral	1.4	1.0	5.8
Type of Intervention Requested	One-Call Program	29.5	35.4	31.8
	Multi-Call Program	67.3	59.8	66.0
	General Questions	3.2	3.7	1.5
	Materials Only	0.0	0.8	0.3

* Information on callers who did not provide information and selected categories with very few respondents are not reported, thus percentages do not sum to 100%.

D.2.a. Primary Caregivers and School/Childcare Employees (25 years and older)

The majority (72%) of all Quitline NC callers who used tobacco were adults 25 years or older. Forty percent (1,817) of all Quitline NC callers were primary caregivers of youth and/or school or childcare employees whose services were funded by the HWTF. Primary caregivers/school employees made up 53% of all callers who were supported by HWTF funding.

Most primary caregiver/school employee callers (73% or 1,323) were between the ages of 25-44. About two-thirds (1,197) were female. Among female primary caregivers/school employees, 7% (82) were either pregnant, planning a pregnancy, or breastfeeding.

Nearly half (48%) of all primary caregiver/school employee callers reported their race as white, and over one-third (36%) reported their race as black or African American. About 7% of primary caregivers/school employee callers reported Hispanic ethnicity. Ninety-five percent of callers in this group completed calls in English and 5% completed calls in Spanish.

About two-thirds of all primary caregiver/school employee callers had achieved a GED certificate, high school degree, or had some college education (but no degree). Nineteen percent had a college degree. Sixteen percent had a level of education less than grade nine or had completed some high school but not earned a high school degree.

Nearly one-third (32% or 577) of all primary caregiver/school employee callers had no health insurance coverage. Sixteen percent had Medicaid coverage and 4% had Medicare coverage. Thirty percent of primary caregivers/school employees had some type of commercial insurance. Seventeen percent of all primary caregiver/school employee callers had chronic asthma, 11% had diabetes, 9% had chronic obstructive pulmonary disease (COPD), and 5% had coronary artery disease. Twelve percent had more than one of these conditions.

Primary caregiver/school employees from 98 out of North Carolina's 100 counties called Quitline NC during Year 3. Counties with the highest number of primary caregiver/school employee callers include Mecklenburg (181 callers), Wake (160), and Guilford (99). Cumberland, Durham, and Forsyth counties each had over 50 callers from this group.

The majority (94%) of primary caregiver/school employee callers smoked cigarettes exclusively. Ninety-one percent smoked every day. Two percent of primary caregivers/school employees used smokeless tobacco, 1% used cigars, and 2% used multiple forms of tobacco. Most (92%) callers who used multiple forms of tobacco smoked cigarettes in conjunction with the use of other tobacco products.

The majority (89%) 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. Seven percent were in the action stage (i.e., had already quit in the last six months).

Most (89%) of primary caregiver/school employee callers entered Quitline NC via an inbound English call. Six percent (105) were referred by fax. Two-thirds of primary caregiver/school employee callers enrolled in the Multi-Call Program and 32% enrolled in the One-Call Program at the time of intake.

See Figures 10-12 for visual highlights of primary caregiver/school employee callers.

Figure 10. Primary Caregiver/School Employee Age (n=1817)

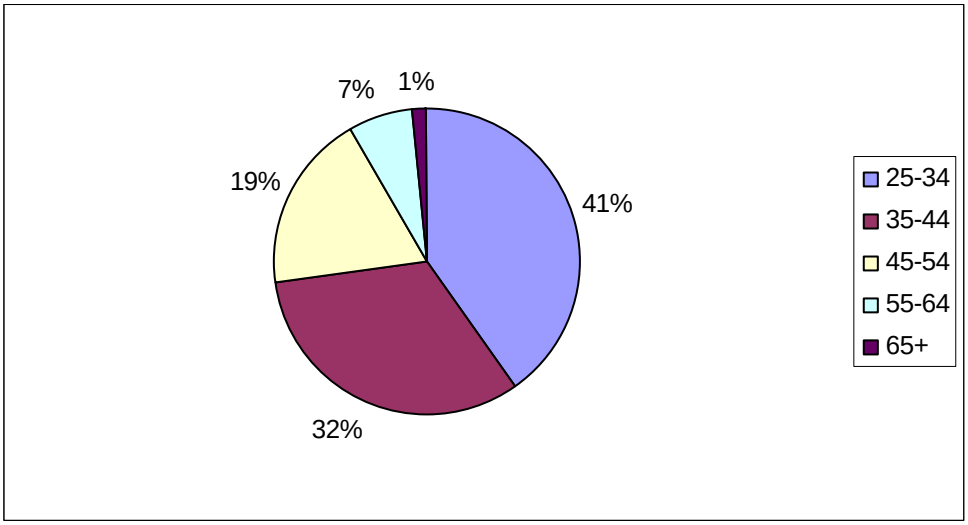


Figure 11. Primary Caregiver/School Employee Education (n=1817)

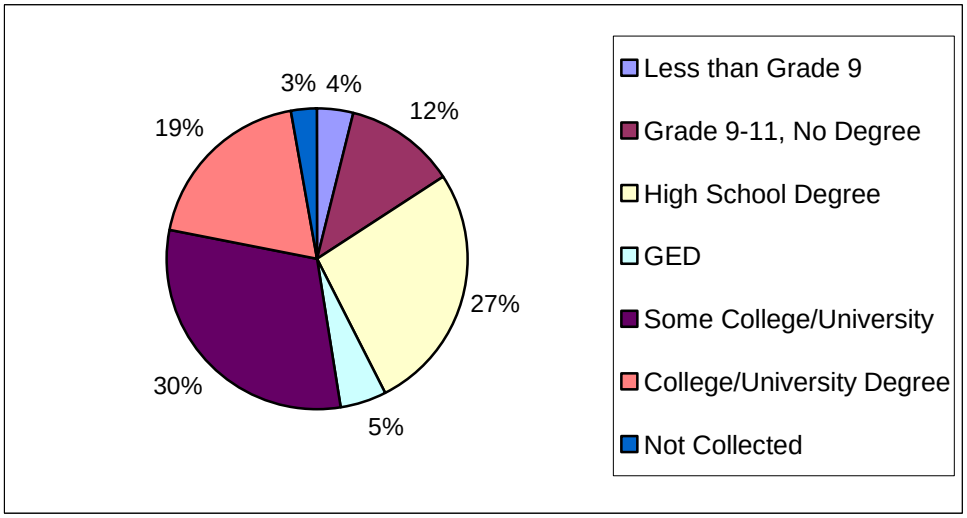
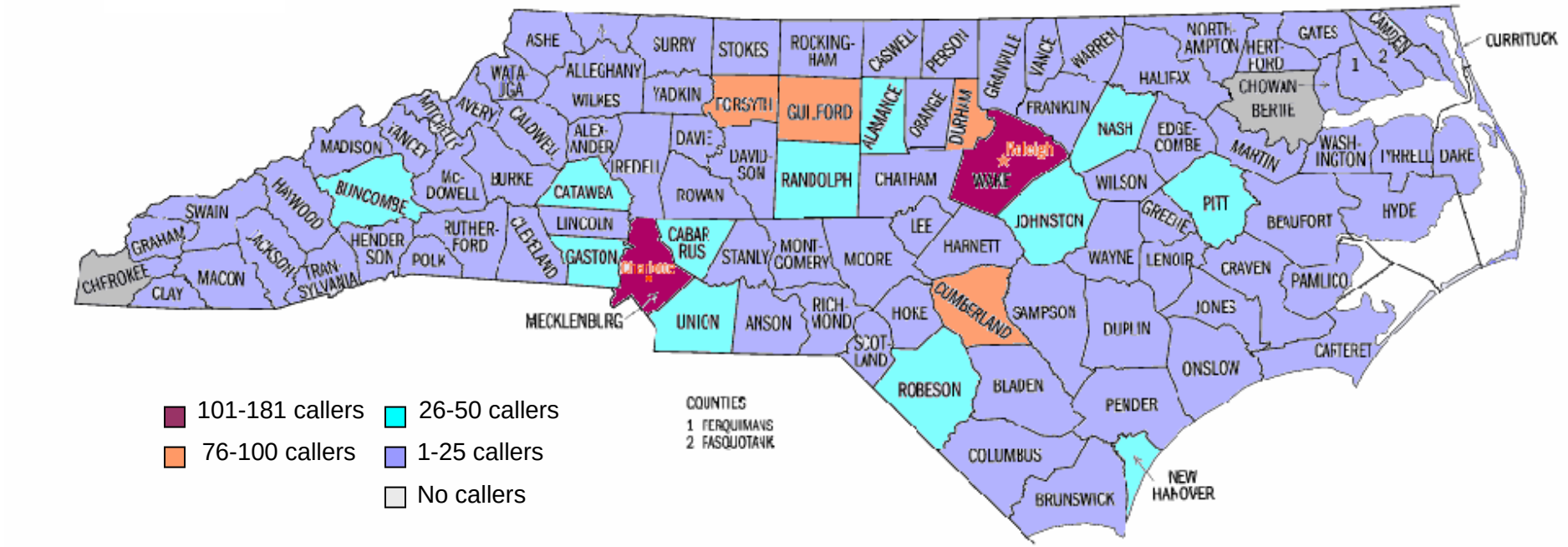


Figure 12. Primary Caregiver/School Employee Call Volume by County of Residence (n=1817)



D.2.b. Young Adults (18 to 24 years old)

Young adults, ages 18-24, continue to have the highest prevalence of smoking among all age groups in North Carolina, with 31% identified as current smokers. Nearly 60% of NC young adult smokers have made quit attempts in the last year.[4]

In Year 3, young adults accounted for 22% (1,414) of all Quitline NC callers who used tobacco. Young adult callers were 41% of all HWTF-funded callers during Year 3.

Approximately half of young adult callers were female (49%). Of all female young adult callers, 18% (127) were planning a pregnancy, currently pregnant, or breastfeeding. Young adult females accounted for 45% (127 of 280) of all female Quitline NC callers who used tobacco and reported being in one of these three pregnancy stages.

Over half (58%) of young adult callers reported their race as white, 26% as black or African American, and 2% as American Indian or Alaskan Native. Less than 1% reported their race as Asian (8) or Native Hawaiian/Other Pacific Islander (6). Nine percent reported their race as "other." Seven percent of young adult callers reported Hispanic ethnicity, and 2% completed calls in Spanish.

Only one-third (32% or 451) of young adult callers reported that they currently attended school. Among those who were not currently in school (63% or 897), most (67%) reported finishing high school, attending some college, or completing a college degree. Sixteen percent (146) of young adult callers not enrolled in school had a level of education less than ninth grade.

Compared to adult callers over 25, young adult callers were slightly more likely to not have health insurance. About two-thirds (64%) of young adult callers either had no health insurance coverage (49% or 689) or had Medicaid (15% or 214). About 19% of young adult callers had health insurance coverage through a commercial provider. Sixteen percent of young adult callers had chronic asthma. Twenty-one (2%) young adult callers had diabetes; 11 had COPD; and 4 had coronary artery disease. Twenty-two (2%) had multiple chronic diseases.

Young adults from 93 of North Carolina's 100 counties called Quitline NC during Year 3. Counties with the highest number of calls include Mecklenburg (163), Guilford (117), and Wake (88). Cumberland, Forsyth, Durham, and New Hanover counties all had between 40 and 60 young adult callers. Nine of the top 10 counties have college campuses with either direct or indirect support from a HWTF Tobacco-Free Colleges Initiative grantee. College grantees work to promote Quitline NC to young adults and healthcare professionals on NC college campuses.

Most (94%) young adult callers smoked cigarettes. Ninety-two percent smoked every day. About 9% used multiple forms of tobacco;1% used smokeless tobacco, and less than 1% used either cigars or pipes. Most (99%) of young adult callers who used multiple forms of tobacco smoked cigarettes in conjunction with use of other tobacco products. The majority (88%) of young adult callers were in the preparation stage of quitting tobacco; 4% were in the action stage; 3% were in the contemplation stage; and less than 1% were in either the precontemplation or maintenance stage.
The majority (96%) of young adult callers entered Quitline NC via an inbound English call. Fourteen callers (1%) were referred by fax. Sixty percent of young adult callers accepted participation in the Multi-Call Program and 35% accepted the One-Call program at intake.

Figures 13-14 provide visual highlights of young adult callers.

Figure 13. Young Adult Age (n=1414)

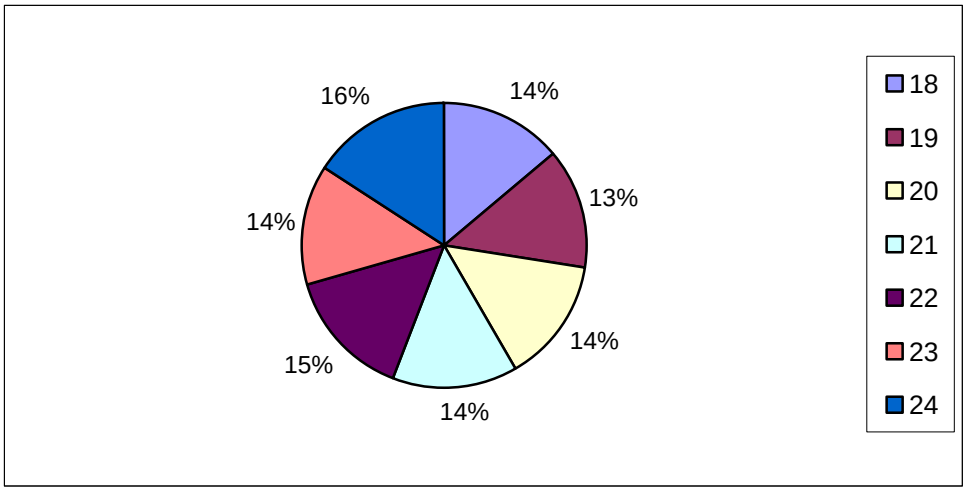


Figure 14. Young Adult Call Volume by County of Residence (n=1414)

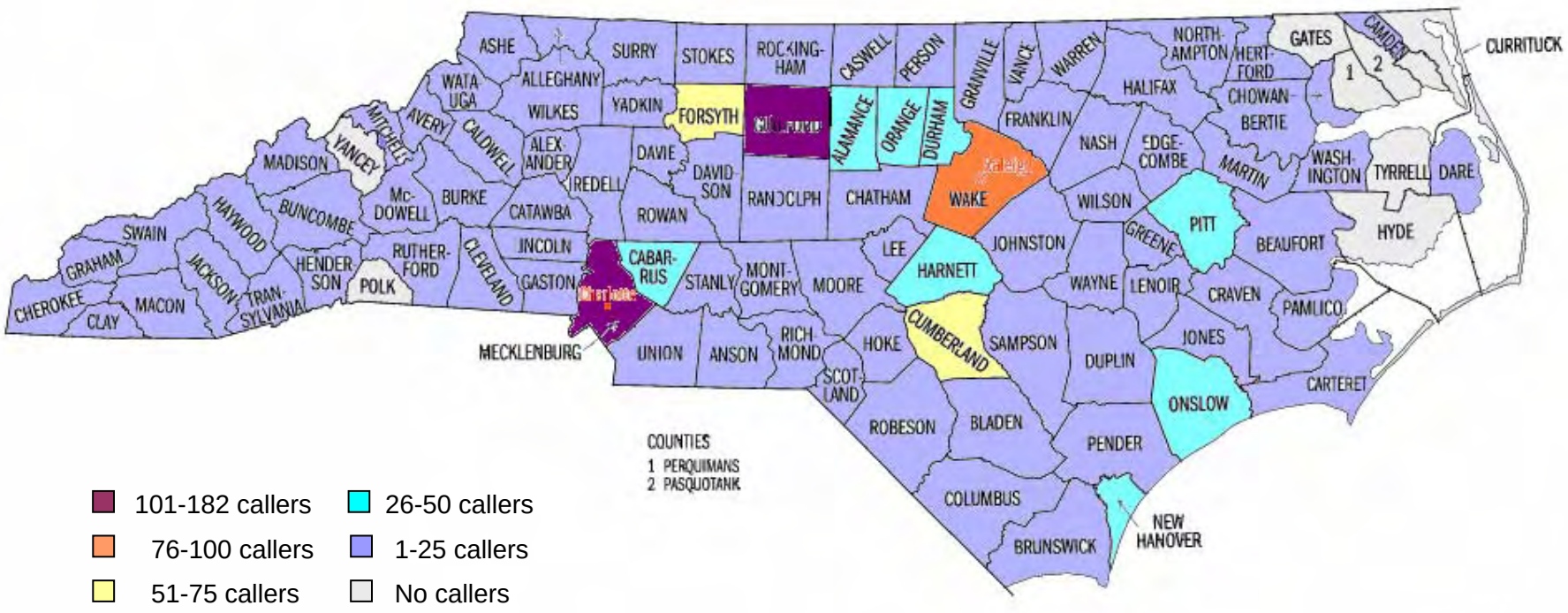


Figure 15 highlights the current employment status of young adult callers. Fifty-eight percent (824) of all young adult callers reported they were currently employed. Of those who were currently working, 70.5% worked full-time and 29.5% worked part-time. Thirty-six percent of young adult callers said they were not currently working. Six percent were missing information about their work status.

Figure 15. Young Adult Employment Status (n=1414)

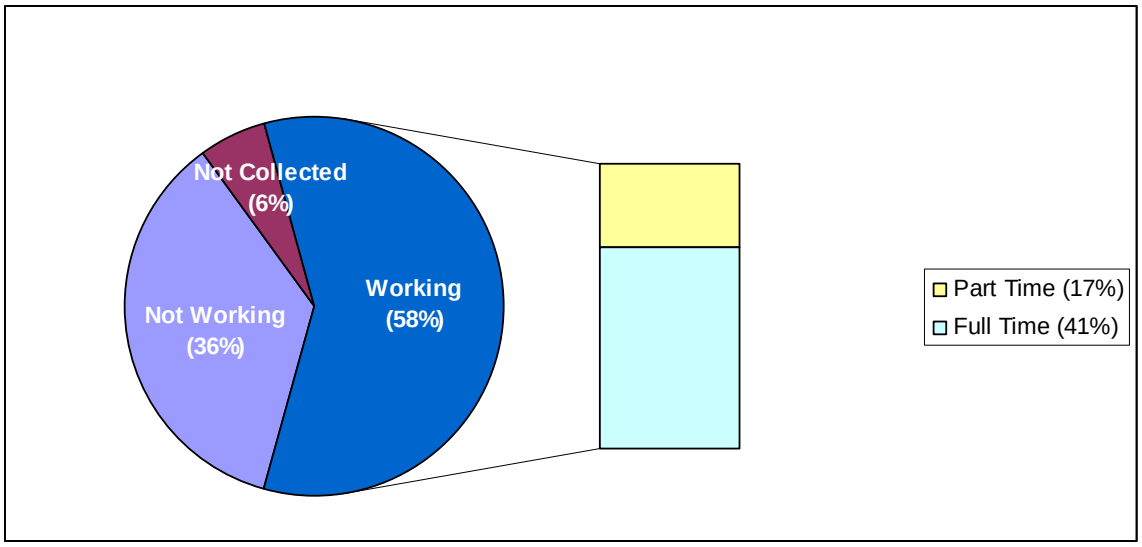


Figure 16 illustrates the current school status of young adults who have called Quitline NC. The majority of young adult callers (63% or 897) reported that they were not currently attending school. Thirty-two percent (451) reported currently attending school. Data on school attendance were missing for 5% (66) of all young adult callers. Among young adults who reported current school attendance, most (74% or 332) were in college, 24% (109) were in high school. Figure 17 highlights the highest level of education achieved by those young adult callers not currently attending school.

Figure 16. Young Adult School Status (n=1414)

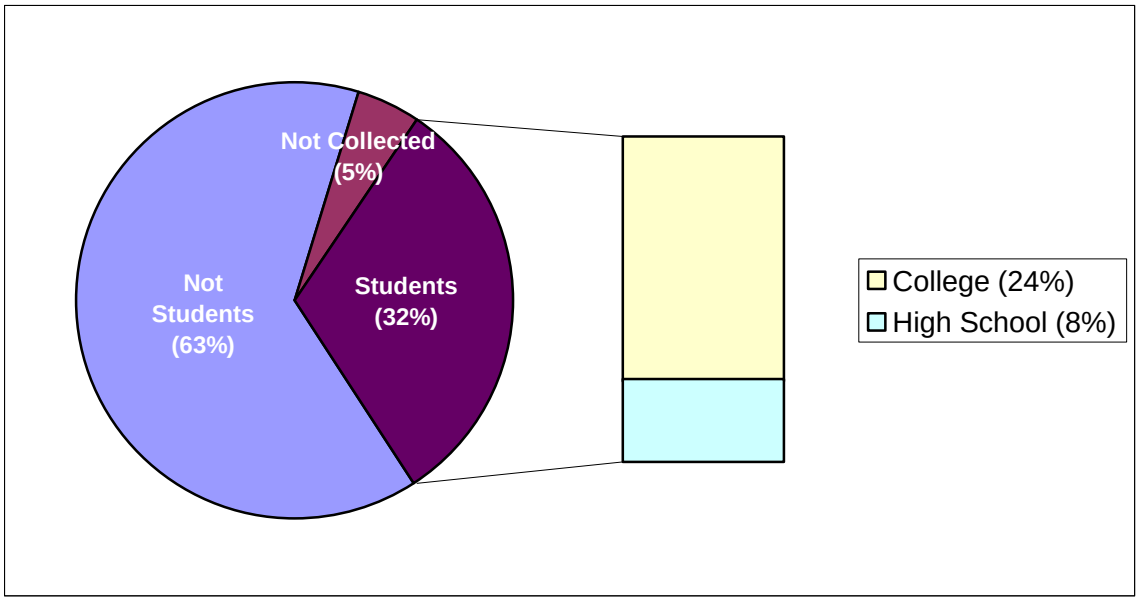


Figure 17. Young Adult Highest Education Completed (Young Adults not currently in school, n=897)

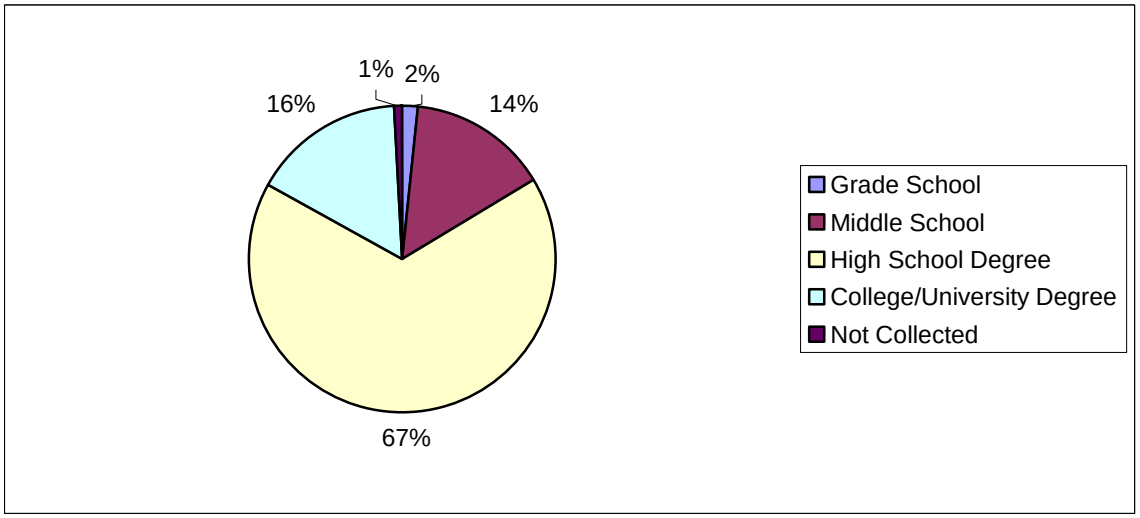


Table 4 compares characteristics of young adult callers who currently attend college with young adult callers who do not currently attend school (i.e., non-college students). Slightly more female college students called than male college students, while slightly more male non-college students called than female non-college students. Female non-college students were more likely to be in a stage of pregnancy than female college students. Female non-college students in this age group made up 34% (95 of 280) of all female callers who reported that they were either planning a pregnancy, pregnant, or breastfeeding (female college students made up 7% of the same group). A greater percentage of non-college students reported Hispanic ethnicity, having no health insurance, or using Medicaid. Non-college students were slightly more likely to use multiple forms of tobacco than college students. Non-college students were also more likely to work full time than were college students.

Table 4. Demographic Comparison of College and Non-College Students

Characteristic	College Students* (n=332)		Non-College Students** (n=897)	
	#	%	#	%
Gender				
Female	178	53.6	423	47.2
Male	154	46.4	474	52.8
Age				
18	50	15.1	88	9.8
19	59	17.8	101	11.3
20	50	15.1	134	14.9
21	48	14.5	131	14.6
22	47	14.1	140	15.6
23	38	11.4	139	15.5
24	40	12.0	164	18.3
Race/Ethnicity				
White	199	59.9	547	61.0
Black/African American	99	29.8	228	25.4
Hispanic	12	3.6	84	9.4
American Indian/Alaskan Native	4	1.2	18	2.0
Pregnancy Status (Females, n=178 and n=423)				
Breastfeeding	0	0	5	1.2
Planning Pregnancy	10	5.6	25	5.9
Pregnant	9	5.1	65	15.4
Health Plan				
Uninsured	121	36.4	493	55.0
Medicaid	37	11.1	147	16.4
Commercial Insurance	91	27.4	135	15.1
Tobacco Use†				
Cigarettes	296	89.2	785	87.5
Cigars	7	2.1	4	0.4
Smokeless Tobacco	2	0.6	12	1.3
Multiple	27	8.1	90	10.1
Currently Working				
Yes	194	58.4	568	63.3
Full Time	*94*	*28.3*	*110*	*51.1*
Part Time	*100*	*30.1*	*110*	*12.3*

*18-24 year old callers who currently attend school and reported college as the school level
**18-24 year old callers who report that they do not currently attend school
† Callers who used cigarettes and some other form of tobacco are classified as multiple tobacco users only

D.2.c. Youth (12 to 17 years old)

In Year 3, youth ages 12 to 17 accounted for 3% (217) of all Quitline NC callers who used tobacco. Youth were 6% of all callers supported by HWTF funding.

Over three-quarters (79%) of youth callers were 16 to 17 years old. Only 3% were middle school age (12-13 years old). Slightly more male youth called than did female youth (53% vs. 47%). Nine youth (9% of all female youth) were either pregnant or planning a pregnancy. Youth made up 3% of all Quitline NC female callers who used tobacco and reported being pregnant, planning a pregnancy, or breastfeeding.

The majority (65%) of youth callers reported their race as white; 22% as black or African American youth; 2% as American Indian or Alaskan Native; and 1% as Asian. About 6% of youth reported their race as "other." Seven percent (16) of youth callers reported Hispanic ethnicity, and one youth caller completed calls in Spanish.

Information about health insurance was not collected for most (98%) youth callers. Seventeen percent (35) of all youth callers reported having chronic asthma.

Youth from 61 of NC's 100 counties called Quitline NC during Year 3. Counties with the highest number of youth callers included Mecklenburg (18), Cumberland (14), Guilford (12), and Wake (12). Six counties had between 5 and 8 callers; the remaining counties each had fewer than 5 callers. Nine of the top ten counties for youth callers received direct support from a HWTF Teen Tobacco Use 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 and include information about Quitline NC in some of their activities.

Most youth callers (94%) smoked cigarettes. Among all youth callers who used cigarettes, 89% smoked every day and 9% smoked some days. Twenty-nine youth callers (13%) reported using multiple forms of tobacco and five callers (2.3%) reported using smokeless tobacco. All youth callers who reported using multiple forms of tobacco smoked cigarettes in conjunction with use of other tobacco products. The majority (90%) of youth callers were in the preparation stage of quitting. Three percent were in the action stage and 2% were in the contemplation stage.

The majority of youth callers entered Quitline NC via an inbound English call. Less than 2% (3 callers) were referred by fax. Over two-thirds (67%) of youth callers enrolled in the Multi-Call Program and 30% accepted the One-Call Program at intake. Three percent called with general questions.

Figures 18 -19 provide visual highlights for youth callers.

Figure 18. Youth Age (n=217)

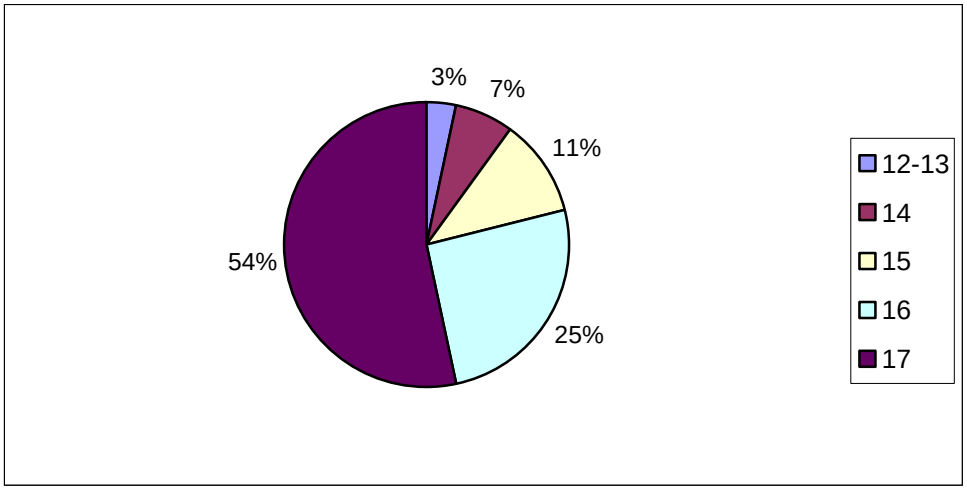
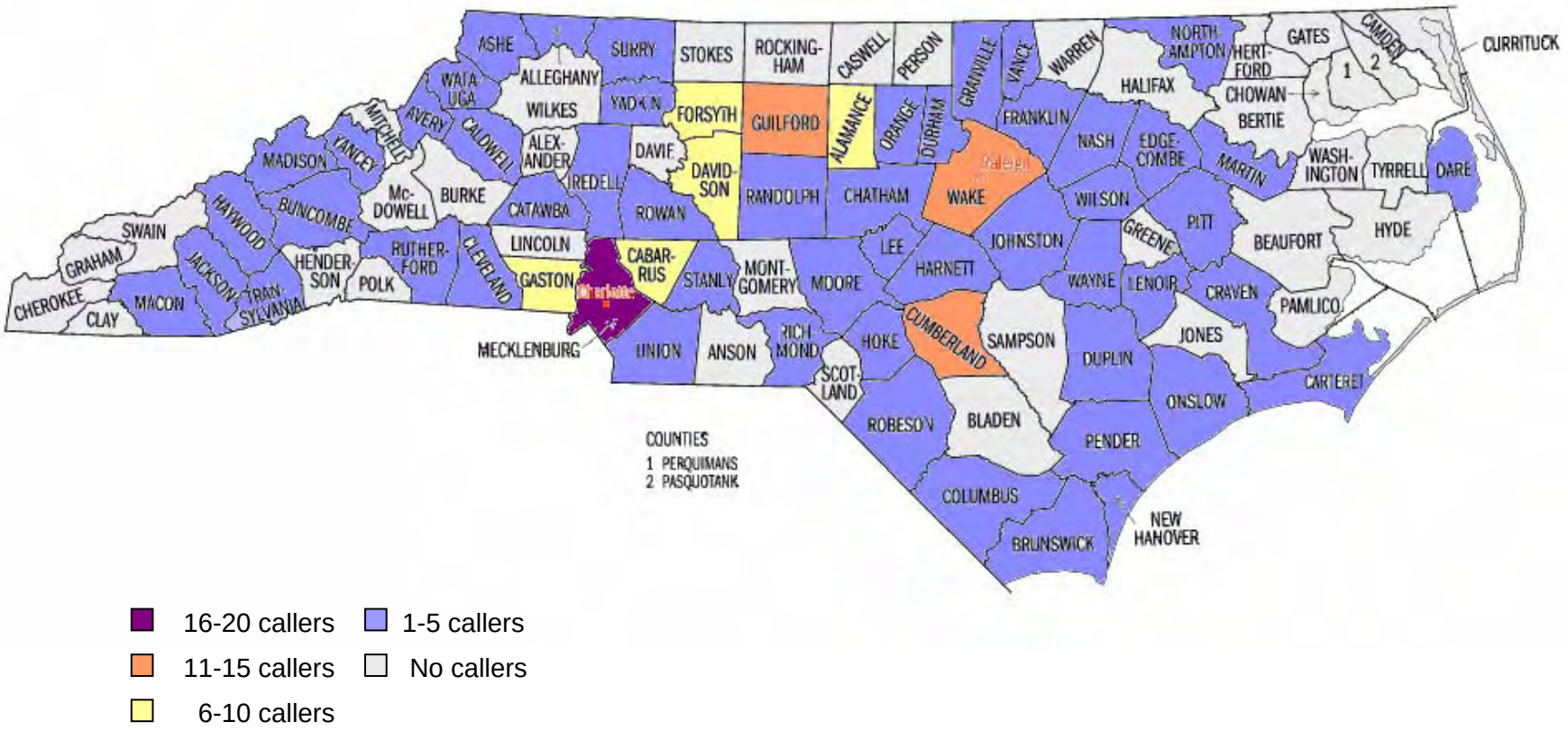
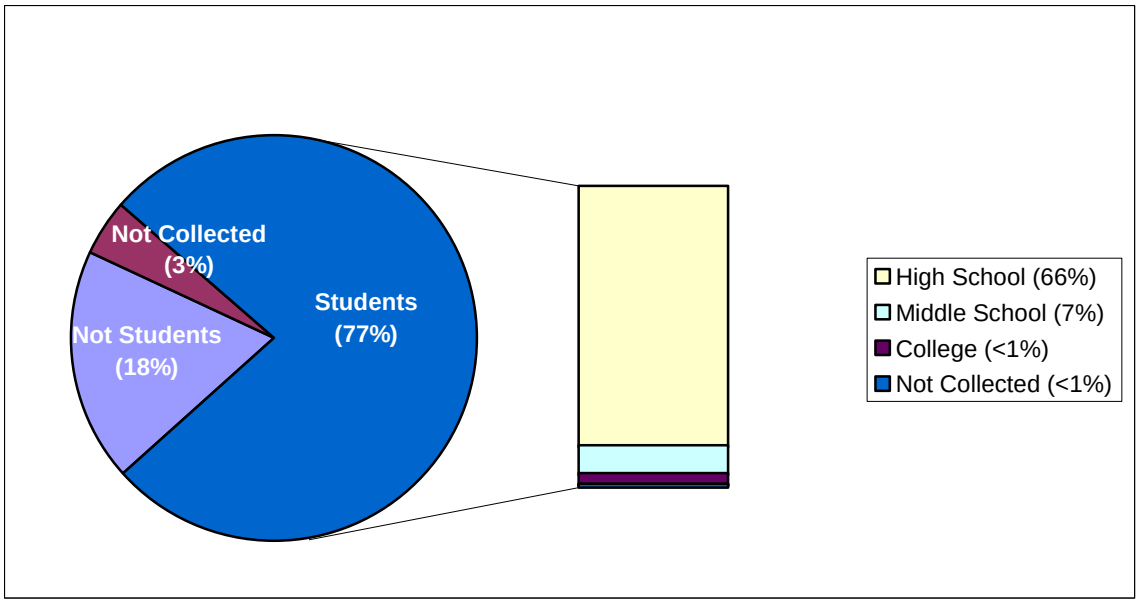


Figure 19. Youth Call Volume by County of Residence



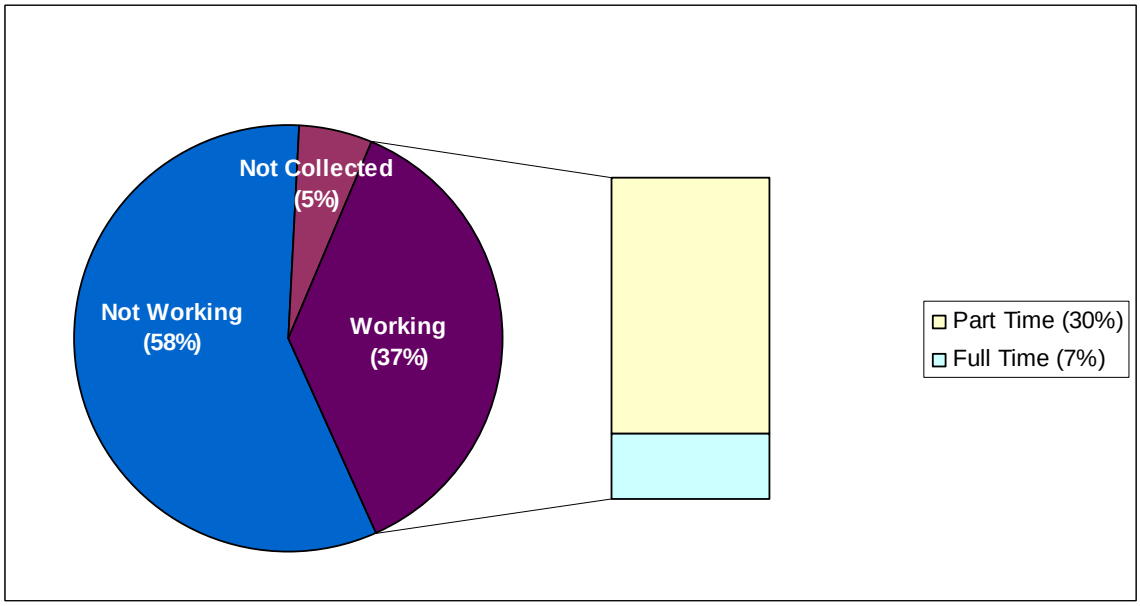
Most youth callers (77% or 167) reported that they currently attended school (Figure 20). Among youth currently attending school, 86% (144) were in high school; 9% (15) were in middle school; and less than 1% were in college (6).

Figure 20. Youth School Status (n=217)



Over one-third (37% or 80) of youth callers reported that they were currently employed (Figure 21). Of those who reported working, most (80% or 64) worked part time and 20% (16) worked full time.

Figure 21. Youth Employment Status (n=217)



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. The fax referral program allows physicians and medical staff to directly refer patients who sign a waiver form and are ready to quit within 30 days. After the referral form is faxed to the quitline, a Quitline NC coach initiates an intake call to the patient to offer assistance with cessation.

In total, 4.2% (265) of all tobacco users who called Quitline NC during Year 3 entered via the fax referral service (Figure 22). Forty-six percent (122) of all callers who entered the quitline via fax referral were supported by HWTF funding. Most (92%) callers who used tobacco entered the quitline via an inbound English call. Two percent of tobacco users entered the quitline via an inbound Spanish call.

The number of HWTF-funded fax referrals declined slightly during the first three months of Year 3, then increased steadily over the next nine months (Figure 23). The majority (86%) of HWTF-funded fax referral calls were for primary caregivers and school employees. Fax referrals for youth and young adults fluctuated throughout Year 3 and did not exceed five referrals per month.

During Year 3, the HWTF led an effort to promote Quitline NC and the fax referral service to health professionals. Over 10,000 North Carolina physicians received fax referral promotional items as well as Quitline NC items to distribute to their patients who use tobacco. Materials were mailed to physicians beginning in March 2008 and continued through the end of Year 3 in June. Fax referrals for adult callers increased sharply in March and remained higher through the end of Year 3, compared with the months before the promotion began.

The majority (82% or 100) of HWTF-funded callers who entered the quitline via fax referral were in the preparation stage of quitting, indicating they were ready to quit in the next 30 days. This is slightly lower than the 89% of HWTF-funded callers entering the quitline via an inbound English call who were in the preparation stage.

Figure 22. Entry Method for All Quitline NC Callers, Year 3 (Tobacco Users Only, n=6362)

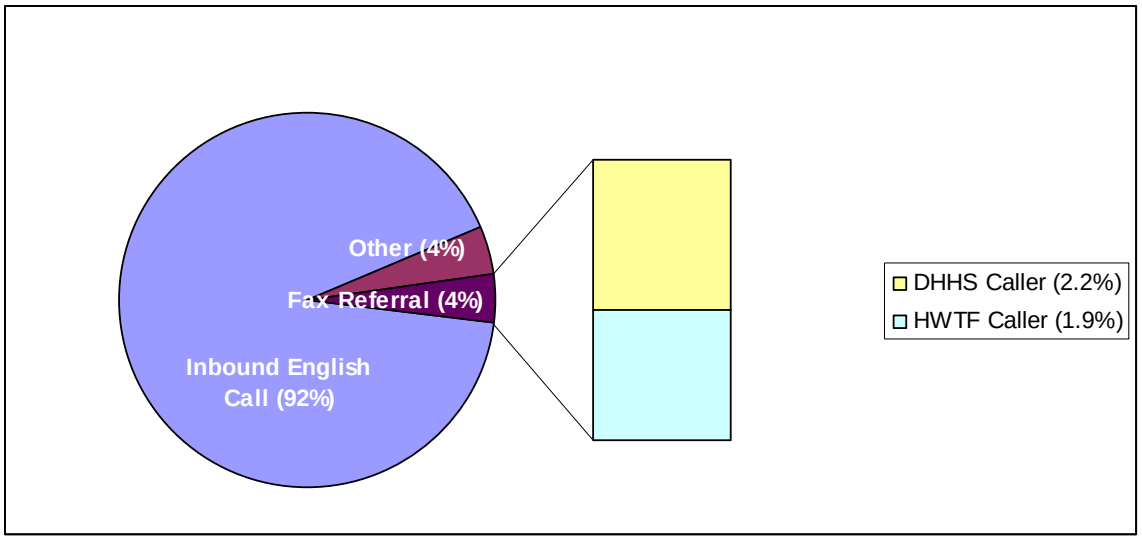
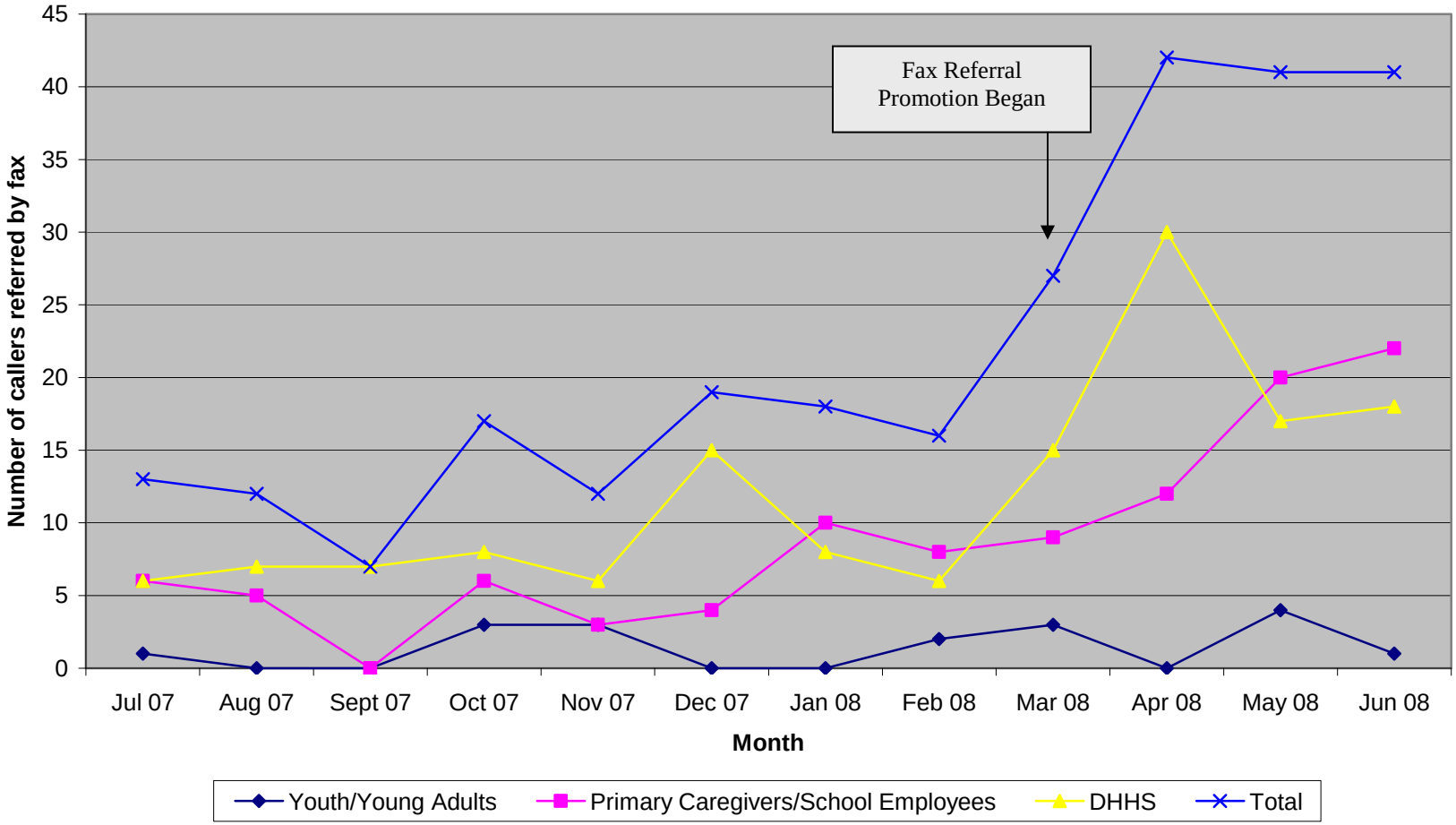


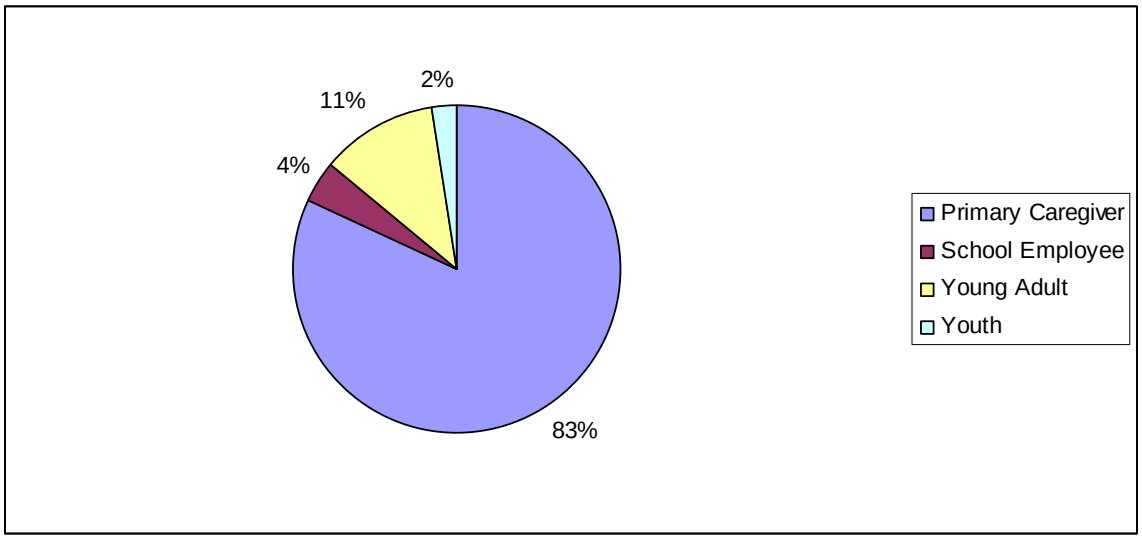
Figure 23. Number of Fax Referrals Over Time (Tobacco users only, n=6362)
July 2007 – June 2008



Overall, the number of fax referrals for HWTF-funded callers remains relatively low. During Year 3, 3.5% of all HWTF-funded callers were referred by fax (average of 10.2 HWTF callers referred by fax each month). Most (86%) of these callers were primary caregivers or school employees (Figure 24). Young adult callers accounted for 11.5% of HWTF fax referrals, and youth callers accounted for 2.5% of HWTF fax referrals.

Additional data tables to accompany this section are included in Appendix C.

Figure 24. Type of HWTF Callers Referred by Fax, Year 3 (n=122)



D.4. Promotion

Research indicates that targeted quitline promotional campaigns are effective at driving callers to the quitline.[2,8-10] During the first 20 months of operation, the HWTF and the DHHS ran several small-scale, statewide and local promotions for Quitline NC. During this period the HWTF also invested in market research and the development of a new paid media campaign targeted to young adult tobacco users.

During Year 3, the HWTF launched "Call it Quits," a multimedia quitline promotional campaign targeted to young adults. The "Call it Quits" campaign began in September 2007, making North Carolina one of the first states in the country to use a multimedia promotion targeting young adults. The campaign used television, radio, and print advertisements that featured simulated calls between young adult smokers and a Quitline NC coach. Online components of the campaign featured a redesigned Quitline NC website (www.QuitlineNC.com) using the same theme as the TV and print ads. The HWTF also targeted young adults through online ads on the social networking website Facebook www.facebook.com. "Call it Quits" was the primary focus of promotional activities by HWTF during the first six months of Year 3.

Table 5 outlines the components of the "Call it Quits" campaign. During Year 3, no other paid Quitline promotional media campaigns were run by the HWTF, DHHS, or other state level organizations.

Table 5. HWTF-funded "Call it Quits" Quitline NC Media Promotion

Type of Media	Market	Time Period
TV	Six regional television markets across the state	September 07 October 07 November 07 January 08 February 08
Radio	Six regional radio markets across the state	September 07 October 07 November 07 December 07 January 08 February 08 April 08
Hispanic Radio	Three regional radio markets across the state	November 07 December 07
Newspaper	Statewide specialty newspaper	September 07 (statewide specialty newspaper)
Online	Social networking site facebook.com	January 08 February 08 March 08 April 08 June 08

HWTF Teen and College Initiative Grantee Promotions

The HWTF currently funds two statewide tobacco initiatives targeted to youth and young adults: the Teen Tobacco Use Prevention and Cessation Initiative and the 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, and meetings with student health services. College Initiative grantees reported 372 Quitline NC promotions between July 2007 and June 2008; Quitline NC promotional activities are not tracked as an indicator for the Teen Initiative.

How Callers Heard About Quitline NC

TV, radio, health professionals, and family/friends were the four most frequently reported ways HWTF callers heard about Quitline NC during Year 3. TV and radio promotions included both commercials (i.e., paid media like the "Call it Quits" campaign) and news broadcasts (i.e., earned media). Overall, more HWTF callers reported hearing about the quitline from TV commercials (40%) than TV news reports (1%). Other frequent sources of information about the quitline included brochures/newsletters/flyers, websites, health insurance, or other sources not listed on the caller intake form. Three percent of HWTF callers reported being a past caller as their primary means of hearing about Quitline NC. Figure 25 shows how all HWTF-funded callers heard about Quitline NC in Year 3.

Figures 26 – 28 show the top ten promotions for each group of HWTF callers. Each age group reported the same top four sources of information about the quitline: TV, radio, family/friend, and health professional. Youth and young adult callers were more likely to hear about the quitline from a family member or friend than a health professional. Conversely, adult callers were more likely to hear about the quitline from a health professional than a family member or friend.

TV and radio ads from the "Call it Quits" campaign had the greatest impact on young adult call volume. Seventy-five percent of young adult callers reported that they heard about the quitline from TV or radio, compared to 65% of youth callers and 51% of primary caregiver/school employee callers. The proportion of young adult callers who reported TV and radio ads as their primary source of information about the quitline, and the spikes in young adult call volume during months in which these ads aired suggest that the "Call it Quits" media promotion was successful in reaching young adults.

The majority of HWTF callers who heard about Quitline NC from TV, radio, or health professionals were in the preparation stage of quitting (90%, 89%, and 86%, respectively). This implies that the top three methods of promotion are reaching the quitline's target audience of tobacco users who want to quit in the next 30 days.

Additional data tables to accompany this section are included in Appendix C.

Figure 25. How HWTF Callers Heard About Quitline NC (Tobacco users only, n=3448)
July 2007 – June 2008

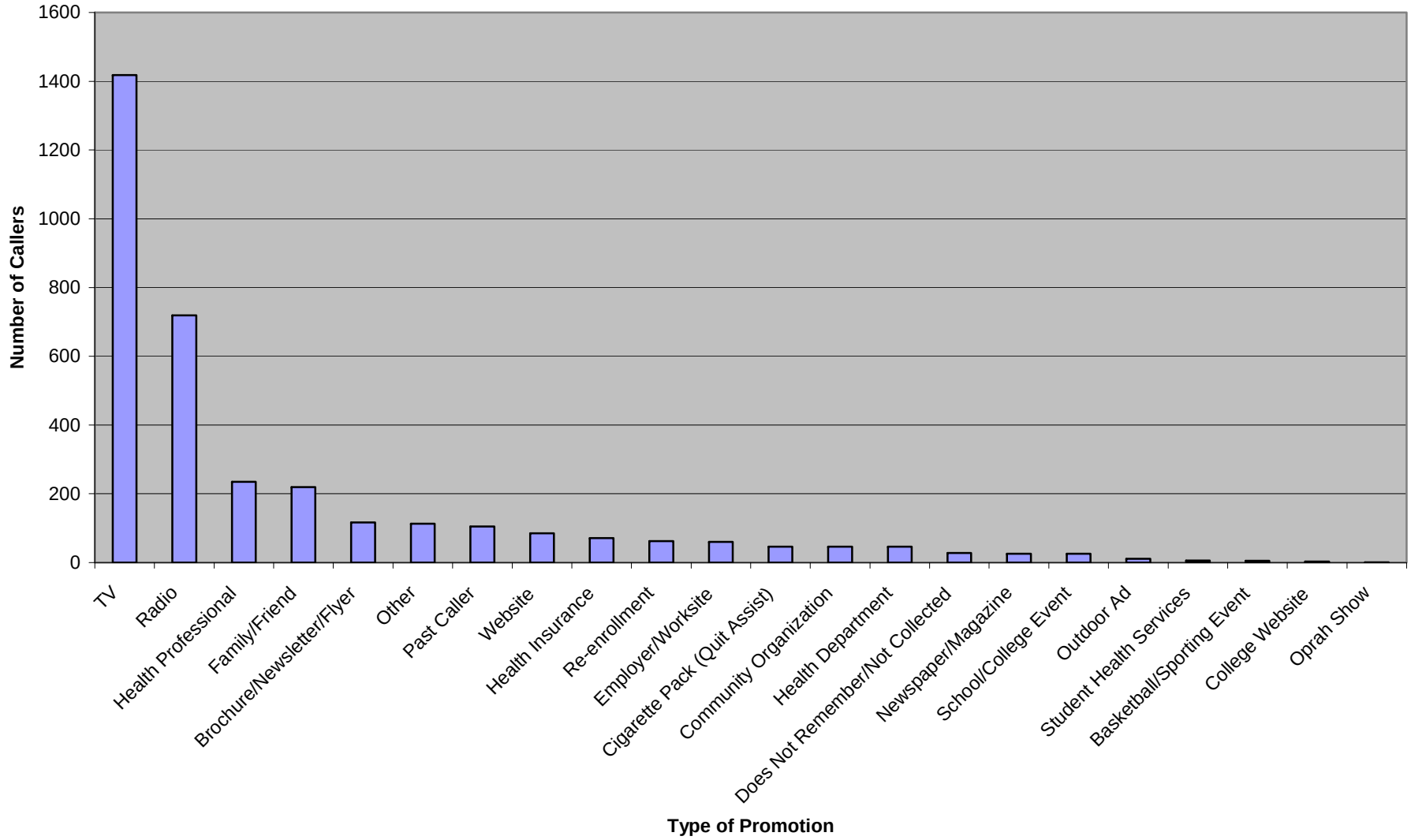


Figure 26. Top Ten "How Heard About" Responses for Primary Caregiver/School Employee Callers (n=1817)

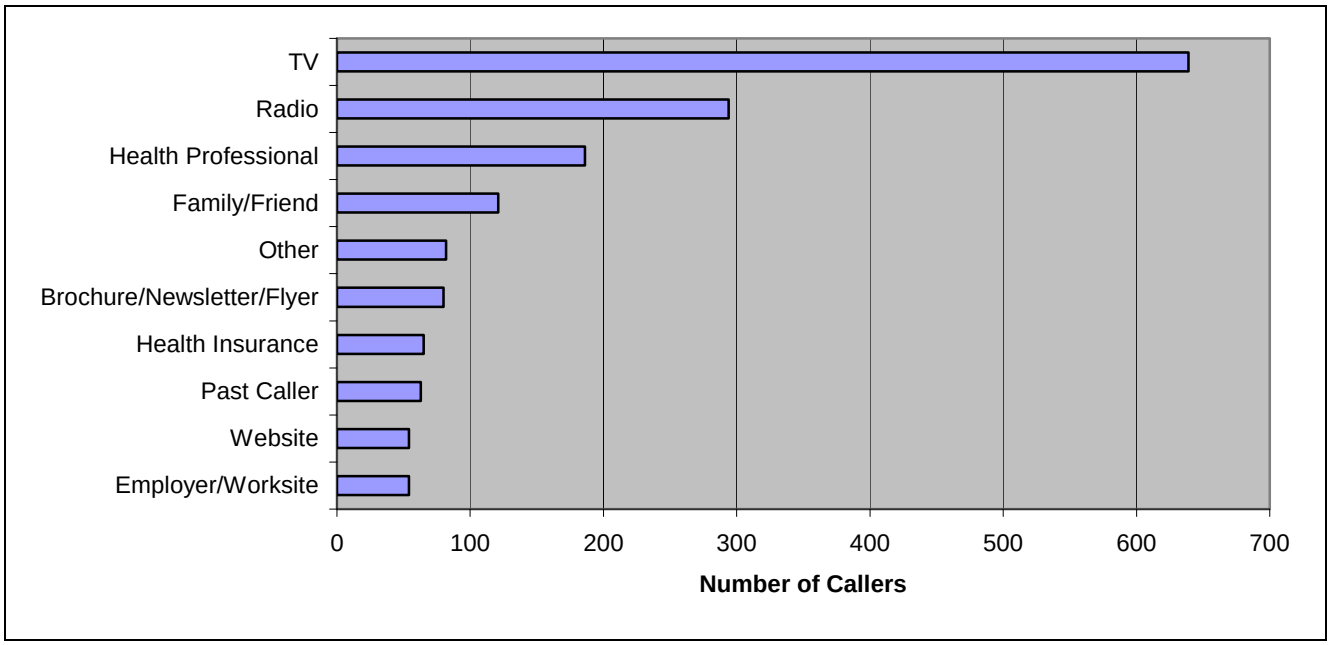


Figure 27. Top Ten "How Heard About" Responses for Young Adult Callers (n=1414)

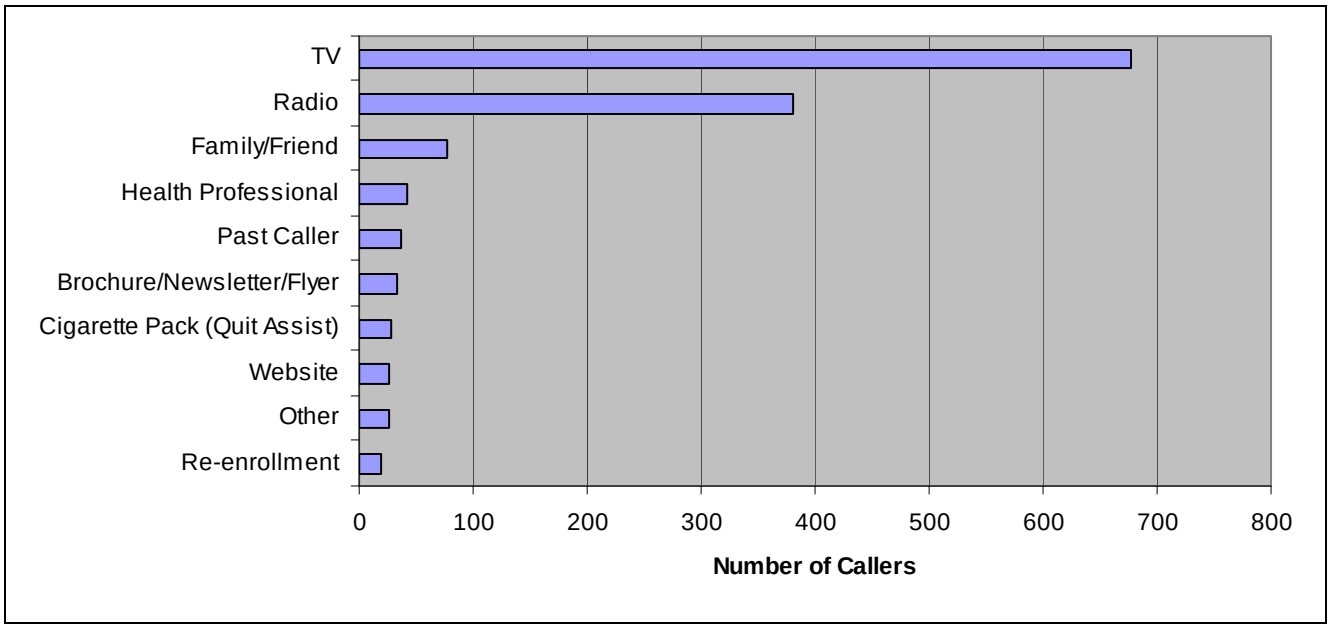
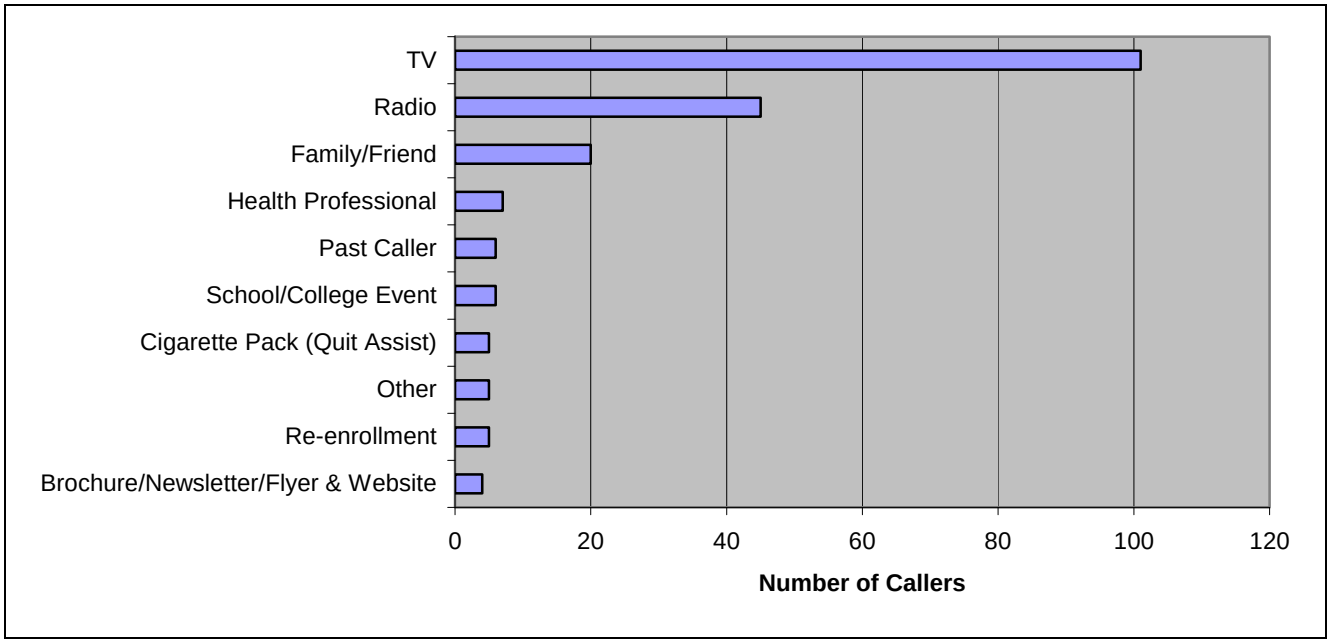


Figure 28. Top Ten "How Heard About" Responses for Youth Callers (n=217)



Figures 29 – 31 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) during Year 3.

Television: Television ads from the “Call it Quits” campaign were aired across the state for one or two week segments in the months of September - November of 2007 and January and February of 2008. Higher numbers of callers reported hearing about the quitline from TV during these months. While the campaign targeted young adults, increases in callers reporting hearing about the quitline via TV occurred for all age groups during this month, suggesting that the campaign had some spillover influence to youth and adult callers. The number of callers who heard about the quitline via TV increased more substantially during the first three months of the TV promotions than during the final two months

Radio: Radio ads were aired across the state in one or two week segments in the months of September - December of 2007 and in January, February, and April of 2008. The number of HWTF callers who heard about the quitline via radio peaked in January, one of the months in which radio ads from the “Call it Quits” campaign aired. Higher numbers of young adult and primary caregiver/school employee callers reported hearing about the quitline via radio during the months in which “Call it Quits” radio ads aired compared to months in which ads did not air. Like the TV ads, the “Call it Quits” radio ads were targeted to young adults and appeared to have similar spillover influence on youth and adult callers, as evidenced by increased numbers of callers who heard about Quitline NC via radio during months in which radio ads aired.

Health Professionals: During Year 3, the HWTF led an effort to promote Quitline NC and the fax referral system to health professionals. Over 10,000 North Carolina physicians received fax referral promotional items as well as Quitline promotional items to distribute to their patients who smoke. Distribution of these items began in March 2008 and continued through the end of Year 3 in June 2008. HWTF Tobacco-Free Colleges grantees reported 38 meetings with campus healthcare providers to promote Quitline NC and the fax referral system during Year 3. Numbers of callers who heard about the quitline via health professionals increased sharply after the fax referral promotion began.

Figure 29. HWTF Callers Who Heard About Quitline NC via TV (n=1418)

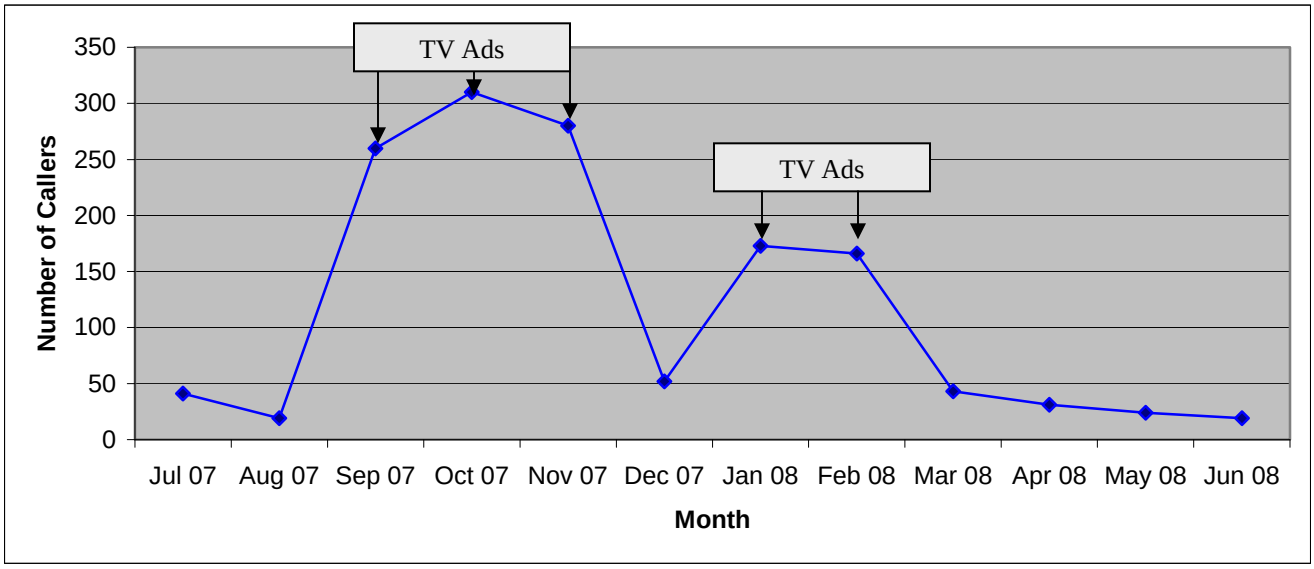


Figure 30. HWTF Callers Who Heard About Quitline NC via Radio (n=719)

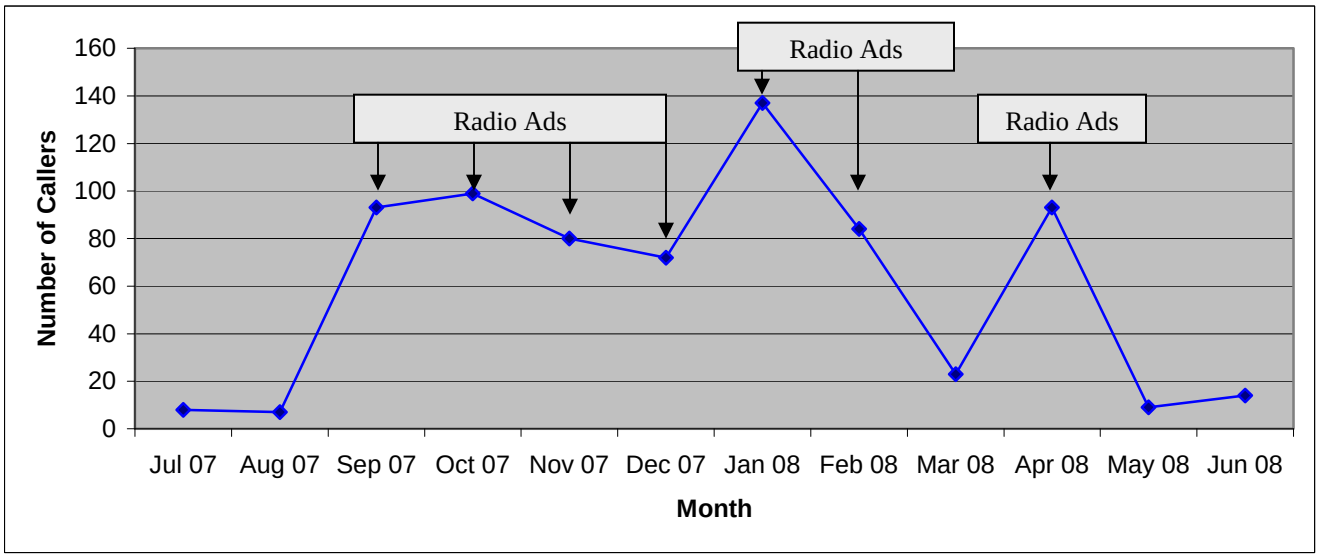
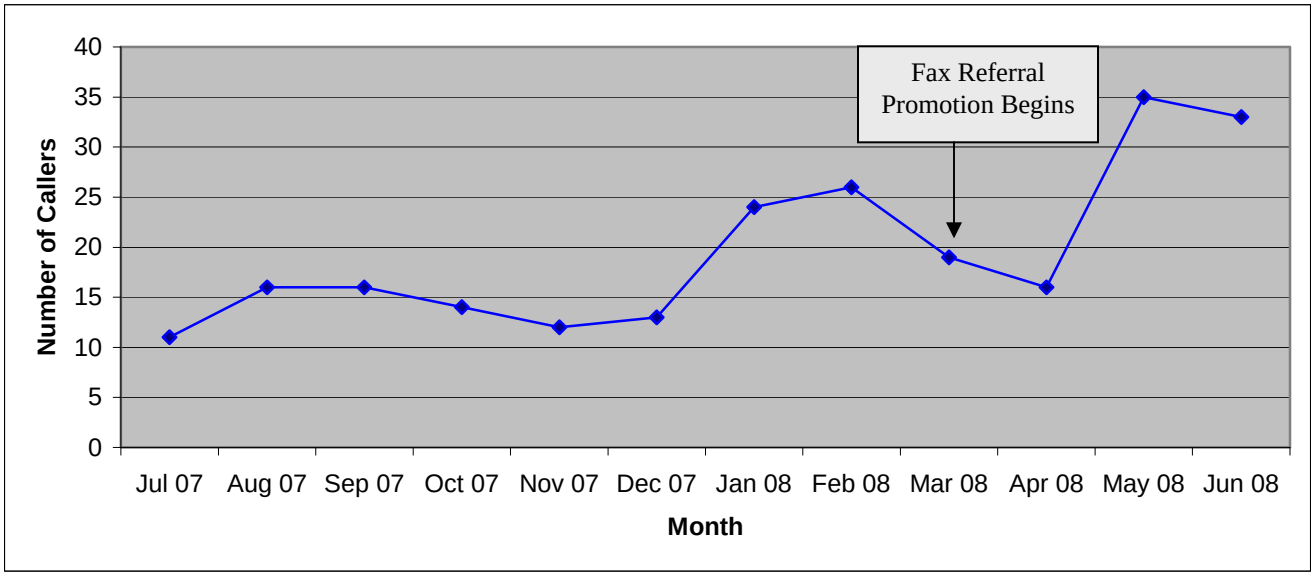


Figure 31. HWTF Callers Who Heard about Quitline NC via Health Professionals (n=235)



D.5. Satisfaction and Quit Rates

The Quitline NC vendor, Free & Clear, assesses Quitline NC callers' success with quitting and satisfaction with quitline services through an End-Of-Program (EOP) survey administered to a group of callers seven months post-registration. The survey is administered via telephone to a randomly selected sample of Quitline NC callers.

Quit rate and satisfaction results for Year 3 callers were summarized in the North Carolina Tobacco Use Quit Line Evaluation Report Year 03 published by Free & Clear in August 2007. UNC TPEP did not complete any additional analyses 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 1000 individuals who called Quitline NC between April 1, 2007 and October 31, 2007. Three hundred ninety-two callers (39%) completed the survey, 155 (39.5%) of whom were from HWTF-funded populations. In total, 83 youth were sampled with 19 (23%) completing the survey; 199 young adults were sampled with 58 (29%) completing the survey; and 200 primary caregivers/school employees were sampled with 78 (39%) completing the survey.

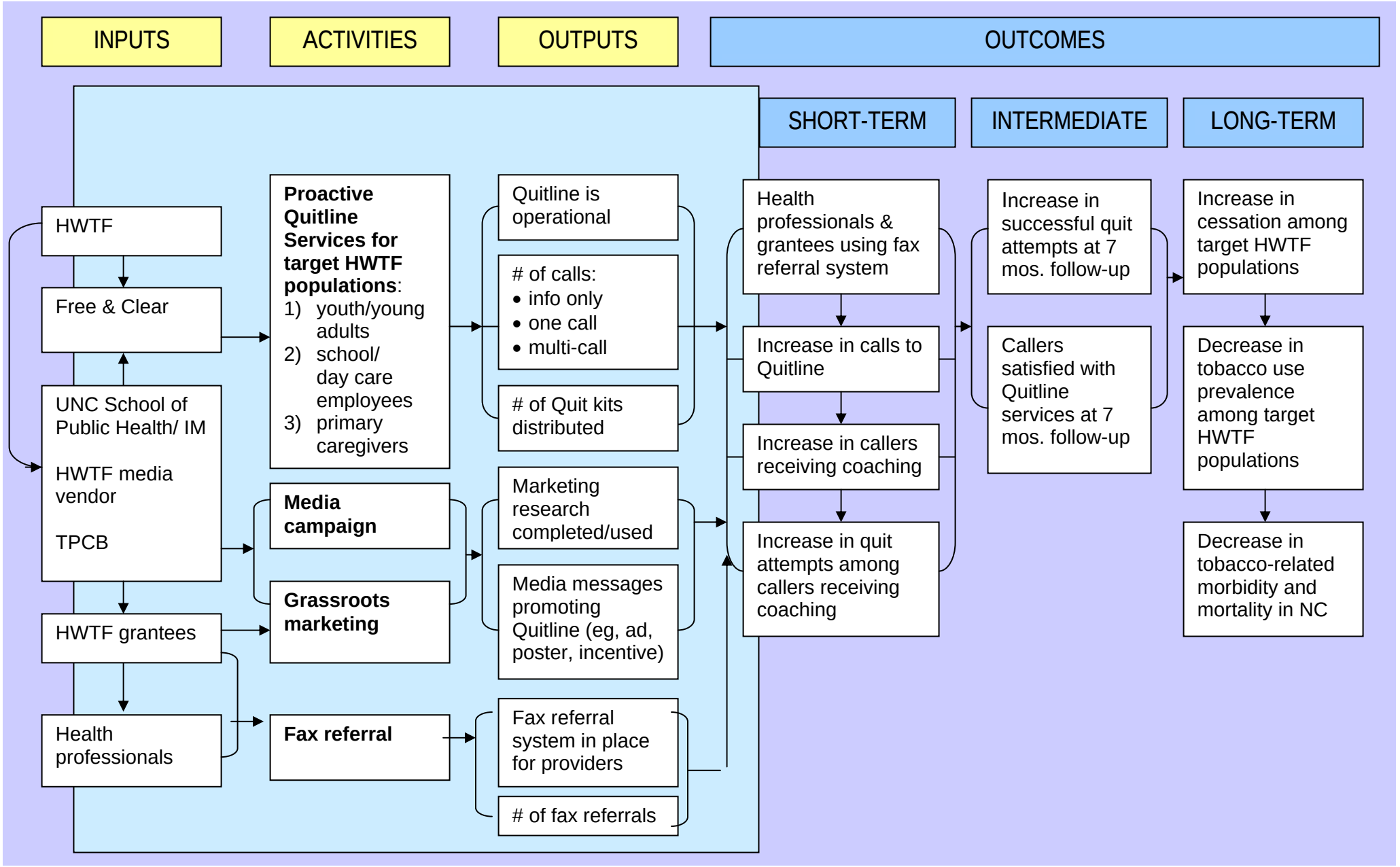
Table 6 summarizes satisfaction and quit rate data for HWTF-funded callers for Year 3. *Respondent quit rates* are calculated by dividing the number of respondents who report quitting by the total number of respondents to the EOP survey. *Intent-to-treat quit rates* are calculated by dividing the number of respondents who reported quitting by the total number of survey respondents and non-respondents (i.e. those in the sample who did not complete the survey), and are thus a more conservative estimate. Intent-to-treat analysis treats all non-respondents as current smokers. The overall satisfaction rate is defined as being "somewhat" to "very" satisfied with Quitline NC services.

Table 6. Summary of Satisfaction and Quit Rates for HWTF Callers from Free & Clear Report* (n=155)

	All HWTF Callers (n=155)		Youth (n=19)		Young Adults (n=58)		Primary Caregivers/ School Employees (n=78)	
	N	%	N	%	N	%	N	%
Satisfaction Rate								
Satisfied	132	94.3	17	100.0	47	92.2	68	94.4
Not Satisfied	8	5.7	0	0.0	4	7.8	4	5.6
Number of Serious Quit Attempts Lasting >24 hours								
0 time	13	10.4	0	0.0	4	8.9	9	13.6
1 time	26	20.8	4	28.6	10	22.2	12	18.2
2 times	39	31.2	4	28.6	15	33.3	20	30.3
3 times	24	19.2	5	35.7	7	15.6	12	18.2
4 or more	23	18.4	1	7.1	9	20.0	13	19.7
7-Day Point Prevalence Tobacco Abstinence Rates								
Respondent 7-Day Quit Rate	57	36.8	12	63.2	18	31.0	27	34.6
Intent-to-treat 7-Day Quit Rate	57	11.8	12	14.5	18	9.0	27	13.5
30-Day Point Prevalence Tobacco Abstinence Rates								
Respondent 30-Day Quit Rate	52	33.5	12	63.2	15	25.9	25	32.1
Intent-to-treat 30-Day Quit Rate	52	10.8	12	14.5	15	7.5	25	12.5

***** Some respondents did not answer all questions. Free & Clear reports percentages calculated based on the number of respondents to each question.

Appendix A
Logic Model for the HWTF-funded Portion of Quitline NC (2006)



Appendix B
Data Tables for Characteristics of Callers

Table B-1. Callers by Age (Tobacco Users Only, n=6155)*

	Funding Source				Total	
	HWTF		DHHS			
Age	#	%	#	%	#	%
0 to 17 years old	217	6.3	0	0.0	217	3.5
18 to 24 years old	1414	41.0	0	0.0	1414	23.0
25 to 34 years old	734	21.3	626	23.1	1359	22.1
35 to 44 years old	590	17.1	477	17.6	1067	17.3
45 to 54 years old	343	9.9	773	28.6	1116	18.1
55 to 64 years old	126	3.7	570	21.1	696	11.3
65 years and older	24	0.7	261	9.6	285	4.6
Total	3448	100.0	2707	100.0	6155	100.0

* 208 DHHS callers missing age data

Table B-2. Callers by Gender (Tobacco Users Only, n=6362)

	HWTF Status											
	Youth		Young Adults		Primary Caregivers		School Employees		DHHS		Total	
Gender	#	%	#	%	#	%	#	%	#	%	#	%
Female	102	47.0	691	48.9	1091	64.7	106	80.3	1556	53.4	3546	55.7
Male	115	53.0	723	51.1	593	35.2	26	19.7	1272	43.7	2729	42.9
Other*	0	0.0	0	0.0	1	0.1	0	0.0	1	0.0	1	0.0
Total	217	100.0	1414	100.0	1685	100.0	132	100.0	2914	100.0.	6362	100.0

* Refused or not collected.

Table B-3. Callers by Pregnancy Status (Female Tobacco Users Only, n=3546)

	HWTF Status											
	Youth		Young Adults		Primary Caregivers		School Employees		DHHS		Total	
Pregnancy Group	#	%	#	%	#	%	#	%	#	%	#	%
Not Asked	93	91.2	564	81.6	1010	92.6	105	99.1	1494	96.0	3266	92.1
Planning Pregnancy	3	2.9	43	6.2	31	2.8	1	0.9	31	2.0	109	3.1
Pregnant	6	5.9	78	11.3	38	3.5	0	0.0	31	2.0	153	4.3
Breast Feeding	0	0.0	6	0.9	12	1.1	0	0.0	0	0.0	18	0.5
Total	102	100.0	691	100.0	1091	100.0	106	100.0	1556	100.0	3546	100.0

Table B-4. Callers by Ethnicity (Tobacco Users Only, n=6362)

	HWTF Status											
	Youth		Young Adults		Primary Caregivers		School Employees		DHHS		Total	
Ethnicity	#	%	#	%	#	%	#	%	#	%	#	%
Hispanic	16	7.4	101	7.1	133	7.9	0	0.0	139	4.8	389	6.1
Non-Hispanic	192	88.5	1254	88.7	1509	89.6	128	97.0	2486	85.3	5569	87.5
Other*	9	4.1	59	4.2	43	2.6	4	3.0	289	9.9	404	6.4
Total	217	100.0	1414	100.0	1685	100.0	132	100.0	2914	100.0	6362	100.0

* Refused, does not know, or not collected.

Table B-5. Callers by Race (Tobacco Users Only, n=6362)

	HWTF Status											
	Youth		Young Adults		Primary Caregivers		School Employees		DHHS		Total	
Race	#	%	#	%	#	%	#	%	#	%	#	%
White	141	65.0	814	57.6	810	49.9	67	50.8	1638	56.2	3500	55.0
Black or African American	48	22.1	370	26.2	597	35.4	53	40.2	745	25.6	1813	28.5
Other Race	12	5.5	125	8.8	143	8.5	4	3.0	159	5.5	443	7.0
American Indian or Alaskan Native	4	1.8	27	1.9	44	2.6	3	2.3	62	2.1	140	2.2
Asian	2	0.9	8	0.6	6	0.4	0	0.0	14	0.5	30	0.5
Native Hawaiian/Other Pacific Islander	0	0.0	6	0.4	5	0.3	1	0.8	2	0.1	14	0.2
Other*	10	4.6	94	4.5	50	3.0	4	3.0	294	10.1	422	6.6
Total	217	100.0	1414	100.0	1685	100.0	132	100.0	2914	100.0	6362	100.0

* Refused, does not know, or not collected.

Table B-6. Callers by Language (Tobacco Users Only, n=6362)

	HWTF Status											
	Youth		Young Adults		Primary Caregivers		School Employees		DHHS		Total	
Language	#	%	#	%	#	%	#	%	#	%	#	%
English	216	99.5	1367	96.7	1595	94.7	132	100.0	2820	96.8	6130	96.4
Spanish	1	0.5	47	3.3	88	5.2	0	0.0	93	3.2	229	3.6
Other	0	0.0	0	0.0	2	0.1	0	0.0	1	0.0	3	0.0
Total	217	100.0	1414	100.0	1685	100.0	132	100.0	2914	100.0	6362	100.0

Table B-7. Callers by Highest Level of Education Attained (Tobacco Users Only, n=6362) *

Highest Level of Education	HWTF Status								DHHS		Total	
	Youth		Young Adults		Primary Caregivers		School Employees					
	#	%	#	%	#	%	#	%	#	%	#	%
Less than grade 9	0	0.0	1392	98.4	69	4.1	2	1.5	135	4.6	206	3.2
Grade 9-11, no degree	0	0.0	6	0.4	214	12.7	4	3.0	344	11.8	568	8.9
High School degree	0	0.0	6	0.4	452	26.8	33	25.0	687	23.6	1178	18.5
GED	0	0.0	0	0.0	86	5.1	5	3.8	118	4.0	209	3.3
Some College or Univ.	0	0.0	6	0.4	516	30.6	36	27.3	786	27.0	1344	21.1
College or Univ degree	0	0.0	4	0.3	301	17.9	47	35.6	541	18.6	893	14.0
Other**	217	100.0	1392	98.4	47	2.8	5	3.8	303	10.4	1964	30.9
Total	217	100.0	1414	100.0	1685	100.0	132	100.0	2914	100.0	6362	100.0

* From Intake Question asked primarily to callers age 25 and older. See Sections D.2.b and D.2.c for accurate young adult and youth data
**Refused or not collected.

Table B-8. Callers Responding Yes to Having a Chronic Condition* (Tobacco Users Only, n=6069) *

Chronic Condition	HWTF Status								DHHS		Total	
	Youth		Young Adults		Primary Caregivers		School Employees					
	#	%	#	%	#	%	#	%	#	%	#	%
Asthma	35	16.7	220	16.0	148	8.9	10	7.7	177	6.6	590	9.7
Chronic Obstructive Pulmonary Disease	1	0.5	11	0.8	66	4.0	6	4.6	186	6.9	270	4.4
Coronary Artery Disease	4	1.9	4	0.3	29	1.7	4	3.1	102	3.8	143	2.4
Diabetes	0	0.0	21	1.5	80	4.8	8	6.2	177	6.6	286	4.7
Multiple Diseases	1	0.5	22	1.6	127	7.6	6	4.6	390	14.5	546	9.0
None	168	80.4	1082	78.9	1203	72.2	96	73.8	1636	60.8	4185	69.0
Not Collected	0	0.0	11	0.8	13	0.8	0	0.0	25	0.9	49	0.8
Total	209	100.0	1371	100.0	1666	100.0	130	100.0	2693	100.0	6069	100.0

* 293 Callers Missing Information

Table B-9. Callers by Type of Health Insurance (Tobacco Users Only, n=6362)

	HWTF Status											
	Youth		Young Adults		Primary Caregivers		School Employees		DHHS		Total	
NC Health Plan	#	%	#	%	#	%	#	%	#	%	#	%
Uninsured	0	0.0	689	48.7	559	33.2	18	13.6	810	27.8	2076	32.6
Medicaid	2	0.9	214	15.1	294	17.4	2	1.5	393	13.5	905	14.2
Blue Cross/Blue Shield	0	0.0	142	10.0	173	10.3	4	3.0	282	9.7	601	9.4
Other Health Plan	1	0.5	163	11.5	216	12.8	9	6.8	338	11.6	727	11.4
Medicare	0	0.0	10	0.7	76	4.5	4	3.0	375	12.9	465	7.3
United Health Care	0	0.0	29	2.1	48	2.8	2	1.5	61	2.1	140	2.2
Cigna	0	0.0	21	1.5	48	2.8	1	0.8	52	1.8	122	1.9
State Employees Plan	0	0.0	50	3.5	167	9.9	91	68.9	283	9.7	591	9.3
Aetna	0	0.0	16	1.1	43	2.6	0	0.0	26	0.9	85	1.3
Well Path	0	0.0	3	0.2	13	0.8	0	0.0	10	0.3	26	0.4
First Carolina Care	0	0.0	1	0.1	0	0.0	0	0.0	3	0.1	4	0.1
Other*	214	98.6	76	54	48	2.8	1	0.8	281	9.6	620	9.7
Total	217	100.0	1414	100.0	1685	100.0	132	100.0	2914	100.0	6362	100.0

* Refused, does not know, or not collected.

Table B-10. Callers by NC County (Tobacco Users Only, n=6362)

County	HWTF Status				DHHS	Total	
	Youth	Young Adults	Primary Caregivers	School Employees		#	%
ALAMANCE	6	27	28	1	49	111	1.7
ALEXANDER	0	7	8	0	9	24	0.4
ALLEGHANY	2	1	4	0	3	10	0.2
ANSON	0	7	6	0	9	22	0.3
ASHE	1	6	2	1	4	14	0.2
AVERY	1	4	1	0	7	13	0.2
BEAUFORT	0	6	11	0	13	30	0.5
BERTIE	0	1	0	0	4	5	0.1
BLADEN	0	1	9	1	12	23	0.4
BRUNSWICK	2	7	22	0	27	58	0.9
BUNCOMBE	2	16	24	3	67	112	1.8
BURKE	0	9	11	1	34	55	0.9
CABARRUS	6	26	30	3	54	119	1.9
CALDWELL	1	3	12	1	20	37	0.6
CAMDEN	0	1	4	0	0	5	0.1
CARTERET	1	5	15	0	33	54	0.8
CASWELL	0	3	6	1	8	18	0.3
CATAWBA	4	16	33	0	38	91	1.4
CHATHAM	2	5	10	2	25	44	0.7
CHEROKEE	0	1	0	0	4	5	0.1
CHOWAN	0	2	7	1	5	15	0.2
CLAY	0	1	1	0	2	4	0.1
CLEVELAND	3	17	11	3	21	55	0.9
COLUMBUS	2	6	11	0	18	37	0.6
CRAVEN	4	16	19	3	37	79	1.2
CUMBERLAND	14	58	72	4	72	220	3.5
CURRITUCK	0	0	1	2	6	9	0.1
DARE	1	2	4	0	6	13	0.2
DAVIDSON	8	22	20	2	29	81	1.3
DAVIE	0	3	2	0	10	15	0.2
DUPLIN	4	7	7	0	9	27	0.4
DURHAM	1	44	70	8	104	227	3.6
EDGECOMBE	2	10	13	1	20	46	0.7
FORSYTH	6	55	75	11	113	260	4.1
FRANKLIN	2	7	13	0	17	39	0.6
GASTON	6	25	31	1	46	109	1.7
GATES	0	0	1	0	2	3	0.0
GRAHAM	0	1	1	0	2	4	0.1
GRANVILLE	2	7	6	1	16	32	0.5
GREENE	0	2	4	0	6	12	0.2
GUILFORD	12	117	93	6	160	388	6.1
HALIFAX	0	8	13	2	25	48	0.0

Table B-10 contd.	HWTF Status					Total	
County	Youth	Young Adults	Primary Caregivers	School Employees	DHHS	#	%
HARNETT	3	31	19	0	28	81	1.3
HAYWOOD	1	8	3	0	17	29	0.5
HENDERSON	0	9	9	1	16	35	0.6
HERTFORD	0	2	4	0	9	15	0.2
HOKE	1	5	5	1	7	19	0.3
HYDE	0	0	3	0	2	5	0.1
IREDELL	3	22	17	1	36	79	1.2
JACKSON	1	2	9	1	9	22	0.3
JOHNSTON	3	19	37	2	44	105	1.7
JONES	0	3	1	0	1	5	0.1
LEE	2	11	10	1	21	45	0.7
LENOIR	1	7	24	0	30	62	1.0
LINCOLN	0	12	14	0	17	43	0.7
MACON	1	2	5	0	1	9	0.1
MADISON	1	1	2	0	3	7	0.1
MARTIN	1	3	7	1	11	23	0.4
MCDOWELL	0	4	5	0	15	24	0.4
MECKLENBURG	18	163	170	11	299	661	10.4
MITCHELL	0	1	3	3	0	7	0.1
MONTGOMERY	0	7	7	0	7	21	0.3
MOORE	2	8	17	0	19	46	0.7
NASH	2	16	23	4	20	65	1.0
NEW HANOVER	2	41	26	8	74	151	2.4
NORTHAMPTON	1	2	1	0	4	8	0.1
ONSLOW	2	29	18	3	37	89	1.4
ORANGE	3	30	24	0	43	100	1.6
PAMLICO	0	2	2	0	4	8	0.1
PASQUOTANK	0	0	1	1	3	5	0.1
PENDER	1	13	5	1	7	27	0.4
PERQUIMANS	0	0	2	0	2	4	0.1
PERSON	0	6	10	0	24	40	0.6
PITT	4	33	29	2	63	131	2.1
POLK	0	0	1	0	9	10	0.2
RANDOLPH	4	18	25	1	29	77	1.2
RICHMOND	2	3	10	1	16	32	0.5
ROBESON	3	9	31	2	27	72	1.1
ROCKINGHAM	0	10	16	0	21	47	0.7
ROWAN	5	24	22	3	37	91	1.4
RUTHERFORD	2	11	6	5	21	45	0.7
SAMPSON	0	9	14	3	17	43	0.7
SCOTLAND	0	6	5	0	9	20	0.3
STANLY	2	12	14	1	11	40	0.6
STOKES	0	3	9	0	18	30	0.5
SURRY	2	7	12	3	16	40	0.6

Table B-10 contd.	HWTF Status					Total	
County	Youth	Young Adults	Primary Caregivers	School Employees	DHHS	#	%
SWAIN	0	2	2	0	1	5	0.1
TRANSYLVANIA	1	2	3	0	4	10	0.2
TYRRELL	0	0	1	0	5	6	0.1
UNION	3	19	39	1	19	81	1.3
VANCE	1	4	10	0	21	36	0.6
WAKE	12	88	150	10	258	518	8.1
WARREN	0	2	3	0	7	12	0.2
WASHINGTON	0	3	2	0	5	10	0.2
WATAUGA	1	9	2	0	13	25	0.4
WAYNE	3	21	24	0	34	82	1.3
WILKES	0	10	10	0	20	40	0.6
WILSON	2	9	14	1	25	51	0.8
YADKIN	2	5	7	0	18	32	0.5
YANCEY	1	0	2	0	2	5	0.1
Unknown	23	73	28	1	234	359	5.6
Total	217	1414	1685	132	2914	6362	100.0

Table B-11. Callers by Age Started Using Tobacco (Tobacco Users Only, n=6054)*

	HWTF Status								DHHS		Total	
	Youth		Young Adults		Primary Caregivers		School Employees					
Start Age	#	%	#	%	#	%	#	%	#	%	#	%
0-11 years old	42	20.0	110	8.1	116	7.0	2	1.5	163	6.1	433	7.2
12–17 years old	167	79.5	972	71.3	972	58.4	53	40.8	1445	53.8	3609	59.6
18-24 years old	0	0.0	272	20.0	450	27.1	50	38.5	775	28.8	1547	25.6
25 years old or older	0	0.0	1	0.1	116	7.0	24	18.5	264	9.8	405	6.7
Other*	1	0.5	8	0.6	9	0.5	1	0.8	41	1.5	60	1.0
Total	210	100.0	1363	100.0	1663	100.0	130	100.0	2688	100.0	6054	100.0

* 308 callers missing data
** Refused or not collected.

Table B-12. Callers by Type of Tobacco Use (Tobacco Users Only, n=6362)

Type of Tobacco Use	HWTF Status								DHHS		Total	
	Youth		Young Adults		Primary Caregivers		School Employees					
	#	%	#	%	#	%	#	%	#	%	#	%
Cigarette	175	80.6	1204	85.1	1584	94.0	124	93.9	2515	86.3	5602	88.1
Multiple*	29	13.4	131	9.3	36	2.1	2	1.5	95	3.3	293	4.6
Smokeless	5	2.3	18	1.3	29	1.7	3	2.3	46	1.6	101	1.6
Cigar	0	0.0	12	0.8	15	0.9	0	0.0	24	0.8	51	0.8
Other type of tobacco	0	0.0	0	0.0	0	0.0	0	0.0	3	0.1	3	0.0
Unknown	8	3.7	48	3.4	21	1.2	3	2.3	223	7.7	303	4.8
Total	217	100.0	1414	100.0	1685	100.0	132	100.0	2914	100.0	6362	100.0

* Callers who reported using cigarettes and some other form of tobacco were categorized as multiple tobacco users only.

Table B-13. Callers by Cigarette Frequency (Cigarette Users Only, n=5891)

Cigarette Use Frequency	HWTF Status								DHHS		Total	
	Youth		Young Adults		Primary Caregivers		School Employees					
	#	%	#	%	#	%	#	%	#	%	#	%
Every day	181	88.7	1230	92.2	1474	91.2	114	90.5	2259	86.6	5258	89.3
Some days	18	8.8	46	3.4	50	3.1	8	6.3	119	4.6	241	4.1
Other*	5	2.5	58	4.3	93	5.8	4	3.2	232	8.9	392	6.7
Total	204	100.0	1334	100.0	1617	100.0	126	100.0	2610	100.0	5891	100.0

***Refused, not collected, and not at all responses.

Table B-14. Callers by Stage of Readiness to Change (Tobacco Users Only, n=6362)

Stage	HWTF Status								DHHS		Total	
	Youth		Young Adults		Primary Caregivers		School Employees					
	#	%	#	%	#	%	#	%	#	%	#	%
Precontemplation	2	0.9	7	0.5	2	0.1	0	0.0	10	0.3	21	0.3
Contemplation	5	2.3	38	2.7	31	1.8	1	0.8	69	2.4	144	2.3
Preparation	196	90.3	1250	88.4	1492	88.5	124	93.9	2328	79.9	5390	84.7
Action	6	2.8	62	4.4	128	7.6	3	2.3	253	8.7	452	7.1
Maintenance	0	0.0	1	0.1	4	0.2	1	0.8	21	0.7	27	0.4
Unknown	8	3.7	56	4.0	28	1.7	3	2.3	233	8.0	328	5.2
Total	217	100.0	1414	100.0	1685	100.0	132	100.0	2914	100.0	6362	100.0

Table B-15. Callers by Type of Service Requested (Tobacco Users Only, n=6362)

	HWTF Status											
	Youth		Young Adults		Primary Caregivers		School Employees		DHHS		Total	
Call Program	#	%	#	%	#	%	#	%	#	%	#	%
One-Call Program	64	29.5	500	35.4	533	31.6	44	33.3	883	30.3	2024	31.8
Multi-Call Program	146	67.3	846	59.8	1116	66.2	84	63.6	1767	60.6	3959	62.2
General Questions	7	3.2	53	3.7	24	1.4	3	2.3	225	7.7	312	4.9
Materials Only	0	0.0	12	0.8	5	0.3	1	0.8	35	1.2	53	0.8
All Transfer Types	0	0.0	3	0.2	7	0.4	0	0.0	4	0.1	14	0.2
Total	217	100.0	1414	100.0	1685	100.0	132	100.0	2914	100.0	6362	100.0

Table B-16. Callers by First Call to Quitline NC in 12 Months (Tobacco Users Only, n=6362)

	HWTF Status											
	Youth		Young Adults		Primary Caregivers		School Employees		DHHS		Total	
Stage	#	%	#	%	#	%	#	%	#	%	#	%
Yes	205	94.5	1321	93.4	1521	90.3	121	91.7	2531	86.9	5699	89.6
No	12	5.5	88	6.2	116	6.9	7	5.3	317	10.9	540	8.5
Not Collected	0	0.0	5	0.4	48	2.8	4	3.0	66	2.3	123	1.9
Total	217	100.0	1414	100.0	1685	100.0	132	100.0	2914	100.0	6362	100.0

Table B-17. Youth and Young Adult Callers Who Currently Attend School (Tobacco Users Only, n=1631)

	HWTF Status					
	Youth		Young Adults		Total	
Currently Attending School?	#	%	#	%	#	%
Yes	167	77.0	451	31.9	618	37.9
No	40	18.4	897	63.4	937	57.4
Other*	10	4.6	66	4.7	76	4.7
Total	217	100.0	1414	100.0	1631	100.0

* Refused and not collected.

Table B-18. Current School Attended by Youth and Young Adult Callers (Tobacco Users Only, n=618)*

Current School Level	HWTF Status				Total	
	Youth		Young Adults			
	#	%	#	%	#	%
College	6	3.6	332	73.6	338	54.7
High School	144	86.2	109	24.2	253	40.9
Middle School	15	9.0	4	0.9	19	3.1
Grade School	1	0.6	4	0.9	5	0.8
Refused	1	0.6	2	0.4	1	0.5
Total	167	100.0	451	100.0	618	100.0

* Includes callers under 24 years old responding “Yes” to “Are you Currently Attending School?”

Table B-19. Youth and Young Adult Callers Who Are Currently Working (Tobacco Users Only, n=1631)

Currently Working?	HWTF Status				Total	
	Youth		Young Adults			
	#	%	#	%	#	%
Yes	80	36.9	824	58.3	904	55.4
No	125	57.6	505	35.7	630	38.6
Other*	12	5.5	85	6.0	97	5.9
Total	217	100.0	1414	100.0	1631	100.0

*

Unknown, does not know, refused, and not collected.

Table B-20. Type of Employment for Youth and Young Adult Callers (Tobacco Users Only, n=904)*

Current Type of Employment	HWTF Status				Total	
	Youth		Young Adults			
	#	%	#	%	#	%
Part Time	64	80.0	243	29.5	307	34.0
Full Time	16	20.0	581	70.5	597	66.0
Total	80	100.0	824	100.0	904	100.0

* Includes callers under 24 years old responding “Yes” to “Are you Currently Working?”

Appendix C
Data Tables for Fax Referral Service

Table C-1. How Callers Entered the Quitline (Tobacco Users Only, n=6362)

	HWTF Status								DHHS		Total	
	Youth		Young Adults		Primary Caregivers		School Employees					
	#	%	#	%	#	%	#	%	#	%	#	%
Fax Referral	3	1.4	14	1.0	100	5.9	5	3.8	143	4.9	265	4.2
Inbound English Phone Call	211	97.2	1359	96.1	1496	88.8	127	96.2	2641	90.6	5834	91.7
Inbound Spanish Phone Call	0	0.0	28	2.0	61	3.6	0	0.0	55	1.9	144	2.3
Registration Short Form	0	0.0	3	0.2	2	0.1	0	0.0	8	0.3	13	0.2
Client Services	1	0.5	3	0.2	5	0.3	0	0.0	5	0.2	14	0.2
Evaluation Call Transfer	0	0.0	2	0.1	6	0.4	0	0.0	7	0.2	15	0.2
Re-enrollment	2	0.9	4	0.3	9	0.5	0	0.0	26	0.9	41	0.6
Warm Transfer from Partner	0	0.0	1	0.1	5	0.3	0	0.0	25	0.9	31	0.5
Program Lookup Tool	0	0.0	0	0.0	0	0.0	0	0.0	3	0.1	3	0.0
Not Asked	0	0.0	0	0.0	1	0.1	0	0.0	1	0.0	2	0.0
Total	217	100.0	1414	100.0	1685	100.0	132	100.0	2914	100.0	6362	100.0

Table C-2. Number of Fax Referrals by Month and Funding Source (Tobacco Users Only, n=265)

	Funding Source				Total	
	HWTF		DHHS			
Month	#	%	#	%	#	%
JUL 07	7	5.7	6	4.2	13	4.9
AUG 07	5	4.1	7	4.9	12	4.5
SEP 07	0	0.0	7	4.9	7	2.6
OCT 07	9	7.4	8	5.6	17	6.4
NOV 07	6	4.9	6	4.2	12	4.5
DEC 07	4	3.3	15	10.5	19	7.2
JAN 08	10	8.2	8	5.6	18	6.8
FEB 08	10	8.2	6	4.2	16	6.0
MAR 08	12	9.8	15	10.5	27	10.2
APR 08	12	9.8	30	21.0	42	15.8
MAY 08	24	19.7	17	11.9	41	15.5
JUN 08	23	18.9	18	12.6	41	15.5
Total	122	100.0	143	100.0	265	100.0

Appendix D
Data Tables for Promotion

Table D-1. How Year 1 Callers Heard About Quitline NC (Tobacco Users Only, n=6362)

	HWTF Status											
	Youth		Young Adults		Primary Caregivers		School Employees		DHHS		Total	
How Heard About Quitline	#	%	#	%	#	%	#	%	#	%	#	%
Basketball/sporting event	0	0.0	0	0.0	4	0.2	1	0.8	3	0.1	8	0.1
Brochure/Newsletter/Flyer	4	1.8	33	2.3	61	3.6	19	14.4	142	4.9	259	4.1
Cigarette Pack (Quit Assist)	5	2.3	28	2.0	13	0.8	0	0.0	36	1.2	82	1.3
College Website	0	0.0	2	0.1	1	0.1	0	0.0	6	0.2	9	0.1
Community Organization	1	0.5	12	0.8	28	1.7	5	3.8	106	3.6	152	2.4
Employer/Worksite	0	0.0	6	0.4	43	2.6	11	8.3	60	2.1	120	1.9
Family/Friend	20	9.2	78	5.5	117	6.9	4	3.0	176	6.0	395	6.2
Health Department	2	0.9	9	0.6	30	1.8	5	3.8	60	2.1	106	1.7
Health Insurance	1	0.5	5	0.4	41	2.4	24	18.2	110	3.8	181	2.8
Health Professional	7	3.2	42	3.0	177	10.5	9	6.8	355	12.2	590	9.3
Newspaper/Magazine	1	0.5	12	0.8	11	0.7	2	1.5	48	1.6	74	1.2
Oprah Show	0	0.0	0	0.0	1	0.1	0	0.0	1	0.0	2	0.0
Other Type of Promotion	5	2.3	26	1.8	73	4.3	9	6.8	148	5.1	261	4.1
Outdoor Ad	1	0.5	3	0.2	7	0.4	0	0.0	13	0.4	24	0.4
Past Caller	6	2.8	36	2.5	60	3.6	3	2.3	188	6.5	293	4.6
Radio	45	20.7	380	26.9	289	17.2	5	3.8	298	10.2	1017	16.0
Re-enrollment	5	2.3	20	1.4	33	2.0	4	3.0	88	3.0	150	2.4
School/College Event	6	2.8	6	0.4	13	0.8	1	0.8	21	0.7	47	0.7
Student Health Services	1	0.5	1	0.1	3	0.2	1	0.8	3	0.1	9	0.1
TV/Commercial	97	44.7	663	46.9	600	35.6	19	14.4	819	28.1	2198	34.5
TV/News	4	1.8	15	1.1	18	1.1	2	1.5	33	1.1	72	1.1
Website	4	1.8	27	1.9	48	2.8	6	4.5	74	2.5	159	2.5
Other*	2	0.9	10	0.7	14	0.8	2	1.5	126	4.3	153	2.4
Total	217	100.0	1414	100.0	1685	100.0	132	100.0	2914	100.0	6362	100.0

* Refused, does not remember, and not collected.

Appendix E
References

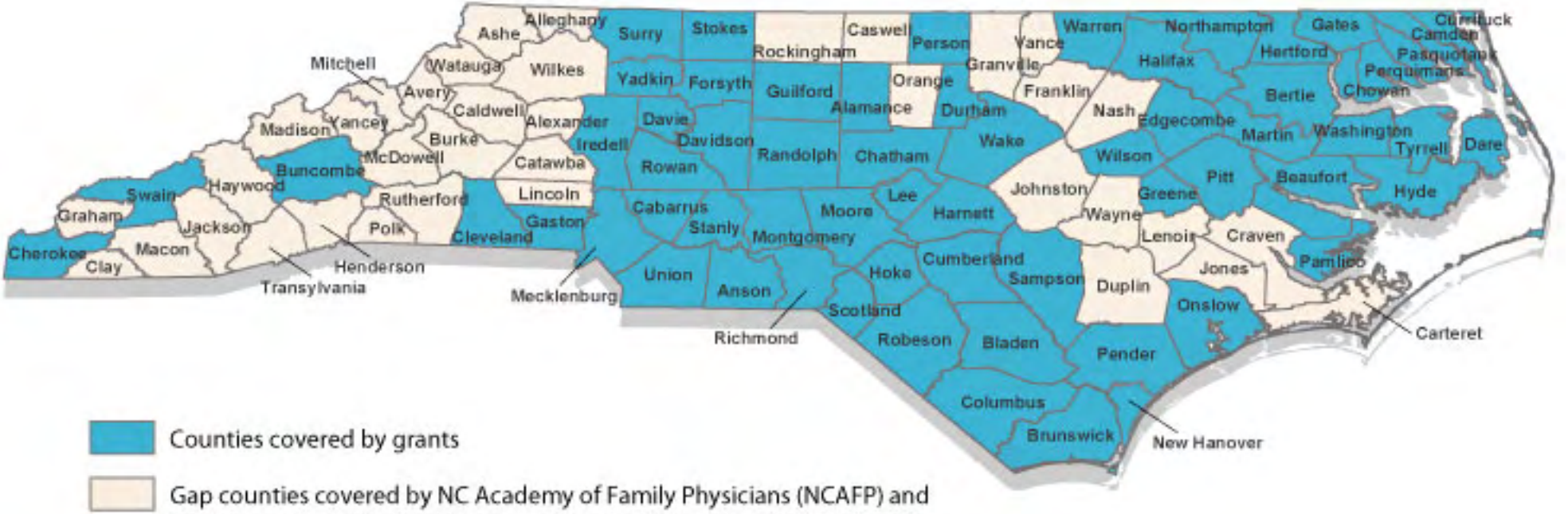
1. Stead LF, Lancaster T, Perera R. Telephone counseling for smoking cessation. Cochrane Database Syst Rev 2003: CD002850
2. Centers for Disease Control and Prevention (CDC). Telephone Quitlines: A Resource for Development, Implementation, and Evaluation. Atlanta, GA: U.S. Dept. of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on smoking and Health, Final Editions, September 2004.
3. Free & Clear, Inc. North Carolina Tobacco Use Quit Line Evaluation Report Year 03. Prepared Patricia Yepassis-Zembrou, Clinical & Behavioral Services Department, June 30, 2008.
4. Campaign for Tobacco-Free Kids, 2008: http://www.tobaccofreekids.org/reports/settlements/toll.php?StateID=NC
5. National Center for Health Statistics, Behavioral Risk Factor Surveillance System (BRFSS), 2007: http://www.schs.state.nc.us/SCHS/brfss/2007/nc/all/_rfsmok3.html
6. North Carolina Tobacco Prevention and Control Branch, NC 2007 Youth Tobacco Survey (YTS) Fact Sheets: http://www.tobaccopreventionandcontrol.ncdhhs.gov/data/yts/index.htm.
7. An LC, Schillo BA, Kavanaugh Am, Lachter RB, Luxenburg MG, Wendling AH, Joseph AM. Increased reach and effectives of a statewide tobacco quitline after the addition of access to free nicotine replacement therapy. *Tob Control.* 2006; 15:286-293.
8. 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.
9. Farrelly MC, Hussin A, Bauer UE. Effectivenss and cost effectivenss of television, radio and print advertisements in promoting the New York smokers' quitline. Tob Control. 2007;16(Suppl 1):i21-i23.
10. Cummins SE, Hebert KK, Anderson CM, Mills JA, Zhu S. Reaching young adult smokers through quitlines. *AJPH.* 2007; 97:1402-1404.
11. Fiore MC, Jaen CR, Baker TB, et al. Treating Tobacco Use and Dependence: 2008 Update. Clinical Practice Guideline. Rockville, MD: U.S. Department of Health and Human Services. Public Health Service. May 2008.
12. Cummins SE, Bailey L, Campbell S, Koon-Kirby C, Zhu S-H. Tobacco cessation quitlines in North America: a descriptive study. *Tob Control*. 2007;16(Suppl 1):i9-i15.
13. Hollis JF, McAfee T. Evaluation of Year 4 of the Utah Teen Tobacco Quitline. July, 2004.
14. Free and Clear, Inc. website (2007), Quit Rates: http://www.freeclear.com/case_for_cessation/quit_rates.aspx?nav_section=2

NORTH CAROLINA Health Wellness TRUST FUND

Eliminating Health Disparities Initiative (HDI)

NORTH CAROLINA Health Wellness TRUST FUND

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 (NCAAHPERD)*

* NCAFP and NCAAHPERD provide statewide services

Updated: 11-01-08

HWTF ELIMINATING HEALTH DISPARITIES
GRANT AWARDS

	Local & Statewide Grants	Counties Served	Phase I
1	ACESS III of Lower Cape Fear	Bladen, Brunswick, Columbus, New Hanover, Onslow, Pender	$390,000
2	American Indian Mothers	Columbus, Cumberland, Hoke, Robeson, Scotland,	$120,632
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 (NCAAHPERD)	Statewide	$400,000
18	NC A&T University	Guilford	$360,000
19	Roanoke Chowan Community Health Center	Bertie, Hertford, Gates, Northampton	$360,000
20	Robeson County Health Department	Anson, Bladen, Cumberland, Harnett, Hoke, Lee, Montgomery, Moore, Randolph, Richmond, Robeson, Sampson, Scotland	$660,000
21	Robeson Health Care Corporation	Robeson	$326,699
22	Rural Health Group, Inc	Halifax, Northampton, Warren	$360,000
23	Strengthening the Black Family, Inc	Wake	$360,000
24	Wake County Human Services-Community Health	Wake	$390,000
25	ZARA Betterment Corporation	Bladen	$289,896
		Total Grant Award	**$9,572,227**

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
QUARTERLY PROGRESS REPORTS
(July 2007 – June 2008)

REPORTING PERIOD: July– September 2007

Describe the objectives that were achieved during the past six months:
During the past three months (July – September 2007), NCCU provided oversight, monitoring, and technical assistance to the 23 HDI grantees; assisted HDI Grantees with their HDI Project carry-forward request, budget justifications documents (budget narratives, budget adjustment requests); preparing for the Annual HDI Grantee Meeting that will be held on October 24-26, 2007 at Sunset Beach, NC; conducted three (3) HDI Conference Calls; developed materials to assist the HD Task Force Meeting; and conducted site visits to assist recommendations for new funding opportunities via HWTFC-HDI grant per the request of the HWTFC.

Technical Assistance/Monitoring Provided to HDI Grantees:
1. Providing guidance, reviewing carry-forward request and budget justification documents and suggesting revisions. During this quarter, NCCU Technical Assistance Team has provided assistance to twenty-three (23) HDI grantees. The 23 grantees include the twenty-one (21) HDI project grantees and the two (2) PLAY grantees. The two PLAY projects were past Department of Public Health grantees that became HDI grantees. The NCCU Technical Assistance Team has worked closely with the twenty-one (21) HDI grantees who requested carry-forward requests for their Year 2 annual budget to ensure that they receive approval to move their project forward in a timely manner.

2. The NCCU TA Team Coordinated and facilitated three (3) group conference calls during this period with HDI grantees, HWTF representatives and NCCU HDI Management Team.
    a. First Conference call was held on July 10, 2007. Attendees included nineteen (19) HDI grantees, NCCU TA Team, HWTF representatives and one (1) PLAY project grantee.
    b. Second conference call was held on August 14, 2007. Attendees included twenty (20) HDI grantees, NCCU TA Team, HWTF representatives, and NCCU HDI Management Team representatives.
    c. Third conference call was held on September 11, 2007. Attendees included seventeen (17) HDI grantees, NCCU TA Team, HWTF representatives, NCCU Management Team representatives, and two (2) PLAY grantees.

Assisting HDI Grantees through HWTFC contracting process (Carry-Forward Budget Adjustment Requests) by:

1. Assisted grantees in submitting budget adjustments and carry-forward request for year 2, by reviewing requests to ensure that grantees were adhering to Carry Forward Request Procedures as well as Budget Adjustment Instructions prior to submitting to HWTFC.
2. Communicated with HWTFC in reference to revisions that needed to be made to request, and informed grantees of HWTFC feedback.
3. NCCU Project Officers submitted 14 budget adjustments/carry-forward requests to HWTFC. To-date, all 14 requests have been approved by HWTFC.
4. Ensured that carry-forward request would strengthen grantees year 2 action plan components, and that request was in line with year 2 action plan activities.

Developed materials to assist HD Task Force Commissioners Meeting

1. Created chart noting successes, challenges and future direction for year 2 for all 21 grantees proceeding to year 2 for the HDI Task Force Commissioners Meeting on Aug. 27, at NCSU McKimmon Center in Raleigh, NC.
2. Provided HWTFC feedback to assist in developing the *Health Disparities Initiative Technical Assistance and Grantee Update* Powerpoint presentation for HDI Task Force Commissioners Meeting on Aug. 27, at NCSU McKimmon Center in Raleigh, NC. The presentation included the number of site visits conducted, conference calls, regional trainings, year 1 challenges and successes, and the number of grantees exceeding, meeting or below expectations.
3. Assisted HWTFC in revising *Health Disparities Initiative Technical Assistance and Grantee Update* Powerpoint presentation for the HWTFC Commissioners meeting on September 24, at NCSU McKimmon Center in Raleigh, NC.

Planning, Coordination and Logistics for October Annual HDI Grantee Meeting:

1. A site visit was conducted on August 16, at the Sea Trail Convention Center at Sunset Beach, NC by the NCCU TA Team to ensure location was suitable for meeting accommodations.
2. The NCCU TA Team have planned, coordinated and arranged the following agenda activities for the HDI Annual Meeting Oct. 24-26 at Sunset Beach, NC. A topics list that includes a keynote speaker and topic for the keynote address, confirmed session speakers, grantees project on exhibit and "HDI Grantees Spotlight" session, HDI Commissioners Panel,

implementing policy change session, advocacy/sustainability session, evaluator's session, media vendor's update, and a partnerships part III session.
3. The NCCU TA Team contracted with Sea Trail to host 65 meeting participants. To-date, the list of participants is beyond capacity. In addition, meeting flyers were created to assist grantees in making hotel accommodations, meeting materials have been purchased, and speakers presentations are currently being received by NCCU. Eleven exhibitor spaces were ordered for grantees to display their projects. To-date, 11 exhibitors have submitted their form for exhibit.

Conducted Site Visits to assist Recommendations for New Funding Opportunities:

1. Robeson Health Care Corporation (RHCC) Reverse Site Visit; July 11, 2007; HWTFC Office, Raleigh, NC -- (SEE Site Visit Report Notes).
2. UNC-Pembroke Department of Nursing Site Visit; September 19, 2007; Lumberton, NC (Robeson County) -- (SEE Summary Report Notes).
3. Zara Betterment Corporation Site Visit; October 4, 2007; Council, NC (Bladen County) -- (SEE Site Visit Report Notes).
4. Provided the HWTFC with a copy of the Site Visit Reports as well a Summary and Analysis of Original Proposals Recommended for Funding and Recommendation on New HDI Funding Opportunity (SEE summary for more information).

REPORTING PERIOD: October – December 2007

Describe the objectives that were achieved during the past six months:

During the past three months (October – December 2007), NCCU provided oversight, monitoring, and technical assistance to the twenty-five (25) HDI grantees, assisted HDI Grantees with programmatic needs (i.e. review/approval of media requests, provided guidance regarding project activities, etc...); hosted the Annual HDI Grantee Meeting that was held on October 24-26, 2007 at Sunset Beach, NC; conducted three (3) HDI Conference Calls, and assisted the ECU Evaluation Team in gathering information regarding the HDI grantees.

Technical Assistance/Monitoring Provided to HDI Grantees:

1. During this quarter, NCCU Technical Assistance Team has provided assistance to twenty-five (25) HDI grantees. The 25 grantees include the twenty-three (23) HDI project grantees and the two (2) PLAY grantees. Two (2) of the 23 HDI grantees are newly approved projects with the initiative. The NCCU Technical Assistance Team has worked closely with the two new HDI grantees: Robeson Health Care Corporation and Zara Betterment Corporation. The assigned project officer assisted the grantee with the following activities (i.e. 6-Month Action Plan, Budget Narrative) to ensure the grant documents were approved in a timely manner prior to presenting them to the HWTFC-HDI Commissioners.
2. The NCCU TA Team Coordinated and facilitated three (3) group conference calls during this period with HDI grantees, HWTF representatives and NCCU HDI Management Team.
    a. First Conference call was held on October 9, 2007. Attendees included eighteen (18) HDI grantees, NCCU TA Team, HWTF representatives and two (2) PLAY project grantees.

b. Second conference call was held on November 13, 2007. Attendees included seventeen (17) HDI grantees, two (2) PLAY project grantees, NCCU TA Team, HWTF representatives, and NCCU HDI Management Team representatives.
c. Third conference call was held on December 11, 2007. Attendees included eighteen (18) HDI grantees, NCCU TA Team, HWTF representatives, NCCU Management Team representatives, and two (2) PLAY grantees.

3. Distribution of 6-Month Progress and Evaluation Report Forms to the HDI grantees via email.
   a. NCCU TA Team communicated with the ECU Evaluation Team in ensuring the evaluation report form was received in a timely manner to submit to the grantees via email.
   b. NCCU TA Team submitted the reports (NCCU TA Progress Report & Evaluation Report forms) via email to the HDI grantees highlighting the required deadlines.

Revised materials to assist HWTFC Update Meetings (i.e. MA Reporting documents)

1. Revised grantees monthly progress report format to depict monthly activities information in greater detail.

Held October Annual HDI Grantee Meeting:

1. The NCCU TA Team held its HDI Annual Meeting Oct. 24-26, 2007 at Sunset Beach, NC. The meeting theme was *"Combating Health Disparities by Maintaining & Sustaining Community Programs"* keynote speaker was Dr. Moses Goldman, *Ed.D.,* Director of the Action Research in Ministry Institute and Assistant Professor of Field Education at Shaw University. The topic for the keynote address was *"A Web of Disparities: Overcoming the Complex Challenges of Eliminating Health Disparities in North Carolina."* Prior to the meeting, 11 grantees registered to exhibit their projects, and 4 showcased their project during the "HDI Grantees Spotlight" session.

2. Breakout sessions included *Latinos in NC: Who are They and What are Their Healthcare Needs?"* with Dr. Rafael Torres, Family Practitioner Torres Quality HealthCare, P.A. (Raleigh, NC). Session goals included to understand the changing demographics of the Latino population in North Carolina and the U.S.; to learn about the most common diseases affecting the Latino community; and to understand the cultural and language barriers that impact minority health care.

   "Improving and Assessing Your Program Goals & Objectives" was presented by Dr. Gail Hughes, DrPH, MPH (Cary, NC). Session goals included to provide grantees with tools, resources and other methods to improve their health disparities program; to assess grantees program progress; and to provide grantees an opportunity to vision how far they have come in implementing their project – where are they headed, and what program component(s) need improving in order to meet local goals/objectives and the overall HDI objectives.

   Other session included, Policy Change: Identifying Opportunities and Making It Happen Moderator for this session was Phyllis Gray, MPH, Public Health Consultant, with Dr. John Hatch Professor Emeritus Department of Health Education at UNC School of Public Health and Lucille Webb, M.Ed., President, Strengthening the Black Family, Inc. as panelist**.**

Session goals highlighted HDI Grantees success in implementing policy change in their organization and community, and provided routes for grantees to take in implementing policy change locally. *"Advocacy: The Art of Maintaining and Sustaining Programs to Eliminate Health Disparities."* The speaker was Sue McLaurin, M.Ed., PT NCCU Department of Public Health Education. Session goals included to identify key elements in advocacy strategies to effectively communicate with both law and policy makers; and stake holders to maximize project sustainability

Other activities included "*Eliminating Health Disparities in North Carolina: Challenges and Opportunities."* Moderator was Dr. LaVerne Reid, InterimAssistant Dean NCCU Department of Behavioral and Social Sciences**,** and two members of the HDI Task Force served as panelist. Session goals included to provide grantees with insight on the priorities of HDI Task Force members.

The HDI Evaluation—Outcome Data from Year 1 and Next Steps was provided by Dr. Laura McCormick, HWTFC Evaluation & Development Director. During this session the East Carolina University (HDI Evaluation Contractor) evaluation team was introduced who also shared some of the next steps for our evaluation process. Session goals included highlighting the impact of current data collected; clarifying future direction of the evaluation plan, and it provided more information about the evaluator's plan for providing HDI grantees assistance through trainings and workshops.

On Day 3 of the meeting, opening remarks were given by Vandana Shah, HWTFC Executive Director. Presentation & Introduction of Ballen Media was provided by Barbara Moeykens, HWTFC Social Marketing and Communications Officer. The HDI Media Campaign Update was provided by HDI Media Vendor, Ballen Media. *Partnerships Part III—(continuation from the March 2007 meeting)* was presented by Dr. LaHoma Romocki, Interim Chair NCCU Department of Public Health Education as well as a presentation and introduction to the NCCU Eagles "E-HEALTH" Project for Promoting Health & Wellness – UNCFSP/NLM Grant.

NCCU contracted with the Sea Trail Golf and Convention Center to host the meeting that consisted of approximately 65 meeting attendees. An evaluation analysis was also completed and shared with all necessary parties. Per the HDI grantees, the analysis clearly showed that the meeting goals were met.

Assisted New HDI Grantees Approved by the HWTF Commissioners with Contractual Obligations:

1. Robeson Health Care Corporation (RHCC) Reverse Site Visit; July 11, 2007; HWTFC Office, Raleigh, NC -- (SEE Site Visit Report Notes).
2. Assisted Zara Betterment Corporation and Robeson Health Care Corporation with the completion of their action plan, budget narrative, proposal, and provide other needed assistance to their organization to assist them in submitting the necessary documents for approval that was granted by HWTF-HDI Task Force and HWTF Commissioners.

Assisted the ECU Evaluation Team in getting oriented to the HDI grantees:

1. Provided HDI grantees action plans, site visit notes and other supporting documents needed to the ECU Evaluation Team.
2. Participated in HDI grantees cohort data conference calls held Nov. 2007 – January 2008.

Monitoring and Oversight of the PLAY Projects

NCCU Project Officers begin monitoring and providing oversight for the PLAY projects (Haliwa-Saponi, Johnston and Lee Counties) that to-date has included reviewing an MER and assisting grantees with contractual questions and concerns.

REPORTING PERIOD: January – March 2008

During the past three months (January to March 2008) the following objectives were achieved by the NCCU Technical Assistance Team:

During the past three months (January to March 2008), NCCU provided oversight, monitoring, and technical assistance to the twenty-five (25) HDI grantees, assisted HDI Grantees with programmatic needs (i.e. budget adjustments, monthly activity reports, monthly expense reports, review/approval of media requests, provided guidance regarding implementation of project activities, etc...); conducted (14) site visits; held (4) Year 3 Annual Action Plan (APP) and Budget Narrative (BN) training sessions per disease foci via conference calls ; conducted three (3) HDI Conference Calls, participated in the ECU Evaluation Team grantee cohort conference calls, and participated in ECU Event Codes Training with HDI grantees via conference call. In addition, NCCU TA Team participated in HWTF/ECU meetings to provide feedback on the HDI Database and participated in (2) monthly (February & March) conference calls with ECU Evaluation Team to review grantees Monthly Activity (MA) reports to ensure coding was done correctly.

Technical Assistance/Monitoring Provided to HDI Grantees:

1. During this quarter, NCCU Technical Assistance Team has provided assistance to twenty-five (25) HDI grantees. The 25 grantees include the twenty-three (23) HDI project grantees and the two (2) PLAY grantees. NCCU POs have provided additional monitoring and technical assistance during this period to the following grantees:
    a. Dare County Health Department: To prevent duplication of services.
    b. NC A & T State University: Frequent communication (via email & phone) regarding the status of HDI project (i.e. staff, implementation, spending, etc...). Grantee received 30-day grace period to conduct an internal investigation regarding former project PI and project spending.

2. The NCCU TA Team Coordinated and facilitated three (3) group conference calls during this period with HDI grantees, HWTF representatives and NCCU HDI Management Team.
    a. First Conference call was held on January 8, 2008. Attendees included seventeen (17) HDI grantees, NCCU TA Team, HWTF representatives and two (2) PLAY project grantees.

b. Second conference call was held on February 12, 2008. Attendees included nineteen (19) HDI grantees, one (1) PLAY project grantee, NCCU TA Team, HWTF representatives, and NCCU HDI Management Team representatives.
c. Third conference call was held on March 11, 2008. Attendees included twenty-one (21) HDI grantees, (2) PLAY project grantees, NCCU TA Team, HWTF representatives, and NCCU Management Team representatives.

Year 3 Annual Action Plan/Budget Narrative Trainings

Conducted (4) trainings, per disease foci (Diabetes, CVD, Obesity, Cancer) via conference calls. Trainings highlighted the following: Focus for Year 3, Overview of Yr. 3 AAP template, Writing SMART objectives, General Formatting Guidelines, Guidelines for Naming/Submitting AAP/BN to NCCU PO, AAP/BN Timeline, Individualized grantee assistance from assigned NCCU PO (via conference call) and Q & A Session.

NCCU Technical Assistance Team scheduled/conducted HDI 14 site visits

From January to March 2008, the NCCU TA Team scheduled and conducted Year 2 site visits for the following grantees: Access III of Lower Cape Fear; Green County Health Care; Cornerstone Ministries, Inc.; Roanoke Chowan Community Health Center; Elizabeth City State University; Northeastern NC Partnership (Hertford County); Rural Health Group; Buncombe County Medical Society; Cleveland County Health Department; Charlotte Communities of Shalom; Lincoln Community Health Center, Inc.; Chatham Hospital Immigrant Health Initiative; Forsyth Medical Center; and GBO Partnership for Children. Each site visit agenda included the following items: Welcome, Introductions, Purpose of Year 2 Site Visit; Overview of Year 2 (Project Strengths/Weaknesses, Project Achievements/Challenges, and Future Direction for Year 3; Project Officer Feedback on Year 2 Action Plan "Status Column"; HDI Project Showcase (i.e., project observation of on-site activities); Review of Current Year 2 Budget and highlight recommendations for Year 3 Budget; Q&A Session.

ECU/NCCU TA Team Monthly Activity Report (MAR) Conference Calls to ensure correct coding of events in HDI database

After the ECU Evaluators conducted their coding of event training on January 31, 2008 it was determined that monthly conference calls needed to be established between ECU and NCCU to review and discuss the hardcopy monthly activity reports submitted by the HDI grantees. NCCU receives and reviews the reports for coding accuracy then submits the reports to ECU to review and provide feedback during the scheduled MAR conference call. NCCU returns the report to the HDI grantees highlight revisions recommended by ECU and NCCU. Grantees are asked to make revisions, forward a copy to their assigned PO, and keep a copy for their records and enter the information in the database when it's ready.

NCCU TA Team provided Continuing Education Opportunity to HDI grantees: Health training meetings, sessions and preparation

The NCCU TA Team in partnership with the NCCU E-Health Team provided National Library of Medicine (NLM) training opportunities for all HDI grantees. These training were held on March 27 in Snow Hill for grantees in the eastern region, and on March 31 in Greensboro for grantees in the Piedmont region. The NCCU E-Health project is a grant opportunity received by NCCU's Department of Public Health Education from the United Negro College Fund Special

Projects in partnership with the National Library of Medicine. The E-Health project provides available on-line resources from the NLM's website that can serve as a useful tool for HDI grantees.

Provided feedback for HDI presentation prepared for HWTF-HDI Task force Meeting April 28, 2008

Per request from HWTF-HDI Program Officer the NCCU TA Team provide feedback and suggestions in reference to the HDI presentation that was prepared for the HWTF-HDI Task force Committee Members.

Preparation for HDI Annual HDI Grantees Meeting, October 9 --10:

The NCCU TA Team has confirmed the location for the HWTF-HDI site visit as the Friday Center in Chapel Hill. The TA Team has planned frequent meetings to discuss the logistics of the meeting, i.e. theme, speakers, workshop topics, etc.

Monitoring and Oversight of the PLAY Projects

NCCU Project Officers continued monitoring and providing oversight for the PLAY projects (Haliwa-Saponi, Johnston and Lee Counties) that to-date has included reviewing an MER and assisting grantees with contractual questions and concerns.

REPORTING PERIOD: April – June 2008

During the past three months (April - June 2008) the following objectives were achieved by the NCCU Technical Assistance Team:

During the past three months (April - June 2008), NCCU provided oversight, monitoring, and technical assistance to the twenty-five (25) HDI grantees, assisted HDI Grantees with programmatic needs (i.e. budget adjustments, monthly activity reports, monthly expense reports, review/approval of media requests, provided guidance regarding implementation of project activities, etc...); conducted (23) site visits; held (4) Year 3 Annual Action Plan (APP) and Budget Narrative (BN) training sessions per disease foci via conference calls; conducted three (3) HDI Conference Calls, participated in the ECU Evaluation Team grantee cohort conference calls, participated in ECU Event Codes Training with HDI grantees via conference call, and participated in the HDI Check Database Training held in May at NCCU. In addition, NCCU TA Team participated in HWTF/ECU meetings to provide feedback on the HDI Check Database and participated in (2) monthly (April & June) conference calls with ECU Evaluation Team to review grantees Monthly Activity (MA) reports to ensure coding was done correctly. In efforts to increase awareness of the HDI and our role with the HDI; NCCU TA Team submitted an abstract entitled, *"Reducing Health Inequities in North Carolina: A Model for Providing Technical Assistance to Community Based Organizations"* to the Society for Public Health Education (SOPHE) in March 2008. In June, NCCU TA Team received notification that the abstract was accepted and therefore an NCCU TA Team member will be giving a presentation during the SOPHE 59th Annual Meeting that will be held on October 23-25th in San Diego, CA.

Technical Assistance/Monitoring Provided to HDI Grantees:

1. During this quarter, NCCU Technical Assistance Team has provided assistance to twenty-five (25) HDI grantees. The 25 grantees include the twenty-three (23) HDI project grantees and the two (2) PLAY grantees. NCCU POs have provided additional monitoring and technical assistance during this period to the following grantees:
    a. Dare County Health Department: To prevent duplication of services.
    b. NC A & T State University: Frequent communication (via email & phone) regarding the status of the HDI project (i.e. staff, project implementation, spending, etc...). Grantee received approval in June 2008 to continue as an HDI grantee. During this time, individualized guidance was provided to NC ATSU in the following areas: review/approval of financial documents to remove the grantee from non-payment status, review and frequent feedback regarding the Yr. 3 AAP/BN documents and meetings to orient new project staff members to the grants monitoring plan.

2. The NCCU TA Team Coordinated and facilitated three (3) group conference calls during this period with HDI grantees, HWTF representatives and NCCU HDI Management Team. For detailed information regarding the information that was provided during these calls, please see the conference call minutes *(note: they were submitted to the HWTFC during the Update Meetings held in May, June and July).*
    a. First Conference call was held on, **April 8, 2008**. Attendees included nineteen (19) HDI grantees, two (2) PLAY project grantees, NCCU TA Team, HWTF representatives, and ECU Evaluation Team.
    b. Second conference call was held on, **May 13, 2008**. Attendees included twenty-three (23) HDI grantees, one (1) PLAY project grantee, NCCU TA Team, HWTF representatives, and ECU Evaluation Team.
    c. Third conference call was held on, **June 10, 2008**. Attendees included twenty (20) HDI grantees, (2) PLAY project grantees, NCCU TA Team, HWTF representatives, and ECU Evaluation Team.

Year 3 Annual Action Plan/Budget Narrative Trainings

Conducted (4) trainings, per disease foci (Diabetes, CVD, Cancer, Obesity) via conference calls. Trainings highlighted the following: Focus for Year 3, Overview of Yr. 3 AAP template, Writing SMART Objectives, General Formatting Guidelines, Guidelines for Naming/Submitting AAP/BN to NCCU PO, AAP/BN Timeline, and Individualized grantee assistance from assigned NCCU PO that was held via conference calls. The calls provided the opportunity for grantees to ask additional questions during the Q & A Session. During this period between April-June; NCCU TA Team conducted several reviews of grantees Yr. 3 AAP/BN documents and provided feedback (via email and phone) on the required revisions in a timely manner *(within 72 hours from the date the documents were received)*, and submitted recommendations for approval to the HWTFC to ensure all (22) grantees received their Yr.3 contract renewal packets by July 2008.

*Note: *Chatham Hospital Immigrant Health Initiative informed the NCCU TA Team and HWTFC of their interest to not continue as an HDI grantee in Year 3 due to restructuring of their organization, Chatham Hospital.*

NCCU Technical Assistance Team scheduled/conducted HDI 14 site visits

From April to May 2008, the NCCU TA Team scheduled and conducted Year 2 site visits for the following grantees: Robeson County Health Department, NC A&T State University, Wake County Human Services, NC Academy of Family Physicians, Strengthening the Black Family, Inc., NCAAHPERD, Robeson Health Care Corporation, Zara Betterment Corporation, Inc. and Dare County Health Department. Each site visit agenda included the following items: Welcome, Introductions, Purpose of Year 2 Site Visit; Overview of Year 2 (Project Strengths/Weaknesses, Project Achievements/Challenges, and Future Direction for Year 3; Project Officer Feedback on Year 2 Action Plan "Status Column"; HDI Project Showcase (i.e., project observation of on-site activities); Review of Current Year 2 Budget and highlight recommendations for Year 3 Budget; Q&A Session.

ECU/NCCU TA Team Monthly Activity Report (MAR) Conference Calls to ensure correct coding of events in HDI database

For April and May 2008, NCCU continued its monthly conference calls with ECU that were established to review and discuss the hardcopy monthly activity reports submitted by the HDI grantees. NCCU continued to receive and reviews the reports for coding accuracy then submitted the reports to ECU to review and provide feedback during the scheduled MAR conference call. NCCU then returned the reports to the HDI grantees highlighting revisions recommended by ECU and NCCU. Grantees are asked to make revisions, forward a copy to their assigned PO, and keep a copy for their records then enter the information in the database when available. This process was created to assist grantee with database coding accuracy prior to entering information into the database.

NCCU TA Team provided Continuing Education Opportunity to HDI grantees: EHealth training meetings, sessions and preparation

The NCCU TA Team in partnership with the NCCU E-Health Team provided National Library of Medicine (NLM) training opportunities for all HDI grantees. These training were held on March 27 in Snow Hill for grantees in the eastern region, and on March 31 in Greensboro for grantees in the Piedmont region. However, the training for this reporting period was held on April 16 in NCCU's Shepard Library from 10:00AM-11:30AM. The target group for this training include our central region grantees; Access III, Chatham Hospital, Roberson County, RHCC, and Zara. Other grantees that joined this regional group included RHG and NCAAHPERD. The NCCU E-Health project is a grant opportunity received by NCCU's Department of Public Health Education from the United Negro College Fund Special Projects in partnership with the National Library of Medicine. The E-Health project provides available on-line resources from the NLM's website that can serve as a useful tool for HDI grantees.

Preparation for HDI Annual HDI Grantees Meeting, October 9 --10:

From April to June 2008, the NCCU TA Team held frequent meetings to continue preparation and finalizing the logistics for the 2008 HWTF-HDI Annual Meeting that will be held Oct. 9-10 at the Friday Center in Chapel Hill, i.e. theme, speakers, workshop topics. The theme for this year's meeting is: "**Strengthening and Sustaining Successful Community Based Models for Combating Health Disparities."** The Keynote speaker is Dr. William Jenkins from Professor and Director Research Center on Health Disparities from Morehouse College in Atlanta, Georgia. Other scheduled workshops will include: "Achieving Culturally Relevant Care: Why and How"; "Social Marketing: A planned approach to Behavioral Change"; "Policy Change and

Advocacy: Are they Synonymous and Required for Developing and Sustaining Programs to Eliminate Health Disparities?"

"Real Life Experiences in Recognizing and Overcoming Challenges in Eliminating Health Disparities in North Carolina: Current HDI Grantee Organization Vignettes" Part One & Two; HDI Evaluation—Outcome Data; "Collaborating and Partnering for Sustainability"; and Update on NCCU Eagles "E-HEALTH Project for Promoting Health & Wellness – UNCFSP/NLM Grant". All HDI grantees were given the opportunity to provide feedback, suggestions, etc. for all meeting sessions and speakers. Grantees will also be given the opportunity to exhibit their projects.

Monitoring and Oversight of the PLAY Projects

From April to June 2008, the NCCU Project Officers continued monitoring and providing oversight for the PLAY projects (Haliwa-Saponi, Johnston and Lee Counties) that to-date has included reviewing an MER and assisting grantees with contractual questions and concerns.

HEALTH DISPARITIES INITIATIVE
North Carolina Central University Technical Assistance Team
HDI Grantee Progress Report Analysis
(July-December 2007 and January–June 2008)

July –December 2007

During the past 6-months (July 2007 – December 2007) in Year 2 of the HDI grant, the grantees have reached much success from their respective projects in their communities and across NC. The HDI grantees have been successful in meeting their action plan goals and objectives and in some cases exceeding them. Successful areas of activity mainly include services provided, partnering actions, community communication, assessments, and some resources generated and policy efforts. The table below provides a snapshot of some of their achievements and accomplishments during this period.

HDI Grantee	Successes	Policy Efforts	Challenges
Access III of Lower Cape Fear	• Almost reached projected number of 200 cohort patients for year 2 in the first six months. • Total of 56 patients with at least one follow-up GMV and data. • Average A1C (average blood sugar, goal<7%) dropped from 7.4% to 6.95%. • Average BMI (Body Mass Index: 18-25= normal weight, 25-30= overweight, >30 is obese) decreased from 32.4 to 31.3. • Average LDL Cholesterol (bad cholesterol, goal <100) remained essentially unchanged going from 114 to 115, as did average blood pressure (goal <130/80) going from 135/80 to	Great strides in the efforts to spread the GMV model beyond their network. • ***CCNC infrastructure***, two of the other CCNC networks (the Sandhills and Central Carolina networks) have become interested. • ***Bernstein Fellowship infrastructure***, in Northampton and Halifax counties became interested in the model—will begin to implement GMVs in their five clinics. • ***Quality Improvement Consultants*** (QICs)- organized a GMV workshop sponsored by Mountain AHEC. Conducted an evening workshop on the GMV model. Workshop was	DNA

HDI Grantee	Successes	Policy Efforts	Challenges
	136/80. • New service to begin in January 2008, the provision of **Diabetes Classes by the New Hanover Health Department**. Have partnered with them so that they will conduct these classes every month (consistent) at the Health Department (accessible) utilizing the HWTF-HDI class curriculum which was developed in the first year (culturally appropriate and low literacy).	videotaped; Mountain AHEC hopes to offer it as an online education with free CME credit for providers.	
Buncombe County Medical Society	• Made extensive efforts in outreach to reach target population. • Recruited (30) women into the program for Breast cancer during this 6 month period. • Recruited (27) men into the program for Prostate cancer during this 6 month period. • Recruited (40) people into the program for diabetes during this 6 month period. • Partnership with NC Institute for Minority and Economic Development, held a "rally" at the YMI Cultural Center (grant partner) where information was shared about prostate cancer, had a mass screening with 43 participants, 5 doctors volunteering, and many other volunteers. The Mayor of Asheville was there to proclaim December 8th as Prostate Screening Day.	• In partnership with the American Cancer Society - conducted training specifically targeted towards black churches & policy change. It encourages churches to incorporate fruits and vegetables into food at church gatherings. Two (2) churches, St. James AME and Ray of Hope are making healthier choices and implementing a cooking program as a direct result of this training. Ray of Hope even brought their cook to the training!	• Personnel: departure of grant manager was unexpected. The vacancy forced them to work more closely together to stay on track with the grant goals/objectives. It also allowed them to see their weakness which ultimately forced them to strengthen the program. • Transportation for project participants: Program is centrally located and accessible for their clients; but transportation is still sometimes an issue. Home visits have been made in an effort to serve the clients & to increase cohort.

HDI Grantee	Successes	Policy Efforts	Challenges
			Are actively seeking means of transportation through the City of Asheville e-tran program.
Charlotte Communities of Shalom	• Continued hiring and managing of project staff-HOPE Circle leaders (5), Community Health Advisors (2) and all staff has been hired and trained. Maintained the majority of staff from year one (90%). • Recruited and Managed volunteers-Maintained our coalition partners and relationship with the Urban League. LGFG Coalition meetings have become more participatory in health related activities. • Recruited and registered 168 participants for the HOPE Circles. The goal was 150. • Initiated direct contact with 260 residents; provided CVD and Diabetes education and pledged a commitment to help end stroke in their community. • Trained eleven (11) clergymen on stroke prevention and intervention; pastors made a commitment to open this information up to their congregation. Additionally, they made a commitment to participate in the Go Red	• DNA	• Barriers appear to be hiring individuals from the target population, and the need for a volunteer coordinator. •

HDI Grantee	Successes	Policy Efforts	Challenges
	for Women Healthy Heart Month in February. • HOPE Circle participants have reported an increase in their fruit and vegetable intake and many have stopped frying food. Participants have continued to support each other beyond the group meetings. Participants are making other lifestyle changes such as using virgin olive oil, salt substitutes etc. However, the attitude changes and consciousness about a healthy lifestyle has been impressive.		
Chatham Hospital Immigrant Health Initiative	• Participated in (2) health fairs with (90) participants received cholesterol, blood glucose, blood pressure, BMI screenings and counseling. Twenty four (24) health risk appraisals were performed. Two (2) other events have been scheduled with churches. • Prescription medication assistance has reached (**406**) patients, resulting in **$272,532** in free medications. • Educational programs have been conducted for the aerobic class and the Phase IV participants on a variety of topics. Classes are being held in coordination with various churches and other community agencies. Classes were also conducted for the local high school girls' soccer team.	DNA	• Finding a bilingual health educator continues to be a problem. Part time staff member left after 6 months and has not yet been replaced. • Change in Chatham Hospital leadership for this grant and, initially, there was some confusion and misunderstandings. Has been resolved by establishing weekly meetings. • Phase IV cardiac rehabilitation program is more

HDI Grantee	Successes	Policy Efforts	Challenges
			problematic. The intensity of staff time limits the hours for which the class can be offered.
Cleveland County Health Department	• HDI page has been added to the Cleveland County Health Dept. website to inform the community of upcoming events, the purpose and goals of the grant, and the ability to send inquiries. • A Minority Health Council member translated the 4th Annual Minority Health Conference brochure into Spanish which led to a 350% increase in Hispanic attendance. • Project staff was able to obtain certified personal trainers, free of cost to the project and participants, to lead an aerobics class for three months in Kingstown. • 40 individuals participating in the cohort study. In January, will conduct a 6 month follow up with individuals from the July group.	• Working with a local program, Roots & Wings, that facilitates teen & parenting sessions with families of adjudicated youth as part of probation requirements. Program serves snacks on a regular basis to its clients and typically serves potato chips, cookies, and soda. Have established an agreement that the HDI would provide healthy snack alternatives, i.e. water, baked chips, pretzels, and reduced fat crackers, in exchange for incorporating healthy lifestyle behaviors into the program curriculum, adding a nutrition and exercise session with the children's class, and distributing health information to the parents. • Search Your Heart (SYH) coordinators have introduced policy change in their individual churches by making sure that there are heart healthy food options at special events, serving water at Vacation Bible School instead of Kool-Aid and soda, and serving vegetables and fruit as snacks in tutoring programs.	• Specific to the cohort, many individuals that the staff approached to complete a HRA expressed their discomfort in sharing certain information due to their distrust that the assessment is not completely confidential. • Activity in the Kingstown area is lacking in support or consistent support. • The limited function of the Transportation Association of Cleveland County (TACC). • Was unable to maintain the personal trainers for an ongoing aerobics class in Kingstown once a week.
Cornerstone Ministries, Inc.	• Partnership with Pitt County Health Department, ViQuest, and the local farmers market--were able	• Currently measuring walking trails at nine (9) African American Churches in Pitt County. Plans to	• Difficulty in recruiting a nutritionist to work with

HDI Grantee	Successes	Policy Efforts	Challenges
	to offer a satellite farmers market at Cornerstone Missionary Baptist Church. Approximately **600-700 people** visited the farmers market while open on Cornerstone's campus. • Healthy Lives/Healthy Choices Project has a link on The Cornerstone Ministry, Inc. website (www.tcminc.org). • Received a total of **$6000** in grant money to address physical activity policies and make the environment more conducive to exercise. • Project is currently active in (28) churches in Pitt County. We are currently working with (2) worksites. • Health Advisors have coordinated (23) education sessions with a total of (574) people in attendance. • Fourteen African American churches put information in the church bulletins. • Had (10) community Health Screenings. (270) people were screened at these events. Currently have (300) people enrolled in case management. • Reached approximately (1000) individuals via outreach efforts such as church bulletins, exercise classes and educational classes.	have churches develop physical activity policies.	project. After many months of recruiting a nutritionist, she will begin in February 2008. • Experienced problems in getting case management enrollees rescreened. Are currently brainstorming ideas on how to increase the amount of participants who are rescreened. Currently have (222) participants past due for their 6 month rescreening.
Dare County Health Department	• Peer Power students developed lesson plans about nutrition. • Peer Power students recorded their dietary habits in a journal for the period of one week. • Great Community	• The Great American Smokeout is an event the students have been very successful in promoting policy change. This school year to date, the students have been able to persuade 9 business owners to adopt	• DNA

HDI Grantee	Successes	Policy Efforts	Challenges
	Support • Community organizations and businesses have allowed students to meet with them to share what they have learned in the classroom. The elementary and middle school administration teams have been very receptive to the high school student's lessons and schedules. The resources used to teach lessons have often been complimented as highly effective and engaging by partners of the project.	a smoke free policy for at least one day.	
Elizabeth City State University	*Hiring of appropriate staff that included:* • Two nurses hired in late summer 2007 as implementation of Phase 2 of the project begin. The ECSU Health Resource Center opened its doors to patients on September 12, 2007. • Dr. Anthony Emekalam was appointed as Project Director in May 2007 and functions as the supervisor for all HRC staff and oversees the day to day operations. Dr. Huyla Coker was appointed as PI of Phase Two of the project in May 2007. • An aerobics instructor was hired in September 2007 to coordinate weekly aerobics classes at the HRC. • Students enrolled in the Doctor of Pharmacy Partnership Program on	• DNA	• Reorganizing the entire project in a short period of time and clarifying remaining budgetary concerns from Phase 1 of the grant.

HDI Grantee	Successes	Policy Efforts	Challenges
	the ECSU campus have been informed about the HRC and have been encouraged to volunteer. During the fall 2007 semester two third year PharmD candidates served as volunteers at the HRC. • Dr. Coker maintained contact with the Executive Director of the Housing Authority to insure all partners are informed about activities. • Dr. Emekalam has coordinated 2 yearly screening events with the District Manager of two Food Lion stores in Elizabeth City. The first screening was held in November 2007 and a second event is planned for the spring. • Dr. Coker is working with Port Discover in planning the spring children's health event. *Great way of addressing transportation issues:* • The HRC is located on the Housing Authority complex. Other Housing Authority complexes in Elizabeth City have access to the HRC and can have transportation through a Housing Authority van, if requested. Partnership with the Executive Director of the Housing Authority (HA) has resulting in them working to coordinate transporting groups of patients from other HA		

HDI Grantee	Successes	Policy Efforts	Challenges
	neighborhoods for special programs/events with advanced notice. Some HRC special programs will also be offered at common areas at other HA neighborhoods. • The first of HRC monthly patient group presentations occurred during the first six months. Novartis sponsored a CDE to make a presentation to a group of nineteen diabetic patients about the complications of diabetes. The patients were also able to receive complementary blood glucose meters if needed and education on proper use.		
Forsyth Medical Center/Novant	• Target cohort goal of 300 clients has been revised by the ECU evaluation team to 150 clients; to date we have provided case management to 140 cohort participants. HDI Case Manager has developed and will begin implementation of additional educational programs to improve awareness of disease risk and processes. Grantee has also increased community outreach services to our target population. • Grantee has successfully increased community outreach efforts and provided outreach screenings to a total of 854 target group members with risk factors of obesity and obesity related diseases. • Improved health literacy	• In-house policy to implement Culturally Linguistic Appropriate Services (CLAS) trainings to provider network and community partners.	• Staffing challenges in the Southern Piedmont Region has been a barrier and impeded our efforts to provide ongoing services to the target population groups served by Mecklenburg County community partners. However, we have been able to offset this barrier by increasing our outreach in the community. We have identified new venues for outreach screenings in Mecklenburg County to include

HDI Grantee	Successes	Policy Efforts	Challenges
	of cohort target group members, related to obesity, diabetes, and cardiovascular disease by incorporating new educational programs. Our HDI Case Manager has developed and will implement educational topics relating to exercise, smart (food) shopping, food portion size and healthy eating. • Case managers have also been very successful in encouraging cohort patients to implement lifestyle and behavior change. Providing ongoing case management and educational programs has proved to impact the decisions of our cohort patients with positive outcomes. Numerous patient success stories have been shared.		health expos and community events that reach and impact our target population. •
GBO Partnership for Children, Inc.	• GBO has documented 52 A1C tests thus far and have at least 2 testing dates set up each month through the month of June 2008. GBO is currently operating after-school programs where the primary focus is obesity prevention, thus providing exercise opportunities for the children. Engaging the adults in exercise opportunities has been challenging but we have received verbal commitments from several groups that will allow us to overcome this hurdle	• DNA	• Children/adults attendance at fitness camp opportunities.

HDI Grantee	Successes	Policy Efforts	Challenges
	relatively quickly. • GBO anticipates that the A1C testing over fiscal year #2 will allow an outsider to see the impact this program is having on the community. From past results, approximately 90% of the people with elevated A1C levels did not know their numbers. •		
Greene County Healthcare, Inc.	• Has a van available for transporting patients to and from medical appointments. • Nutrition and Diabetes Health Fair held in October 2007. This was a first for the community and was well received by (46) community members.	• Policy of entering data by the Medical Family Therapy Researcher. Researcher has been entering data responses into a SPSS (statistical data software program, which is installed on a personal laptop computer). This will be installed onto the desktop computer. These responses come from the research questionnaires that the Medical Family Therapist administers to patients. Question: why is this considered to be a policy effort?	DNA
Hertford County Public Health Authority	• Recruited 2 volunteers (at a minimum) in each church that work with our staff on all program components (one Lay Health Advisor and one Youth Sentinel). These volunteers help with recruiting folks to participate, setting up for events, talking to pastor etc. • Each staff member conducted an assessment of each church to determine what hours were best for program	• Successful in making policy changes. Each church that adopts a healthy eating or fitness policy actually adopts 4-5. Grantee documents their efforts and they (church) adopts them usually without much force. By the end of the year we will have 4-5 policy changes in all participating churches.	• Barrier faced is finding a youth to volunteer when the churches are mostly elderly.

HDI Grantee	Successes	Policy Efforts	Challenges
	activities. Schedules are set up to be conducive to the churches weekly events as well as the participant's needs. Some churches with a more elderly population have classes in the day time so they do not have to travel at night and all exercise classes are developed with disability and age in mind. • Developed exercise classes for those with limited mobility. • Ongoing educational sessions for the community members. Educational sessions include cooking classes, nutrition education, physical activity instruction, diabetes prevention, and lifestyle modification. Attended policy board meetings to educate about policy change and advocate for policy change		
Lincoln Community Health Center, Inc.	• Successful in recruiting (11) volunteer speakers including physicians, nurses, health educators, fitness trainers and dieticians for our English and Spanish-speaking diabetes support groups. • Success in engaging the community with a twice-weekly Diabetes Walking Club that meets in space donated by the WD Hill Center. The group has (24) members that attend on a weekly basis. The Walk	DNA	• Developed an electronic appointment system to make appointments with patients on a 3-month follow-up schedule. In an effort to further improve this process, anyone visiting the Lincoln Diabetes Empowerment office for any

HDI Grantee	Successes	Policy Efforts	Challenges
	Club has received over (90) physician referrals. • Performed a complete assessment on 107 individuals including a health literacy assessment, diabetes knowledge assessment, and an individualized action plan. • 6-month follow up information on (24) of them. Of these (24), 12 (50%) have reduced their A1C by at least 1%. Additionally, (16) of these 24 (67%) have reduced their A1C at all and are on target for a 1% reduction by June 30, 2008. • Had 685 in-person one-on-one encounters with patients with diabetes including assessments, follow-ups, and education sessions. Team has also made more than 1,000 phone calls to clients that include brief education sessions, reminders and follow-ups. •		reason does not leave without a follow up appointment with his or her primary care provider scheduled.*The Health Educator has 3 half-day clinics open each week for 45-minute Diabetes Educational Assessments that includes problems solving barriers to keeping appointments. The assessment concludes with the creation of a plan of action documented in the center's electronic medical record.
NC Academy of Family Physicians	• Great attendance at on-site educational programs in December. Reached 537 physicians at the general sessions which included a presentation by Dr. Torontow, a pilot practice physician, on providing culturally appropriate care to Hispanics when treating diabetes. The other general session was held by the California Academy of Family Physicians. Dr. Mutha	• The N.C. Academy presented policies to the American Academy of Family Physicians. The resolutions state that the AAFP support initiatives to increase physicians' knowledge of the CLAS standards, that the AAFP develop a policy to have all members support the CLAS standards and implement the required language access standards and that the AAFP develop a program to educate family physicians and their office	• DNA

HDI Grantee	Successes	Policy Efforts	Challenges
	and Dr. Jafri presented on addressing language assess issues in medical practices. • Established partnerships with other grantees after discussion at the HDI Grantee Annual Meeting in October. Specifically, partnering with the Buncombe County Medical Society, Forsyth Medical Center and Lincoln Community Health Center. • Grantee continues to have successful follow up meetings with each of the five pilot practices. Each of these practices are creating and working on implementing action plans that they created based on the medical students' assessments of their practice. • Great outreach efforts that include 1) Articles about the project published in the August and November issues of *The North Carolina Family Physician* magazine; 2) booths promoting the project and the online curriculum at both the July and December meetings of the NCAFP; 3) articles about the project in our electronic newsletter *NCAFPNotes*; 4) articles about the project on the Academy's website; and 4) an e-newsletter send out to all members of the Health Disparities Advisory Group and all other project	staff about the CLAS standards and provide educational resources to facilitate implementation of the CLAS standards. • The N.C. Academy also presented two policy resolutions to the N.C. Medical Society regarding supporting legislation that North Carolina hospitals will be required to report accurate race and ethnicity data for all hospital discharges and supporting initiatives including those of the North Carolina Academy of Family Physicians to increase physicians' knowledge of the CLAS standards. Finally, some of the pilot practices are considering corporate policy changes as a result of this initiative. •	

HDI Grantee	Successes	Policy Efforts	Challenges
	partners updating them on project activities. •		
NC AAHPERD	• Continue to work with 266 trained teachers in 135 schools both elementary and middle schools. Teachers are responding to requests for fitness data using Fitnessgram, software program that collects fitness parameters. • County coordinators of our targeted counties provide encouragement to teachers to participate in SPARK. All of the coordinators have also implied that they will encourage a county-wide policy change of SPARK curriculum use. • Received a grant from the Blue Cross and Blue Shield Foundation in the amount of $126,000 to include K-2 trainings and expansion. • Over 50,000 health surveys have been completed by students.	• DNA	• Promoting efforts state-wide better. Most of promoting has been through NCAAHPERD website and NCAAHPERD events. • Biggest barrier at the present time is the need for assistance in collecting and analyzing data. Grantee has solicited assistance from UNCG.
NC A & T State University	DNA	DNA	DNA
Roanoke Chowan Health Center	• During the first 18 months of implementation, monitored 55 in-home patients (60% female, 65% African-American) using in-home monitors. 50 patients have used blood pressure monitors. We have installed kiosks in three Centers for Aging Facilities; one in Ahoskie, Murfreesboro and Winton. From July 1, 2007 to December 31, 2007, 26 seniors were screened and a total of 25 seniors were enrolled. Twelve of those	• In October and November 2007, RCCHC worked with Portia Cole, the Legislative Aide for Senator Ted Kennedy to draft telehealth language into the Community Health Center reauthorization bill. •	• Collaborating with schools

HDI Grantee	Successes	Policy Efforts	Challenges
	were from the 26 screened and others from screenings prior to July 1, 2007. • Successful in responding to clients with language barriers by offering individualized patient assessments and education, as well as brochures and additional resources, in English and Spanish. • *RCCHC has excelled at outreach efforts to the community and at presenting data at national conferences. From July 1, 2007 to December 2007, RCCHC conducted eight community health screenings, screening a total of 151 citizens for Cardiovascular Disease (CVD) and Diabetes Mellitus (DM).* *The following presentations have been completed:* **July 2008** – Fourth Annual Healthcare Unbound Conference in San Francisco August 2008 Hertford County Public Health Authority Grant Expo at Rock Spring Center in Greenville Gates County Ruritan Club **Sept. 2008 –** School Health Advisory Board Department of Health for Social Services in Gates County Annual American Telemedicine Association (ATA) Meeting in Tennessee. **Oct. 2008** – US Senate Sub-committee Health,		

HDI Grantee	Successes	Policy Efforts	Challenges
	Education, Labor and Pensions **Nov. 2008 --** OHIT Meeting in Arlington Virginia School Health Advisory Committee *Great efforts to generate resources:* • RCCHC was granted $251,658 from Kate B Reynolds Foundation to expand the diabetes education and management program. An additional $51,500 was received from UHS Foundation to further expand the diabetes management program. • RCCHC also received $195, 924 from the Obici Foundation to expand the PPCTN into Gates County for patients with CVD and DM. • Increased in-home daily monitoring from 51 patients being monitored to 93 patients (increase of 42 patients) • Exceeded target of 27 in-home daily monitoring patients per quarter by 12. • Total of 72 seniors enrolled (Year two projections were based on Year one results.		
Robeson County Health Department	• Eight (8) health fairs/presentations have been conducted including a Minority Health Summit, through a partnership with 20+ various agencies in	• Each recruited church has agreed to establish a church policy committee to develop and adopt a healthy eating and a physical activity policy for its	• Collaborations & partnerships have been established with local cooperative extension

HDI Grantee	Successes	Policy Efforts	Challenges
	Richmond County. • Exercise classes have been started at (6) church sites. One (1) church is incorporating physical activity into their Sunday morning worship service. Walking groups and walking challenges have been conducted at (3) churches. • Provided services to **2745** participants in the first 6 months of Year 2 (**1085** African Americans, **670** general public, **512** policy makers, **446** health care professionals, and **32** community task force members). • Baseline data and 6 month re-screening data continues to be collected on **276** participants. • **172** additional surveys and **71** quarterly resurveys on healthy eating practices and physical activity behaviors have been completed. • Health Fairs have been conducted **reaching 580+** members of our targeted population. • Community Presentations on CVD have been conducted reaching an additional 655+ members of our targeted population. • Health Policy Committees have been established in **12** churches and has resulted in **3** churches adopting and signing physical activity and nutrition policies. • Grocery stores in **4** counties frequented by our target population are participating in a piloting of signage	congregation. Three (3) churches have signed and adopted policies for nutrition and physical activity and the remaining churches are reviewing policies for adoption. A walking trail has been established at two (2) churches. • Local grocery stores/stands and convenience stores in the church communities have been identified and will be encouraged to add health messages/signage to encourage increased consumption of fruits/vegetables. Signage is being piloted in four (4) counties. • Anson, Cumberland, and Montgomery counties have adopted nutrition & physical activity policies. Bladen has adopted a policy that designates one day each month for health ministry events. All (13) churches have implemented a policy to include heart health messages in their church bulletins or church announcements. •	agencies, hospitals, non-profits, health providers, Healthy Carolinian Task Forces through meetings, phone calls, and email. *Staff turnover in these agencies have posed challenges at times. • Increasing gas prices has posed a challenge for our budget because of the large geographic area of this 13-county region. • Recruitment of churches continues to be more of a challenge than anticipated. Patience, perseverance, and creativity are key skills needed by staff working with faith communities. • Illiteracy among some participants has presented a challenge in the completion of surveys. Low literacy educational materials are necessary with a large portion of participants.

HDI Grantee	Successes	Policy Efforts	Challenges
	encouraging healthier eating options.		
Rural Health Group, Inc.	• 300 patients are being tracked and 64 completed the Diabetes Series in December 2007. • Registered Dietitian was hired in August 2006 on a part-time basis completing the project staff. • Implementation of a Lay Health Advisor Program of volunteers • RHG selected 16 volunteers to participate in this program. Participants were selected based upon community involvement, the service area, and interests. • Successful in receiving client referrals. • The Roanoke Rapids Daily Hearld has supported RHG in publishing articles to highlight our programs. • A collaborative of Federal Qualified Health Centers has been formed with the NC Community Health Association to collect data, adopt forms, and implement procedures as a joint effort to submit applications to the American Diabetes Association •	•	• Transportation is a major barrier in a rural community. Underserved or uninsured patients have limited transportation means. Due to the maintenance expense of a handicap accessible van, RHG can no longer transport patients to the clinics which may inhibit patients visits. • Another barrier has been the overwhelming number of participants for one CDE and one RD. Rural Health Group has over 2500 patients living with diabetes.
Strengthening the Black Family, Inc.	• Approximately 60 actively enrolled participants of the program.	• Plans are to "increase the capacity of (20) African American community and	DNA

HDI Grantee	Successes	Policy Efforts	Challenges
	• Weekly senior health education sessions: average 8 – 10 participants each week. • Weekly free aerobics class to program participants-average (6-8) participants each week.	faith-based organizations to adopt and sustain healthy lifestyle policies and environments."*A survey to assess the existing nutrition and physical activity polices of the groups and organizations have been developed and are ready for use.	
Wake County Human Services	• 25 volunteer LHAs who give generously of their time (approximately 200 hours to-date). • Provided a total of **38** women with screening services. • To date, **72** women have received breast health services through HWHW. Of these 72 women, one (**1**) breast cancer was detected and that woman was connected to another program for her treatment. • Contact was made with **25** Latina breast cancer survivors. Of those 25, there are (**15)** who regularly attend the monthly support group meetings. • **39** health fairs and community events reaching **5260** African American & Latina women; • **20** training sessions reaching **588** African American & Latina women; • An established pool of **25 LHA**s; and • In October 2007, WCHS sponsored the "Passionately Pink" Initiative and **raised $1500** – proceeds benefited the Susan G. Komen for the Cure Foundation. • With the help of the LHAs and other dedicated staff,	• Greatest policy changes would come about via insurance companies and legislative actions. However, the BCAN group (with its many medical providers) continues to work at the local level to encourage hospitals and medical practices to bond and offer reduced &/or complimentary services to the targeted population.	• Limited medical providers in outlying areas willing to accept patients without insurance, the challenge of scheduling those women persists. • Offer program services to women if there were funds available. • Too many time demands and not enough volunteers to accommodate all of the community requests; so therefore, we are quite deliberate in the requests that we honor.

HDI Grantee	Successes	Policy Efforts	Challenges
	the Outreach Coordinator has proven successful in reaching 5845 African American & Latina women at community health fairs, trainings, salons, and church events.		

HEALTH DISPARITIES INITIATIVE
North Carolina Central University Technical Assistance Team
HDI Grantee Progress Report Analysis

January – June 2008

During the past 6-months (January 2008 – June 2008) in Year 2 of the HDI grant, the grantees have reached much success from their respective projects in their communities and across NC. The HDI grantees have been successful in meeting their action plan goals and objectives and in some cases exceeding them. Successful areas of activity mainly include services provided, partnering actions, community communication, assessments, and some resources generated and policy efforts. The table below provides a snapshot of some of their achievements and accomplishments during this period.

HDI Grantee	Successes	Policy Efforts	Challenges
Access III of Lower Cape Fear	• Continued GMV's; recruited (2) new practices. • Exceeded the numbers for GMV project participants. • Leveraging local resources. • Evening Education sessions with over 100 doctors. • Impact on patients—participation in the HWTFC-HDI media campaign.	• Spreading the GMVs beyond local network. • Continued partnership with Improving Performance In Practice (IPIP) program. • Funding expanded with IPIP to fund several new staff Quality Improvement Consultants (QICs) in several AHECs in the state.	• Outreach efforts in regards to formal publicity.
Buncombe County Medical Society	• Streamlined case management and volunteer assignment procedures. • Recruited 5 volunteers. • Program operates 5 days a week and on weekends/evenings when necessary. • Project located in the historical AA district known as "The Block". • Rally for prostate cancer. • Church mailing w/ bulletin inserts to over 55 churches. • Assess to free prescription program for project participants. • 24 diabetes meters and strips donated. • Over 1,000 media	• Introduction of policy around healthy eating at Black Business Alliance Mtg., and (3) churches. • Entered policy dialogue with Healthy Equity Coalition around healthy homes, fire safety, ABC store zoning.	• ABIPA's ED resigned in May 08. • Due to internal challenges, partner was unable to provide assessment to participants. • Private space in the office to conduct one-on-one counseling with participants re their health. • Low attendance at housing development sessions. • Cultural barriers and resistance to

HDI Grantee	Successes	Policy Efforts	Challenges
	announcements; (2) articles appeared in the Urban News. • 43 women had mammograms. • 10 abnormal PSA uncovered out of 86 men. • Screened over 85 individuals for diabetes.		changing eating habits.
Charlotte Communities of Shalom	• Recruiting and managing volunteers—maintained coalition partners and relationship with the Urban League. • Coordination with collaborators and partners—the coalition model has proven successful • Recruited 168 participants for the HOPE Circles—goal was 150—Actual participants 14. • Direct contact with 260 residents—provided CVD and Diabetes Education • Implementing Power to End Stroke and Go Red for Women activities	• None reported	• Involving target population • Need volunteer coordinator • Low community representation at coalition meetings • Minimal community presentations
Chatham Hospital Immigrant Health Initiative	• Less structured programs; aerobic classes and walking clubs. • Partnering with small groups, such as churches were the best avenue to reach Latinos. • Volunteers' assistance via UNC community. • Participation in (2) health fairs with 90 participants. • Conducted 24 Health Risk Appraisals. • 10 patients referred to Lions Club for assistance. • Prescription medication assistance reached 690 patients, resulting in $603,368 in free	• None reported.	• Follow-up with individuals-phone numbers changed. • Transportation issues. • Staff working after hours to make phone calls in an attempt to follow-up with individuals.

HDI Grantee	Successes	Policy Efforts	Challenges
	medication. • Bilingual project staff.		
Cleveland County Health Department	• Maintained community volunteers. • Recruited new partners (i.e. Boys & Girls Club & Carolina Recreational Products). • Creation of the 1st Annual MLK Celebration, • Creation of 7 Kingstown community teams for the Step One Challenge—teams combined total of 13,422,760 steps in a 6-week period. • Continued educational sessions in the community.	• Continued efforts to encourage the serving of healthier snacks with the Roots & Wings program. *the healthier snack policy was not kept due to reasons not shared with project staff. • Offering of healthier foods choices at Georgia's Country Kitchen.	• Did not reach the goal of 100 project participants. • Transportation issues with project participants. • Low participation with Kingstown community residents.
Cornerstone Ministries, Inc.	• Project collaborations & partnerships. • Offer screenings and educational sessions at churches and community sites. • Project publicized on organization's website. • Aired (2) radio ads reaching over 150,000 listeners. • Received donation of $450 to provide gift certificates to project participants to assist the Satellite Farmers Market. • Received $1500 donation to purchase incentives for participants that complete follow-up screenings. • Approx. 600-700 people have visited the Satellite Farmers Market. • Measured walking trails at 9 churches; 5 of the 9 developed walking groups and/or exercise programs. • Weekly exercise classes; education on proper use of exercise equipment. • Active in 28 churches;	• Creation of walking trails at churches.	• Engaging pastors at African American churches. • 90 of the 293 had had at least 1 follow-up screening. Getting people back to be rescreened.

HDI Grantee	Successes	Policy Efforts	Challenges
	working with 3 worksites and 3 grocery stores. • Held 15 education sessions with a total of 339 people. • Provided nutrition consults for 16 case management enrollees. • Held 19 community health screenings; 285 people screened. • 293 peopled enrolled in case management. • Reached over 1000 individuals via outreach efforts.		
Dare County Health Department	• Dare County Schools partnership in implementing the Peer Power Program • Maintaining appropriate staff • Community Support • Implementing curriculum into classroom activities	• None Reported	• Enter back data into HDI Check
Elizabeth City State University	• Hiring appropriate HRC staff (Project Director, PI, 2 PTE RNs and 1 Research Assistant) • Effective partnership maintained with Housing Authority ED • Established partnership with Food Lion stores to implement outreach activities • Held first annual Kids' Healthpalooza in April '08. Partners, Port Discover and Southgate Mall, co-sponsored, 200+ participants attended • Frequent media coverage via ECSU radio and TV • University and community support	• None Reported	• Recruiting student volunteers to work at the HRC • Tracking some of the HRC clients for follow-up
Forsyth Medical Center/Novant	• Maintained collaborations with community partners in Forsyth and Davie Counties	• Recommendation to implement CLAS Standards as part of diversity training	• Tracking transient clients for follow-up

HDI Grantee	Successes	Policy Efforts	Challenges
	• Monthly HDI staff meetings to facilitate communication, process information flow, and address team members concerns • Ongoing case management to 179 cohort members • On-site services to alleviate transportation issues • Bi-lingual case managers • Provided community outreach screenings to 540 participants in Forsyth and Mecklenburg counties • Well documented patient success stories	for Novant physicians	
GBO Partnership for Children, Inc.	• Recruiting volunteers • Partnership with Communities in Schools to address health needs of students in after school program at targeted Title I schools • Success in providing community outreach efforts to underserved families. • In-kind contributions • Encouraging African American churches to provide healthier options • Establishing Disparate Little League Baseball per The City of Greensboro	• Encouraging target African American churches to establish health ministries	• Management of project staff • Working with African American churches to implement policies • Efforts to engage adults in physical activity
Greene County Healthcare, Inc.	• MFT's offer support to patients. • 1 MFT bi-lingual; translated materials into Spanish. • Materials in English and Spanish. • 122 cohort patients seen by MFTs. • 289 patients received services.	• Not clear on those reported on the report *(see report for further detail).*	• Majority of the patients don't have health insurance. • Majority of patients unable to pay the cost for services. • Difficult to get 10 people to attend the monthly group classes. • Transportation issues.

HDI Grantee	Successes	Policy Efforts	Challenges
			• Access to medication via prescription assistance.
Hertford County Public Health Authority	• Excellent/dedicated staff (Four staff members located throughout the region is beneficial to program success) • All targeted churches have an active Lay Health Advisor • Collaborate with over 60 agencies • Accommodating church members schedules • No transportation issues • Adapt to individuals needs for exercise • Developing a good rapport to implement, maintain, and sustain program activities • Held 46 diabetes risk assessment screenings, 32 youth-led events, 49 community events and 73 educational workshops • Leveraging great resources from local health departments, Carolina Diabetic Supply • Dedicated volunteers • Implemented 17 policies that have been passed or pending • Decrease in food cost for churches • Great support from targeted churches • All churches have advisory boards except for two • Provide formal diabetes education to 500 members of target population • Great program/client success stories	• 17 policies that address water availability, fruits and vegetables, highlighting health in church bulletins, providing whole wheat foods and low fat dairies. Sixteen churches regularly insert tips in church bulletin, and most have an area designated for exercise.	• Limited resources and volunteers in Northeastern North Carolina • Difficulty in recruiting volunteers for weekends and evenings
Lincoln Community	• Outreach efforts target low-income minority	• None reported.	• Departure of 1st Project Health

HDI Grantee	Successes	Policy Efforts	Challenges
Health Center, Inc.	populations. • Donated space for Walking Club. • 28 walking club members; recruited from over 120 provider referrals. • Holds regular educational forums. • Incentive and education donations. • 815 in-person one-on-one encounters. • Over 1,500 follow-up phone calls made. • 100 out of 160 individuals have follow-up data. • Developed and electronic appointment system—places patients on a 3-month follow-up schedule. • With 28 members in the walking club—cumulative weight loss of 200 pounds in 6 months. • Providing one-on-one group education & activities.		Educator. • Overall patient satisfaction. • Volunteers feeling overwhelmed. • Data reporting efforts. • Following-up with patients before & after assessments.
NC Academy of Family Physicians	• NC State student recruited as project intern • Partnership growth with UNC School of Medicine • Presenting findings conducted on pilot practices at national conferences • Reached 1230 family physicians, medical students and residents by providing educational activities at CME • Great cooperation with 5 pilot sites • Policy adoption • Successfully enrolled over 120 physicians and 60 practices in the online CLAS training program	• Each pilot practice has adopted the CLAS Standards as policy. • AAFP has reaffirmed a resolution as policy to support HDI	• Recruiting student intern
NC AAHPERD	• Leveraging resources (secured major KBR grant)	• Encouraging counties to change current curriculum	• Incorporating remaining 2

HDI Grantee	Successes	Policy Efforts	Challenges
	• Lobby legislators • 3 of 6 counties are re-writing their curriculum goals for PE and integrating SPARK in those plans • 90-95% of teacher participation in IsPOD	to include SPARK	schools
NC A & T State University **Note: Grantee doesn't have any data to report during this period due to internal organization issues that placed the project on non-payment status until June 2008.*	DNA	DNA	DNA
Roanoke Chowan Health Center	• Hired FTE RN to support all telehealth initiatives • 13 in-home monitors from Obici to lower waiting list • Monitored 29 in-home patients (52% female, 76% African-American), 29 have used blood pressure monitors – total 92 in-home and 78 blood pressures • Maintained kiosks in three Centers for Aging facilities; 13 seniors screened and 13 enrolled • Accommodating patients with language barriers • Conducted 8 community health screenings, screenings a 199 citizens for CVD and DM • Conducted 5 national conference presentations • Leveraging resources (KBR & partnering) • Developing statewide roll-out plan	• Partnering with North Carolina Community Health Center Association to develop statewide roll-out	• Funding youth program

HDI Grantee	Successes	Policy Efforts	Challenges
	• Great media coverage • Great compilation of outcome data		
Robeson County Health Department	• Provided services to 5,395 participants (1000 general public, 991 policy makers, 914 health care professionals, and 31 community task force members. • Conducted 112 workshops with 1,550 participants. • 19 LHA recruited. • Conducted 429 additional surveys and 178 quarterly resurveys on healthy eating practices and PA behaviors. • 10 health fairs, reaching 1,100 individuals. • 10 community presentations on CVD, reaching 684 individuals. • 3 newspaper articles.	• Health Policy Committees established in 12 churches; 7 churches adopted and signed PA and nutrition policies. • Signage on healthier eating options in 7 grocery stores in 7 counties. • 5 churches have established walking trails at church site. 1 church has established a "paved walking trail".	• Increasing gas prices; places challenges on the project staff's ability to implement the project activities.
Robeson Health Care Corporation	• Hiring of (2) Care Coordinators (CCs). • Project operated at (4) medical sites. • CCs help close the gap between patients and the resources available. • CCs established communication with 754 diabetic patients. • CCs assisted with making 490 medical care appointments at their (4) medical sites. *421 appointments were kept (86%) of the patients who were contacted by CCs.	• Implemented clear process for CCs when contacting patients who have little or no medical visits in the past year.	• Transportation, although it's offered.
Rural Health Group, Inc.	• Effective partnerships & local community support • Successful Lay Health Advisors program • Recruiting and maintaining	• Collaborating with the North Carolina Community Health Center Association to become an ADA recognized site.	• Resources only provide for a limited number of clients • Labor pool limit

HDI Grantee	Successes	Policy Efforts	Challenges
	volunteers • Seeking ADA site recognition • DSME Series provided to target • Currently 400 patients in DSME program, but tracking 220 • Establishing holistic approach for RHG now patients receive education along with primary care • Avg. 20 clients in group class held at 5 sites • Great collaboration with media vendor and program promotions via newsletters, news articles, TV, etc.		made hiring process for RD extremely slow
Strengthening the Black Family, Inc.	• Retained Project Coordinator at Riley Hill site and Admin. Assistant. • 128 active project participants; completed wellness plans, physical assessments. • Ability to leverage community resources. • Maintain LHA meetings. • Continue educational sessions in the community.	• Begin complete organizational policy change dialogue and MOUs with STBF Board Members. • 20 MOUs provided to churches; churches will be trained on the Body & Soul program.	• Resignation of Project Coordinator (3rd staff turnover for this position). • Project participants face challenges with transportation, limited mobility, and schedule availability to participate in project activities.
Wake County Human Services	• 28 LHA; approx. 539 hours devoted to the project. • Leveraging community resources. • Provided 22 non-insured women with screening services on the (2) mobiles. • 19 Latino breast cancer survivors actively participate in the monthly support group. • 18 women received diagnostic services. • Approx. 14,849 women reach via outreach efforts. • Approx. 8,810 women	• Began communication at the local level with hospitals and practices to offer reduce and/or complimentary services to target populations.	• The ability to see more women if funds were available. • Women face language barriers once present at the Rex Breast Care Center. • HDI Database not able to capture the project data needed. • Mechanical failure of the

HDI Grantee	Successes	Policy Efforts	Challenges
	received breast health education training. • Participation in 66 health fairs & community events; reaching 7,813 women. • 10 training sessions reaching 367 women. • Held 2nd Annual Breast Care Conference; 130 participants.		mobile. *it was noted this was out of anyone's control when this occurs.*
Zara Betterment Corporation	• Health Education Link Project (HELP) professional staff dedication to project • Collaboration with Bladen Family Support Initiative to implement HELP • Increase number of days clinic operates • Accommodating patients with transportation, limited mobility, and language barriers • Dedicated volunteer and partners • Health-fairs for Hispanics • Collaboration with faith-based organization • Community support • 21 presentations at health fairs and other local events	• Working with agencies to provide healthier options at meetings • Encouraging churches to alter eating habits	• Time constraints in meeting program demands • Access to Hispanics and other minorities living in remote areas

Year Two Report to the NC Health & Wellness Trust Fund Commission

Eliminating Health Disparities Initiative Outcomes Evaluation July 2007 – June 2008

Brody School of Medicine at East Carolina University Department of Family Medicine Research Division

Health Disparities Initiative
Year 2 Executive Summary and Recommendations

The Department of Family Medicine at East Carolina University conducted an evaluation of grant activities for the period July 2007 through June 2008, as part of our contract to provide evaluation services for the Health Disparities Initiative. This report summarizes these evaluation activities.

In May 2006 the North Carolina Health and Wellness Trust Fund Commission (HWTF) awarded $9.2 million in grant funding to local government and non-profit organizations across North Carolina under the Health Disparities Initiative (HDI). The purpose of the Health Disparities Initiative is to reduce the disparities in the incidence, prevalence and mortality related to certain diseases in North Carolina, which are a result of race, ethnicity and socio-economic status. Grants were awarded to projects that specifically focused on reducing disparities for children/youth and adults relating to obesity and/or chronic diseases, including but not limited to: cardiovascular disease, diabetes, and cancer. These three chronic diseases have been identified as three of the six major areas of health disparities in North Carolina.

Evaluation of the Health Disparities Initiative consists of 3 components:

- Process evaluation: Progress toward the HDI goals and objectives
- Overall outcomes evaluation: The cohort study
- Evaluation of the North Carolina Central University technical assistance team

Process evaluation: Progress toward HDI goals and objectives

This component of the evaluation assesses progress toward the goals and objectives of the Health Disparities Initiative through analysis of the activities reported by grantees. Grantees reported their activities in the newly revised HDI database, HDI Check. Each activity was assigned an event code that matches the activity and was tied to a grantee objective and concurrently to an HDI objective. Grantees reported over 3,000 events in Year 2 of grant funding. Event codes are based on a logic model that divides activities into groundwork, actions, and accomplishments. As predicted by the logic model, in year 2 60% of the activities were actions, which are efforts to engage and influence outside agencies and to engage the community. Most of the actions reported were services provided directly to citizens. Grantees began to make progress on achieving environment and policy outcomes (EPOs), the ultimate goal for sustainability. Grantees reported 73 EPOs.

For their six-month report, grantees had an opportunity to provide both quantitative and qualitative self-assessments of their program and the progress made. Overall, the grantees reported they had achieved their program objectives over the previous six months and felt they had been able to use existing partners or new partners to assist them in meeting program objectives. Grantees felt they were on target to achieve their program objectives for the upcoming six months.

Overall outcomes evaluation: The cohort study

The goal of the cohort study is to examine the collective impact of the projects on specific biological and behavioral outcome variables that are important in addressing the priority areas within the HDI: cardiovascular disease (CVD), diabetes, and obesity/healthy lifestyle. To examine the impact of the initiative, eighteen grantees recruited and are following a longitudinal cohort of participants from their grant-funded programs. Measures for each participant are taken when s/he is first enrolled in the cohort study and then every six months until the end of the grant period. These measures include: blood pressure, body mass index (BMI), fruit and vegetable consumption, physical activity, quality of life, access to care, cholesterol (for those grantees focusing on CVD), and HbA1c, a measure of average glucose control over the last eight weeks (for those grantees focusing on diabetes).

Time 1 data collection was completed in Year 2; there are 2,471 participants. There are 1,011 participants with Time 2 data. The major findings of the cohort study analysis are:

1. Systolic blood pressure was reduced among participants in projects focusing on CVD, diabetes, and obesity. Across all participants systolic blood pressure was reduced from 138.22mmHg at Time 1 to 134.00mmHg at Time 2.
2. Among participants who are presumed to have diabetes, average HbA1c was significantly reduced from 8.9 to 7.9 while the percentage of participants with HbA1c<7 increased from approximately 25% to 40%.

Evaluation of technical assistance

The grantees rated the NCCU Technical Assistance team on their helpfulness over the past 6 months when requesting information or assistance and in assisting with the transition to year 3 of the project. The Central team received high marks on both measures.

Overall evaluation summary

The grantees are making progress toward attaining the goals of the Health Disparities Initiative. Over 1,000 service events were provided to citizens of North Carolina and 73 environment or policy changes were reported. All grantees feel they are on target to accomplish their program goals for the coming six months and most feel that they have been achieving their program goals thus far.

These preliminary outcomes data from the cohort study suggest that the HDI interventions are positively impacting the health of North Carolinians, especially underserved minority citizens. Improvements of this magnitude, if maintained, have been associated with reductions in diabetes and cardiovascular morbidity and mortality. Additional follow-up data will be carefully evaluated to confirm these initial findings.

The grantees continue to be highly satisfied with the technical assistance and support provided by the NCCU TA team.

Recommendations

The following recommendations are offered as a result of this evaluation report.

- In their communities, grantees should continue to advocate for environmental and policy changes that support the Health Disparities Initiative goals and objectives. Exploring opportunities to adopt environment and policy changes is important, as those changes will impact sustainability of grantee efforts.
- Grantees should persist in their efforts to generate external funding resources while continuing their program activities with support from the HWTF.
- Grantees should seek media opportunities to promote program objectives and HDI exposure.
- Grantees should continue to utilize their existing community partnerships to meet their objectives and should increase their efforts towards the development of new community partnerships to advance and achieve program objectives.
- Continue to follow cohort participants at requested six-month intervals. Use extra effort to contact difficult to find participants.

Table of Contents

List of Tables

List of Figures

Background

In May 2006 the North Carolina Health and Wellness Trust Fund Commission (HWTF) awarded $9.2 million in grant funding to local government and non-profit organizations across North Carolina under the Health Disparities Initiative (HDI). Grants were awarded for a three-year period starting July 1, 2006 and ending June 30, 2009. The purpose of the Health Disparities Initiative is to reduce the disparities in the incidence, prevalence, and mortality related to certain diseases in North Carolina, which are a result of race, ethnicity, and socio-economic status. Grants were awarded to projects that specifically focused on reducing disparities for children/youth and adults relating to obesity and/or chronic diseases, including but not limited to: cardiovascular disease, diabetes, and cancer. These three chronic diseases have been identified as three of the six major areas of health disparities in North Carolina. The organizations funded represent a diverse geographic, organizational, and racial mix.

The initial contract for the outcomes evaluation of the HDI was awarded to Shaw University's Institute for Health, Social and Community Research. In October 2007 East Carolina University (ECU) was selected as the new evaluator for this initiative.

HDI goals and objectives

The goals and objectives for the Health Disparities Initiative are:

1. 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: 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: 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. 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: 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: Increase the percentage of target group members who have detected their risk factors for cardiovascular disease and who implement lifestyle or other interventions to manage those risks
3. 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: Increase the number of target population members who implement lifestyle or other changes/interventions to successfully control their diabetes
    - Objective: Increase the number of target population members who have their risk factors for diabetes detected and treated
4. To reduce the number of deaths resulting from diabetes, heart disease and/or cancer among the target group members consistent with the goals of the Healthy Carolinians 2010 goals.
5. To reduce the number of deaths resulting from diabetes, heart disease and/or cancer among the target group members consistent with the goals of the Healthy Carolinians 2010 goals.
    - Objective: 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.

Health Disparities Initiative evaluation plan

The evaluation of the Health Disparities Initiative consists of 3 components:

- Process evaluation: Progress toward the HDI goals and objectives
- Overall outcomes evaluation: The cohort study
- Evaluation of the North Carolina Central University technical assistance team

Process evaluation plan: Progress toward HDI goals and objectives

This component of the evaluation assesses the extent to which the goals and objectives of the Initiative (specified in the RFP) were met. The data to evaluate this component are taken from information that is entered into the HDI database by grantees and from grantee self-assessments that are included in the grantee six-month reports. The HDI database was revised after meetings with the HWTF and NCCU to discuss content and structural changes. Regional

HDI database trainings were offered in spring 2008. A conference call workshop was held in January 2008 to train grantees on activity coding that they use in their monthly activity reports.

Outcome evaluation plan: The cohort study

The goal of the cohort study is to examine the collective impact of the projects on specific biological and behavioral outcome variables that are important in addressing the priority areas within the HDI: cardiovascular disease (CVD), diabetes, and obesity/healthy lifestyle. To examine the impact of the initiative, eighteen grantees identified and are following a longitudinal cohort of participants from their grant-funded programs.

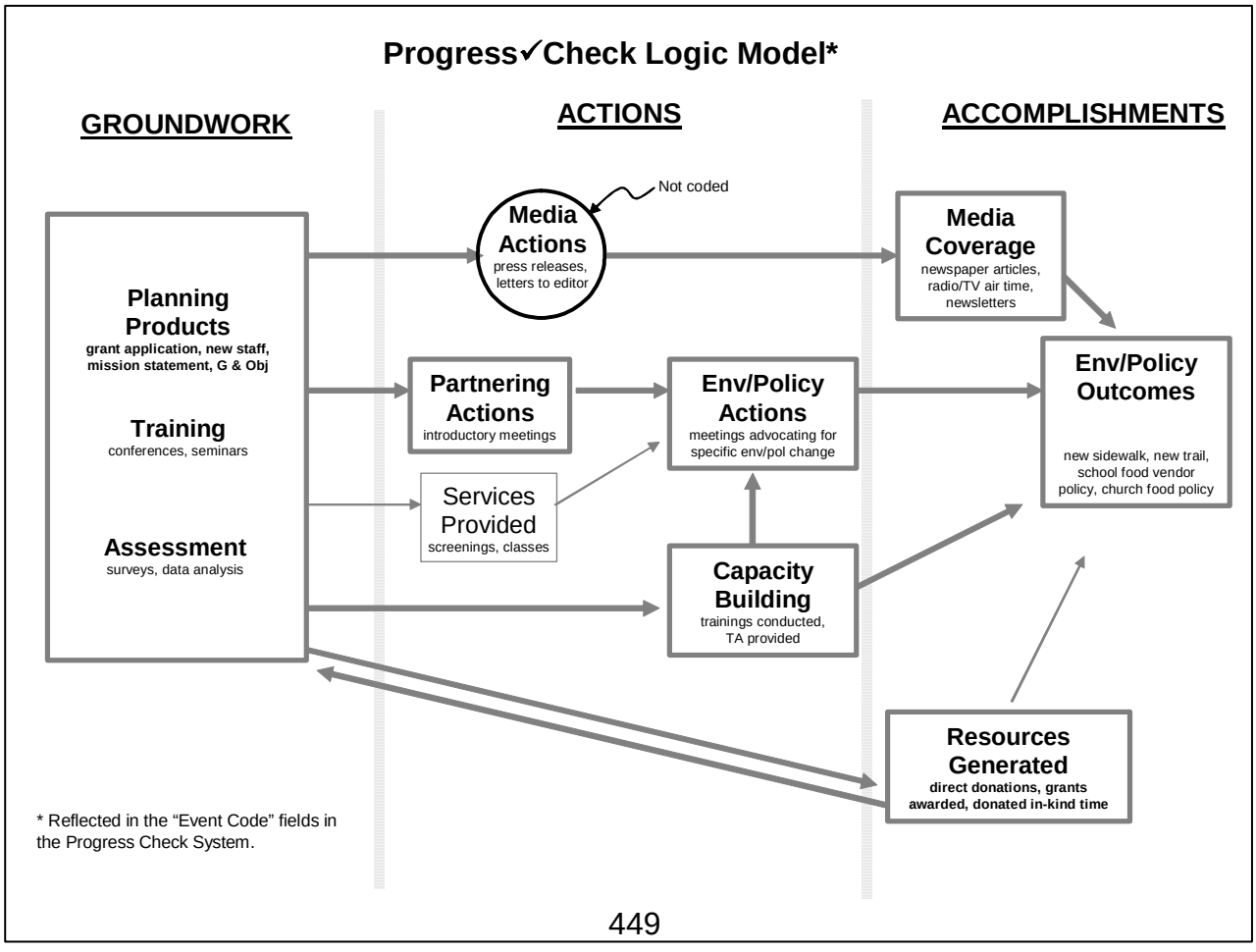
Technical assistance evaluation plan

The final component of the evaluation assesses the technical assistance provided by the NCCU team to the grantees. Specific questions included in the six-month reports completed by grantees were used to evaluate of the technical assistance provided by North Carolina Central University. For this six month period the questions focused on how helpful the NCCU TA team was when the grantee sought information or assistance and how helpful the TA team was in assisting in the transition to year 3 of the grant.

Process evaluation:
Year 2 grantee program activities

The implementation this year of the revised Health Disparities Initiative database (HDI Check) by all grantees allows for rich analysis of the grantees' program activities and their impact. HDI Check is a Microsoft Access based tool that enables grantees to systematically document and evaluate their efforts in reaching goals and objectives as well as the ability to summarize and document monthly activities. HDI Check is an outgrowth of the progress documentation system of the Fit Together Progress Check system, which 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 system originated from the CDC's seminal publication, "Evaluating Community Efforts to Prevent Cardiovascular Diseases." (Fawcett, S. B., Paine-Andrews, A., Harris, K. J., Francisco, V. T., Richter, K. P., & Lewis, R. K. (1995). *Evaluating community efforts to prevent cardiovascular diseases*. Lawrence, KS: Work Group on Health Promotion and Community Development, University of Kansas.) The following figure contains the logic model on which HDI Check is based.

Figure 1
Logic model



For year 2 of the HDI grant program, grantee objectives and strategies were linked to HDI goals and objectives. These objectives and strategies were entered into HDI Check and all program activities were linked with both a grantee objective and a HDI objective. When grantees report their activities in HDI Check, they assign a code to each activity or event (e.g. Planning Product, Services Provided). Event codes help the evaluators quantify and standardize the information reported by grantees.

GROUNDWORK consists of activities that prepare grantees to advocate for and create healthier environments. These efforts enable grantees to set priorities and move into direct actions to bring about change.
Within **GROUNDWORK**, coded events include:

- **Planning Products (PP):** tangible results of the planning process
- **Training (T):** efforts to enhance knowledge and skills of project staff to carry out its mission, goals, and objectives
- **Assessment (A):** formal or semi-formal actions taken to collect, analyze, and/or interpret data for needs assessment and/or evaluation

Efforts to engage and influence outside agencies are considered **ACTIONS** in the HDI Check database. Activities coded as **ACTIONS** include:

- **Partnering Actions (PA):** help create the critical relationships needed to implement initiatives and to influence other organizations and government bodies
- **Services Provided (SP):** events that directly target individuals or groups to improve individual behaviors or health status
- **Capacity Building (CB):** actions and events taken to build the capacity of other organizations, groups, or volunteers to support health that provide training or skill building to other groups
- **Environment/Policy Action (EPA):** specific recommendations made to key decision-makers or groups of influence to advocate for environmental or policy level change that may/will result in an Environment/Policy Outcome
    - Partnering actions, services provided, and capacity building activities each may provide opportunities for this advocacy.

Finally, **ACCOMPLISHMENTS** are outcomes that involve a decision or change by some organization or governing body. In the database, activities coded **ACCOMPLISHMENTS** include:

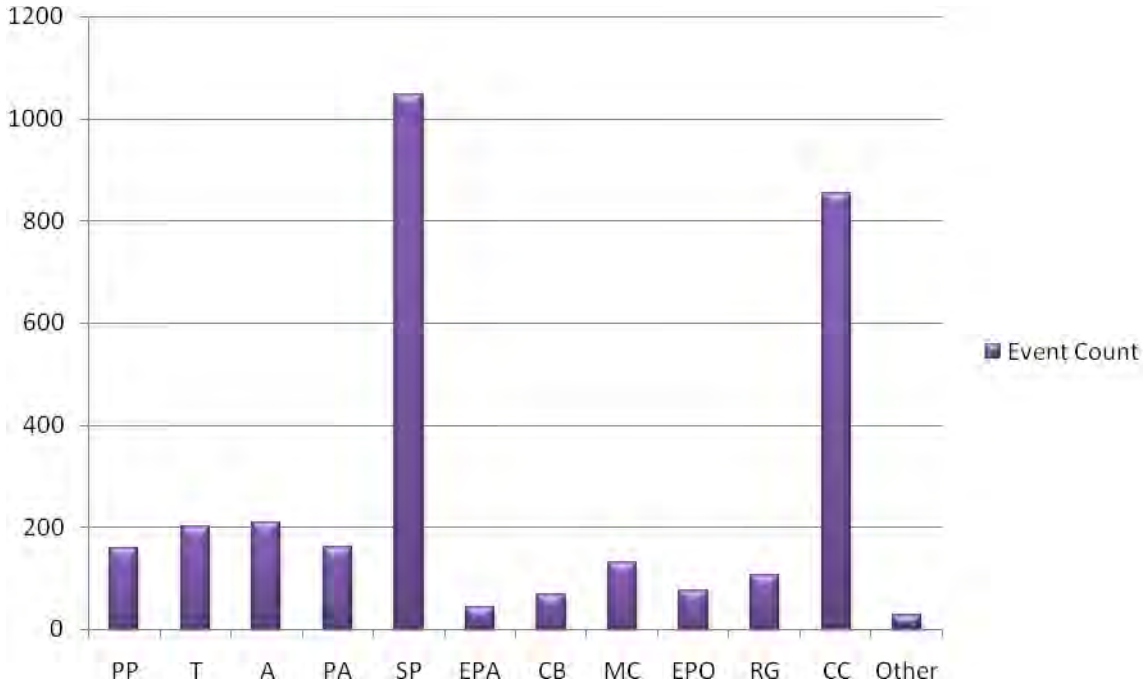
- **Media Coverage (MC):** requires that a media agency (e.g., newspaper) cover grantee's programs/health issues

- **Resources Generated (RG):** represents the additional tangible assets (i.e., money, goods, labor) contributed to grantee initiatives and outreach
- **Environmental/Policy Outcomes (EPO):** represent changes that require a decision-maker to adopt (or not adopt) a change

Another coding option is **Community Communication**. It is designed to capture activities involving communication(s) with project staff concerning HDI-related information or communication(s) with community members, partners, collaborators, state, and/or national organizations. It is not a part of the logic model but a necessary code to encapsulate important activities that represent the sharing of HDI information, such as monthly HDI program conference calls, event planning meetings, and community presentations.

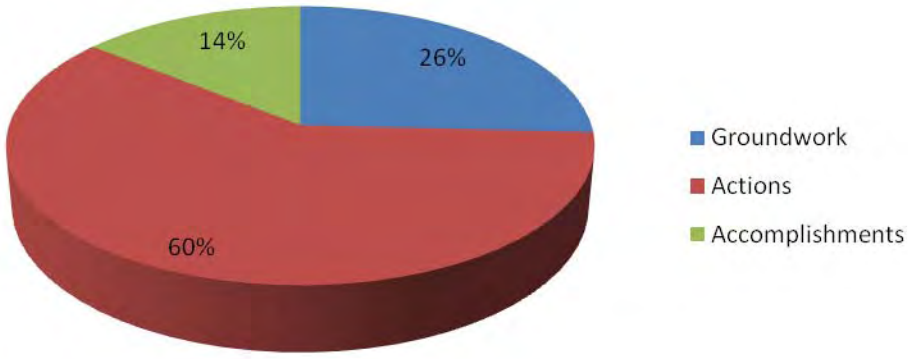
The activities summarized in this report represent event codes entered into the database from July 1, 2007 to June 30, 2008. A total of 3,082 events were entered into the system for Year 2 of the Health Disparities Initiative. The following chart (Figure 2) represents the program activities by event type.

Figure 2
Program activities by event type



The logic model on which the coding of events is based shows a progression of activities, with movement from groundwork to actions to accomplishments, with the ultimate accomplishment being environment and policy outcomes. Early in the life of a project much of the activity will focus on groundwork, such as planning activities, training staff, and assessing needs in the community. As the project progresses, more activities will be focused on actions that will engage and influence other agencies and the community. Ultimately, the project will progress such that more of the focus will be on accomplishments, such as coverage of project activities and generating resources for project activities and sustainability of the project. As the project matures, environmental and policy changes should increase. In summarizing year 2 HDI activities we expect to see continued groundwork, a large proportion of actions, and the introduction of accomplishments. Figure 3 shows the distribution of the 3,082 year 2 events separated by each section of the logic model. As expected, there was a concentration of groundwork and action activities with a smaller portion of accomplishments.

Figure 3
Distribution of program activities from logic model



*CCs were not included in this figure as they are not in the logic model.

Groundwork

In Year 2 of the project, a little over 25% of the activities were groundwork. The logic model would predict that groundwork would have been a larger focus of Year 1 since it involves preparatory efforts to advocate for healthier environments.

Planning Products

Planning Products emerge as part of the planning process and provide a foundation for future activities. They are tangible tools or products used to promote health. Grantees reported 158 planning products including grantees' action plans, patient education materials, and program guides. The majority of coded planning products for Year 2 were the creation of individual behavioral materials (30) and policy/practice change materials (13).

Training

Training enhances the knowledge and skills of project staff members to carry out their mission, goals, and objectives. Grantees reported 202 training events that included coding workshops, annual meetings, and learning specific interventions (e.g., group medical visits).

Assessment

Actions taken to collect, analyze, or interpret data for needs assessment and/or evaluation are coded as assessment events. Grantees reported 208 such events of which 84% focused on assessment of children. The setting for 48% of these assessments was in the faith community.

Actions

In Year 2, HDI grantees coded many more action activities than groundwork or accomplishments (60% of the activities were coded as actions). Much of the necessary groundwork was established in Year 1 of the initiative and the projects are mobilized and prepared as evidenced by the number of services provided to their communities.

Partnering Actions

Grantees reported 160 partnering action events. The majority of these coded partnering actions were exploring/creating new partnerships (128) and maintaining existing partnerships (30).

Services Provided

Events that directly target individuals or groups to improve individual health behaviors or health status are coded as services provided. In year 2 of the HDI there were 1,047 events coded as services provided. The majority of services provided in Year 2 occurred in the faith community (592), the community environment (531), and healthcare settings (229). Table 1 provides the event count for services provided delineated by type of service.

Table 1
Service provided by type of service

Service provided	Event count
Case management	122
Counseling	12
Exercise classes	185
Group education/support	225
Group medical visits	31
Screening/referral/follow-up	116
Workshops	180
Other	176
Total services provided	**1,047**

Capacity Building
Capacity building documents actions and events that build the capacity of other organizations, groups, or volunteers to support health. These are events that provide training or skill building to other groups. Through 67 capacity building actions, grantees have reached 940 individuals during Year 2 of their funding. Most of these individuals were teachers/childcare providers (343) and healthcare professionals (248), and the majority of activities were group training and skill building with fewer events coded as one-on-one technical support.

Environment/Policy Actions
Environment/policy actions are specific recommendations made to key decision-makers or groups of influence to advocate for environmental or policy level change. Grantees reported 44 such events, which included recommendations made to various faith communities (26), community groups (13), and healthcare systems (9). The majority of these recommendations were made to policy/decision makers of these settings.

Accomplishments

In Year 2, 14% of program activities were coded as accomplishments. This is consistent with the logic model, which would predict a further increase in accomplishments during Year 3.

Media Coverage

HDI grantees have generated coverage through a wide variety of media outreach efforts. The table below (Table 2) illustrates the coverage generated by type of outlet utilized by grantees.

Table 2

Media coverage by outlet

Media outlet	Event count	Potential media exposures
Billboard	1	500
Brochure	3	25
Email	5	10,525
Flyer	25	7,670
Newsletter	28	1,068,750
Newspaper	13	862,700
Radio	38	2,369,500
TV	4	1,237,000
Other	13	14,990
Total	**130**	**5,562,660**

Throughout Year 2 of the funding period, there were over 5 million opportunities for North Carolina citizens to read or hear about a HDI grantee or the health disparities initiative. About one third of these exposures were through radio with approximately 2,500 minutes of radio airtime being reported. Grantees also generated many television (4), newsletter (28), and newspaper (13) media coverage events.

Media coverage included general project coverage (61), health promotion messages (42), and local event/resource promotion (27). According to their program activity reports, grantees indicated that media outreach impacted all levels from neighborhoods to the state of North Carolina. Specifically, most of the media coverage targeted specific counties (69). When grantees record a media event they select the level of potential impact for that event. Table 3 outlines the distribution of media coverage by level of impact. Over half of the media events recorded were distributed at the county level.

Table 3
Media coverage by level of impact

Level of impact	Event count
State	24
Region	9
County	69
Municipality	5
Neighborhood	10
Multiple organizations	4
Single organization	8
Other	1
Total media coverage	**130**

Resources Generated

Grantees have been successful in generating resources for their activities. Materials (32) and professional time (26) were the most frequently reported resources generated. Grantees have been able to encourage local businesses and agencies to supply incentives for programs and to provide transportation for events. Materials donated to grantees for various projects and outreach efforts include exercise equipment and healthy snacks for screenings and other events. The table below (Table 4) lists the types of resources and the in-kind or direct dollars generated.

Table 4
Resources generated by resource type

Resource type	Event count	In-kind Dollars ($)	Direct dollars ($)
Administrative	10	4,580	
Funding	18	100	4,181,410*
Materials	32	16,136.95	560
Professional time	26	9,420	50
Volunteer time	11	9,050.04	
Other	10	1,325	
Total resources generated	**107**	**40,612**	**4,182,020**

*Over $3,500,000 was generated by one grantee

Environment/Policy Outcomes

Environment/policy outcomes (EPOs) are new or modified policies, practices, or environments that contribute to program objectives. The main difference between environment/policy *actions* (EPAs) and environment/policy *outcomes* is that EPAs are actions that lead toward the adoption of EPOs. Since EPOs are outcomes of EPAs, they can be adopted policies, changed policies, continued policies, or declined policies. Only one EPO for Year 2 was a declined policy; this was a policy for which the grantee advocated, but it was not adopted by the organization. For Year 2, 11 grantees reported 73 EPOs. The types of EPOs reported by grantees in Year 2 are shown in Table 5 below.

Table 5

Types of Environment/policy outcomes (EPOs)

EPO Type	Event Count
Cues to action	11
Facilities and environment	14
Policies, practices, and incentives	48
Total EPOs	**73**

In 90% of Year 2 EPOs, HDI grantees assumed the lead role. Grantees were contributors in 8% of the reported EPOs. In the remaining EPOs, grantees had an indirect role. Within the HDI Check database, grantees were asked to indicate a setting for each EPO. More than one setting could be selected. The settings represent the environment that the EPO will ultimately influence. Over 60% of the reported EPOs in Year 2 were implemented in the faith community (45). Table 6 summarizes the settings and descriptions for the Year 2 EPOs.

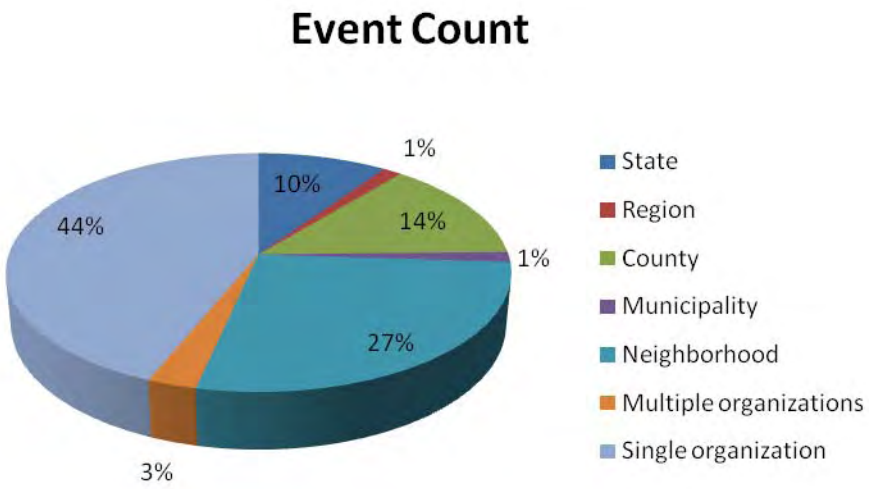
Table 6
Settings for EPOs

Setting	Description	Event count
Faith community	Physical activity and/or nutrition policy adopted	21
	Walking trails established	10
	Letter of agreement for project participation	8
	Incorporate nutrition messages into sermons/bulletins	3
	Designate day each month for health ministry activities	2
	Established health classes	1
Health care	Medical practice agrees to participate in project	5
	AAFP and NCMS adopt resolutions to endorse CLAS Standards	2
	New patient scheduling system implemented	1
	Extend hours of patient walking club	1
	Implement "Return Appointment" card system	1
	Practice implements Group Medical Visit model	1
Community environment	Signs promoting healthy foods posted at grocery stores	9*
	Housing Authority policy revised to allow use of their gym for exercise classes	1
	Restaurant displays table tents with warning signs of heart attack/stroke	1
	Opened a Health Resource Center	1
	Health department begins offering diabetes education/support to public	1
	Restaurant adds healthy item to menu	1
	Mayor proclaims Prostate Screening Day	1
Community group	Teen Safety Club adopts physical activity schedule	1
	Establish policy of healthy foods at meetings	1
Total events		**73**

*Includes one environment change that was not approved

Grantees' successes in impacting multiple levels of the environment are summarized in Figure 4. With comprehensive and broad-reaching impacts, these EPOs are affecting behavior change from the individual to state levels.

Figure 4
EPO levels of impact



In summary, grantees have worked on EPOs in many settings and with varying populations that relate to improvements in leading health indicators such as physical inactivity, poor eating behaviors, and access to appropriate care.

HDI goals and objectives

Grantee program activities are intended to address and support the goals and objectives of the Health Disparities Initiative as defined by the Health and Wellness Trust Fund and summarized at the beginning of this report. Figure 5 shows the distribution of total program activities by HDI objective. Over one-third of the activities are related to diabetes program implementation and almost one quarter are related to CVD health literacy. Figure 6 shows program activity types by HDI objective. Figure 6 provides a visual representation of activities, which demonstrates that they are similar across all objectives. The most common activity is services provided followed by community communication. In the second year of the grant, many activities were directed toward providing services and opportunities to citizens of North Carolina, as reflected in the large number of activities coded as services provided. Again, this reflects movement through the logic model away from groundwork and toward actions. Community communication is a common activity as it reflects the many meetings and presentations related to the HDI.

Figure 5

Total program events by HDI objective

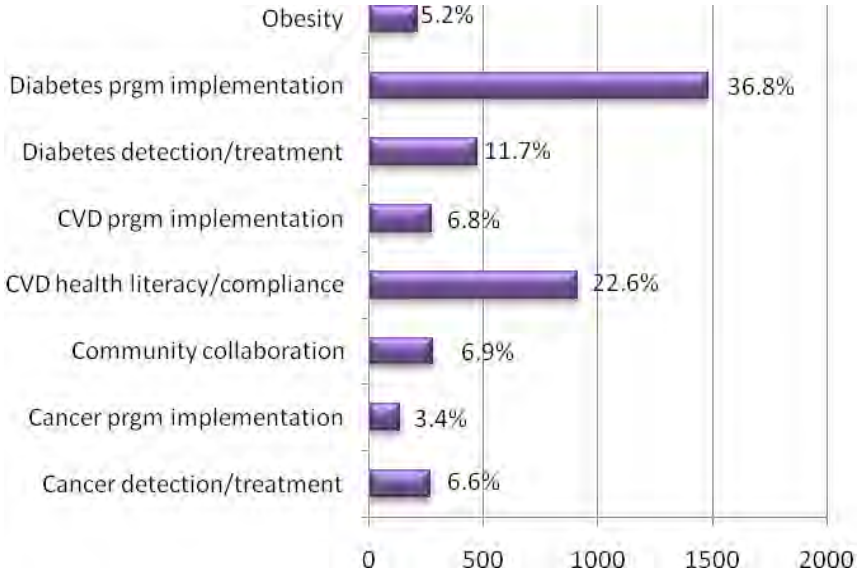
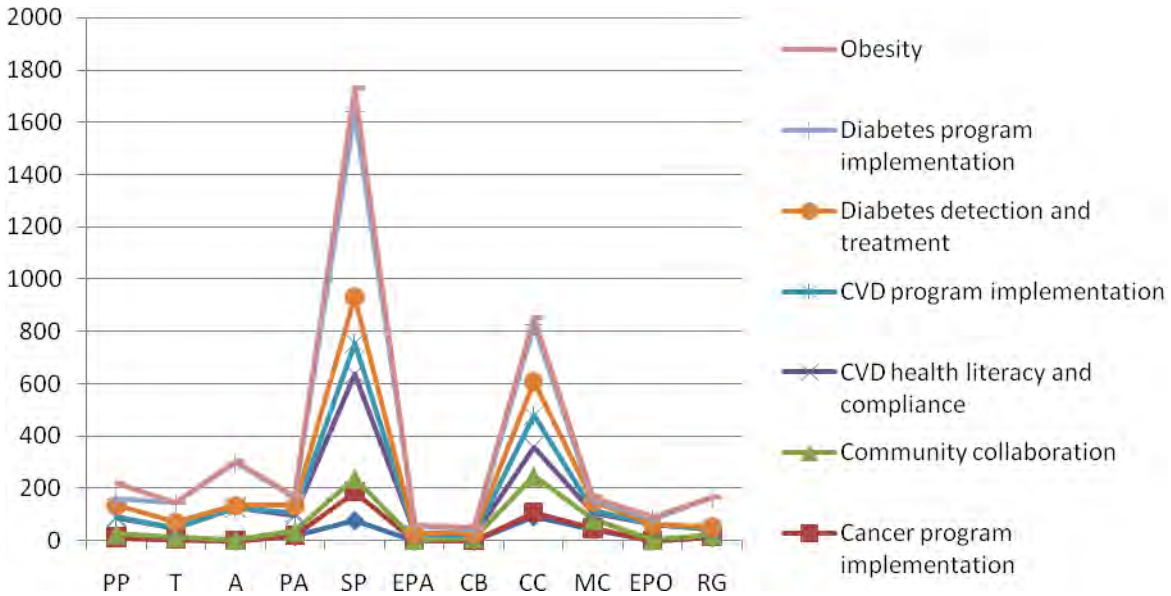


Figure 6

Program events by HDI objectives



Grantee Self-Assessments

All grantees had an opportunity to provide both a qualitative and quantitative self-assessment of their program and the progress that had been made in the previous six months. This assessment covers the period of January – June 2008.

Table 7 below summarizes the grantees' responses to self-assessment questions about progress toward their program objectives during the past six months and in the next six months.

Table 7
Progress toward program objectives

During past 6 months	Mean	Range (1-10)[+]	N
Achieved program objectives	8.6	5-10	23
Encountered significant barriers to program objectives	4.7	1-9	23
Utilized media advocacy techniques to promote program objectives	5.8	1-10	23
During next 6 months	**Mean**	**Range (1-10)**	**N**
Believe you are on target to achieve program objectives	9.1	8-10	22*

[+]Scale 1 (not at all) – 10 (to a large extent)

*Chatham Hospital Immigrant Health will not be continuing into year 3, so this question was not applicable.

The grantees reported that they achieved their program objectives over the previous six months, overall. In fact, five grantees rated this statement a "10." All grantees believed they were on target to achieve their program objectives in the next six months.

Eight of twenty grantees felt they encountered significant barriers to their program objectives (reported scaled scores from 6 to 10). The primary barriers included: staff education and implementation, community involvement, and patient follow-up and participation. To overcome these obstacles, grantees reported creation of patient education and follow-up

systems, modified community advocacy and outreach, and different approaches to staff education.

There was a wide variety of the extent of media advocacy utilization to promote program objectives reported by the grantees.

Table 8 below summarizes the grantees' responses to self-assessment questions related to their partnerships.

Table 8
Partnerships

During past 6 months	Mean	Range (1-10)[+]	N
Able to use existing partnerships to assist in meeting program objectives	8.9	7-10	23
Able to develop new partnerships to assist in meeting program objectives	6.9	1-10	23

[+]Scale 1 (not at all) – 10 (to a large extent)

Some grantees indicated significant progress in working with partners to achieve their program objectives while others encountered minor problems. One group noted that their local partners were their most significant barriers. These partnerships were with churches where many of the members were elderly and not very mobile, or with churches that we being renovated. However, the grantee reported that they were "coming up with ideas to get around this barrier."

Best Stories

Grantees were asked to share their "coolest things" and/or "best stories" from the previous six months that happened as a result of their project. A few select examples are below and a complete listing can be found in Appendix B.

The project staff was able to help sponsor the very first Martin Luther King Celebration in [town] since the town's establishment 19 years ago, which was named after the famous man. This celebration replaced the family dinner described in the Year 2 AAP objective. The project staff provided blood pressure checks, recruited new cohort participants, and collected 6-month follow

up assessments, and distributed "Down Home Healthy" cookbooks. The event received high attendance from both [town] residents and general [county] population. All of this was with the help of the new [town] Events Committee who is working hard to improve the community in all aspects. [Local restaurant owner] added a grilled chicken wrap to her everyday menu at [Local Restaurant] in [town] as a result of the [Project Name] staff efforts.

Our breast cancer support group [Name of Group] leader is a pastor on a mission. She is a breast-cancer survivor. She invited us to her church to conduct the American Cancer Society "Body & Soul" program for 4 weeks in March. It is a bible class and nutrition training. She participated right alongside her church members in study and exploring new foods. They ate salads and fruit for 4 weeks tasting and sampling different foods. She became inspired and hired a personal trainer for 8 weeks and has lost 20 lbs. She no longer has a trainer but is walking 20,000 steps a day, 4-5 days a week. She is setting an example for her church members. The church now has committed to not having fried foods at their meals.

The church cook (Black male in his late 30's) assisted weekly with the sessions and signed on as a Parity Action Team member in April. While he was in the office signing his papers to volunteer, the volunteer coordinator suggested he see our nurse case manager to follow-up on a diabetes assessment he completed at the church. The NCM [Nurse Case Manager] found his blood pressure dangerously high and referred him to a community partner, who gave him the necessary medicine to regulate his blood pressure. He called in May to follow-up and to let us know how he was doing. The NCM also signed him up for the prostate screening in June. He attended and got several screenings done (cholesterol, BP, BMI, DRE, PSA) as well as overall lifestyle counseling. He is now committed to taking better care of himself.

Another exciting update comes from the pilot practice where none of the CLAS [Culturally and Linguistically Appropriate Services] Standards were being met at the initial assessment last June. The practice worked on updating patient forms to include "language preferred" and "race" and they also put a sign in the waiting room that said in Spanish that interpreter services were available. They had a position open in the chart room and decided that it would be an opportunity to hire someone bilingual and so they did. The person mostly works in the chart room but also serves as an onsite interpreter for the practice. Before this there was no one in the clinic who was spoke fluent Spanish.

Cohort participant, African American male, has been a cohort patient since December 2007. He has lost 26 lbs since the start of the program. The participant is now exercising at work 4 times a week, lifting weights and eating healthier. He now eats more salads, fruits, vegetables, and has cut back almost completely on fried foods, beef, and pork products. His diet now consists of

more lean chicken, fish and shrimp. The patient also walks with his wife a couple evenings a week. He has noticed a better fit to his clothes and now has more energy to be active with his family. He is very glad to be a part of our HDI program and stated that the program has encouraged him to live and be healthy for himself and his family.

Hispanic female, who initially did not see the importance of losing weight. Now (since about 3 months ago) decided to try hard and has lost 11 pounds. She never exercised, but started doing10 minutes a day of exercise and is now exercising 20 minutes+ per day. [Participant Name] also did not eat vegetables before starting our program, and now she is trying to eat 2 to 3 servings a day. She looks much younger, her complexion looks clearer, and her blood sugars have been going down and are almost at normal levels now!

[Patient Name] is a resident and community leader. She began the Yoga classes in a chair; then on the floor. Before she began the class, her husband had to assist her to get in and out of the tub. Now, she testifies that since the Yoga classes, she can get in and out of the tub without any assistance. Additionally, she attributes her overall improvement in walking and reduction in pain to the Yoga class. Because of her success and progress, she has convinced 7 of her relatives to join the Yoga class.

Outcomes evaluation:
The cohort study

Overall outcomes evaluation (cohort study) plan

The goal of the cohort study is to examine the collective impact of the projects on specific biological and behavioral outcome variables that are important in addressing the priority areas within the HDI: cardiovascular disease (CVD), diabetes, and obesity/healthy lifestyle. To examine the impact of the initiative, eighteen grantees have identified and are following a longitudinal cohort of participants from their grant-funded programs.

Five grantees were not required to participate in the cohort study. The grantee and the reason for non participation are listed below.

1. Wake County Human Services is the only grantee that is exclusively addressing cancer.
2. The work by Dare County and NC AAHPERD is focused on children. As there are only two grantees with this focus and because the required measures are interpreted differently for children than for adults, these two grantees will not participate in the cohort study.
3. North Carolina Academy of Family Physicians is focusing on cultural appropriateness and their main participants are physician practices. They do not work directly with patients or community members.
4. The activities of Charlotte Communities of Shalom address fewer participants and follow-up is very difficult.

The cohort study allows us to assess the same group of adults over time to measure biological and behavioral changes that are associated with the initiative's priority areas. Measures for each participant are taken when s/he is first enrolled in the cohort study and then every six months until the end of the grant period. Some grantees measured the biologic variables directly while others abstracted the data from existing medical records. The biological outcome variables selected for each priority area are listed in Table 9.

Table 9
Outcome variables by priority area

Topic area (Number of grantees)	Body Mass Index (BMI) [1]	Blood pressure	HbA1c [2]	Cholesterol [3]
CVD (3)	X	X		X
Diabetes (9)	X	X	X	
CVD and diabetes (3)	X	X	X	X
Obesity (3)	X	X		

[1] BMI is a measure of body fat based on measured height and weight that applies to both adult men and women. The formula for BMI is:
(Weight in Pounds / (Height in inches) x (Height in inches)) x 703

The standard weight status categories associated with BMI ranges for adults are:
Underweight = <18.5
Normal weight = 18.5-24.9
Overweight = 25-29.9
Obesity = 30 or greater

[2] HbA1c = glycosylated hemoglobin; a measure of average glucose control over the last eight weeks

[3] Grantees were instructed to obtain measurement of low density lipoprotein (LDL) cholesterol, but grantees who could not obtain LDL recorded total cholesterol

In addition, all cohort participants complete a survey that includes questions on fruit and vegetable consumption, physical activity, quality of life, and access to care (See Appendix A). The survey was developed by the ECU evaluation team using existing questions from instruments developed by the Centers for Disease Control and Prevention (CDC) including the Behavioral Risk Factor Surveillance System (BRFSS) and the Healthy Days Core Module (CDC HRQOL-4), which is part of the CDC Health-Related Quality-of-Life 14-Item Measure. The source is listed next to the questions in the Appendix. The survey was designed to be either self-administered or interviewer-administered. Grantees chose the method that worked best for their specific participants, taking into consideration issues such as time to administer the survey and literacy levels of participants.

Cohort study analysis

Time 1 data collection was completed by all grantees by June 2008. Table 10 shows the current enrollment status of the HDI cohort. The goal is for follow-up data to be collected for each participant every six months, however, the average time between data collection periods varied widely among participants. As noted earlier, some grantees collected biologic data directly and some collected the data via medical record review. It is possible that this difference in data collection methods contributed to the variability in the average time to follow-up. Ideally, Time 3 should be 12 months after Time 1, but the average time is 10.8 months and varies from 1 month to 19 months. Time 4 should be 18 months after Time 1, yet among those that do have data at four time points the average time is 13.7 months after Time 1 and ranges from 1 to 21 months. To standardize the length of time between measurements and to approximate our desired standard of 6 months of follow-up, all of the analyses were limited to those participants for whom Time 2 data were collected between four and eight months after Time 1 data were collected. These analyses were conducted separately for each of the focus areas (CVD, diabetes, and obesity).

It should be noted that the number of participants with Time 3 and Time 4 data is small. Not all grantees began Time 1 data collection at the start of the funding period (July 2006) and therefore have not had time to collect data three or four times. In some instances grantees have attempted to collect follow-up data but have not been able to locate participants or for participants to make a visit to have their data collected. All analyses for this report are limited to comparisons of Time 1 and Time 2 data. The earliest Time 1 data were collected July 2006 and the latest Time 1 data in June 2008.

Table 10
Status of cohort study

	Number of participants	Average time from Time 1
Time 1	2,471	
Time 2 (1 six-month follow-up)	1,011	6.9 months (<1–19 months)
Time 3 (2 six-month follow-ups)	325	10.8 months (<1-19 months)
Time 4 (3 six-month follow-ups)	93	13.7 months (<1 -21 months)

Cohort study results

The demographic characteristics of the HDI cohort at Time 1 are shown in Table 11. Nearly 75% of the participants are women and over 75% are African American, thus reflecting the focus of the projects on minority populations. The average age is 52.8 years.

Table 11

Demographic characteristics of participants

Characteristic	
Female	73%
Race	
African American	79%
Caucasian	10%
Native American	8%
Other	3%
Average age	52.8 years (18 – 92 years)

Cardiovascular disease

There were 987 participants from projects focusing on CVD at Time 1 (588 from projects focusing on CVD alone and 399 from projects focusing on CVD and diabetes). BMI, blood pressure, and cholesterol were measured. Of these 987, 122 had BMI data available for the time period 4 – 8 months following their Time 1 data and 180 had systolic blood pressure data. Table 12 shows the change in BMI and systolic blood pressure. There was no significant difference in BMI from Time 1 to Time 2; however there was a significant reduction in systolic blood pressure. Importantly, reductions in blood pressure have been associated with significant reductions in the risk of adverse cardiovascular outcomes including stroke, a historically disparate outcome in North Carolina. Reductions in the incidence of stroke would be expected to result in reduced health care costs associated with hospitalization, rehabilitation, and permanent disability.

Table 12
Change in biologic measures for CVD

	BMI follow-up between 4 – 8 months	Systolic BP follow-up between 4 – 8 months +
CVD only + *CVD and diabetes*	(n=122)	(n=180)
Time 1	33.06	144.65 mmHg *
Time 2	32.87	136.28 mmHg *

*p<.001

+ Goal blood pressure <140/90 mmHg; for those with diabetes goal is 130/80 mmHg

LDL is generally measured annually therefore we did not have Time 2 data available to assess changes in LDL. At Time 1 the average total cholesterol was 186 mg/dL and ranged from 84-315 mg/dL (n=595). According to the National Heart, Lung and Blood Institute the desirable range for total cholesterol is less than 200 mg/dL and less than 100 mg/dL is optimal for LDL. About 34% of these participants had total cholesterol values greater than 200 mg/dL.

Diabetes

At Time 1 there were 1,619 participants from projects focusing on diabetes (1,220 from projects focusing on diabetes alone and 399 from projects focusing on diabetes and CVD). BMI, blood pressure, and HbA1c were measured in these participants. Of these 1,619, 317 had BMI data available for the time period 4 – 8 months following their Time 1 data and 366 had systolic blood pressure data. Table 13 shows the changes in BMI and systolic blood pressure. The same pattern of change was found for diabetes-focused projects as was reported for CVD above, the change in BMI was not significant; however, there was a significant reduction in systolic blood pressure.

Table 13
Change in biologic measures for diabetes

	BMI follow-up between 4 – 8 months	Systolic BP follow-up between 4 – 8 months +
Diabetes only + CVD and diabetes	(n=317)	(n=366)
Time 1	34.85	138.70 mmHg *
Time 2	34.83	133.96 mmHg *

* p<.001

+ Goal blood pressure <140/90 mmHg; for those with diabetes goal is 130/80 mmHg

There were 948 participants for whom HbA1c was measured at Time 1. Since HbA1c is a specific test used to monitor patients with diabetes mellitus, we are assuming these are people with an established diagnosis of Type 1 or Type 2 diabetes mellitus.

The average HbA1c among this group was 8.3 and ranged from 3.8 to 18.0. Of these 948 participants, 240 had HbA1c measured again between four to eight months later. There was a significant reduction in average HbA1c. The American Diabetes Association recommends that adults with diabetes have HbA1c < 7%. The percentage of participants with HbA1c < 7% increased significantly from Time 1 to Time 2. Table 14 shows these results.

Table 14
HbA1c results

	HbA1c follow-up between 4 – 8 months (n=240)	% HbA1c < 7% follow-up between 4 – 8 months (n=240)
Time 1	8.9 *	24.6% *
Time 2	7.9 *	39.6% *

*p<.001

The average change in HbA1c from Time 1 to Time 2 was approximately 1. This ranged from a 7.9 reduction in HbA1c to a 5.4 increase in HbA1c. A reduction in HbA1c of 1 unit, if maintained, is very important. Sustained changes in HbA1c of this magnitude in the Diabetes Control and

Complications Trial (DCCT) and in the United Kingdom Prospective Diabetes Study (UKPDS) have been associated with substantial and significant reductions in the microvascular complications of diabetes including renal (kidney) failure, neuropathy (nerve damage), and retinopathy (eye disease that can lead to blindness) and with modest reductions in macrovascular disease (heart attacks, etc). Further, these findings suggest that community based interventions designed to improve both self-management as well as medical management for diabetes can have important implications for the morbidity and mortality associated with this important chronic disease in minority populations.

While important changes were identified in glycemic control, there appeared to be little impact on systolic blood pressure levels or BMI. A similar pattern has been observed in other studies and reflects the wide inter- and intra-individual variation in blood pressure values. Among this group of participants there were no significant changes from Time 1 to Time 2 in average systolic BP (134.42 mmHg v 134.33 mmHg, n=205) nor in average BMI (34.56 v 34.61, n=196). The goal set forth by the American Diabetes Association is systolic blood pressure <130 mmHg. The percentage of participants with systolic BP < 130 mmHg was 45.9% at Time 1 and 44.4% at Time 2 (n=205). We also looked at a higher risk subset of these participants who had a systolic blood pressure greater than 140 mmHg. There was a significant reduction in the percentage of participants with a systolic BP greater than 140 mmHg (37.1% v 31.2%). At Time 1 76 participants had systolic BP greater than 140 mmHg, at Time 2 64 did. This reduction in blood pressure among the subset of diabetic participants with higher levels of blood pressure is also an important finding that may contribute to a longer term reduction in the risk of cardiovascular disease including strokes.

Obesity

There were 264 participants from projects focusing on obesity at Time 1. BMI and blood pressure were measured for these participants. Of these 264, 73 had BMI data available for the time period 4 – 8 months following their Time 1 data and 63 had systolic blood pressure data. Table 15 shows the changes in BMI and systolic blood pressure. As with CVD and diabetes, there was no significant reduction in BMI, but there was a significant reduction in systolic blood pressure.

Table 15

Changes in biologic measures for obesity

	BMI follow-up between 4 – 8 months (n=73)	Systolic BP follow-up between 4 – 8 months (n=63) +
Time 1	36.32	133.29 mmHg #
Time 2	36.05	127.63 mmHg #

# p<.01

+ Goal blood pressure <140/90 mmHg; for those with diabetes goal is 130/80 mmHg

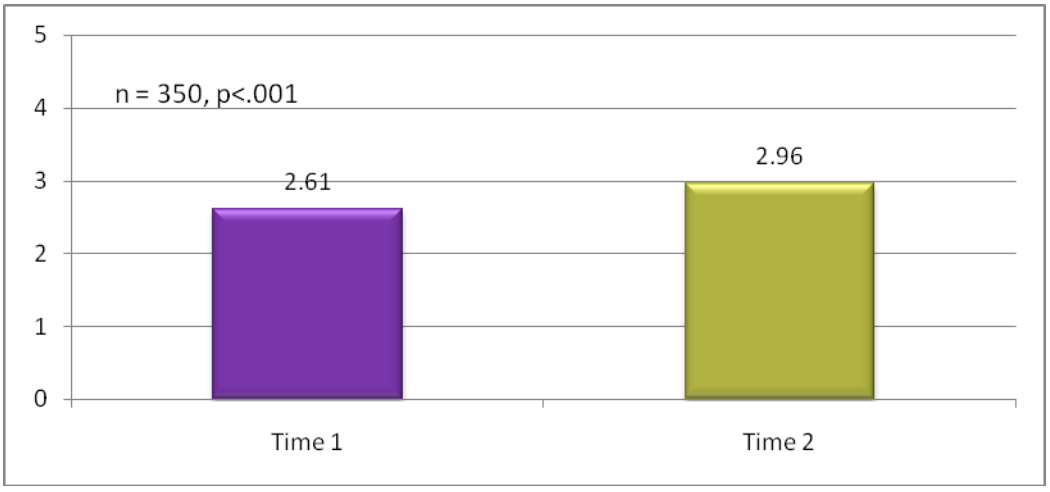
HDI Health Survey

The HDI Health Survey was distributed to grantees in February 2008. Grantees were instructed to administer the survey the next time that they saw each participant and then every six months following. The goal was to have the survey administered on the same schedule as the biologic measures were collected. The full survey is in Appendix A.

Fruits and vegetables. The survey contained one question that had been included in the original evaluation plan, so we were able to assess change in daily servings of fruits and vegetables consumed. Figure 7 shows that, on average the number of servings increased significantly from Time 1 to Time 2.

Figure 7

Change in average daily servings of fruits and vegetables



The following describes the Time 1 responses to the HDI Health Survey. The next report to the HWTF will describe changes in responses to the survey questions.

Physical activity. Participants were asked on how many days in a typical week they engaged in moderate physical activity for at least 10 minutes each time and how many days in a typical week they engaged in vigorous activity for at least 10 minutes each time. Over 35% said they engaged in moderate physical activity five or more days per week and 44% said that they engaged in vigorous physical activity 3 or more days per week. Measuring change in physical activity will be important as lifestyle changes including increased physical activity were a principal component of a major study that demonstrated a reduction of up to 67% in the 5-yr risk of developing Type 2 diabetes in at risk individuals (Diabetes Prevention Program, NEJM 2002; 346:393)

Smoking status. Table 16 shows that the majority of the respondents never smoked and another 20% are past smokers. Current smokers smoke an average of 12 cigarettes per day.

Table 16
Smoking status

Smoking status	%
Current smoker	11.3
Past smoker	20.8
Never smoked	67.9

Health status. Cohort participants were asked to rate their health. About 20% said that their health was excellent or very good; yet over 40% reported their health to be fair or poor (Table 17).

Table 17
Self-rated health

Would you say that your health is:	%
Excellent	3.9
Very good	16.0
Good	39.8
Fair	33.8
Poor	6.5

The participants were also asked about the number of days in which their physical and mental health was not good, and for how many days this prevented them from engaging in their regular activities. Participants reported an average of nearly 13 days per month that their physical health was not good and nearly 11 days per month that their mental health was not good (Table 18). They also reported that for an average of almost 12 days their poor physical or mental health kept them from doing their regular activities.

Table 18
Physical and mental health

For how many days during the past 30 days was your:	Number of days
Physical health not good (n=278)	12.5
Mental health not good (n=102)	10.6
For how many days did your poor physical health or mental health keep you from doing your usual activities?	**Number of days**
(n=68)	11.9

Access to care. The HDI health survey contains a section concerning access to health care. Table 19 summarizes the responses to those questions.

Table 19
Access to care responses

Response	%
Have health care coverage (n = 601)	65
Have one person they think of as their personal doctor or health care provider (n = 344)	72
Where go for care when sick or for advice about their health (n = 401)	
A doctor's office other than your personal doctor	63
A public health clinic or community health center	23
Needed medical care in the past 12 months but could not get it (n = 352)	23
Cost or lack of insurance as main reason for not getting medical care when needed	62

Among the 407 participants who went to the doctor in the past year, the average number of visits was 5.3.

Limitations

This cohort study is designed as a pre/post comparison. There are limitations to this type of design, most notably the lack of a control group. In addition, participants were not randomly selected or randomly assigned to interventions, which could result in selection bias. The interventions were designed at the local level to meet local needs and be culturally sensitive. While this is an important feature of these projects, this results in a wide range of interventions making evaluation more difficult.

Cohort study conclusions

These findings represent the initial results of community-based interventions by HWTF HDI grantees specifically designed to impact previously disparate health outcomes associated with cardiovascular disease, diabetes, and obesity in communities representing a substantial portion of North Carolina. The findings were collected from a defined cohort of individuals selected to

represent the effects of the community-based interventions. The strength of the community-based design is that grantees often hired individuals from the same communities to provide the interventions and further, that grantees could tailor their interventions to be culturally relevant. The major clinically and statistically significant findings include:

1. Systolic blood pressure was reduced among participants in projects focusing on CVD, diabetes, and obesity. Reductions in blood pressure may be associated with future reductions in the risk of adverse cardiovascular outcomes including stroke.
2. Among participants who are presumed to have diabetes, average HbA1c was significantly reduced from 8.9 to 7.9 while the percentage of participants with HbA1c<7 increased from approximately 25% to 40%.

These preliminary outcomes suggest that the HDI interventions are positively impacting the health of North Carolinians, especially underserved minority citizens. Improvements of this magnitude, if maintained, have been associated with reductions in diabetes and cardiovascular morbidity and mortality. Additional follow-up data will be carefully evaluated to confirm these initial findings.

Technical assistance evaluation: The NCCU technical assistance team

Grantees rated the North Carolina Central Technical Assistance (NCCU TA) team over the past six months as part of their report. Table 20 summarizes those responses.

Table 20
Grantee assessment of NCCU TA

During the past 6 months how helpful was the NCCU TA team	Mean	Range (1-10)[+]	N
When you requested assistance or information	9.1	7-10	23
In assisting your transitions to year 3 (e.g., carry forward requests, action plan revisions)	9.3	8-10	23

[+]Scale 1 (not at all helpful) – 10 (very helpful)

The grantees continue to rate the NCCU TA team highly in regard to their helpfulness. As one grantee stated:

They really deserve a '10.' They have been very proactive in their timing with HWTF deadlines and helping grantees get things done with a maximum amount of notice. Our project has experienced major challenges in this time period and we have found the TA team not only helpful but substantially more skilled and confident in their ability to assist us. Definitely they've taken it up a notch!

Appendix A

HDI Health Survey

This survey is about your health. It has been developed so you can tell us what you do that may affect your health.

Completing this survey is voluntary. If you are not comfortable answering a question, just leave it blank. However, the answers you give are very important and we hope that you will choose to answer all of the questions. The answers you give will be kept private.

After reading each question, please choose the one best answer. Please fill in completely the circle next to your answer choice or write the answer legibly in the blank provided. If you would like to change your answer, please erase completely.

SURVEY PROFILE

Date of survey _____

Location _____ County _____

Location is the actual place from where the participant was drawn, for example, the name of the church, medical office, or community.

PARTICIPANT

Participant ID _____

Participant zip code _____ Date of birth _____

Are you

O A. Male
O B. Female

Which of the following would you say best describes you?
O A. African American
O B. Asian American
O C. Caucasian
O D. Hispanic
O E. Native American
O F. Multi-ethnic
O G. Other _____

Please turn the page over to begin.

PHYSICAL ACTIVITY: These questions are modified versions of the physical activity questions in the 2007 version of the BRFSS. (Slight wording changes). Questions 17.2, 17.3, 17.4, 17.5, 17.6, and 17.7.

1. In a typical week, on how many days do you engage in moderate physical activity for at least 10 minutes at a time? Moderate physical activity includes activities such as brisk walking, bicycling, vacuuming, gardening or anything else that causes some increase in breathing or heart rate. **PLEASE CHOOSE ONLY ONE ANSWER.**
   - O A. None
   - O B. One day
   - O C. Two days
   - O D. Three days
   - O E. Four days
   - O F. Five days
   - O G. Six days
   - O H. Seven days
   - O I. Don't know/not sure

2. On the days you engage in moderate physical activity for at least 10 minutes at a time, how much total time per day (**in minutes)** do you spend doing these activities?

   Please enter number of minutes _____

   O Don't know/not sure

3. In a typical week, on how many days do you engage in vigorous physical activity for at least 10 minutes at a time? Vigorous physical activity includes activities such as running, aerobics, heavy yard work, or anything else that causes large increases in breathing or heart rate. **PLEASE CHOOSE ONLY ONE ANSWER.**

   O A. None
   O B. One day
   O C. Two days
   O D. Three days
   O E. Four days
   O F. Five days
   O G. Six days
   O H. Seven days
   O I. Don't know/not sure

4. On the days you engage in vigorous physical activity, how much total time (**in minutes)** do you spend doing these activities?

   Please enter number of minutes _____

   O Don't know/not sure

FRUIT AND VEGETABLE INTAKE: This question is from the original HDI database.

5. How many servings of fruit or vegetables do you eat daily?

Please enter number of servings _____

O Don't know/not sure

A serving of fruit is….

1 medium apple, banana, orange or pear

¼ cup chopped, cooked, or canned fruits

¼ cup dried fruit

¾ cup 100% fruit juice

A serving of vegetables is….

1 cup raw leafy vegetables

½ cup other vegetables raw, cooked, or canned

¾ cup 100% vegetable juice

SMOKING: This question is from the original HDI database.

6. What is your current smoking status?
   - O A. Current smoker (smoked in past 30 days)
   - O B. Past smoker
   - O C. Never smoked
   - O D. Don't know/not sure

7. IF YOU ARE A CURRENT SMOKER, how many cigarettes do you smoke per day?

   _____

   O Don't know/not sure

HEALTH STATUS These questions are from the Healthy Days Core Module (CDC HRQOL-4) which is part of the CDC Health-Related Quality-of-Life 14-Item Measure and are also included in the 2007 BRFSS (questions 1.1, 2.1, 2.2, 2.3).

8. Would you say that in general your health is:

   O A. Excellent
   O B. Very good
   O C. Good
   O D. Fair
   O E. Poor
   O F. Don't know/not sure

9. Now thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?

   Number of days _____

   O Don't know/not sure

10. Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?

    Number of days _____

    O Don't know/not sure

11. During the past 30 days, for how many days did your poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation?

    Number of days _____

    O Don't know/not sure

ACCESS TO CARE: These questions are from the 2007 and 2002 versions of the BRFSS

12. Do you have any kind of health care coverage, including health insurance, prepaid plans such as HMOs, or government plans such as Medicare? **2007, question 3.1**
    - O A. Yes
    - O B. No
    - O C. Don't know/not sure

13. Do you have one person you think of as your personal doctor or health care provider? **2007, question 3.2 – slightly modified for ease of administration.**
    - O A. Yes, only one
    - O B. More than one
    - O C. No
    - O D. Don't know/not sure

14. When you are sick or need advice about your health, to which **one** of the following places do you usually go? PLEASE CHOOSE ONLY ONE ANSWER. Would you say: **2002, question 2.3 First two response options modified.**

    - O A. Your personal doctor's office
    - O B. A doctor's office other than your personal doctor
    - O C. A public health clinic or community health center
    - O D. A hospital outpatient department
    - O E. A hospital emergency room
    - O F. Urgent care center
    - O G. Some other kind of place
    - O H. No usual place
    - O I. Don't know/not sure

15. How many times have you been to a doctor's office in the past year?
    Number of times _____
    - O Don't know/not sure

16. Was there a time in the past 12 months when you needed medical care, but could not get it? **2002, question 2.4**

O A. Yes PLEASE ANSWER QUESTION 17
O B. No
O C. Don't know/not sure

17. What is the main reason you did not get medical care? PLEASE CHOOSE ONLY ONE ANSWER

2002, question 2.5

O A Cost or no insurance
O B. Distance
O C. Office wasn't open when I could get there
O D. Too long a wait for an appointment
O E. Too long a wait in waiting room
O F. No child care
O G. No transportation
O H. No access for people with disabilities
O I. The medical provider didn't speak my language.
O J. Other _____
O K. Don't know/not sure

THANK YOU VERY MUCH FOR YOUR PARTICIPATION.

Appendix B

Grantee 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 previous six months. Some grantees reported more than one account.

One of the best stories from these six months involves the impact of praising a patient for the success that they have had, and the chain reaction that their achievements can have. I spoke with one of our cohort patients participating in the Group Medical Visits (GMVs) at a [name of county] practice to see if he would be willing to share the success he has had with controlling his diabetes by participating in the HWTF media campaign. He was at first hesitant, stating he did not think he had really done anything. As we began to talk about the improvements in his outcomes, and the changes he had made over time to his lifestyle and habits, he began to appreciate all he had really been able to accomplish. He agreed to have his name submitted, and was subsequently interviewed by the HWTF media vendors. Shortly afterward we had another GMV, with about 10 other patients with diabetes present. Toward the end of the GMV, this patient, who has never spoken out before and has always been more of an observer, asked if he could say something. He proceeded to stand, and walk to the middle of the room. He began to share his story with the group. He said he had come to appreciate the accomplishments he had made in managing his diabetes, and how much his health had improved. He said he never thought before that his story could impact other people, and maybe help them along the path toward change, but that he figured that was one of the reasons "doc" was doing these appointments in the group like this. He went on to share some of the things that had worked for him, and said he hoped it might help somebody else to hear it. He got lots of applause from all the patients, and it impacted him, as well as everyone there, as a real inspiration.

Our breast cancer support group leader is a pastor on a mission. She is a breast-cancer survivor. She invited us to her church to conduct the American Cancer Society "Body & Soul" program for 4 weeks in March. It is a Bible class and nutrition training. She participated right alongside her church members in study and exploring new foods. They ate salads and fruit for 4 weeks tasting and sampling different foods. She became inspired and hired a personal trainer for 8 weeks and

has lost 20 lbs. She no longer has a trainer but is walking 20,000 steps a day 4-5 days a week. She is setting an example for her church members. The church now has committed to not having fried foods at their meals.

The church cook (Black male in his late 30's) assisted weekly with the sessions and signed on as a Parity Action Team member in April. While he was in the office signing his papers to volunteer, the volunteer coordinator suggested he see our nurse case manager [NCM] to follow-up on a diabetes assessment he completed at the church. The NCM [nurse case manager] found his blood pressure dangerously high, referred him to a community partner, who gave him the necessary medicine to regulate his blood pressure. He called in May to follow-up and to let us know how he was doing. The NCM also signed him up for the prostate screening in June. He attended and got several screenings done (cholesterol, BP, BMI, DRE, PSA) as well as overall lifestyle counseling. He is now committed to taking better care of himself.

[Patient's name] is a resident and community leader. She began the Yoga classes in a chair; then on the floor. Before she began the class, her husband had to assist her to get in and out of the tub. Now, she testifies that since the Yoga classes, she can get in and out of the tub without any assistance. Additionally, she attributes her overall improvement in walking and reduction in pain to the Yoga class. Because of her success and progress, she has convinced (7) of her relatives to join the Yoga class.

The aerobic exercise program and its offshoot, the Walking Club, were obviously successful. Attendees participated without prompting and sincerely enjoyed themselves.

The project staff was able to help sponsor the very first Martin Luther King Celebration in [name of town] since the town's establishment 19 years ago, which was named after the famous man. This celebration replaced the family dinner described in the Year 2 AAP objective. The project staff provided blood pressure checks, recruited new cohort participants and collected 6-month follow up assessments, and distributed "Down Home Healthy" cookbooks. The event received high attendance from both [name of town] residents and general [name of county] population. All of this was with the help of the new [name of town] Events Committee who is working hard to improve the community in all aspects.

[Name of local restaurant owner] added a grilled chicken wrap to her everyday menu at [name of local restaurant] in [name of town] as a result of the [name of grantee] project staff efforts.

Our program has achieved success due to the many community partnerships and collaborations. Our Health Advisors are passionate about what they do and have a genuine concern for the well-being of their church members as well as their community. Through the hard work of our Health Advisors we are currently working in 28 African American Churches in the county. Through our community partnerships we were able to reopen the satellite Farmers Market at [name of church]. This initiative makes the Farmers Market more accessible to residents of [location]. We were also able to measure walking trails at nine of our participating churches due to our partnership with [name of county] Health Department. This resulted in 5 of the 9 churches creating walking groups or exercise programs.

Each semester it is nice to hear from the "new" Peer Power Peer Health Educators say that they signed up for the class because of the "cool" things their peers have told them about the Peer Power class. Recruitment is getting easier because the students really enjoy taking the class and high school students often make life altering decisions as a result of their involvement in the Peer Power class. Seniors decide they want to go to college to become teachers because our program allows the students to truly take control of a classroom (middle and elementary level), whereas other programs such as the "peer tutoring" class only allows them to assist a teacher. It is powerful to witness the impact of the program from a project staff's perspective because change occurs in not only the middle and elementary classrooms, but the high school classroom as well.

I saw the client initially at the [name of festival] Festival on June 21 and the client's blood pressure (BP) was elevated which wasn't a real surprise to her. Informed her of our location, hours, etc. and strongly suggested that she come by the HRC on Monday. She didn't come on Monday but did return a few days later. Again I checked her BP and it was high. She was given information about blood pressure and also given information/application about the DIC and the CCC (Drug Information Center and Community Care Clinic). She was referred to these places for one thing because one of her problems was that she didn't have medical insurance and not able to get the care and medication that she needed. In the meantime, I let her know that according to my judgment her BP was too high to wait for treatment (she would have to apply for the CCC and that would take more time) and she needed to get it checked out right away and so I

referred her to the [local hospital] ED or to First Choice. She came back and told me later that she also had to take her husband to [name of hospital] and this was more stress on her and she got the hospital staff to take her BP and they found it extremely high as well. So she ended up going to the ED and got her BP checked and got the medication that she needed. This worked out so good because I was able to see the client all the way through from start to finish and she not only got the help she needed in a timely manner, but also since she didn't have health insurance was able to get referred to other places to help for free - she really appreciated everything.

One client recently moved from another part of NC and did not have a doctor in this area, no job and no medical insurance. To say the least she was extremely stressed. She was able to get checked out for free and she was referred to the CCC for continued F/U (follow-up). She has an appt. for the end of this month to get her A1c level re-checked at the HRC because it was very high. Hopefully she will return. She too was very grateful for our services.

This client started with us in January. He came into the center to get checked out because he felt bad. I did a mini assessment on him and afterward called and reported my findings to his doctor's office. After a discussion with the MD office staff, they said to tell the client to go to the hospital ED and get checked out. I relayed this information to the client and his wife and they decided to do so. It was nice to see how we can be an interim or co-workers with the MD offices and work together to get the clients taken care of and also that the MD office trust our judgment and are willing to work with us to help the clients. I can't quite remember, but if it wasn't this time it was another time that the client had to actually stay in the hospital for a few days. Even though we don't want anyone to go into the hospital, it was nice to see that further problems were avoided because the client was able to get checked out in a timely manner and at no extra cost.

Cohort participant, African American male, has been a cohort patient since December 2007. He has lost 26 lbs since the start of the program. The participant is now exercising at work 4 times a week, lifting weights and eating healthier. He now eats more salads, fruits, vegetables and has cut back almost completely on fried foods, beef and pork products. His diet now consists of more lean chicken, fish and shrimp. The patient also walks with his wife a couple evenings a week. He has noticed a better fit to his clothes and now has more energy to be active with his family.

He is very glad to be a part of our HDI program and stated that the program has encouraged him to live and be healthy for himself and his family.

Hispanic female, who initially did not see the importance of losing weight. Now (since about 3 months ago) decided to try hard and has lost 11 pounds. She never exercised, but started doing10 minutes a day of exercise and is now exercising 20 minutes+ per day. [Patient name] also did not eat vegetables before starting our program, and now she is trying to eat 2 to 3 servings a day. She looks much younger, her complexion looks clearer, and her blood sugars have been going down and are almost at normal levels now!

At the end of the school year, 4 Youth Development Coordinators at 4 title I elementary schools in [name of county] participated in a conference reviewing the school year. Each of the 4 title I elementary schools that [grantee] teaches a fitness and nutrition class at raved about [grantee]. So much so that a United Way sponsored agency, Communities in Schools asked [grantee] to put together a program format for all of the elementary schools that they work with in [name of county] to have access to [grantee's] fitness/nutrition education and activities. It really helped to validate our organization for such a well known, well established non-profit to commend our organization and propose outsourcing the fitness portion of their program to [grantee] so that a nutrition component could be added as well. The Youth Development Coordinators commented that they had never seen children so excited to learn about nutrition and exercise and how to prevent disease.

Since August 2007, I have been a supervisor candidate, which means that I supervise family therapy interns under the guidance of an AAMFT Approved Supervisor. One of my supervisees is one of our newest family therapy interns with the Health and Wellness Trust Fund Project. On April 15th, 2008, he began seeing patients while transitioning from researcher to clinician. It is always exciting to observe a therapist perform clinical work since it reminds me of my transition a few years ago. This time is often full of anxiety and anticipation. Since April, I have been impressed with his ability to relate with patients and the other members of the team. This is particularly validating for me since I have been his supervisor candidate and feel that my supervisory work has 'paid off'. No doubt, he and other team members all bring a crucial component to the diabetes project. During this year, their dedication, resilience, and capabilities have shined. I consider these individuals both colleagues and friends who are truly making an incredible difference in the lives of many underserved patients.

The best story and experience I have had as a Medical Family Therapist with [name of grantee] since January has been the rewarding experience of meeting and interacting with one of my female Hispanic patients and her daughter who always come in together. This patient is in her 80's and has had diabetes for a few years now. Her leg was amputated in El Salvador due to diabetes. This patient is a remarkably resilient human being. One of the most memorable experiences the therapeutic team has had with this patient and her daughter occurred when the patient began to talk about her husband who has passed away in the last 2 years. She began to open up and share with us about her grief and the beautiful love she has for him and how she misses him. Both the patient and her daughter began to cry and release both the emotional hurt and joy that came with talking about this husband and father. They had not had the chance to express their emotions and be able to cry and release those feelings together. It was a very special moment in that room that day for them and also for me. The patient could not stop expressing her gratitude to all of us (two therapists and Diabetic Educator) and said how helpful and relieving that session had been for her since she does not talk about it often. This session stands out for me because it manifests how valuable and rewarding integrative/collaborative care can be and what a difference it can make in a patient's life and provider's experiences. That day this family learned that the therapeutic team was really interested in their overall well being and how this holistic care that [grantee] is offering them has impacted their lives in a fully biopsychosocial-spiritual way.

A female Hispanic patient met with a Medical Family Therapist and the Diabetic Health Educator for an initial therapeutic evaluation. During the session the patient stated that she was very appreciative of the services rendered, because she stated that her depression would have gone unnoticed and that her medical provider alone would not have been adequate in improving her overall health, and specifically her diabetes. She reported that because of the emphasized biopsychosocial approach, she feels more motivated to adhere to the recommendations set forth by her medical providers and the therapeutic team, as well as sustaining the changes she has already made.

Watching patients' faces when they realize that diabetes is not the 'big ugly thing,' but something that they can actually manage. When patients 'get it' that diabetes management is really in their control is a great thing to witness. It is incredibly rewarding to see patients

become very empowered to take actions to manage diabetes. I think in every patient experience there is something that is very interesting or very memorable about each interaction.

In April 2008 the [name of grantee] program launched a three month physical activity challenge to try to get people motivated and switch up the activities a little bit. The idea was that we could motivate the participants through competition and hopefully get the churches to realize that they are not alone in this program that it is actually a regional program with many churches participating. We set up a system to award the most active church in the region and then to identify the individuals that exercised the most and lost the most weight both sub-regionally and within their own church. We had 13 churches join the challenge. Each participant received a manual which included a log book, educational facts about exercise and diabetes, information on portion sizes, spiritual "fitness" versus from the bible, do's and don'ts about exercising, and a page for their three month plan. We had approximately 202 people participate and they exercised for 8,698 hours in a three month period. Each participant exercised almost 4 hours per week for 12 hours (on average) which we view as a huge success. We had a 6 year old that weighed 106 pounds when she started and in the three month period she lost 10 pounds. Here is her story:

> *There is a 6 year old who attends Antioch Church of Christ in Beaufort County. [Name of patient] weighed in at 106 lbs on April 22, 2008. Her mother was very concerned about her weight and its impact on her health. [Patient's name] mother (age 26) weighed in at 360 lbs on April 22, 2008. She knew it was important to get to a healthy weight to increase her quality of life and be a role model to her daughter. According to her mother, as a mother/daughter team, she and [patient's name] exercised every free minute they had during the three month challenge. As a result, [patient's name] lost 10 lbs, winning the "most weight lost" award for her church.*

We had one woman that is legally blind lose 40 pounds during the challenge.

The Walk Club has been an inspiration to many [grantee name] patients. One provider, who has seen his patient's return for follow-up with enthusiasm and results, i.e. lower A1cs, weight loss, more energy, more self-control, was personally touched. [Name of physician], who is a full-time clinician in the Adult Medicine Clinic, has volunteered his free time and efforts to facilitate the Walk Club every other Saturday morning. And because of his participation, more people than previously expected are now coming to the Walk Club on Saturday. [Name of physician] talks to the walkers one-on-one and takes their blood pressures as part of his goal

for improving overall health. The patients also witness his commitment to their cause and are even more motivated by it.

The most exciting part of the project continues to be the work in the pilot practices where it is easy to see the direct impact the project is having in local communities. In [name of local town], the pilot practice that was already most compliant in the CLAS Standards decided that they would work on educating staff on different cultures. Since most staff has either come from another county or had traveled abroad at some point, they organized a luncheon for staff to share their experiences. All staff were required to attend and to bring a dish and a story from either a place where they have traveled or their home country. The stories served as a way to debunk myths about certain cultures and to increase knowledge of disparate population groups. The luncheon was very well received, and [name of physician] thought it was even a great team building activity for the staff. He plans to continue this as an annual staff event.

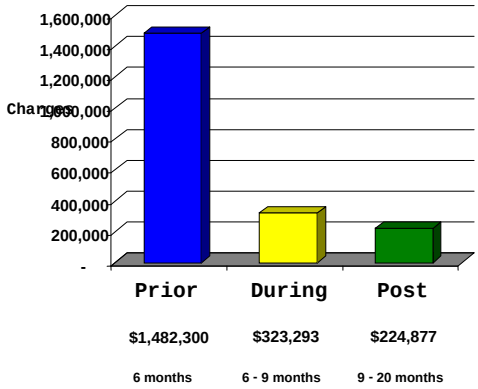
Another exciting update comes from the pilot practice where none of the CLAS Standards were being met at the initial assessment last June. The practice worked on updating patient forms to include "language preferred" and "race" and they also put a sign in the waiting room that said in Spanish that interpreter services were available. They had a position open in the chart room and decided that it would be an opportunity to hire someone bilingual and so they did. The person mostly works in the chart room but also serves as an onsite interpreter for the practice. Before this there was no one in the clinic who was spoke fluent Spanish.

To date, over 1200 family physicians, residents and medical students have been reached through our educational efforts at the [name of grantee] CME meetings. We continue to track each educational event that a physician participates in. We redistributed the Health Disparities survey to all NCAFP members with a valid email address in February 2008. The original survey was sent out in February 2006 and the third collection will be in February 2009. From the second data collection, we found that physicians improved dramatically in 5 of the 10 areas of implementing the CLAS standards and the response rate also increased substantially. A more detailed survey will be developed for year 3 through our partnership of the Carolina's Center for Medical Excellence.

Patient Hospital Charges

n = 52 In-home patients

Telehealth patient charges decreased 78% from 6 months prior to telehealth to during telehealth. Patient charges decreased 85% from prior to telehealth to post telehealth.



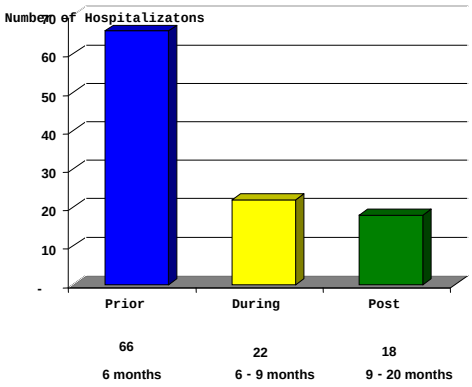
Analyzed charges are related to diseases being monitored.

Patient Charge Data Ending March 2008

Patient Hospitalizations

n = 52 In -home patients

Telehealth patient hospitalizations decreased 67% from 6 months prior to telehealth to during telehealth. Patient hospitalizations decreased 73% from prior to telehealth to post telehealth.



Hospitalizations

Prior to Telehealth: $1,419,888.36 (270 days total)
During Telehealth: $311,558.64 (81 days total)
Post to Telehealth: $204,504.36 (64 days total)

Analyzed charges are related to diseases being monitored.

Patient Charge Data Ending March 2008

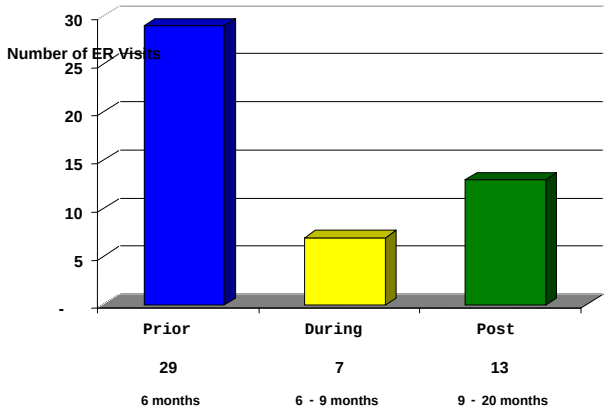
Patient Emergency Visits

n = 52 In -home patients

Telehealth patient ED visits decreased 76% from 6 months prior to telehealth to during telehealth. Patient ED visits decreased 55% from prior to telehealth to post telehealth.

Emergency Visits

Prior to Telehealth: $62,411.60
During Telehealth: $11,734.81
Post to Telehealth: $20372.36



Analyzed charges are related to diseases being monitored.

Patient Charge Data Ending March 2008

[Name of church] in [name of county] church leaders purchased a digital blood pressure monitor to assist their members with managing their blood pressures. A success story written by a participant stated "I have lost weight, my cholesterol is back to normal, blood pressure stays normal and I owe it all to the [name of grantee]." Another participant wrote "In January of 2007, I was overweight, had high blood pressure, high cholesterol, and was very fatigued. A year has passed since I started the [name of grantee]. I was taking 2 blood pressure pills a day, as well as one Lipitor for high cholesterol. At the present time, I am taking one blood pressure pill and one Lipitor a day. I have lost over 20 pounds. I am confident and more energetic."

The following are narratives given by Care Coordinators in their own words:

- *Getting patients to return to [project location] who have not had any care for their diabetic symptoms by just showing how much we care with a simple letter or telephone call;*
- *Help patients to discover resources available to assist in meeting their simple everyday needs (for example, buying a pair of diabetic shoes.)*

- *I have had patients to cry because they were happy to receive the extra support while in the physician's office.*
- *I have had patients to call me back just to say thank you. This made me feel special. When I felt like I was not making good progress that one phone call made me feel like continuing.*

I am especially excited about this one middle age lady who hasn't been to the doctor in almost two years. She has insurance and she has transportation but she was just discouraged about having this "diabetes disease." The first time I called her she just begins to talk to me and cry. She was so frustrated. She thought that she was too young to be affected by this disease. I called her several times throughout the month as she waited for her appointment date to come. I was sure that I would be there to greet her. Finally meeting her was a pleasure. She had so many issues. I was able to greet her at the front and follow her throughout her visit. I left the room whenever [name of physician] came in. Before she left she asked [name of physician] to find me. She was in the lab getting her blood drawn and she told [name of physician], "She's the reason why I am here, she's the reason why I am back. This really touched my heart.

One of our participants was selected by Ballen Media for the Diabetes Awareness ad.

The continuation, growth and success of the Latina breast cancer support Group has been the "coolest thing" with the [name of grantee] project. The support group began in December 2006 and consists of 27 Latina survivors with 19 women attending on monthly basis. The support group provides emotional and spiritual support and acts as a resource center for Latinas with breast cancer. Lay Health Advisors (LHAs) and project staff were able to connect survivors with community resources to obtain goods and services worth over $4,000. These resources were given to women to help pay for living expenses and household needs while receiving chemotherapy. The outreach coordinator and lead LHA were also instrumental in securing donations of food from restaurants for the monthly support group meetings to help offset the costs of meetings. Several of the Latina survivors are now actively helping other Latinas in need and are also attempting to recruit more newly diagnosed breast cancer survivors.

It seems like yesterday, our team was just hired and getting started. We now have over 125 active participants who are moving and eating well. One of our more "cool" stories involves our group of 40 or more participants at the local barber and cosmetology school. The students of the college range in age, level of experience in the work world, and health concerns. The group was really anxious and somewhat hesitant to begin their process with [name of grantee]. At the

initial two meetings, our group was ready. They were looking forward to the "Ready, Set, Walk programs", the food demonstrations, and support sessions. The students would see us out in the community and report that they had started a weight-loss program to keep them motivated. We are so excited that they are excited about improving their health!

We have another group growing at [name of college]. This college is mostly young women. They were also equally excited and motivated about having the program come to their campus. They would hold group workout sessions for participants. Five Lay-Health Advisors were from [name of college] women's basketball team, they were able to motivate the students more and be a positive role model for good health. One of the Lay-Health advisors was so excited about the program and her involvement in the program she decided to take what she learned and share her knowledge with her family and friends in Ohio. The three lay-health advisors that graduated this spring made a commitment to find a lay health advisor to continue their legacy to be a proud participant of [name of project].

[Name of project partner] has been partnering with us from the beginning. I am pleased to report that they have retained 50 project participants. From the past 6 months [name of project partner] continues to have great programs with high attendance. They have continued to maintain a fall and summer community garden were they grow fresh watermelon, collard greens, tomatoes, and other fruits and vegetables. Since February, [name of project partner] coordinator and ten participants have joined the gym. Together they meet at the gym twice a week. Many have reported that they have seen tremendous weight loss and their health has been improving mentally and physically.

The group medical visits which we initiated at [name of healthcare clinic] have been well received by our cohorts. One of our patients who was in the group medical visits announced in a church meeting that he had been involved in a different way of treating his diabetics. "They trained us in a group he said. They only do it every other month and I have already put my name down for every time. I know I can understand this. You need to put your name down and see if they will take you."

A physician reported that a patient had lost weight and explained that she had used the recipes that she got from her diabetic classes.

As noted in the objectives submitted for this year, we proposed to use the media, specifically [name of grantee's institution] radio station to recruit students for the program. Additionally, we proposed to give two presentations on the prevention of diabetes. Not only did the radio station agree to do PSAs on the [name of project], but those who do the health programming were excited about our efforts and offered to assist the project during its in publicizing the community-based activities, such as the health fairs and screenings.

Quarterly Reports to the NC Health & Wellness Trust Fund Commission

Eliminating Health Disparities Initiative

Brody School of Medicine at East Carolina University Department of Family Medicine Research Division

October 2007 – June 2008

Note: The original contractor for the Eliminating Health Disparities Initiative elected not to renew their contract after the first year, and their contract ended June 30, 2007. The process of replacement took several months, and the contract for the current outcomes evaluation contractor, East Carolina University Department of Family Medicine, was awarded October 2007. There are no progress or outcome reports available for the time period when an outcomes evaluator was not under contract. Following are reports from October 2007 through the end of the fiscal year.

Reporting Period: October – December 2007

Executive Summary and Recommendations

East Carolina University Department of Family Medicine conducted an evaluation of the grant activities for the period October – December 2007, as part of our contract to provide evaluation services for the Health Disparities Initiative. This report summarizes these evaluation activities.

In May 2006 the North Carolina Health and Wellness Trust Fund Commission (HWTF) awarded $9.2 million in grant funding to 23 organizations under the Health Disparities Initiative (HDI). The purpose of the Health Disparities Initiative is to reduce the disparities in the incidence, prevalence and mortality related to certain diseases in North Carolina, which are a result of race, ethnicity and socio-economic status. Grants were awarded to projects that specifically focused on reducing disparities for children/youth and adults relating to obesity and/or chronic diseases, including but not limited to: cardiovascular disease, diabetes and cancer. These three chronic diseases have been identified as three of the six major areas of health disparities in North Carolina.

The evaluation of the Health Disparities Initiative consists of 3 components:

- Overall outcomes evaluation (the cohort study)
- Evaluation of the specific goals and objectives outlined in the Request for Proposals
- Evaluation of the North Carolina Central University technical assistance team

Overall outcomes evaluation (the cohort study)

The goal of the cohort study is to examine the impact of the projects on specific biological and behavioral outcome variables that are important in addressing the priority areas within the HDI: cardiovascular disease, diabetes, and obesity/healthy lifestyle. To examine the impact of the initiative, sixteen grantees are identifying and following a longitudinal cohort of participants from their grant-funded programs. Measures for each participant are taken when s/he is first enrolled in the cohort study and then every six months until the end of the grant period. These measures include: blood pressure, BMI, cholesterol, fruit and vegetable consumption, physical activity, quality of life, access to care, and HbA1c (for those grantees focusing on diabetes).

As of this reporting period, some grantees had already enrolled sufficient numbers of participants in their cohort and were instructed to stop enrollment and begin or continue follow-up with their existing cohort. The remaining grantees were instructed to continue enrollment through either February or April 2008 to increase their cohort size. At the time of this report, a total of 2,408 participants were enrolled in the HDI cohort study.

Evaluation of goals and objectives

In future reports the data necessary to evaluate this component will be taken from information that is entered into the revised HDI database by grantees. For the current report, a summary of grantee achievements and activities were derived from the hard

copy monthly activity reports that grantees sent to the NCCU TA team from October through December 2007. Examples of activities are included in the body of the report.

For their six-month report, grantees had an opportunity to provide both a quantitative and qualitative self-assessment of their program and the progress that had been made. Overall, the grantees reported they had achieved their program objectives over the previous six months and felt they had been able to use existing partners or new partners to assist them in meeting program objectives. Grantees felt they were on target to achieve their program objectives for the upcoming six months.

Evaluation of technical assistance

The grantees rated the NCCU Technical Assistance team on their helpfulness over the past 6 months when requesting information/assistance and in assisting with the transition to year 2 of the project. The Central team received high marks on both measures.

Recommendations to grantees

The following recommendations follow from this evaluation report:

- Grantees should use the new event codes to accurately capture monthly activities. This will allow us to evaluate the types of activities grantees as using to address the goals of the initiative.
- Grantees who are participating in the cohort study should continue cohort enrollment and follow up
- Exploring opportunities to effect environment and policy changes is important, as those changes will impact sustainability of grantee efforts.

Background

In May 2006 the North Carolina Health and Wellness Trust Fund Commission (HWTF) awarded 23 grants under the Health Disparities Initiative (HDI). Grants were awarded for a three-year period starting July 1, 2006 and ending on June 30, 2009. The purpose of the Health Disparities Initiative is to reduce the disparities in the incidence, prevalence and mortality related to certain diseases in North Carolina, which are a result of race, ethnicity and socio-economic status. Grants were awarded to projects that specifically focused on reducing disparities for children/youth and adults relating to obesity and/or chronic diseases, including but not limited to: cardiovascular disease, diabetes and cancer. These three chronic diseases have been identified as three of the six major areas of health disparities in North Carolina. The organizations funded represent a diverse geographic, organizational, and racial mix.

Evaluation team activities: October – December 2007

The initial contract for the outcomes evaluation of the HDI was awarded to Shaw University's Institute for Health, Social and Community Research. In October 2007 East Carolina University (ECU) was selected as the new evaluators for this initiative. Since assuming the role of outcomes evaluators the ECU evaluation team has spent considerable time with staff from the HWTF, the North Carolina Central University

(NCCU) technical support team, speaking with individual grantees, and planning evaluation components.

Following is a timeline of these activities from October – December 2007.

October 2007
- Participated in several calls and in-person meetings with HWTF staff and with the NCCU technical assistance team
- Held numerous evaluation team meetings to discuss evaluation plan
- Participated in the monthly HDI program conference call
- Prepared an evaluation presentation for the annual HDI meeting
- Attended the annual HDI meeting held in Sunset Beach, North Carolina

November 2007
- Individual conference calls with each grantee
    - Nineteen calls were completed
- Participated in the monthly HDI program conference call
- Held numerous evaluation team meetings to discuss evaluation

December 2007
- Completed individual conference calls with grantees
    - One call completed
- Participated in the monthly HDI program conference call
- Reviewed current HDI database and began to determine changes needed
- Began developing cohort survey
- Developed grantee 6 month/annual report template
- Follow-up conference calls with grantees about their cohort
    - Seven calls completed

The remainder of this report summarizes additional activities by the ECU evaluation team from October through December 2007, including:

A. a description of the evaluation plan
B. a summary of grantee achievements and activities from October – December 2007
C. a summary of grantee self-assessments that were completed as part of the grantee's six-month reports covering July – December 2007

A. Health Disparities Initiative evaluation plan

The evaluation plan for the Health Disparities Initiative (HDI) consists of three components: an overall outcomes evaluation (the cohort study), evaluation of the specific goals and objectives outlined by the Commission in the Request for Proposals, and evaluation of the technical assistance provided by the North Carolina Central University technical assistance team.

Overall outcomes evaluation (cohort study) plan

The goal of the cohort study is to examine the impact of the projects on specific biological and behavioral outcome variables that are important in addressing the priority areas within the HDI: cardiovascular disease, diabetes, and obesity/healthy lifestyle. To examine the impact of the initiative, sixteen grantees are identifying and following a longitudinal cohort of participants from their grant-funded programs. This will allow us to assess the same group of adults over time to measure biological and behavioral changes that are associated with the initiative's priority areas. Measures for each participant are taken when s/he is first enrolled in the cohort study and then every six months until the end of the grant period.

The biological outcome variables selected for each priority area are listed in the table below.

Topic Area	Blood Pressure	BMI	A1c	Cholesterol
CVD	x	x		x
Diabetes	x	x	x	
CVD and Diabetes	x	x	x	x
Obesity	x	x		

In addition, all cohort participants will complete a survey that includes questions on fruit and vegetable consumption, physical activity, quality of life, and access to care. (See Appendix A.) The survey was developed by the ECU evaluation team using existing questions from multiple sources. These are indicated in the Appendix.

As the majority of the grantees had already begun some cohort study data collection prior to ECU becoming the outcome evaluators, we conducted conference calls with each grantee to help us better understand their grant-funded program activities and to help us determine each grantee's level of participation in the cohort study. The ECU team developed a protocol for the calls, so that we obtained the same information from each grantee. This protocol is in Appendix B.

Following the conference calls the ECU evaluation team assessed the current standing of the cohort study and developed a specific plan for each grantee. In December, we began follow-up calls with each grantee to discuss their specific cohort study plan. This included whether they would participate in the cohort study, which measures they would be required to collect, how long they should continue to recruit new cohort participants, and realistic goal numbers of participants. Seven follow-up calls were made in December and the remainder of the calls will be made in January.

We determined that five of the grantees would not participate in the cohort study for the reasons stated below.

1. Wake County Human Services is the only grantee that is exclusively addressing cancer.
2. The work by Dare County and NC AAPHERD is focused on children. As there are only two grantees with this focus and because the required measures are interpreted differently for children than for adults, these two grantees will not participate in the cohort study.
3. North Carolina Academy of Family Physicians is focusing on cultural competence and their main participants are physician practices. They do not work directly with patients or community members.
4. The activities of Charlotte Communities of Shalom address fewer participants and follow-up is very difficult.

Some grantees had already enrolled sufficient numbers of participants in their cohort and were instructed to stop enrollment and begin or continue follow-up with their existing cohort. These grantees and their enrollment as of November 2007 are listed below.

No new enrollment

Grantee name	Topic area	Current #
Northeastern NC Partnership	Diabetes	650
Rural Health Group	Diabetes	220
Access III	Diabetes	180
Robeson County Health Dept	CVD	275
Cornerstone	CVD	297

The remaining grantees were instructed to continue enrollment through either February or April 2008 in order to increase their number of participants. These grantees and their enrollment as of November 2007 are shown below.

End enrollment at the end of February 2008

Grantee name	Topic area	Current #
Forsyth Medical Center	Obesity	118
Greene County Health Care	Diabetes	105
Lincoln Community Health Center	Diabetes	95
Roanoke Chowan Community Health Center	CVD/Diabetes	130

End enrollment at the end of April 2008

Grantee name	Topic area	Current #
NCA&T	Obesity	65
Cleveland County Health Department	Obesity	35
GBO Partnership for Children	Diabetes	50
Buncombe County Medical Society	Diabetes	80

Chatham Hospital Immigrant Health	CVD	0
Elizabeth City State University	CVD/Diabetes	58
Strengthening the Black Family	CVD/Diabetes	50

At the time of this report a total of 2,408 participants were enrolled in the HDI cohort study.

HDI goals and objectives evaluation plan
The second component of the evaluation assesses the extent to which the goals and objectives of the Initiative (specified in the RFP) were met. In future reports the data necessary to evaluate this component will be taken from information that is entered into the HDI database by grantees. Beginning in January 2008 the HDI database will be revised. ECU will participate in meetings with the HWTF and NCCU to discuss content and structural changes to the database. As a result of these changes we are planning regional HDI database trainings in the spring 2008. We have also planned a conference call workshop in February 2008 to train grantees on activity coding that they will begin to use immediately in their monthly activity reports.

For the current report a summary of grantee achievements and activities were derived from the hard copy monthly activity reports that grantees sent to the NCCU TA team from October through December 2007. We did not have access to the grantee's activity data from July through September 2007. The results are described in section B.

Technical assistance evaluation plan
The final component of the evaluation assesses the technical assistance provided by the NCCU team to the grantees. Specific questions included in the six-month reports that are completed by grantees will be used to evaluate of the technical assistance provided by North Carolina Central University. The questions will vary depending on the major type of assistance that was provided by NCCU during each six-month period. For this six month period the questions focused on how helpful the NCCU TA team was when the grantee sought information or assistance and how helpful the TA team was in assisting in the transition to year 2 of the grant. The results are summarized at the end of the grantee achievement/activities section that follows.

B. Grantee Achievements/Activities

The implementation of the Health Disparities Initiative database allows for rich analysis of program activities and their impact. The Health Disparities Initiative database 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 Health Disparities Initiative database 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.) The HDI database has been unavailable to grantees for several months. Revisions to the database will begin in January, 2008.

When grantees report events in the Health Disparities Initiative Progress Check System, they will assign a code to each "event". 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. An additional event code not included in the original logic model, **Community Communication**, was developed to capture activities where there is communication with project staff, community members, partners and collaborators, state or national organizations.

Efforts to engage and influence outside agencies are considered **ACTIONS** in the Health Disparities Initiative 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.

Summarized below are examples of each event code taken from the grantees' monthly activity reports for October-December 2007. In this report we did not provide activity counts for each event code as many activities will need to be recoded following the coding training in February. At the time of preparing this report, one grantee had not submitted their monthly activity reports thus this summary does not reflect their

activities. Following are examples of activities that are correctly coded and reflect the range of activities that grantees reported.

Planning Product

- Developed monthly health highlights and PSA for program activities announcing monthly health screenings and walking club activities.
- Developed a brochure for the local county Search Your Heart program with the American Heart Association.
- Completed a grant application to Blue Cross/Blue Shield to provide exercise equipment and additional programming in the churches participating in the HDI project.
- Worked with local university students to create Diabetes Education Tear Sheets for provider use in clinical care.
- Staff developed signage to display in grocery stores to increase access to and consumption of healthier food options.
- Drafted a physical activity and nutrition policy to be considered for adoption by participating churches.

Training

- Provided introduction and training on Group Medical Visits and the HWTF grant to new project employees.
- Staff attended a grant writing seminar.
- Provided training for 2 new case managers on the diabetes curriculum and teaching tools.
- Attended training on effective ways to use electronic blood pressure monitors.
- Attended Minority Health Summit.
- Attended Health Carolinians Conference on Health Disparities.

Assessment

- Staff review for the lack of participation at an exercise program.
- Evaluated the condition of a local park. Noted that it needs clean up, repairs, paint, and regular maintenance. In addition, the park's playground area is not up to safety standard for the equipment.
- Conducted a 6-month rescreening for blood pressure and BMI at an exercise workshop. 7 participants attended the workshop. 2 participants were added to the cohort and baseline data was captured. Rescreening data was captured on 5 participants.
- Conducted meeting with church leaders to assess effectiveness of project activity.

Community Communication

- Held monthly staff meeting – updates on projects and practices provided.
- Conference call with ECU Evaluation Team.
- Spoke with health promotions coordinator for local health department to find out information about the mini-grant program for African American churches.

- Met with Alliance for Health and NC Action for Healthy Kids and shared the goals and objectives of our grant.
- Presented 10 community agencies with information regarding the project.

Partnering Action

- Met with the Health Promotion Coordinator at the local county Health Department to discuss the walking trail initiative. She agreed to partner with this project and mark off trails at participating churches in the county.
- Meeting with the Blue Cross Blue Shield Latino Outreach Coordinator about possible sponsorship of the Latina Support Group Retreat.
- New medical practice signs on to partner with the Group Medical Visit initiative.
- Met with director and board member of the local county Boys and Girls Club to discuss possible programming to begin in the spring.
- Contact with Lay Health Advisor from local county, local health department, and cooperative extension to partner on health fair to be offered in February to coincide with American Heart Month.

Services Provided

- Held Group Medical Visits.
- Mailed flu shot reminders to all grantee participants with diabetes.
- Conducted support group for cancer survivors.
- Conducted health assessments at local Housing Authority.
- Provided door-to-door CVD education for target population.
- Held an educational workshop titled “Healthy Holiday Favorites Sampler Workshop”. The workshop highlighted heart healthy, diabetic friendly variations of holiday favorites, as well as provided information on physical activity, eye and foot care, and folic acid awareness.
- Project staff visited target middle school to deliver a health education class on the heart and its relationship to tobacco use, nutrition, and physical activity.
- Held aerobic exercise classes twice a week for Latinas.

Capacity Building

- Lay Health Advisors Kickoff meeting held to build the capacity of volunteers. Informative meeting to provide health disparities information and criteria for selecting a LHA.
- Conduct group medical visit training with local medical practice.
- Partnered with the health department and presented Diabetes Peer Education to Lay Health Advisors.

Environment and Policy Action

- Attended church policy board meeting to discuss the recommendation for a healthy foods policy at the church. The policy was presented to the church conference on 11/10/07 for approval.
- Visits to local grocery stores to request space to hang signs promoting project activities and healthy eating.

- Policy board discussed adopting a policy for next year that would address group walks and walking trail development.

Media Coverage

- Newspaper article published in local paper recognizing Breast Cancer Month and to promote coverage of the Kick Off for the Lay Health Advisor Program.
- Developed, recorded, and aired radio announcement promoting upcoming prostate screening.
- Free TV media coverage provided by local station during 5pm broadcast in honor of World Diabetes Day. Grantee discussed the symptoms of diabetes and the steps to take if you have diabetes, as well as provided brief nutrition education.

Resources Generated

- Received a donation of office supplies from AT&T.
- Awarded a grant to expand program activities into an additional county.
- Received donation of 500 flyers and posters for upcoming prostate screening.
- Received grant money to purchase walking trail markers for nine African American churches.

Environment and Policy Outcome

- Policies adopted by churches to provide physical activity opportunities and healthy food options for youth and adults at all church functions.
- Healthy eating messages to be included in sermons and/or church bulletins during the holiday season.
- Church establishes a night aerobics class as part of its ministry.
- Project information posted at local grocery store.

C. Grantee Self-Assessments

For their six-month report, grantees had an opportunity to provide both a quantitative and qualitative self-assessment of their program and the progress that had been made. At the time of preparing this report, one grantee had not submitted their six-month report; thus this assessment does not reflect their responses. The table below summarizes grantee responses to six self-assessment questions.

During the past 6 months	Mean*	Minimum	Maximum	N
During the past 6 months, to what extent have you achieved your program objectives?	7.90	4	10	20
During the past 6 months, to what extent have you encountered significant barriers to your program objectives?	4.55	2	10	20
During the past 6 months, to what	5.30	1	10	20

extent did you utilize media advocacy techniques (e.g. letter writing, press release, interviews, PSA, etc.) to promote your program objectives?				
During the past 6 months, to what extent have you been able to use your existing community partnerships to assist you in meeting your program objectives?	8.75	5	10	20
During the past 6 months, to what extent have you been able to develop new community partnerships to assist you in meeting your program objectives?	7.30	1	10	20
For the **upcoming 6 months**, to what extent do you believe you are on target to achieve your program objectives?	8.45	5	10	20

*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. However, one grantee rated their progress lower than the other grantees (4 out of 10). This grantee had difficulty achieving their objectives because of personnel changes and because of challenges they have had with one of their partners.

Three grantees felt they had encountered significant barriers to their program objectives, giving ratings between 8 and 10 out of 10. For one grantee the grant manager resigned and they had difficulties with partners. Another grantee had difficulty when church partners needed to reschedule events due to other church activities and responsibilities.

Media use varied significantly among the grantees. Eight of the grantees scored their use of media below 5. Examples of challenges in utilizing media include identifying media opportunities, determining the best methods to ensure publicity across many sites, and not having a media plan in place. In addition media use was influenced by other project barriers such as personnel turnover.

All but two of the grantees rated their use of partners to achieve their program goals at 7 or greater on the 10 point scale. One grantee is facing challenges associated with resistance from personnel at a partner organization. In addition, the process for IRB approval at the partner organization slowed down some efforts. Another grantee has had to completely regroup their project, which has affected their progress.

Two grantees rated the extent to which they developed new partnerships at 4 or less on the scale. Both of these grantees have strong existing partnerships and may not have had the opportunity or need to establish new partnerships.
Finally, the lowest rating on the extent to which grantees are on target for the next six months was a 5. This grantee has had personnel changes in key roles in their project. This created stress on the remaining project staff while working toward meeting their objectives.

In addition to the quantitative measures above, grantees were asked to provide responses to the following questions:

1. What unexpected opportunities has your project had in the first six months of the grant (new partnerships, etc)?
2. What barriers has your project faced in the first six months of the grant?
3. What strategies have you used to overcome those barriers?
4. Please tell us about the "coolest thing" or "best story" that has happened as a result of your project in the first six months.

For the first three questions the responses given by the grantees were categorized and are summarized in the following tables, along with the number of grantees who reported them. Following each table are examples of the situations described by the grantees.

Unexpected Opportunities

	N
Partnerships (develop new and/or strengthen existing)	13
Expansion of program activities	4
Media coverage	2
Training	2
Grants/additional funding	2
Articles/presentations about program activities	2

Over half of the grantees described partnership development and strengthening of existing partnerships as unexpected opportunities.

[One unexpected opportunity] *"has been the success of being able to partner with the* [local] *Health Department so that beginning in January of 2008, they will begin providing monthly, free, diabetes education classes utilizing the curriculum and tools we developed in year 1 of our HWTF grant. This is something that we had hoped for, but that I thought was a long shot."*

"We have been approached by [10] *organizations for a variety of projects and partnerships. All of these partnerships have been beneficial to [grantee] and have included such benefits as additional grant funding, increased community awareness, and community volunteers."*

Several grantees reported that their program activities had expanded beyond their expectations, and some had opportunities to discuss their program activities in venues they had not anticipated.
"We had expected about 100 teachers to participate in our initiative, but were pleasantly surprised that 276 teachers participated. We received tremendous support from the county coordinators."

"[Grantee] *had the unique opportunity to present our program to the US Senate Health, Education, Labor and Pensions Subcommittee in Washington DC in October. The presentation was well received and we were invited to meet with Portia Cole, Legislative Aide for Senator Ted Kennedy in November to further discuss our program and the need for legislative change for Telehealth Reimbursement. During this process we were able to write telehealth language into the Community Health Center continuation bill."*

Barriers

	N
Low participation by participants in program activities	8
Staffing issues for grantee and/or among partners (need new staff, leadership change)	7
Collaboration issues: recruiting volunteers/support for activities/withdrawal of participation (not participants)	5
Inconsistency in relationships with partners/communication problems with partners	3
HDI evaluation (inconsistency, reporting problems)	3
Financial concerns and limitations among program participants	2

One of the major barriers reported by grantees involved low participation in program activities.

"Another barrier has been outreach and effectively reaching our target population. We have had low participation in our program. With [program] *being a new program we still have to earn the trust of the community. Getting the "right" participants who respond to our phone calls, follow through and to attend* [program] *educational sessions is challenging."*

Another important barrier was staffing – both in the grantee staff and in partner's staff.

"Staffing challenges in the [Local] *Region has been a barrier and impeded our efforts to provide ongoing services to the target population groups served by* [local] *County community partners."*

"Two churches that were recruited in year 1 had to withdraw from the Project due to problems that arose within those churches (one fired their pastor and the other realized they were not ready to fully commit to the programming efforts)."

Strategies to Overcome Barriers

	N
Recruit new volunteers, use new recruitment strategies, new places/expand outreach	6
Building and strengthening partnerships and collaborations, network	6
Use creative problem solving/improve processes	5
New staff/advertise for new staff	4
Communication with HWTF, new HDI evaluation team, develop own database for reporting	3
Provide incentives/find free supplies for participants	3
Seek additional funding	2

Grantees were creative in their strategies to overcome the barriers they experienced.

"Looking for unique settings, like the grocery store, to target new patients. Passing out flyers at Homecoming, the Christmas parade, etc. to reach people who normally might not be reached and may be in need of our services."

"In the last town election, new members were elected to the town council who are very enthusiastic and encouraged as to what the initiative has to offer. These new elected officials have demonstrated a quickness to act and new found support for project interventions and ideas."

"After months of recruiting we were able to contract with a nutritionist. She will begin doing consultations in February 2008.""

"[Grantee] *is employing a strategy that involves using community leaders to advocate the importance of exercise and health eating (pastors and school principals)."*

Best Story

Grantees related their best stories or coolest thing that happened as a result of their HDI project in the last six months. Below are three examples. The remaining stories are in Appendix C.

"*The "coolest thing" happened in [our county]. The Lay Health Advisor and our [project] staff had laid out a walking trail at the church site. The LHA noticed that city workers were in the neighborhood repairing streets with asphalt. She decided to approach them and ask if they had any asphalt "left-over" would they consider paving the walking trail. As a result the church got their walking trail paved for FREE!!!*"

"*It was very exciting to hear so much buzz about the 4th Annual Minority Health Conference after it was over. The health council received praise for a job well done by the community and in turn the council members congratulated the staff on a job well*

done. Advertising was incredible and hard to miss; we were able to serve a delicious heart healthy lunch to conference participants; and we offered them workshops that demonstrated how to live a healthy lifestyle in the presence of diabetes. We also experienced an increase in youth and Hispanic attendance by over 300%. Furthermore, community members have expressed personal changes in lifestyle behaviors in relation to increases in physical activity, improved food preparation, and adequate food consumption. "

"*The "best story" involved the wife of the pastor of our* [local church] *in* [our county]. *She reported a reduction in her A1c from 11.1 to 6.8. This was accomplished in 6 months!!! She also had lost weight from 310 lbs. to 262 lbs.! As she states "Eating right and getting exercise really does pay off".* "

Evaluation of North Carolina Central University Technical Assistance Team
As part of their six-month report, grantees rated the NCCU technical assistance team over the past six months. The table below summarizes the responses.

	Mean*	Minimum	Maximum	N
During the past 6 months, how helpful was the NCCU TA Team when you requested information or assistance?	8.95	5	10	20
During the past 6 months, how helpful was the NCCU TA Team in assisting your transition to year 2 (e.g. carry forward requests, action plan revisions, etc.)	8.80	4	10	20

*Scale = 1 (Not at all helpful) – 10 (Very helpful)

Grantees were given the opportunity to include narrative regarding their technical assistance experiences. These responses are included in the appendix.

Summary
East Carolina University assumed the contract for evaluation of the Health Disparities Initiative in October 2007. Since then the evaluation plan was refined and implemented. The components of the evaluation are:

- Overall outcomes evaluation (the cohort study)
- Evaluation of the specific goals and objectives outlined in the Request for Proposals
- Evaluation of the North Carolina Central University technical assistance team

The grantees have enrolled participants in their cohort and some have already enrolled sufficient numbers of participants. The remaining grantees will end baseline enrollment in either February or April 2008. The grantees were introduced to a new survey covering access to health care and quality of life that will be required of their cohort participants. They will incorporate this into their data collection.

The second component of the evaluation assesses the extent to which the goals and objectives of the Initiative were met. The data to evaluate this component will be taken from information that is entered into the HDI database by grantees and will be available for the next six month report.

Overall the grantees have made progress toward attaining the goals of the Health Disparities Initiative. Grantees reported they had achieved their program objectives over the previous six months and felt they were on target to achieve their program objectives for the upcoming six months.

Grantees are facilitating environment and policy changes such as: policies adopted by churches to provide physical activity opportunities and healthy food options for youth and adults at all church functions, and a long-term agreement with a grocery store to post HDI project information.

The evaluations of the technical assistance provided by NCCU were high and indicated the grantees were satisfied with the help they received from the TA team.

Recommendations

The following recommendations follow from this evaluation report:

- Grantees should use the new event codes to accurately capture monthly activities. This will allow us to evaluate the types of activities grantees as using to address the goals of the initiative.
- Grantees who are participating in the cohort study should continue cohort enrollment and follow up
- Exploring opportunities to effect environment and policy changes is important, as those changes will impact sustainability of grantee efforts.

Appendix I – HDI Health Survey

This survey is about your health. It has been developed so you can tell us what you do that may affect your health.

Completing this survey is voluntary. If you are not comfortable answering a question, just leave it blank. However, the answers you give are very important and we hope that you will choose to answer all of the questions. The answers you give will be kept private.

After reading each question, please choose the one best answer. Please fill in completely the circle next to your answer choice or write the answer legibly in the blank provided. If you would like to change your answer, please erase completely.

SURVEY PROFILE

Date of survey _____

Location _____ County _____

Location is the actual place from where the participant was drawn, for example, the name of the church, medical office, or community.

PARTICIPANT

Participant ID _____

Participant zip code _____ Date of birth _____

Are you

O A. Male O B. Female

Which of the following would you say best describes you?

O A. African American
O B. Asian American
O C. Caucasian
O D. Hispanic
O E. Native American
O F. Multi-ethnic
O G. Other _____

PHYSICAL ACTIVITY: These questions are modified versions of the physical activity questions in the 2007 version of the BRFSS. (Slight wording changes). Questions 17.2, 17.3, 17.4, 17.5, 17.6, and 17.7.

1. In a typical week, on how many days do you engage in moderate physical activity for at least 10 minutes at a time? Moderate physical activity includes activities such as brisk walking, bicycling, vacuuming, gardening or anything else that causes some increase in breathing or heart rate. **PLEASE CHOOSE ONLY ONE ANSWER.**

   O A. None
   O B. One day
   O C. Two days
   O D. Three days
   O E. Four days
   O F. Five days
   O G. Six days
   O H. Seven days
   O I. Don't know/not sure

2. On the days you engage in moderate physical activity for at least 10 minutes at a time, how much total time per day (**in minutes)** do you spend doing these activities?

   Please enter number of minutes _____
   O Don't know/not sure

3. In a typical week, on how many days do you engage in vigorous physical activity for at least 10 minutes at a time? Vigorous physical activity includes activities such as running, aerobics, heavy yard work, or anything else that causes large increases in breathing or heart rate. **PLEASE CHOOSE ONLY ONE ANSWER.**

   O A. None
   O B. One day
   O C. Two days
   O D. Three days
   O E. Four days
   O F. Five days
   O G. Six days
   O H. Seven days
   O I. Don't know/not sure

4. On the days you engage in vigorous physical activity, how much total time (**in minutes)** do you spend doing these activities?

   Please enter number of minutes _____
   O Don't know/not sure

FRUIT AND VEGETABLE INTAKE: This question is from the original HDI database.

5. How many servings of fruit or vegetables do you eat daily?

Please enter number of servings _____
O Don't know/not sure

A serving of fruit is….
1 medium apple, banana, orange or pear
¼ cup chopped, cooked, or canned fruits
¼ cup dried fruit
¾ cup 100% fruit juice

A serving of vegetables is….
1 cup raw leafy vegetables
½ cup other vegetables raw, cooked, or canned
¾ cup 100% vegetable juice

SMOKING: This question is from the original HDI database.

6. What is your current smoking status?

O A. Current smoker (smoked in past 30 days)
O B. Past smoker
O C. Never smoked
O D. Don't know/not sure

7. IF YOU ARE A CURRENT SMOKER, how many cigarettes do you smoke per day?

_____

O Don't know/not sure

HEALTH STATUS These questions are from the Healthy Days Core Module (CDC HRQOL-4) which is part of the CDC Health-Related Quality-of-Life 14-Item Measure and are also included in the 2007 BRFSS (questions 1.1, 2.1, 2.2, 2.3).

8. Would you say that in general your health is:

O A. Excellent
O B. Very good
O C. Good
O D. Fair
O E. Poor
O F. Don't know/not sure

9. Now thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?

Number of days _____
O Don't know/not sure

10. Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?

    Number of days _____
    O Don't know/not sure

11. During the past 30 days, for how many days did your poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation?

    Number of days _____
    O Don't know/not sure

ACCESS TO CARE: These questions are from the 2007 and 2002 versions of the BRFSS

12. Do you have any kind of health care coverage, including health insurance, prepaid plans such as HMOs, or government plans such as Medicare? **2007, question 3.1**
    - O A. Yes
    - O B. No
    - O C. Don't know/not sure

13. Do you have one person you think of as your personal doctor or health care provider? **2007, question 3.2 – slightly modified for ease of administration.**
    - O A. Yes, only one
    - O B. More than one
    - O C. No
    - O D. Don't know/not sure

14. When you are sick or need advice about your health, to which **one** of the following places do you usually go? PLEASE CHOOSE ONLY ONE ANSWER. Would you say: **2002, question 2.3 First two response options modified.**

    - O A. Your personal doctor's office
    - O B. A doctor's office other than your personal doctor
    - O C. A public health clinic or community health center
    - O D. A hospital outpatient department
    - O E. A hospital emergency room
    - O F. Urgent care center
    - O G. Some other kind of place
    - O H. No usual place
    - O I. Don't know/not sure

15. How many times have you been to a doctor's office in the past year?
    Number of times _____
    O Don't know/not sure

16. Was there a time in the past 12 months when you needed medical care, but could not get it? **2002, question 2.4**
    - O A. Yes PLEASE ANSWER QUESTION 17

O B. No
O C. Don't know/not sure

17. What is the main reason you did not get medical care? PLEASE CHOOSE ONLY ONE ANSWER

2002, question 2.5

O A Cost or no insurance
O B. Distance
O C. Office wasn't open when I could get there
O D. Too long a wait for an appointment
O E. Too long a wait in waiting room
O F. No child care
O G. No transportation
O H. No access for people with disabilities
O I. The medical provider didn't speak my language.
O J. Other _____
O K. Don't know/not sure

APPENDIX II – Agenda for Grantee Phone Calls November 2007

Grantee _____ **Date**_____

Conference Call Participants _____

- 5 minute summary of project, including:
  - Topic area(s)
  - Adults and/or children
  - Race
  - Location (churches, schools, medical facilities, etc)
  - Coverage (multiple counties, county, city, 1 facility, etc)

- Were you trained on how to use Progress Check to enter monthly report data?
  - Do you need more training?

- Cohort:
  - What is the status of your cohort? Have you started?
  - How many enrolled?
  - Where are cohort participants pulled from (what program activities exposed to)?
  - What measures are you collecting?
  - Are you able to enter these in Progress Check?
  - What measures are you capable of measuring?

- Have you received IRB approval or an exemption? Which IRB did you use?

APPENDIX III – Grantees Best Story or Coolest Thing

Please tell about the "coolest thing" or "best story" that has happened as a result of your project in the second six months of the grant. Some grantees reported more than one coolest thing.

"*Enrollees in the Pharmacy Assistance program are extremely grateful for their services. Ms. Z. receives an immense amount of personal satisfaction in seeing the improved health and in hearing of the stress relief that the enrollees experience as a result of receiving needed medications. When Ms. G. M. sees the happy faces of patients when they successfully complete the counseling program, she knows that she has played a vital role in a success. She remembers the angry and sad faces at the beginning and contrasts that with the smiles at the end.*"

"*A 30 year old Arabic woman with no insurance and a strong history of breast cancer in her immediate family initially contacted REX Health Care for a free mammogram. She had a sister die at a young age from breast cancer as well as 2 maternal aunts who also expired from this disease. Her mother is a breast cancer survivor. Knowing her high risk for developing breast cancer at a young age, she was anxiously seeking to be screened. However, she did not meet the eligibility requirements for the other breast screening programs in* [her county]*.*

She did not have a medical provider nor had she ever received a clinical breast exam. The [program's] *Cancer Outreach Specialist made contact with her and immediately referred her to Open Door Ministries, a partnering medical office in* [her county], *to be seen by one of their physicians, who performed a clinical breast exam. This allowed her to be scheduled at the November 2007 mobile mammography screening. Because of the sensitivity of the situation it was imperative to accommodate her as soon as possible and project staff were able to do so within a week. Her results revealed that additional imaging was needed. Her additional reports also came back suspicious. On December 13, 2007, she had a biopsy of the suspicious area provided by Project ACCESS. Findings showed signs of early breast cancer and she was immediately referred to the BCCCP program to determine eligibility. Eligibility was established for her medical treatment and care were secured through the BCCCP Medicaid Program. The Project staff's knowledge of other area programs and established relationships with them resulted in the continuum of care for this client and no delay in the provision of service.*"

"*The 'best story' from this six months is that we have been able to turn around the grant from the initial phase. Basically, we started from scratch this year with a new PI, new Program Director, new staff, new action plan, new budget, etc. We are delighted that we have reopened the program as the Health Resource Center and are continuing to see an increase in the number of patients recruited into the program. We are delighted with the support we are receiving from the Housing Authority, the University and the surrounding community. We look forward to growing the program and feel that the next*

six months our program is going to have exponential growth and the types and number of educational programs we are able to offer is going to increase significantly. "
"*One of the best stories that has happened as a result of our project is the story of one of our patients, Ms. CF, and the fact that we were able to interview her for the HWTF video. She is a very low functioning African American woman, living in public housing, and is a Carolina Access Medicaid patient. She attended the classes we had in year 1 of the grant, and was one of the only faithful attendees. She was sad to see them go, but was then happy to find out that her provider had begun Group Medical Visits for diabetes as a part of our project, and she attended those as well. She has come such a long way through her participation in the GMVs, classes, and the close follow-up that her [grantee] case manager has provided in her home. Her behaviors and eating patterns have changed drastically, and her lab values have improved significantly. Her A1C has come down from 9% to an amazing 6.1%, and she feels much better. She also has become a resource to others in her community, sharing how she now tells others with diabetes what she has learned. It gave her tremendous pride to be featured in the filming of that video, and I am so glad we were able to honor her in that way.*"

"*It was very exciting to hear so much buzz about the 4th Annual Minority Health Conference after it was over. The health council received praise for a job well done by the community and in turn the council members congratulated the staff on a job well done. Advertising was incredible and hard to miss; we were able to serve a delicious heart healthy lunch to conference participants; and we offered them workshops that demonstrated how to live a healthy lifestyle in the presence of diabetes. We also experienced an increase in youth and Hispanic attendance by over 300%. Furthermore, community members have expressed personal changes in lifestyle behaviors in relation to increases in physical activity, improved food preparation, and adequate food consumption.* "

"*Our project was featured on NC Public Radio in October 2007. The radio program did a good job of presenting the information about our project and the importance of the church as a channel for health information. The program featured our Lead Health Advisor, Ms. P. G. and the Pastor of* [local church]. *We received a number of positive responses on the program. Being on this program shows that people are hearing about* [our program] *as we did not contact NC Public Radio to do this program they contacted us. We gave an update on our program to a group out of [neighboring county] who were interested in the Health Advisor model. We were also invited to speak at a Ministers' Brunch in [neighboring county] to speak about the Health Advisor Model.*"

"*Key Successes*
A. *Evaluations from the Nutrition and Diabetes programs reflect that participants desire to continue with monthly classes. Participants stated that they benefited tremendously from the classes and felt that the information that they received was useful. They wish to continue with the classes at the same time and feel that more advertising may help bring more people to classes. Participants also wish to incorporate an exercise component into new classes. The inclusion of opportunities to sample nutritional foods is a positive for participants and the Nutritional and*

Diabetes Health Fair was a huge success with many participants eager to attend the next one.

B. *Patients who come in for diabetes education and medical family therapy report feeling more empowered to manage their personal stresses that may hinder progress with medical management of diabetes.*

C. *The 2007 year ends with over 100 patients in the Progress Check database.*

D. *Specifically this week the therapeutic team was able to see a family struggling with the uncertainty of diabetes, substantial psychosocial problems and lacking knowledge in the nutrition realm. Through just the initial visit the couple was reassured that they could manage this disease and planned to take steps in the direction of better biopsychosocial health. This patient and her husband reported at the end of the visit that if they had not seen the therapeutic team she would have remained hopeless about better diabetic control. Her diagnosis of depression would have possibly led to suicide and her diet would have remained poor. This patients' story seems to be a recurring theme in our encounters with this patient population.*"

"*The most exciting aspect of the project so far is the work in the pilot practices. We are seeing total practice by-in in all of the practices and all staff understands the project and wants to help to make change happen. In the initial meetings with each practice it was good to see that each staff person felt a responsibility to make the project work. Everyone tried to come up with ideas and creative ways to meet more of the CLAS Standards. They were receptive to the feedback from the medical students and ready to work on their action plan.*

In one pilot practice they are working to make small changes such as putting signage up in Spanish saying that interpreter services are available. They are also reformatting their patient questionnaire to include language preferred, country of origin and a multiple choice race question. Another practice started with an initial training session where all staff was educated on the CLAS standards. One objective of the training was to make sure that everyone understood the intent of the project and thought it was important to address these issues. One practice is having a lunch and learn to share staff experiences from their native country or from experiences traveling abroad. They are also bringing an authentic dish to share from the country they are discussing."

"*The "coolest thing" happened in* [our county]. *The Lay Health Advisor and our* [project] *staff had laid out a walking trail at the church site. The LHA noticed that city workers were in the neighborhood repairing streets with asphalt. She decided to approach them and ask if they had any asphalt "left-over" would they consider paving the walking trail. As a result the church got their walking trail paved for FREE!!!*"

"*The "best story" involved the wife of the pastor of our* [local church] *in* [our county]. *She reported a reduction in her A1c from 11.1 to 6.8. This was accomplished in 6 months!!!*

She also had lost weight from 310 lbs. to 262 lbs.! As she states "Eating right and getting exercise really does pay off". "

"43 men screened for Prostate Cancer. The doctors in the community came together to volunteer on a Saturday. This was the largest screening we have had thus far. Out of the 43 men screened, 40 were African American, 3 were 3 were suspicious (a little under 10%), 2 were assigned medical homes (had no primary medical doctor). We had the Nursing Sorority giving the men instructions on what to do once they received their results, the [local fraternity chapter] helped with traffic flow, the Mayor of [local town] *proclaimed December 8th, Prostate Cancer Screening Day. People worked together for a common cause. It was awesome.*"

"*I am a 48 year old, single black female who has previously worked 21 years in the hotel industry. I was experiencing burnout and decided to leave the industry. I arrived in Asheville, NC in October 2003 to research my options for starting a business. During the search, I realized it was more of a struggle to build a business and had to find work instead. I had enjoyed having health insurance and supporting wellness however as time went by I no longer had coverage for Health Insurance and finances were slim. This actually added to my stress and weight gain.*

Through a local community center that bases fees for service on a sliding scale, I was able to access a health practitioner who advised me to seriously consider taking steps toward losing weight due to the increased risk of heart disease and my family history. I am at risk for development of diabetes due to family history and this is a disease that I cannot afford.

In late 2005 I was made aware of [HDI grantee partner] *whose focus is to help people of color in this County to get base line assessments, education and to help them navigate through our health system. They helped me to get the assistance I needed to make significant changes. Through the PACE program of* [partner] *I was able to plug into Nutrition classes at no cost, join a walking club at no cost and gain insightful health information. I am making steps towards reducing my risk every day.*

I am a professional facilitator and life /business coach knowing this, [partner] *was able to offer me a paid position as Volunteer Coordinator. I am now able to mentor others in my role as Volunteer Coordinator. Because I do not have health insurance I am still concerned about the unexpected, how will I pay, where will I go. Every day I meet people who are in similar situations however they are not employed, they have been diagnosed with heart disease or diabetes or cancer yet they are hesitant to access quality care or maintain compliance with their recommended treatment due to lack of financial resources and lack of health insurance. We need universal health care. We need liberty and justice for ALL."*

"[HDI grantee project] *is one of several projects facilitated by [the grantee]. As a well respected historic organization of the [neighboring counties], [the grantee], recently hosted a community forum entitled: The Education of Ramon. This forum provided an*

opportunity for community members to converse with the recently hired Director of Human Services for [neighboring county], Mr. R. R. Participants of [grantee project] *from the* [local assisted living facility] *were in attendance and were very vocal about issues related to older adults throughout the county, especially those on fixed and limited incomes. Mr. R.R., the Human Services Director, was so impressed by the emphasis of these participants that his staff has contacted the* [grantee project] *staff to arrange a meeting of himself, his staff, and the residents of the* [local assisted living facility]. *Mr. R.R.'s staff has also been provided with information about* [grantee project]*, and its role in the Eliminating Health Disparities Initiative of the NC Health and Wellness Trust Fund.*"

APPENDIX IV – Grantee Comments Regarding Technical Assistance

"The Technical Assistance team, and specifically my project officer, is extremely responsive, always available, and always supportive. I appreciate all they do!"
"I must say that [our project officer] has been awesome with sending information when requested, answering questions, and supplying feedback. The NCCU TA team has been the only consistent part of the grant since our involvement (July 2006) and I praise them for their support and professionalism."

"The TA team has been very responsive and helpful. Turnaround time for communication is excellent. They are very knowledgeable about our program and HWTF requirements. I feel though, they are constantly hampered by shifting deadlines and expectations on the part of HWTF."

"Some hard data would be nice to have."

"We believe that our project manager is very knowledgeable of our initiative and she is very aware of the problems we face. She has been extremely supportive of our efforts. We also believe that she has represented us well in speaking to the HWTF board, or as well as she is able to do.

We would like to see more support from the Trust itself. I believe that they could assist us more with the promotion of our program. I addressed this issue with our media person at our last annual meeting. It appeared as though we did not fit in the category of "community-based" and we were virtually left out of any proposed media attention. I do believe that what we are doing deserves more state-wide attention and would welcome any assistance with this."

"When the HDI database goes live again, I would like to request that training be provided to grantees."

"*I've been very pleased with how quickly I've been responded to when we've called the TA team with questions—the TA team has been helpful and informative at every step along the way.*"

Reporting Period: January – March 2008

Our activities this quarter were focused on discussing cohort plans with grantees, revising the HDI database, and event coding.

We completed phone calls with grantees about their cohort, informing them of the date on which they should stop collecting baseline data. We reviewed with them who should be included in their cohort, discussed follow-up data collection, and survey administration.

We reviewed the old HDI database and Fit Together Progress Check to determine revisions needed for the new HDI database. We also reviewed the reports that were available in the old HDI database to determine which reports should remain.

We finalized event codes to be used by grantees when reporting their monthly activities and met with HWTF staff and the NCCU technical assistance team to review event codes definitions. We planned and delivered event code training for grantees via conference call. We held a conference call with NCCU to review January activity reports for proper coding.

Timeline

Following is a timeline of our evaluation activities from January-March 2008:

January

- Participated in the monthly HDI program conference call
- Participated in HDI update meeting (HWTF, NCCU)
- Individual conference calls with new grantees (Zara Betterment and Robeson Health Care Corp)
- Follow-up conference calls with grantees about their cohort
    - Eight calls completed
- Database meeting in Raleigh with HWTF staff and NCCU TA team
- Coding meeting in Raleigh with HWTF staff and NCCU TA team
- Finalized cohort survey
- Distributed cohort survey to grantees
- Training for grantees on coding of monthly activities by conference call

February

- Participated in the monthly HDI program conference call
- Monthly evaluation meeting with Laura McCormick
- HDI quarterly meeting with HWTF, NCCU, ECU
- Follow-up conference calls with grantees about their cohort
    - One call completed
- Attended site visit at Cornerstone
- Finalized Spanish version of cohort survey

March

- Participated in the monthly HDI program conference call
- Monthly evaluation meeting with Laura McCormick
- Phone interviews for new faculty position in Research Division, Family Medicine (will serve as project director for HDI evaluation)
    - 6 interviews
- In-person interviews with faculty candidates
    - 2 interviews
- Follow-up conference calls with grantees about their cohort
    - Two calls completed
- Review of coding on monthly activity reports with NCCU

Reporting Period: April – June 2008

Our activities this quarter were focused on interviewing, hiring, and training the new project director for HDI evaluation, grantee HDI database training, and reviews of event coding. We presented an update to the HDI task force. We completed phone calls as well as corresponded via email with grantees about their data entry/management, monthly activity reports, and any programming issues they may have encountered. Also, three live database training sessions were held throughout the state for grantees in each area. We created a database training manual for use during our training sessions. We held conference calls each month with the NCCU technical assistance team to review event codes as well as each individual grantee's monthly activity reports.

Timeline

Following is a timeline of our evaluation activities from April-June 2008:

April

- Participated in the monthly HDI program conference call
- Monthly evaluation meeting with Laura McCormick
- Review of coding on monthly activity reports with NCCU
- In-person interview for new faculty position in Research Division, Family Medicine (will serve as project director for HDI evaluation)
- Conference call(s) with Laura McCormick, Kevin Welsh (database programmer), NCCU about the new database
- Evaluation update presented to HDI task force

May

- Participated in the monthly HDI program conference call
- Monthly evaluation meeting with Laura McCormick
- Finalized database training manual
- Held 3 database training sessions (May 5 – Durham, May 8 – Asheville, May 15 – Greenville)
- Conference call with Laura McCormick and Kevin Welsh about database
- New ECU evaluation project director hired and trained
- HDI Check made available to grantees for data entry. Fielded many calls from grantees about database problems. Worked with HWTF staff and programmer to resolve problems and inform grantees of solutions.

June

- Participated in the monthly HDI program conference call
- Monthly evaluation meeting with Laura McCormick
- Review of coding on monthly activity reports with NCCU
- Fielded calls from grantees about database problems.
- Worked with HWTF staff and programmer to resolve problems and inform grantees of solutions.

NORTH CAROLINA Health Wellness TRUST FUND

Youth Overweight and Obesity Prevention

fittogether

Counties covered by Fit Together grants

Gap counties covered by UNC-TV*

* UNC-TV provides statewide coverage

NORTH CAROLINA Health Wellness TRUST FUND

Updated 11-01-06

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

QUARTERLY REPORTS

Department of Community and Family Medicine
Duke University Medical Center and Health System

REPORTING PERIOD: July 2007 – September 2007

Describe the objectives that were achieved during the past quarter:

During the past quarter (July - September, 2007), the Duke Management Team provided technical support to18 grantees, reviewed grantees' monthly reports, communicated with grantees as necessary, began preparation of the Duke TA team and HWTF Fit Together APHA presentations and planned the HWTF Childhood Obesity Grantee evaluation results meeting.

1. **Monitoring and Technical Assistance to Funded Programs: July - September, 2007**

   A. Technical Assistance to Grantees:

      1. The Management Team provided technical assistance to 12 Performance Period Extension (PPE) grantees from July –September 2007. Technical assistance continued during the quarter as needed for the 6 grantee programs ended as of June 31, 2007:

         a. Assisted HWTF with processing Performance Period Extension documentation for one extended Phase II grantee (Be Active NC). The management team:

            1) Discussed grantee PPE documents with HWTF and gathered additional information as requested.

            2) Received final versions of the PPE documents from grantee, reviewed for completeness and accuracy, and forwarded to HWTF with a recommendation for approval.

         b. Met with three grantees on-site to discuss progress toward action plan goals, budget projections, plans for the remainder of the grant period, or to orient new staff (Albemarle Regional Health Services, UNC-TV, and Wake Forest University).

         c. Reviewed five budget revision requests from four grantees and provided recommendations to HWTF (Avery County Schools (2), North Carolina Academy of Family Physicians, UNC-TV and Cumberland County Schools).

         d. Conducted six extensive reviews of reimbursement requests and project financial closeout reports for three grantees (Person County Schools (2), UNC-TV (3) and Cumberland County Schools).

         e. Reviewed two travel requests from two grantees and provided recommendations for approval to HWTF (Halifax County Health Department, and North Carolina Academy of Family Physicians).

         f. Received three paid-media requests from two grantees (Mecklenburg County Health Department (2) and Cleveland County Health Department). Reviewed ads and forwarded to HWTF for final review and approval.

g. Provided technical assistance for project-specific questions via telephone and email.

B. Monitor Funded Programs

1. The Management Team:
   a. Reviewed monthly expenditure reports from grantees in July (17), August (13) and September (13).
   b. Conducted 13 follow-up inquires 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.
   c. Updated the monthly tracking table for HWTF in July, August and September, summarizing the progress of all grantees with respect to staffing, progress toward meeting action plan objectives, and activities of the management team specific to each grantee.
   d. Met with HWTF Commission staff monthly and communicated as needed to review grantees' program status.

C. Evaluation

1. The Duke Technical Assistance Team supported the East Carolina University Evaluation Team by:
   a. Conducting a comprehensive review of monthly Progress Check entries submitted by the grantees, ensuring complete and accurate capture, and coding of project events.
   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. Communicating with grantees each month to clarify information reported in the monthly progress reports, and providing verbal or written feedback about report entries.
   d. Assisting grantees with technical issues related to the electronic reporting system.
   e. Reviewing 10 grantee Six Month reports and conferring with grantees via email (3), conference calls (5) or site visits(2) to provide feedback and offer assistance with identifying strategies to improve self-assessment success ratings.
   f. 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. Meetings and Presentations

1. The Management Team:
   a. Attended the HWTF Commissioners' meeting on September 24, 2007.

b. Performed tasks associated with planning for the November 15, 2007 grantee meeting (Sharing our Efforts, Celebrating our Successes). The Childhood Obesity grantees will meet to hear program evaluation results, discuss lessons learned and identify replicable program strategies. Tasks completed this period included:
   i. Establishing a planning team with HWTF, Duke and ECU representation to plan all aspects of the meeting.
   ii. Selecting and securing space at the Friday Center for Continuing Education to host the meeting.
   iii. Polling grantees to ascertain interest in meeting attendance.
   iv. Distributing Save The Date notices to prospective attendees.
   v. Finalizing the meeting agenda with HWTF.

c. Developed the HWTF poster presentation and Duke oral presentation drafts for the two abstracts to be presented 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". Provided HWTF with sample poster template and layout along with APHA poster session guidelines and recommendations for graphic production. (Poster)
      2. "Sustaining and replicating obesity prevention projects: North Carolina's Fit Together Initiative". Completed the concept draft PowerPoint presentation. (Oral)

d. 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.

3. **Describe any unanticipated problems. How were they addressed?**

A. As reported last period, Cumberland County Schools' Project MOVE submitted a reimbursement request for aged expenses incurred by the project for which reimbursement had not previously been sought. **C**umberland 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 comprehensive review of the claim and the extensive supporting documentation. Duke TA briefed HWTF staff on the results of the review.

As a follow-up, this problem has been resolved. Cumberland County Schools has withdrawn its reimbursement request, electing to absorb the expense internally.

4. **What are the plans for the project/program for the next quarter?**

The Duke Management Team will:

- Review grantees' program strategy measures of success.

- Review grantees' monthly progress and expense reports.
- Meet with HWTF staff monthly to review grantee progress.
- Continue working with HWTF to identify and document replicable program strategies.
- Respond to grantee requests for information or technical assistance including conducting additional site visits to grantees.
- Continue planning for and facilitation of the Childhood Obesity grantees' meeting.

REPORTING PERIOD: October 2007 to December 2007

Describe the objectives that were achieved during the past quarter:

During the past quarter (October-December, 2007), the Duke Management Team provided technical support to 12 grantees; reviewed grantees' monthly reports; communicated with grantees as necessary focusing on project end requirements; presented on behalf of the Duke TA team and HWTF Fit Together at the APHA annual meeting and facilitated the HWTF Childhood Obesity Initiative Grantee meeting, "Sharing our Efforts, Celebrating our Successes."

4. **Monitoring and Technical Assistance to Funded Programs: October - December, 2007**

D. Technical Assistance to Grantees:

2. The Management Team provided technical assistance to 12 Performance Period Extension (PPE) grantees from October –December 2007. Technical assistance continued during the quarter as needed for any of the grantee programs ended as of June 31, 2007:
   a. Assisted HWTF with gathering data on the status of sustainability efforts of active and inactive grantees. Summarized in report form responses received from grantees.
   b. Finalized report of 26 TA identified replicable project and program strategies. Submitted report to HWTF.
   c. Met with two grantees on site to observe project programs and attend end-of-project meetings. (Halifax Health Department and Goldsboro Family YMCA)
   d. Reviewed four budget revision requests from four grantees and provided recommendations to HWTF (Albemarle Regional Health Services, Avery County Schools, Pitt County Schools and Cumberland County Schools).
   e. Conducted extensive follow-ups on one grantee's financial closeout report to complete the financial reconcilement of grant funds. (UNC-TV [2])
   f. Reviewed one paid-media request from North Carolina Academy of Family Physicians. Forwarded request to HWTF for final review and approval.
   g. Provided technical assistance for project-specific questions via telephone and email.

E. Monitor Funded Programs

2. The Management Team:
   a. Reviewed monthly expenditure reports from grantees in October (12), November (12) and December (12). Duke TA will also monitor final grantee expenditure reports to be submitted in January 2008.
   b. Conducted six follow-up inquires 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.
   c. Updated the monthly tracking table for HWTF in October, November and December, summarizing the progress of all grantees with respect to staffing, progress toward meeting action plan objectives, and activities of the management team specific to each grantee.
   d. Met with HWTF Commission staff monthly and communicated as needed to review grantees' program status and issues.

F. Evaluation

1. The Duke Technical Assistance Team supported the East Carolina University Evaluation Team by:
   a. Conducting a comprehensive review of monthly Progress Check entries submitted by the grantees, ensuring complete and accurate capture, and coding of project events.
   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. Communicating with grantees each month to clarify information reported in the monthly progress reports, and providing verbal or written feedback about report entries.
   d. Assisting grantees with technical issues related to the electronic reporting system.
   e. Communicating to grantees details of program reporting requirements and due dates, providing templates for Six Month, Annual, and Final reports.

5. **Miscellaneous Activities in Support of the HWTF Fit Together Initiative**

A. Meetings and Presentations

1. The Management Team:
   e. Presented at the 135th APHA Annual Meeting
   f. Completed planning for and facilitated the November 15, 2007 grantee meeting (Sharing our Efforts, Celebrating our Successes). The Childhood Obesity Initiative grantees met to hear program evaluation results from the ECU Evaluation Team, and to have grantees discuss lessons learned and identify replicable program strategies. Fifty-one people attended the meeting representing 16 projects, HWTFC management team and HWTF invited guests.

Participants completed event evaluations that indicated a high level of satisfaction with meeting facilities, content and outcomes.

g. Developed the poster presentation template for the HWTF abstract and developed and orally delivered the Duke 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." Provided HWTF with sample poster template and layout along with APHA poster session guidelines and recommendations for graphic production. (Poster)
        2. "Sustaining and replicating obesity prevention projects: North Carolina's Fit Together Initiative." Completed the concept draft PowerPoint presentation. (Oral)

6. **Describe any unanticipated problems. How were they addressed?**

N/A

4. **What are the plans for the project/program for the next quarter?**

The Duke Technical Assistance Team will review and submit a summary report of grantees' December 2007 Progress Check entries and monthly expenses.

The Duke Technical Assistance Team will continue to support, as needed those grantees working to complete project end program and financial reporting requirements.

Community-based physical activity and nutrition programs positively impact children's weight: Evaluation report of the North Carolina Health and Wellness Trust Fund's Childhood Obesity Grant Program

Prepared by:
Brody School of Medicine at
East Carolina University
Department of Family Medicine
ECU-UHS Pediatric Healthy Weight Research and Treatment Center

March 2008

Table of Contents

List of Tables

List of Figures

EXECUTIVE SUMMARY AND RECOMMENDATIONS

Background

The North Carolina Health and Wellness Trust Fund Commission funded 20 programs across the state as part of its Children, Youth and Community Obesity Prevention/Reduction Initiative. This grant program was to support local efforts to slow North Carolina's 40% increase in childhood overweight observed between 1995-2000 in children 5-11 years of age. The locally designed projects were selected from 96 applicants, funded for three years, and engaged schools and local communities to: a) raise awareness of the problems of childhood obesity, b) try different strategies to both increase physical activity and promote healthy eating, and c) encourage policy and environmental changes that support achieving and maintaining a healthy weight. Duke University provided technical assistance, and East Carolina University evaluated the childhood obesity grant program.

In this document East Carolina University Department of Family Medicine and the Pediatric Healthy Weight Research and Treatment Center at ECU provide a summative evaluation of the childhood obesity grant program from January 2004 – December 2007.

The evaluation of the childhood obesity grant program consisted of four components:

- Evaluation of attainment of the specific goals outlined by the Commission in the Request for Proposals
- A cohort study to track program impact on a relevant sample of NC children
- Consultation on the evaluation design for individual projects
- Evaluation of the technical assistance provided by Duke University

Fit Together goals

All grantees 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

Our findings demonstrate that grantees successfully developed innovative models for improving dietary and physical activity behaviors in a variety of community settings that can provide replicable solutions for other communities in NC and elsewhere.

In impacting their communities, grantee activities included more than 2,500 services provided to individuals and groups, 495 instances of successful partnership development and 481 instances of media coverage including over 160,000,000

potential media exposures about childhood obesity and the childhood obesity grant program. Importantly, grantees facilitated 447 instances of significant policy development or policy changes in areas such as physical activity, poor dietary behaviors, and overweight.

Cohort Study

The cohort study included 1,346 NC children in grades K – 12 (average age 9.5 years, range 4.1 – 18.6 years) who were measured at both the beginning and end of the projects. At baseline 17.2% were overweight and 26.8% were obese. Also, at baseline, three in five children drank two or more sugar-sweetened drinks per day, two in five drank whole milk instead of skim, 83% ate French fries or chips daily, and nearly 65% ate fast food at least weekly, with 24% super sizing their meal. At the end of the grant period, the following changes were demonstrated in this cohort of children:

- **90% of the children maintained or improved their weight classification**
    - **35% of overweight children improved their weight classification**
    - **16% of obese children improved their weight classification**

While further weight gain was halted in these children, nationally childhood *overweight* increased 3.2% from 13.9% to 17.1% between 1999 and 2004. Not surprisingly, our findings demonstrated that changing from whole milk to lower fat milk, increasing fruit consumption, and decreasing soda consumption were all related to improved weight status in children in this cohort.

Recommendations

The strategies used to achieve these outcomes are not complex or difficult to do with planning and some resources. Program activities focused on exposing children to new fruits and vegetables during class time, providing fruits, vegetables, and healthy recipes for children to take home, and on incorporating physical activity into the existing school curriculum. These simple programs, if consistently implemented, suggest that unhealthy weight gain in children can be effectively prevented in a significant percentage of children through the consistent application of nutrition and physical activity interventions. The elements of these programs that contributed to slowing the growth of obesity among children in North Carolina need to be sustained and implemented throughout the state.

Introduction

Childhood obesity has increased significantly and is a serious challenge to individuals, families, communities and society. Obesity in adults and children has an impact on the health of the nation and an economic impact that includes direct costs from prevention, intervention, and treatment of conditions related to obesity, and indirect costs, such as loss of income[1] (CDC). National data (NHANES 2003-2004[2]) show that 17.1% of children and adolescents ages 2 – 19 years are obese (at or above the 95th percentile for gender and age), which represents a continued increase over 1999-2000 data (13.9%) and 2001-2002 data (15.4%)[2]. Children who are overweight or obese are at increased risk for chronic diseases such as Type 2 diabetes and sleep apnea and have an increased risk for cardiovascular diseases including high blood pressure and high cholesterol[3] as well as orthopedic problems that affect a child's ability to be physically active. As well, overweight children are more likely to be overweight adults[4]. Many experts believed that if nothing was done, this generation would be the first to have a lower life expectancy than their parents[5]. Reducing the prevalence of childhood obesity has become a national priority in the United States and one of the objectives of Healthy People 2010 is to reduce the proportion of children and adolescents who are overweight or obese[6] (overweight or obese is defined as at or above the 95th percentile for gender and age for Healthy People 2010).

In 2006, the national Institute of Medicine (IOM) issued a progress report on the battle against childhood obesity[7]. It was unable to clearly define a course of action because there still are not enough data to broadly assess progress across a variety of settings. Efforts across the country are often small and fragmented. Even so, the IOM called for organizations to assess and scale up those interventions that work and to eliminate or replace ineffective strategies.

North Carolina data from children seen in public health settings show an increase in childhood overweight[8],[9]. In children age 5 – 11 years there was a 40% increase in the prevalence of overweight between 1995 and 2000. One in eight (12%) children age 2 to 4 years, more than one in five (20.6%) age 5 to 11 years, and more than one in four (26%) 12 to 18 years are overweight (from Moving our Children toward a Healthy Weight). North Carolina Nutrition and Physical Activity Surveillance System (NC-NPASS) data show an increased prevalence of overweight among children and youth of both genders and across all races and ethnicities[10]. In the 2007 report F as in Fat, North Carolina's youth are rated the 5th most overweight in the United States[11].

Background

In 2003 the North Carolina Health and Wellness Trust Fund Commission (HWTFC) committed $10.2 million to expand and enhance the statewide effort to prevent and reduce obesity with a specific focus on childhood obesity. At that time it was not known what type of policy changes and programs would slow or reverse the dramatic and escalating rates of childhood obesity. Most believed, however, that change must

occur at the local level. The HWTFC established a three-year community-based grant program that served schools, community and state agencies, local governments, and nonprofit organizations 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 round of grants was awarded to 17 community-based organizations, totaling $6.8 million. In April 2004, a second round of grants totaling $1.8 million was awarded to four community-based organizations. One grantee did not continue after year one, leaving 20 grantees for the duration of the grant period. These grantees implemented programs in their local communities, schools and churches. (See Figure 1).

Figure 1: Children, Youth and Community Obesity Prevention/Reduction Initiative

This new initiative represented the first attempt to address the statewide childhood obesity problem through the dissemination of grant funds to local entities. Grant funds enabled local entities to tailor local strategies and were not proscriptive.

The childhood obesity grant program was carried out at the same time as several complementary activities were also being carried out statewide. The state of North Carolina made a commitment to address childhood obesity through the NC Healthy Weight Initiative, which was established in 2000 with funding from the Centers for Disease Control and Prevention (CDC). In 2002 a comprehensive plan to prevent and reduce childhood obesity in North Carolina – "Moving our Children toward a Healthy Weight: Finding the Will and the Way" – was written. Eat Smart, Move More...North Carolina (ESMM) grew out of this initiative and is a statewide movement that promotes increased opportunities for healthy eating and physical activity wherever people live, learn, earn, play and pray. The ESMM Plan is a five-year plan (2007-2012) offering overarching goals and measurable objectives for anyone working in the area of overweight and obesity prevention. The plan is designed to help organizations and individuals address overweight and obesity in their community and begin to create policies and environments supportive of healthy eating and physical activity. The goals for the HWTF initiative are linked to "Moving our Children toward a Healthy Weight: Finding the Will and the Way". [12]

Evaluation report overview

East Carolina University Department of Family Medicine and the Pediatric Healthy Weight Research and Treatment Center (ECU) were selected to provide evaluation services for the childhood obesity grant program. This report summarizes the evaluation activities of the ECU team from January 2004 to December 2007, including:

- A summary of grantee program accomplishments
- Self-assessments that were completed as part of the grantees' final reports
- Cohort study results
- Appendix
    - Self-assessments that were completed as part of the grantees' annual (Six month for Phase II grantees) reports – reported in the Appendix
    - Evaluation of technical assistance

At the beginning of the grant period, the evaluation team at ECU assisted grantees in defining measures of success for their individual projects, when requested. This component of the evaluation was completed at the end of year one.

Grantee program accomplishments and self-assessments describe the foundation of the important changes that were reflected in the cohort study.

Grantee program accomplishments

Fit Together Progress Check allowed 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.) This Progress Check System is further described in Appendix A.

When grantees reported events in the Fit Together Progress Check System, they assigned a code to each "event" (e.g., Planning Product, Media Coverage). Event codes helped 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.
- **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. Partnering Actions, Services Provided, and Capacity Building can each provide opportunities for advocacy.

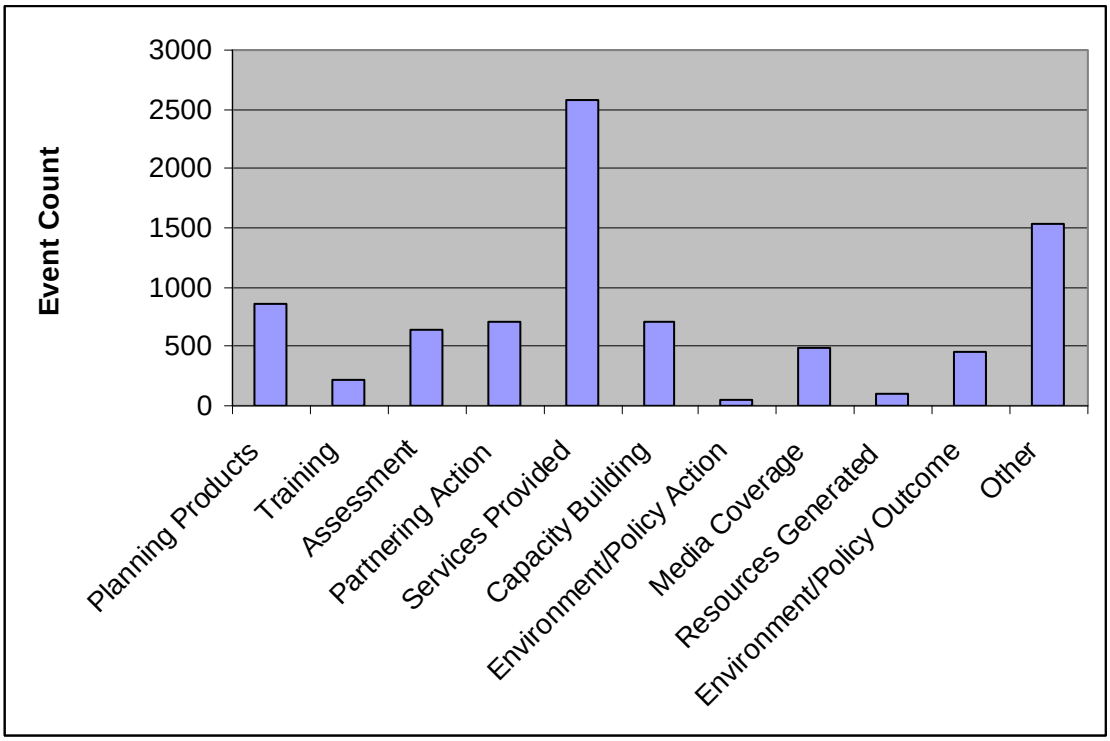
Finally, **ACCOMPLISHMENTS** are "outcomes" that involve a decision or change by some organization or governing body.

- **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 entered in their systems and unless otherwise noted, cover the period from January 2004-December 2007.

Figure 2 presents the number of reported program activities by event type. During the grant period there were 8336 events entered in the system.

Figure 2: Program activities by event type (January 2004 – December 2007)



The reported events occurred in a variety of settings that included the community environment (2727), community groups (759), the faith community (521), healthcare

settings (387), worksites (277) and schools/childcare/after school settings (7979). (More than one setting could be chosen per event.)

The following summarizes grantees' achievements in each of the event codes.

Planning Products

Planning products emerge as part of the planning process and provide a foundation for future activities. A total of 864 planning product events were reported for the entire grant period. The most common types of planning products were categorized as individual change materials, action plans, resource guides, surveys, and articles. Examples of these types of planning products include writing an article for the local newspaper about the amount of sugar in soft drinks, creating lesson plans for healthy cooking classes for elementary school children, publishing a cookbook of recipes, and creating PowerPoint presentations about Energizers to show to teachers at staff development sessions.

Training

Training enhances the knowledge and skills of project staff members to carry out their mission, goals and objectives. There were 218 training events reported for the entire grant period. Grantee staff members attended a wide variety of training events all aimed at increasing their skills and knowledge around childhood obesity. These included trainings and workshops directly related to the grant, for example, evaluation training and coding workshops and annual meetings, and other types of training such as Winner's Circle in Schools trainings, Safe Routes to School workshops and Energizer trainings.

Assessment

Actions taken to collect, analyze, or interpret data for needs assessment and/or evaluation are coded as assessment events. Grantees not only collected their required cohort data, they conducted surveys, analyzed existing data, held focus groups and conducted personal interviews They evaluated educational sessions and held health screenings. Overall, 635 assessment events were reported.

Partnering Actions

Grantees reported 702 partnering action events. These included exploring and establishing new partnerships (495) and collaborating on new projects with existing partners (201). Most of the activities completed as part of the childhood obesity initiative would not have been possible without these valuable partnerships.

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 types of services that grantees provided and reported. “Other” services types included fresh vegetable distributions, food pantry activity, and sponsoring booths or attending events to distribute information.

Table 1: Services provided by service type (January 2004-December 2007)

Service Type	Event Count
Group Education/Support	1662
Counseling (one-on-one)	68
Screening, Referral, Follow-up	4
Direct Patient Care	1
Other	847
Total Services Provided	2582

Capacity Building

Capacity building documents actions and events that build the capacity of other organizations, groups, or volunteers to support health. During the 716 capacity building events reported, training or skill building was offered to over 22,000 individuals with more than a third of these being teachers or childcare providers. This included 560 events that were group training and 100 events that were one-on-one technical assistance.

Environment/Policy Actions

Environment/Policy Actions (EPA) are specific recommendations that grantees made to key decision-makers or other groups of influence to advocate for environmental or policy level change. Grantees reported 56 EPA events, which included recommendations made to school health advisory groups, county commissioners, school system child nutrition directors, and school system administration. The majority of the recommendations were made to a single organization (22) or were made at the county level (23).

Media Coverage

Fit Together grantees 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-December 2007)

Media Outlet	Event Count	Potential Media Exposures	Number Distributed
Newspaper	218	6,513,772	--
TV	121	126,284,100	--
Radio	33	22,994,550	--
Billboard	3	3,367,884	
Brochure	5	3,367,884	9,930
Email	6		8,500
Flyer	7		30,300
Newsletter	53		329,675
Other	35	1,861,601	--
Total Media Coverage	481	161,021,907	378,405

Almost 22,000 minutes (366 hours) of television airplay was reported during the entire grant period along with 8979 column inches of newspaper coverage. Media outreach had an impact at all levels from state to neighborhood. Table 3 outlines the distribution of media coverage by level of impact.

Table 3: Media coverage by level of impact (January 2004-December 2007)

Level of Impact	Event Count
State	57
Region	120
County	264
Municipality	12
Neighborhood	1
Single Organization	22
Multiple Organizations	1
Other	4
Total Media Coverage	481

Health promotion messages accounted for 171 of these events, while 108 were local event promotions and 202 were general project coverage.

Resources Generated

Grantees were 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-December 2007)

Resource Type	Event Count	In-Kind Dollars	Direct Dollars
Funding	42	$23,730	$820,433
Materials	39	$24,717	$1,250
Professional time	2	$1,100	--
Volunteer time	12	$11,800	--
Other	9	$161,267	$100
Total Resources Generated	104	$222,614	$821,783

Grantees obtained contributions for events from a variety of sources. Many of these contributions were incentives for participation and many were healthy food and beverage contributions for program events. Some of the activities for which volunteers donated their time included teaching classes, preparing and serving healthy food at events, and providing child care at events. “Other” in-kind dollars included 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. Changing state and local policies to support healthy eating and increase physical activity was one of the major aims of the HWTF childhood obesity initiative and the grantees were very successful in their efforts to influence policy changes.

Across the funding period, 447 EPOs were reported by the grantees and in 80% of these, the grantee assumed the leading role. For the 18 grantees reporting EPOs, Figure 3 shows the number of EPO events per grantee. The total number of EPO events per grantee ranged from 4 to 67 events. Two grantees did not report EPOs during the grant period. However, their projects were not designed to address environment or policy changes.

Figure 3: EPO events by grantee (January 2004-December 2007)

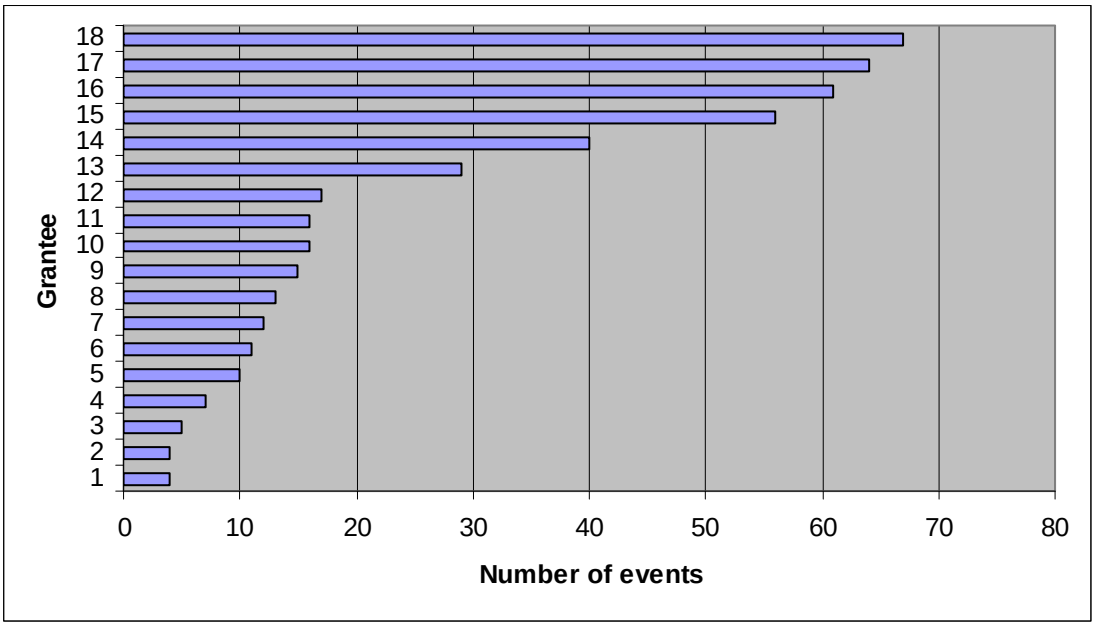
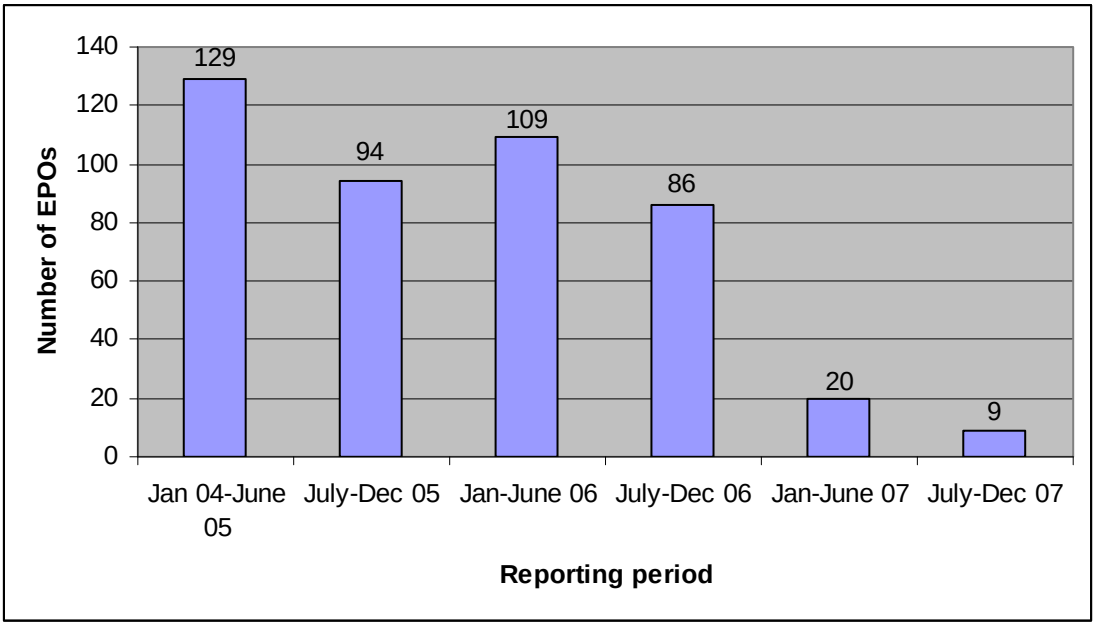


Figure 4 shows the total number of EPOs recorded during each reporting period of the grant. The highest number of EPOs occurred during the first reporting period. It should be noted, however, that the first reporting period covered the first 18 months of the grant, compared to the following reporting periods, which were only 6 months. Reported EPOs peaked again in the January-June 2006 reporting period and have since declined as grantees conclude their program activities.

Figure 4: EPOs by reporting period (January 2004-December 2007)



The setting for an EPO represents the environment the outcome is expected to influence. In the Fit Together Progress Check system, grantees indicated a setting for each EPO; more than one setting could be selected. The most often reported setting for EPOs was in schools/childcare settings. The events reported as EPOs for these settings are listed in Table 5. When more than one setting was selected, the EPO is listed under the first/main setting.

Implementation of nutrition and/or physical activity curricula was the most often reported EPO in schools and childcare settings. Grantees used 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 was integrating the use of physical activity kits/equipment in schools. Grantees 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 6 shows the types of EPOs that were implemented in the community environment, at worksites, in the faith community, in community groups, and in health care.

Table 5: Environment/policy outcomes for schools/childcare settings (January 2004- December 2007)

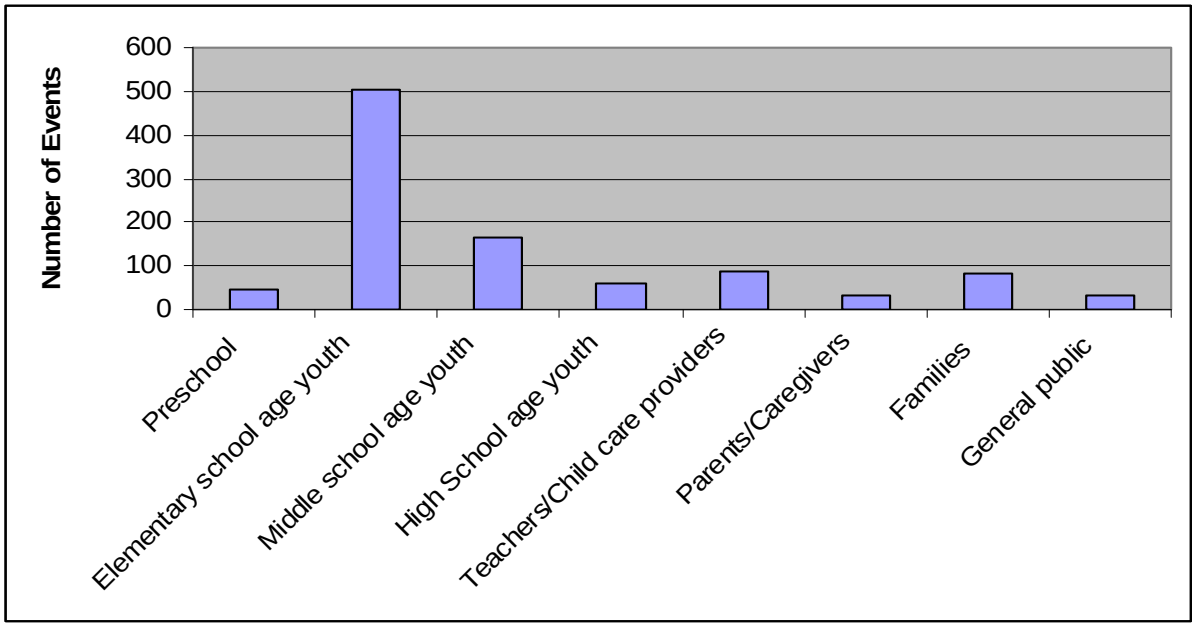
EPO	N
Schools/Childcare	
Implementation of a nutrition and/or physical activity curriculum	129
Physical activity kits/equipment to schools	60
Serve healthy snack to children at school/in after school program	19
Implemented walking program,/supplied pedometers	19
Physical activity/nutrition message in school/after school facility	17
School walking trail	16
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

Table 6: Environment/policy outcomes by setting (January 2004- December 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
Fitness-related businesses adopt smoke free policy	2
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
North Carolina Medical Society supports Eat Smart Move More	1

As seen in the tables above, grantees 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 5 summarizes the populations affected by the 447 EPOs.

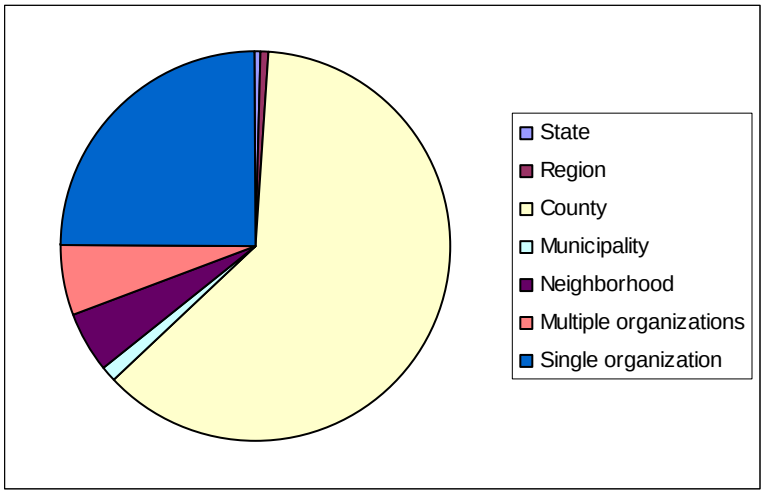
Figure 5: Populations impacted by EPOs (January 2004-December 2007)



The majority of EPOs 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 6. The majority of EPOs was enacted at the county level; about one-fourth had an impact at the single organization level. With comprehensive and broad-reaching impact, these EPOs affect behavior change at both the individual and group levels.

Figure 6: Level of impact of EPOs (January 2004-December 2007)



Especially in schools, grantees made substantial progress toward changing environments and enacting policies that address childhood overweight. The types of EPOs were varied and included changes that support both increased physical activity and support healthy eating.

Grantee self-assessments

Grantees submitted a final report when they completed all grant-related activities. In this final report, grantees responded to several open-ended questions about their key achievements, important environmental/policy outcomes, barriers, project products, "best thing" about their grants and their sustainability efforts. These responses provide insight from the grantees' perspective about some of their most important accomplishments, problems and efforts to continue their programs and activities in the future. These accomplishments and the grantees' efforts to address barriers contributed to the successes that were measured in the cohort study. Two grantees did not submit final reports. One grantee has not yet completed their program activities. The program coordinator for the other grantee left the position and a final report was not filed.

Key achievements

When asked to describe the key achievement of their Fit Together projects, six of the 18 grantees reported increasing awareness of childhood obesity in their local communities. Four others stated that creating, strengthening or sustaining relationships with the schools they were working with or other community partners was their key achievement. Other grantees reported tangible outcomes of their grants such as:

- Developing a walking trail
- Providing physical activity equipment to classrooms
- Developing consistent access to fresh produce in 16 counties with a site coordinator
- Creating a new wellness position
- Developing a swimming and water safety program for all first graders in their service area
- Pilot testing the Healthy Active Children Policy training program for school personnel
- Training lay health advisors to lead efforts in local churches and communities

Specific quotations from the grantees demonstrate the impact and importance of their "key achievements" on their programs and communities.

"The key achievement of our grant project was raising community awareness. Teachers, administrators and the community as a whole are more aware of the childhood overweight epidemic in [county]. We were able to provide statistics of the children right here in our county as opposed to talking about the nation in general."

"[Project name] was able to provide more than 40 physical educators with both staff development and P.E. equipment. This affected more than 16,000 students. The second major achievement of this grant was to pilot Healthy Active Children Policy trainings. The pilot involved 5 counties and trained 409 teachers affecting 16,700 students. The bigger picture is that this pilot has now allowed us to train more than 26,000 teachers affecting more than three-quarters of a million North Carolina students."

"The key achievement of our Fit Together grant is the strengthened relationship between the agency and the school system. We worked together well but this grant helped to solidify our trust and appreciation for what each of us brought to the table."

Most important environmental/policy outcome

Grantees provided a wide range of responses when asked about the most important environmental/policy outcome for their projects. Seven grantees reported specific policies that resulted from their efforts: two of them implemented Winner's Circle programs in their schools; one passed a "school health policy" that governs school lunches, party snacks, vending and a la carte items; one instituted a mandatory physical activity and nutrition curriculum training for their teachers; one required teachers to develop plans for how to meet the Healthy Active Children policy; and two implemented policies related to healthy snacks for YMCA after-school programs, summer camps and events. Other responses included activities, products and environmental changes that support improved physical activity and/or nutrition. Some of these include:

- Building15 new walking trails
- Implementing a pilot test of the training for the Healthy Active Children policy to teachers statewide
- Developing an indoor walking trail and fitness center for students, teachers and staff to use for increased physical activity
- Creating climbing walls in local schools which were incorporated in the physical activity curriculum
- Exposing television viewers across North Carolina to health-oriented messages through media work and trainings
- Providing free physical activity equipment to local schools
- Providing schools with resources and a curriculum to support the Healthy Active Children policy

Specific comments about the most important environmental/policy changes that occurred include:

"The most important policy outcome came from the dedication and commitment to promote the walking trails and the need to increase physical activity in the schools…The reward for all this work is having the school system adopt the walking program into the curriculums. Now students are using the walking trails as part of their music and art classes, as well as during recess. This gives each school the opportunity to reach the goal for increased physical activity outside of physical education classes as mandated by the state."

"I believe the most important EPO that has been achieved is where the principal at [local school] has required a plan from all teachers on how they are going to implement the 30-minutes of required physical activity a day. This is in place when a teacher is not able to take their students outside to the playground and on days that they do not receive physical education."

"The YMCA of [city name] adopted two policies to serve the [project name] approved healthy snacks in all of their summer camp and after-school programs at 13 different branch locations…[County name] Park and Recreation adopted the [project name] Healthy Vending Policy for all 26 recreation centers. The policies affect approximately 10,000 children who attend the YMCA summer camp programs, 3,000 children who attend the YMCA after-school programs and 38,000 children who participate in Park and Recreation youth activities."

Main barriers

Seven of the 18 grantees stated lack of teacher, school administration or partner "buy-in" or support as the biggest barrier to accomplishing their program objectives. Six others found it difficult to maintain relationships with multiple partners or schools with different personnel, policies and ways of functioning. Some grantees experienced problems related to school personnel changes necessitating additional training, etc. Other barriers included:

- Lack of enforcement of school wellness policies
- Lack of connection between the provision of information and behavior change
- Lack of parental involvement in events and activities
- Transportation issues
- Space limitations
- Unhealthy culture and traditions of the local community
- Staff turnover on the Fit Together projects causing delays in accomplishing goals

Quotations by grantees that illustrate some of the barriers encountered include:

"The primary barrier to reaching the full capacity of this program's goals and objectives was changes in key school administrative staffing positions. In the first three years of this grant, all four county school local education associations saw changes in superintendents….As these changes took place, objectives were often delayed and timelines unmet."

"Barriers we encountered were few. Ones we did encounter were difficult principals and reluctant teachers. Teachers reported lack of time to do research on programs and use web sites, plus lack of funds to purchase materials. They reported HAC policy has good lesson plans but felt it was too much to ask of them to look up lesson plans. We had to do a more intensive job of "selling" them on the project and the benefits to them and their schools."

"Staffing! We were unable to hire a qualified dietitian to implement a physician referred after school program."

Project product

When asked what project product the grantees were most proud of and why, their responses varied widely. Six of the grantees stated they were most proud of a manual, handbook, or report (i.e. the Healthy Active Children policy training presentation, Elementary School Health Index Report, school wellness policy "guide" book, physician guide book, etc.). One project was most proud of a community awareness day; another had developed a school fitness center and revitalized their school cafeteria using students' artwork. Others listed actual products including:

- My Health Passport – a booklet containing health information and activities for children
- A program website designed with input from local program participants and community members
- A 5-A-Day event for Kindergartners
- Climbing walls (simulated rock climbing)
- "Let's Go Shopping with Read-A-Roo" DVD
- Energizer Tracking Poster

- Discount cards to local businesses offering healthy food options or activities for children who pledge to be fit

The quotations below demonstrate how proud the grantees were of their programs or products.

"We are extremely proud of the development of a cardio-fitness center on the campus of [school name] because students were totally involved in the development of the center and have been using the exercise equipment to increase their physical activity."

"The climbing walls are the product we are most proud of. We knew the walls would be beneficial and successful, we just didn't know the extent. The walls have had an amazing effect on the students helping with not only their physical strength and dexterity, but also in their critical thinking skills. The feedback from the principals, teachers and students has been extremely appreciative and grateful. These walls will give back to the schools many times over for a long time to come."

Best thing about the grant

Responses to the question about the "best thing" about the Fit Together grants ranged from the positive impact on students and teachers to strengthened relationships with schools and partners to being a catalyst for change within the schools or local community. Others reported providing opportunities for cooking demonstrations, farm field trips for school personnel, participation on a national television show and a Halloween candy exchange for healthier items.

Specific quotations illustrating the kinds of things grantees considered the "best thing" about their grants include:

"The Community Distribution in [town name/local center name] was a success by leaving us! The community felt the produce distribution was so important, that they found a donor to regularly provide fresh produce to their site to meet their needs. That is a great success!"

"Our best achievement is that we have been able to make a name in the community that [county name] health department is dedicated to achieving a healthy weight in our youth. We are called upon by local media to comment on the issue when statewide releases on childhood obesity are highlighted – without us having to call on them."

"The best part of the program was working with the kids and the impact we were able to have on them…the walking program has been a great thing this past year. I feel this way not just because it had a great impact on the teachers, but also because it was so visible to the students. Teachers commented on the surveys they completed on how the students would ask them every day how many steps they had gotten so far."

Sustainability efforts

The grantees' sustainability plans differed depending on their resources, number of partners, funding situation and other factors. Some grantees provided very detailed descriptions of their plans while others were more general. At least six grantees, however, reported school personnel would take responsibility for some of their project components; six others stated they were dividing up their projects among partners and local agencies. Five grantees mentioned having collaborative meetings with their partners and community organizations to discuss how to sustain their programs and to develop concrete, written plans. Five also mentioned seeking funding to support their programs now that the grant funding has ended. A few programs plan to incorporate some of their program components into web sites or specific policies.

Half of the 18 grantees stated obtaining funding to continue their programs as the primary barrier to implementing their sustainability plans. Four others see finding school staff willing to take the lead on their programs as another major barrier. Other barriers reported by grantees include:

- Difficulty in determining which components are easiest or most beneficial to sustain
- Staff turnover among school personnel needed to implement activities
- Limited space for continuing their programs
- Little overlap between existing program staff and new staff that may carry out the projects in the future
- No longer having a full-time person dedicated to the project
- Partners will be less accountable and have less frequent communication now that their formal relationship has ended

The factors grantees used to determine whether a strategy would be continued varied. Factors reported by more than one grantee include determining if the project has the staff, a strong relationship with a partner, key decision maker support and positive program outcomes. In addition, some grantees examined whether the benefits of the program outweighed the costs and whether people would be willing to pay for the service. Other factors included determining if there is sufficient demand for the service, how satisfied participants were with the service and actual costs for the continuing the program.

Quotations that illustrate the grantees efforts to develop sustainable programs are provided below.

"Our sustainability plan was created after a series of local partnership workshops and meetings. We developed a shared definition of sustainability, ranked our programs according to sustainability indicators, addressed weaker area through in depth workshops and created a written plan."

"[Program name] wanted to make sure as many people were involved in the sustainability process as possible; however, with many schedules to coordinate, it was difficult to plan too many meetings with a large group. Because of this, [program name] was not able to implement all the recommended activities in the Sustainability Toolkit. Instead [program name] decided on the most important sustainability steps and planned only two meetings with the [program name] team."

"Each item on our action plan has been looked at and re-visited numerous times to see how we can sustain the project without the current funding. We found some of these items would be sustained if we could include into a policy. We were able to do this with the Take 10! Program as well as our Health Assessments. The Recreation, Arts and Parks department is looking at a variety of grants to help sustain the after school recreation program….We are all working together with the same end result in mind. This grant allowed us to open the door to a variety of programs and this allowed all parties involved to be more aware of what each of us is doing. We will continue to work together to get students and families healthier."

Self-ratings

In addition to the open-ended questions described above, grantees rated several aspects of their grant projects and these are described in Table 7.

Table 7: Overall Achievement of Grant Objectives

During the grant period…	Mean	Range (1-10)*	N
Achieved program objectives	9.2	8-10	18
Encountered significant barriers to program objectives	3.9	1-7	18
Established and maintained community partnerships to meet program objectives	9.2	7-10	18
Maintained partnerships or collaborations	9.0	7-10	18
How helpful were the tools and resources that the Duke TA Team provided to assist with sustainability planning	8.7	5-10	18
Believe community views childhood overweight as a serious health problem	8.3	5-10	18

* Scale 1 (Not at all) – 10 (To a large extent)

Grantees rated their ability to achieve program objectives very highly, with all providing a rating of 8 or higher; five rated their success as a 10. Although most grantees reported relatively few barriers over the grant period as indicated by the mean rating of 3.9, a few encountered fairly significant barriers. These included:

- Project staff turnover
- Lack of support from teachers, school administrators and parents
- Difficulty in establishing and maintaining a strong relationship with the school system due to staff turnover, variable school functioning, and schools that are geographically distant from one another
- Differing views on the benefits of collaboration
- A disconnect between the provision of information and behavior change among members of the target audience or school personnel expected to implement activities
- Lack of enforcement of school wellness policies
- Schools not having physical education teachers on staff

Although some grantees reported difficulties in working with their partners, most rated their ability to establish and maintain relationships with partners very highly (mean scores: 9.1 and 9.0). In addition, most grantees found the technical assistance offered by the Duke Team over the grant period to be very helpful. Seven of the grantees rated the Duke technical assistance with a perfect 10; only one grantee rated the Duke team below a seven, giving them a 5 overall. Most of the grantees also reported that over the period of the grant, their community came to view childhood obesity as a serious problem. Two grantees rated this factor as a 5 or a 6; all others rated it as a 7 or higher. Two grantees also provided an open-ended response for this question:

“We always add this caveat: Childhood obesity is viewed as a serious health problem by our professional peers. In fact, the [city-county community] Health Assessment determined that it was one of the community's Top 5 priority areas and a Obesity Action Team was formed. However, we feel that "regular folks" do not see it as a problem and we could [rate] that as a 3 or 4. Also, there is considerable differences for how [county name] views the problem vs. the more western, rural counties which see it as even less of a problem.”

“Although national media efforts are attempting to educate parents, many still believe that children are expected to be "chubby" because they are growing, and that obesity is a social issue.”

Summary of grantee accomplishments

Our findings demonstrate that grantees successfully developed innovative models for improving dietary and physical activity behaviors in a variety of community settings that can provide replicable solutions for other communities in NC and elsewhere.

In impacting their communities, grantee activities included more than 2,500 services provided to individuals and groups, nearly 500 instances of successful partnership development and almost 500 instances of media coverage including over 160,000,000 potential media exposures about childhood obesity and the childhood obesity grant program. Importantly, grantees facilitated 447 instances of significant policy development or policy changes in areas such as physical activity, poor dietary behaviors, and overweight.

Cohort Study

This section of the report summarizes the purpose, methodology, and findings of the cohort study, which was one component of the evaluation of the HWTF childhood obesity initiative. A cohort study involves following a group of people who receive a particular intervention over time. This design allowed us to examine weight status and behavior changes over time among a subset of the group of children participating in grant funded activities.

Nineteen of the 21 grantees provided participants for the cohort. The following table shows the abbreviated names for each grantee that are used in this report.

Table 8: Grantees and abbreviated names

Full name	Short name
Albemarle Regional Health Services	Albemarle
Avery County Schools	Avery
Be Active North Carolina	Be Active
Children First of Buncombe County	Children First
Cleveland County Health Department	Cleveland
Cumberland County Schools	Cumberland
Durham Public Schools	Durham
FirstHealth of the Carolinas	FirstHealth
Goldsboro Family YMCA	Goldsboro
Halifax County Health Department	Halifax
Mecklenburg County Health Department	Mecklenburg
Mitchell County Schools	Mitchell
NC Academy of Family Physicians	NCAFP
New Life Women's Leadership Project	New Life
Partnership for Health	PFH
Person County Schools	Person
Pitt County Schools	Pitt
Southeastern Regional Medical Center	Southeastern
Wake Forest University School of Medicine	Wake Forest

Purpose

The purpose of the cohort study was to evaluate the overall impact of the disparate projects of the childhood obesity grantees on weight status and on physical activity, nutrition and other health behaviors that have been shown to be related to overweight in children.

Method

To measure weight status, physical activity, nutrition, and health behavior changes in children participating in grant funded projects, a longitudinal survey research design was used.

Cohort study considerations

As the contract for the evaluation of the childhood obesity grant program was awarded after the selection of projects, and these projects were very different from one another, it was recognized during the planning of the evaluation methodology that this would present challenges in measuring the impact of the initiative.

Because the state of the science of evaluating childhood obesity prevention and treatment programs was in its infancy (for example, there were no recognized evaluation tools, expected effect size was unknown, as was the level of intensity of intervention required to achieve impact), we chose to follow a longitudinal cohort that would allow us to assess the same group of children over time to measure behavioral changes that were associated in the research literature with weight in children.

At the outset, experience from small scale studies led the evaluation team to expect little or no decrease in BMI over the grant period, but we did expect to measure some changes in food and physical activity behaviors that would contribute to improved weight and health over time while at the same time do no harm. In this regard, one goal that was articulated and discussed was the potential to achieve weight stabilization, i.e., prevent inappropriate weight gain. By focusing on changing long-term behaviors, policy, and environmental targets, and the potential for weight stabilization, the hope was to impact the future risk of adult obesity and its attendant consequences.

Survey Development

The survey used to collect information from participants in the cohort study was adapted from the Physical Activity and Nutrition (PAN) Behavior Monitoring Tool. The PAN tool was developed by staff in the North Carolina Department of Health and Human Services, Division of Public Health (DPH) with funding from CDC to enhance their surveillance system. Although not a validated tool, the development of the tool is grounded in research. DPH staff conducted a literature search to identify research and survey questions related to weight in children and teens. They specifically sought to identify behaviors that impact weight (e.g. TV watching, soft drink consumption). Many validated instruments from a variety of large projects (e.g. Youth Risk Behavior Survey (YRBS), Texas School project, Girl's Rule, Massachusetts Planet Health) were examined. Even so, DPH staff had to write some new items.

After an extensive review of literature, discussion with nutrition educators in other states, and discussions with DPH staff, the ECU evaluation team selected the original items from the PAN tool for inclusion in the cohort study survey. Additional behaviors that impact weight were added to the survey. These included: number of glasses of water per day, most likely beverage child drinks when thirsty, how often the child super sizes his or her meal, most likely snacks child eats when hungry, how often child buys extra food or drinks at school, on how many days the child eats breakfast, weight description, what child is trying to do about his or her weight, and where child goes after school.

Training

A cohort study training manual was prepared and training sessions were held with the grantees. At the training sessions detailed instructions were given to grantees on the

purpose of the cohort survey, how to identify their cohort sample, the process of informed consent, the data collection process, and the data entry process.

Institutional Review Board

Each grantee was required to submit their cohort plan to an Institutional Review Board (IRB) for approval prior to data collection. Most grantees submitted to the IRB in the NC Division of Public Health. A few of the grantees submitted to their local hospital's IRB. Informed consent was required for each cohort participant. Parents of children in these communities were interested and willing to be engaged in the evaluation process as evidenced by their willingness to grant consent for their child to participate. Active parental consent is often difficult to obtain and it was rewarding to observe the willingness of parents to have their child participate.

Cohort Selection

Each grantee (except for UNC-TV and the NC Division of Public Health) identified a sample of children who represented their target population to include in the cohort study. This sample was chosen based on their exposure to at least one component of the program, as well as the likelihood of success in collecting the information and on following them over the course of the grant. Grantees were encouraged to select children in the 3rd, 6th, and/or 9th grades if possible, as these children would be more likely to stay at the same school over the three years of the grant.

The children who participated in the cohort study represent a much larger group of children who were exposed to these programs; therefore any changes observed in the cohort study most likely extend to the larger group of children who participated in grant funded activities. Again, the objective was behavioral and environmental change in the community and not an individualized weight change program.

Table 9 shows the setting and coverage of the cohort participants. The cohort participants came from a variety of settings. The majority of grantees (n=15) drew their cohort children from school settings. Six of the grantees selected a portion, or their entire cohort, from after school settings. One grantee's cohort was from a faith-based setting and three grantees used community settings, including doctor's offices, a community center, and the YMCA. The majority of grantees' (n=17) cohort participants came from multiple locations, rather than one location. Grantee activities could focus on the risk factors of physical activity and/or nutrition. Through a variety of program activities, all of the grantees addressed physical activity, and all but two grantees addressed nutrition.

Table 9: Setting and coverage by grantee

Grantee	Setting				Coverage	
	School	Afterschool	Faith-based	Community	One location	Multiple
Albemarle	x	x				x
Avery	x					x
Be Active	x					x
Children First	x					x
Cleveland	x				x	
Cumberland		x				x
Durham	x	x		x		x
First Health	x					x
Goldsboro				x	x	
Halifax	x	x				x
Mecklenburg		x				x
Mitchell	x					x
NCAFP	x			x		x
New Life			x			x
Person	x	x				x
PFH	x					x
Pitt	x					x
Southeastern	x					x
WFU	x					x

Data Collection

The health behavior survey and BMI were monitored at intervals over the three year grant period. The following table shows the data collection schedule for each grantee.

Table 10: Data collection schedule by grantee

Grantee	First Data Collection	Final Data Collection
Albemarle	Spring '05	Fall '06
Avery	Winter '05	Fall '06
Be Active	Fall '04	Fall '06
Children First	Spring '05	Fall '06
Cleveland	Fall '04	Fall '06
Cumberland	Spring '05	Fall '06
Durham	Spring '05	Fall '06
FirstHealth	Fall '04	Fall '06
Goldsboro	Winter '05	Fall '06
Halifax	Fall '04	Fall '06
Mecklenburg	Fall '04	Fall '06
Mitchell	Fall '05	Fall '06
New Life	Fall '04	Fall '06
NCAFP	Spring '05	Fall '06
PFH	Fall '04	Fall '06
Person	Fall '04	Fall '06
Pitt	Fall '04	Fall '06
Southeastern	Spring '05	Fall '06
Wake Forest	Fall '05	Fall '06

This table illustrates that some grantees were unable to begin their interventions immediately and therefore the cohort study only reflects the impact of 1 – 2 years of intervention in the identified site.

There were two components of the data collection process:

a. Survey administration (modified PAN form)
b. Measurement of height and weight

For students enrolled in grades K-5, a parent or guardian completed the survey. Students in grades 6-12 completed the survey themselves. Throughout this report those responses are combined. When the terms respondent, child, or children are used they refer to the children themselves for 6 – 12 graders and for parent responses for K -5 graders. Height and weight were measured by trained project staff using a defined protocol.

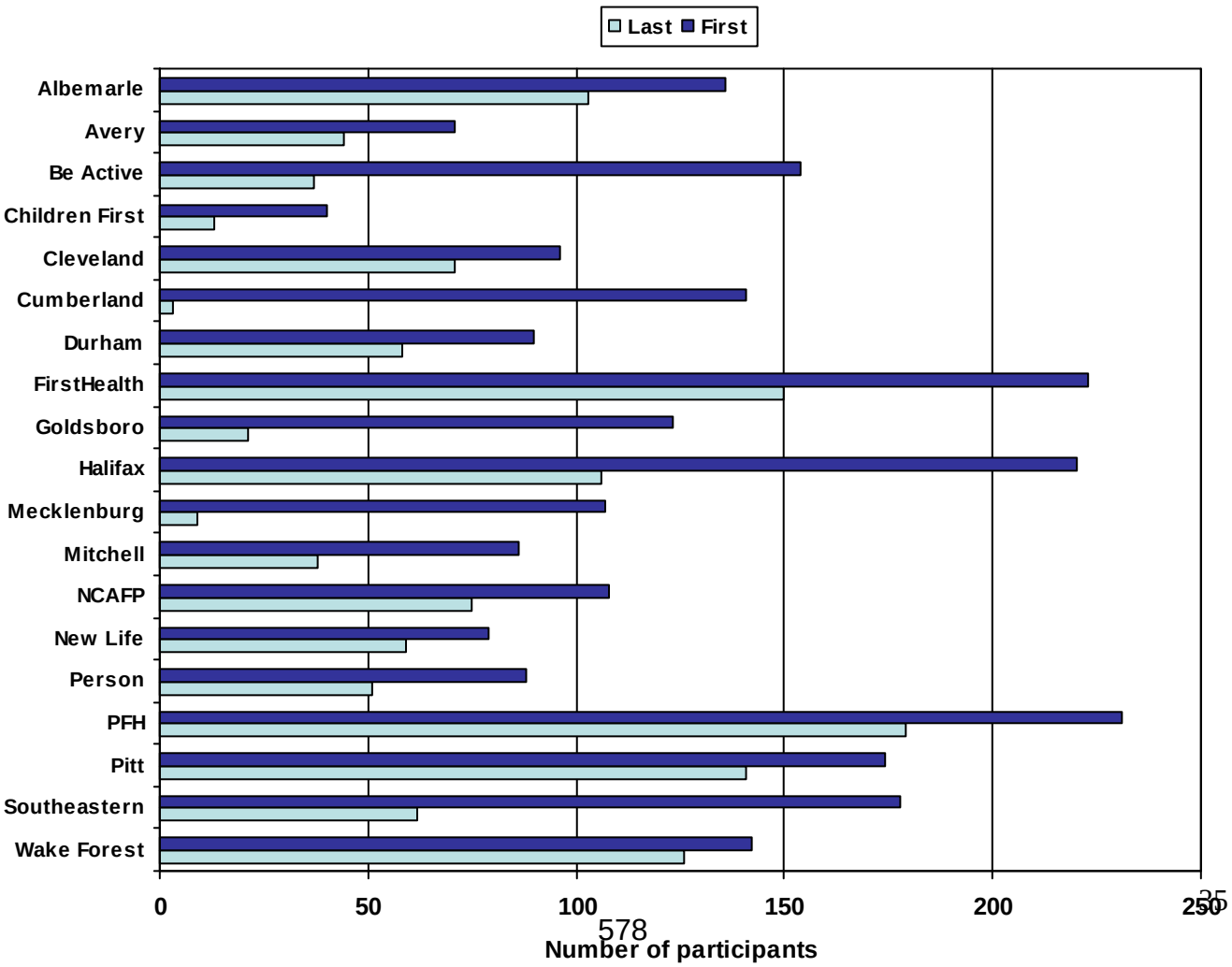
Data Entry

Grantees used the Fit Together Progress Check system to enter their cohort data. (See Appendix for a description of the development and use of this system.)

Results

The size of individual grantees local cohorts at baseline ranged from 40 - 231 children. A total of 2,487 children across the state were enrolled in the cohort at baseline. The size of individual cohorts at the final time point ranged from 3 to 214 children. The total number of children enrolled in the cohort at the final time point was 1,346 (54.1% retention rate). Figure 7 shows the number of participants from each grantee at baseline and the last measurement point. Retention of cohort participants varied and was affected by several factors including changes in project staff, school redistricting that resulted in children attending different schools, lack of commitment from non-grant funded personnel to collect cohort data, and difficulty in following children who were in after school programs that ended before final cohort data were collected. There was also difficulty in getting parents to return survey forms. While there was some difficulty in obtaining follow-up data from all participants, the final cohort of 1,346 exceeded the goal of 1,000 children in the final cohort.

Figure 7: Number of participants from each grantee at baseline and final measurement



Of the 1,346 participants included in the longitudinal cohort, 1,154 have both survey and height and weight data, 125 have height and weight data only, and 67 have survey data only at baseline and final data collection.

The race, region of state, and survey version distributions of those who were lost to follow up differed from those who were included in the longitudinal cohort. A higher percentage of Black participants, those from the Eastern region of the state, and parent version participants were in the lost to follow up group. The groups did not differ by age or gender. Baseline surveys responses from the entire cohort of 2,487 and the longitudinal cohort of 1,346 were similar.

Demographic characteristics of cohort

Table 4 shows the demographic characteristics of the 1,346 longitudinal participants at baseline. The average age of the cohort participants was 9.5 years old and ranged from 4.1 to 18.6 years old. Grantees were encouraged to select children for the cohort from grades 3, 6, and/or 9 to facilitate follow-up data collection.

There were slightly more females in the cohort than males. Over half of the cohort was white, over one third was black, and approximately 6% described themselves as Hispanic or Latino origin. At baseline, a little over 40% of the cohort was from the eastern region of the state, slightly more than one third from the piedmont and the remaining participants were from the western part of the state. About 70% of the surveys were completed by parents or guardians of children in grades K-5 while the remaining 30% were completed by students in grades 6-12.

Table 11: Demographics of the 1,346 longitudinal participants at baseline

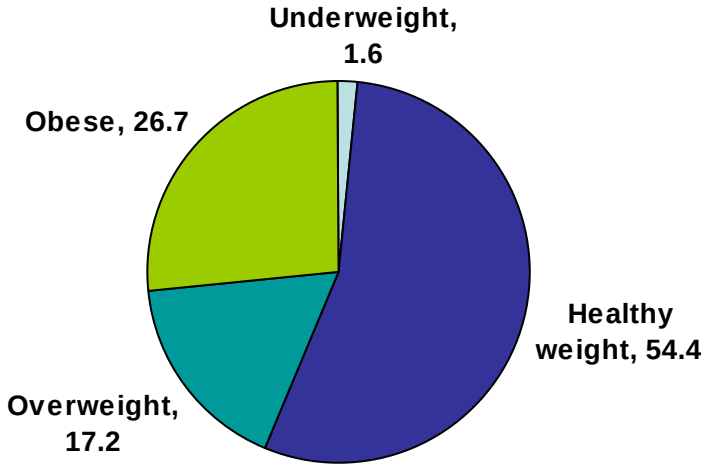
Characteristic		Longitudinal baseline n= 1,346
Age		
	Mean	9.5 years
	Range	4.1-18.6 years
Gender		
	Female	51.7%
	Male	48.3%
Race/Ethnicity		
	White	59.9%
	Black	32.7%
	Other	7.4%
Hispanic/Latino Origin		
	Yes	6.2%
Region of state*		
	Eastern	42.6%
	Piedmont	34.7%
	Western	22.7%
Version of survey		
	Parent	69.4%
	Student	30.6%

***Eastern North Carolina counties:** Beaufort, Bertie, Chowan, Columbus, Cumberland, Halifax, Martin, Pender, Perquimans, Pitt, Robeson, Sampson, Washington, and Wayne.
Piedmont North Carolina counties: Cleveland, Durham, Guilford, Mecklenburg, Person, and Richmond.
Western North Carolina counties: Avery, Buncombe, Henderson, Mitchell, and Wilkes.

Baseline

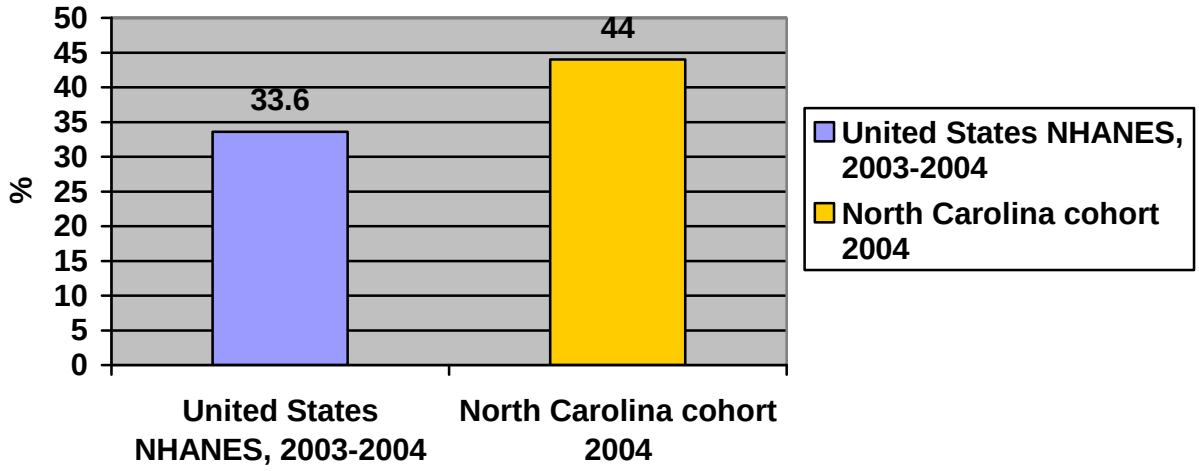
For this report we use the new definitions for children's weight status categories: underweight (BMI for age and gender less than or equal to the 5th percentile), healthy weight (BMI for age and gender between 6th and 84th percentile), overweight (BMI between the 85th and 95th percentile for age and gender) and obese (BMI for age and gender greater than or equal to the 95th percentile). The data from measured height and weight show that 54.5% of the children in this statewide cohort were at a healthy weight at baseline, 1.6% of the children were underweight, 17.2% were overweight, and 26.7% were classified as obese.

Figure 8: Weight status categories of cohort respondents at baseline



The proportion of children who were overweight was comparable to the estimated national prevalence of 16.5%, but the proportion that was obese is higher than the national estimate of 17.1%[2].

Figure 9: Percentage of children who were overweight or obese (NHANES versus NC childhood obesity grant program cohort)



There were marked regional differences in weight status in the cohort study at baseline. A larger percentage of children in the Eastern region were obese than in the Piedmont or Western regions.

Table 12: Weight status by region of state

Weight Status Category	Eastern*	Piedmont*	Western*
Underweight	1.6%	1.5%	2.0%
Normal weight	49.2%	56.7%	61.2%
Overweight	15.2%	20.0%	16.4%
Obese	34.0%	21.9%	20.4%

***Eastern North Carolina counties:** Beaufort, Bertie, Chowan, Columbus, Cumberland, Halifax, Martin, Pender, Perquimans, Pitt, Robeson, Sampson, Washington, and Wayne.
Piedmont North Carolina counties: Cleveland, Durham, Guilford, Mecklenburg, Person, and Richmond.
Western North Carolina counties: Avery, Buncombe, Henderson, Mitchell, and Wilkes.

In 2005 the American Academy of Pediatrics endorsed the dietary and physical activity recommendations for children made by the American Heart Association[12]. These recommendations are used in this report to provide a context in which to consider the cohort study findings.

- While it is recommended that children engage in moderate to vigorous activity at least sixty minutes a day, only a little over half of the children (52.8%) participated in some activity for at least 20 minutes that made them sweat and breathe hard at least five days per week.
- The American Academy of Pediatrics recommends that children watch no more than two hours of television per day. While close to 70% of children in the cohort watched 2 or fewer hours of television on weekdays; only about 30% watched 2 or fewer hours on the weekends.
- Consumption of sugar-sweetened beverages has increased and contributes substantially to total caloric intake in children. Drinking sugar-sweetened beverages and soda has been linked to childhood obesity. The American Academy of Pediatrics recommends that children ages 7 – 18 years should drink no more than 8 – 12 ounces per day of sweetened or naturally sweetened beverages, including fruit juice.
    - On a typical day, almost 30% of children drank soda two or more times and 58% drank other sweetened beverages two or more times. More than 50% of those who drank soda and sweetened beverages drank 8 ounces or more **each time**.
    - About one third drank 1 or fewer glasses of water on a typical day.
    - When asked what they choose to drink when they are thirsty, 22% chose sweetened beverages, 40% chose water.

- It is recommended that children over two years of age drink 2 – 3 glasses of skim milk per day. Over half of the children drank fewer than 2 glasses per day and 45% drank whole milk.
- It is recommended that children eat between 1 – 3 cups of vegetables per day depending on age and gender, and between 1 – 2 cups of fruit per day depending on age and gender.
    - At the time that the cohort survey was developed different recommendations were in place for fruit and vegetable consumption. It was recommended that children eat 5 servings of fruits and vegetables per day. At baseline, about 23% of the children reported eating 3 or more servings of vegetables on a typical day. At baseline, 56% ate 2 or more servings of fruit on a typical day.
    - According to the Continuing Survey of Food Intakes by Individuals (CSFII) [13], a study conducted by the USDA between 1994 and 1996, between 23% and 38% of children consumed at least three servings of vegetables per day and between 23% and 43% of children consumed at least two servings of fruit per day (depending on age).
- Discretionary calories are calories beyond the minimum needed for required daily nutrients. These can be spent on treats or on more food from the food groups. Young children have 130 to 195 and older children have 195 to 290 discretionary calories per day. At the beginning of the cohort study
    - 83% ate French fries or chips at least once a day. (one medium serving of French fries has 325 discretionary calories)
    - About 64% ate from a fast food restaurant at least once per week and 24% super sized their meal at least some of the time.
    - When asked what they choose to eat when they are hungry and want a snack, 22% chose chips, while 14% chose fruit.

These findings illustrate the compelling dietary and physical activity behaviors of NC children that are part of an environment conducive to the development of obesity. Further, they represent the important challenges faced by grantees - to attempt to so profoundly affect the policies, environments, and behaviors of these at risk children, to prevent further inappropriate weight gain and to promote a healthy lifestyle.

Changes over time

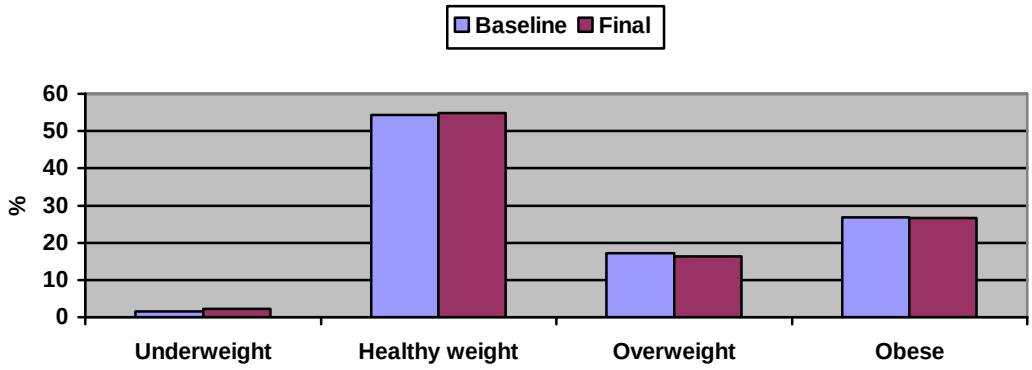
Changes in weight status and weight perception

Table 13 and Figure 10 display the percent of participants in each weight status category at baseline and at the final measurement. A total of 1,274 children had BMI data at baseline and final data collection.

Table 13: Trends in weight status for cohort participants (n=1,274)

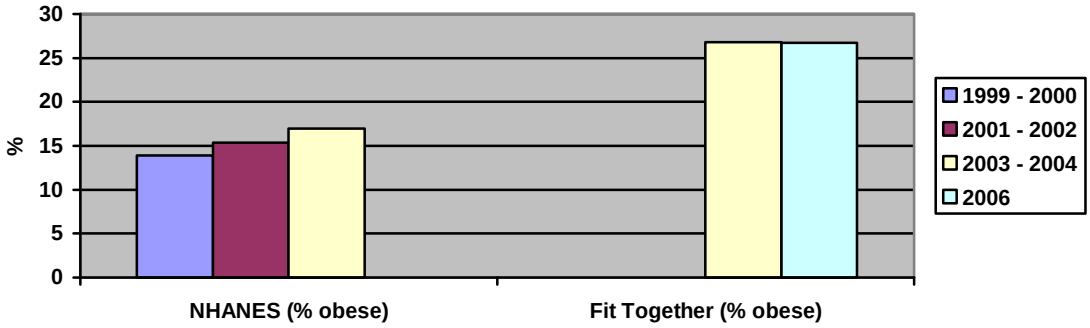
Weight Status Category	Baseline % (n)	Final % (n)
Underweight	1.6 (21)	2.2 (28)
Healthy weight	54.4 (693)	54.8 (698)
Overweight	17.2 (219)	16.3 (208)
Obese	26.8 (341)	26.7 (340)

Figure 10: Trends in weight status for cohort (n=1,274)



The above table and figure illustrate the success of this statewide initiative in limiting further inappropriate weight gain. National data over the last five years suggests a consistent and inexorable increase in the prevalence of overweight and obesity. These data suggest a halting of this trend among cohort participants and movement toward a healthier environment and the adoption of healthy behaviors. Figure 11 shows the steady increase in the percentage of children who are obese in the nation from 1999 – 2004[2], and the change in the percentage of children from the cohort who were obese in 2004 and in 2006.

Figure 11: Obesity trends in the United States versus cohort



Comparisons of weight status category at baseline and final showed that 90% of those enrolled at baseline either stayed in the same weight status category or lowered their weight status category at the time of final data collection. **Focusing specifically on children who were overweight or obese at baseline, 35% of overweight children lowered their weight status category and 45% stayed in the same weight status category while 16% of obese children improved their weight status category and 84% stayed in the same category.** Currently, there is no consensus on appropriateness of weight loss for children, especially young children, unless they have a comorbidity such as type 2 diabetes. Experts suggest that improving physical activity and food behaviors will lead to a healthy weight[14].

The findings from the cohort study paralleled or exceeded those in other states. In 2007, the state of Arkansas reported that in a three-year period (2003-04 to 2006-07) the percentage of Arkansas children who were overweight or obese declined from 38.1 to 37.8[15]. In the current cohort study, over the course of the three year grant period (2004-2007) the percentage of overweight or obese children declined from 44.0% to 43.0%, a significant accomplishment.

Awareness of healthy weight was a problem at baseline as demonstrated by the comparison of actual weight measurements with perceptions. This finding supports other research that shows that parents of overweight children do not perceive them to be overweight[16]. Participants were asked to describe their weight. At baseline, 16% described themselves as underweight, 58% as about the right weight, 20% as slightly overweight, and 6% as very overweight. At the final time, more children described themselves as slightly (23%) or very (7%) overweight, perhaps reflecting a more realistic understanding of their weight status. In addition, there was an increase from baseline (19%) to final (23%) in the percentage of children who were trying to stay the same weight, again, perhaps reflecting an increased understanding of weight maintenance for most children.

Changes in physical activity

All grantees sponsored programs that focused on physical activity and positive changes in physical activity levels were found in the cohort study. Participants were asked on how many of the past 7 days they had exercised or participated in physical activity for at least 20 minutes that made them sweat and breathe hard. Between baseline and final data collection, 38% of the participants increased the number of days per week that they exercise, 28% reported the same number of days of exercise, and 34% decreased their days of exercise or activity. A larger proportion of children increased the number of days they were active than decreased. Overall there was no difference in the average number of days participants exercised between baseline and final. However, there was a significant increase for children who were overweight (mean=4.2 at baseline, 4.6 at final), for white children (mean = 4.7 at baseline, 4.9 at final) and for those who live in the Piedmont (mean = 4.5 at baseline, 4.8 at final).

In the other questions related to physical activity and sedentary behaviors, marked changes were not shown. For example, respondents were asked to compare their physical activity level to others of the same age and sex. 18% increased their activity level relative to others and 18% decreased their physical activity relative to others. Participants were asked how many hours of television they typically watch on schools days and on weekend days. 29% decreased their TV time during the week, 33% decreased TV viewing hours on weekends. In the same time period, 27% increased their weekly TV time while 33% increased their weekend TV hours.

Changes in food behaviors affecting nutritional status and weight

All but two grantees sponsored programs focusing on nutrition. The survey addressed several components of nutrition including beverage consumption and preferences, fruit and vegetable consumption, snack preferences, and fast food behaviors. Several of these behaviors showed meaningful changes from baseline to final data collection.

Fruits and vegetables. The authors of the CDC Research to Practice Series[17] conclude that available indirect evidence suggests that increasing consumption of fruits and vegetables may be helpful to people who want to lose or maintain weight. Cohort participants were asked to report how many servings of fruit they ate and how many servings of vegetables they ate on a typical day. At baseline, almost 7% of participants did not eat any servings of fruit and over 6% did not eat any servings of vegetables. Increases in fruit and vegetable consumption were found:

- 62% of those who ate zero daily servings of fruit at baseline report eating at least one serving per day at final data collection
- 57% of those who ate zero daily servings of vegetables at baseline reported eating at least one serving per day at final data collection

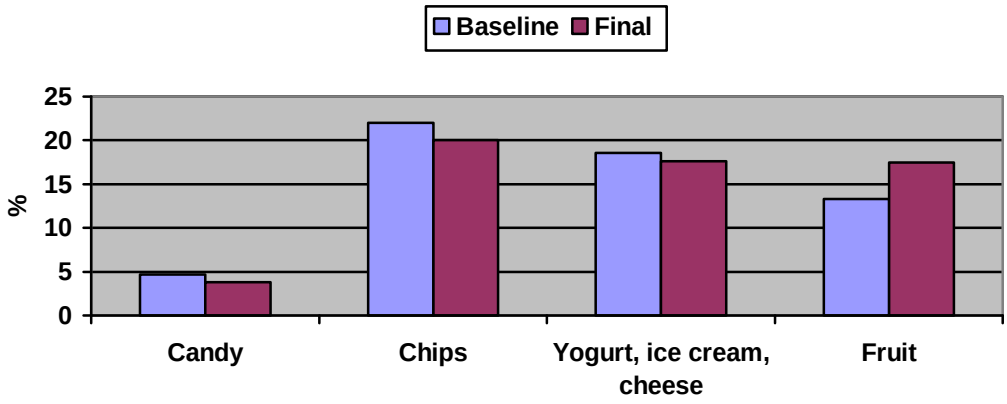
Overall, a larger percentage of children increased their servings of fruits (28%) and vegetables (25%) than decreased (24%, 23% respectively).

These changes were examined by weight status, gender, and race. Improvement among those who ate no servings of fruit at baseline was significant only by race. African American participants increased their consumption of fruit to a greater degree than other race participants. Changes in vegetable consumption among those who ate no servings at baseline did not differ by weight status, gender, or race.

Snacks and fast foods. Questions centering on snacks and fast food were asked. These foods are considered discretionary calories and should be eaten in limited quantities. Participants were asked how many times per day they ate French fries or chips (this included potato chips, tortilla chips, cheetos, corn chips or other snack chips). They were also asked how many times per week they ate at fast food restaurants and how often they supersized their meals. Small changes were seen in snacks and fast food consumption. For example:

- At baseline just under 18% of children reported that they ate no chips or French fries on a typical day; at final data collection 20% ate no chips or French fries on a typical day.
- Respondents were asked what they choose to eat when they are hungry for a snack. There was a decrease in the percentage of students who chose candy (4.7% to 3.8%) chips (22.0% to 20%) and dairy products such as ice cream, yogurt, pudding or cheese (18.6% to 17.6%) and an increase in the percentage of students who chose fruit (13.3% to 17.5%).

Figure 12: Changes in snack food choices



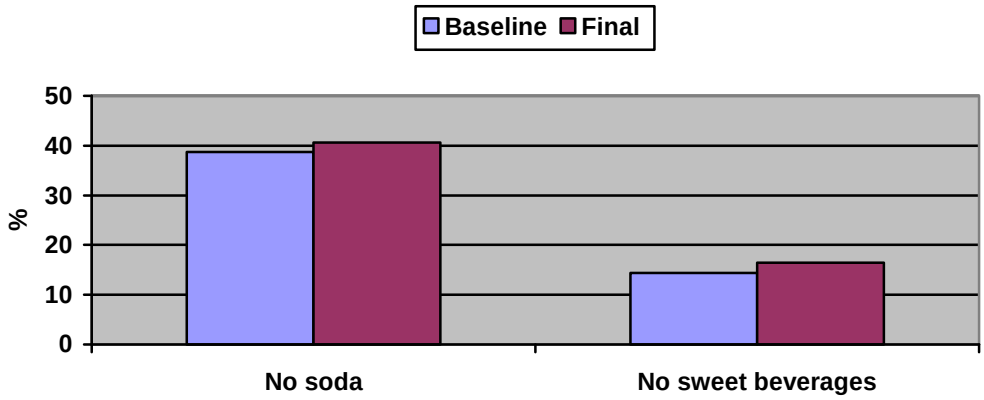
- A small change was noted with slightly fewer children reporting eating fast food 3 or more times per week at final data collection than at baseline.
- There were no changes in supersizing of meals.

The increase in the percentage of students who chose fruit as a preferred snack illustrates the impact of grantee initiatives on the behavioral choices of children regarding snack foods.

Sweetened beverages. Participants were asked how many times per day they drink non-diet sodas and sweetened beverages such as sweet tea, punch, Kool-aid, sports drinks or fruit juice (except 100% juice). Several key changes were noted with regard to sweetened beverage consumption and preference.

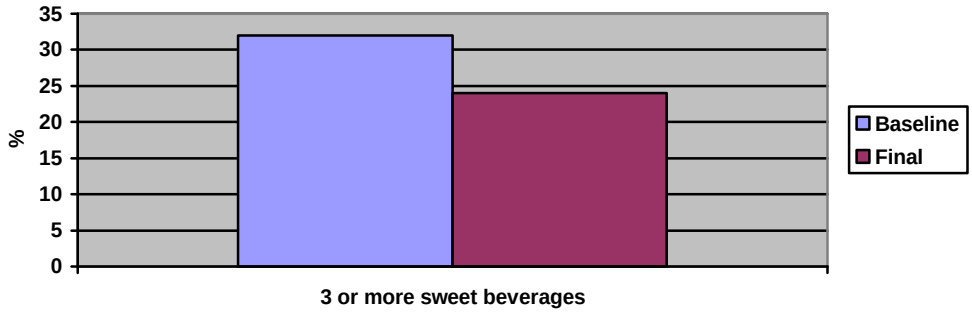
- The percentage of children who did not drink soda on a typical day increased from 38.7% to 40.6% as did the percentage that did not drink sweetened beverages (14.4% to 16.4%).

Figure 13: Changes in soda and sweetened beverage consumption



- At baseline 32% of children drank a sweetened beverage 3 or more times on a typical day, at final data collection this decreased to 23.8%. This decrease in sweetened beverage consumption did not differ by weight status, gender or race. This is especially noteworthy in North Carolina where many children drink sweetened beverages such as sweet tea and sports drinks in addition to soda.

Figure 14: Reduction in percentage drinking 3 or more sweetened beverages



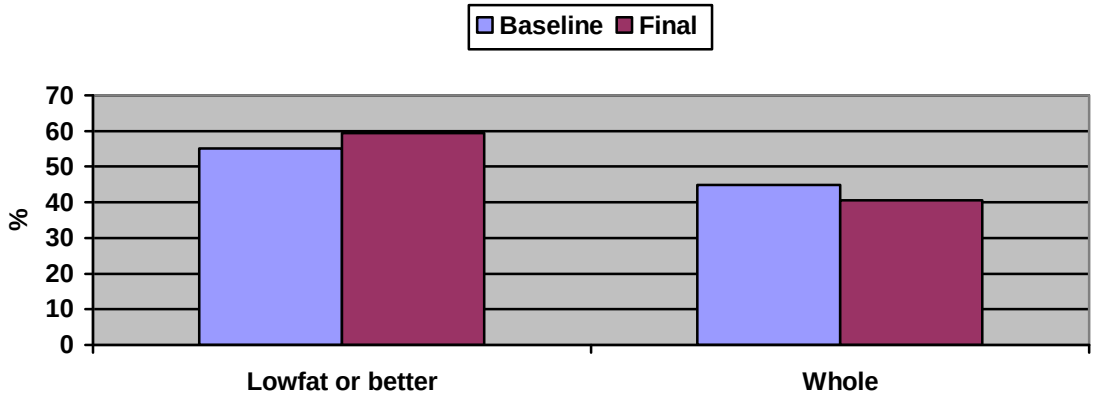
This decrease in the proportion of children who drink sugar sweetened beverages several times per day is an important change as research indicates that a large

proportion of added sugar in the American diet comes from the consumption of sugar-sweetened beverages and consumption of soda rose 137% from 1977 to 2001 in children ages 6 to 11 years. Both observational studies and experimental studies suggest an association between sugar-sweetened beverage intake and weight or BMI.[18]

Milk. Skim milk is recommended for children over 2 years of age. Participants responded to two questions about milk, including how many glasses they drink per day and what type of milk they drink. Important changes were noted for milk consumption.

- Whole milk consumption decreased from 44.9% to 40.5%.
- Of the 472 children who reported drinking whole milk at baseline, 24.8% reported drinking reduced fat (2%), low fat (1/2% to 1%) or nonfat milk at final data collection.

Figure 15: Changes in type of milk consumed



This reduction in whole milk consumption was examined by weight status category. Whole milk consumption was reduced in ideal weight (44.7% to 42.3%), overweight (44.0% to 39.4%) and obese children (46.1% to 37.9%). It is notable that the reduction was largest in the children who were classified as obese. This finding is encouraging also, in that it shows that it is possible for children to change their behavior to adopt a healthier lifestyle.

Relationship between behavior change and weight status category change

The relationship between behavior change and change in weight status category was assessed. The table below shows that a larger percentage of children who changed to lower fat milk, who increased fruit consumption and who decreased soda consumption lowered their weight status category compared to those children who did not make those behavior changes. These results demonstrate that these behavior changes were related to improved weight status.

Table 14: Relationship between behavior change and weight status category change

	% who lowered their weight status category
Changed to lower fat milk	20.4%
Did not change to lower fat milk	8.2%
Increased fruit	18.2%
Did not increase fruit	9.2%
Decreased soda	16.2%
Did not decrease soda	9.9%

Summary

The childhood obesity grant program was designed to address the disturbing increase in the proportion of children who are overweight or obese. Twenty one projects across the state of North Carolina were awarded grant funds for a variety of programs. The majority of the projects was school-based and most focused on elementary school age children. To measure the overall impact of the initiative on the health behaviors and weight status of children, a longitudinal study with a subset of participants was conducted. The funding period for these grants was three years, a relatively short time to assess changes in BMI and weight-related behaviors. This time period included implementation and evaluation of the grantee's projects and of the outcome evaluation of the initiative. It is a testament to the dedication and hard work of the grantees that longitudinal cohort data were collected on 1346 children. At the outset, many of the grantees did not have an existing infrastructure for this type of evaluation work.

Overall, 90% of children maintained or improved their weight status category. Among those overweight or obese at baseline, 35% of overweight children improved their weight status category and 16% of obese children improved. In only three years of the childhood obesity grant program, the percentage of children who were overweight or obese decreased from 44% to 43%. National data show a steady increase in the percentage of children who are overweight or obese. Important improvements in food behaviors and physical activity occurred during the life of these projects and positively impacted the weight of children participating. Significantly, fruit consumption increased, sweetened beverage consumption decreased, and whole milk consumption

decreased. In the research literature these behaviors have been associated with children's weight. In the current cohort data, increased fruit consumption, decreased soda consumption, and changing from whole milk to lower fat milk were significantly associated with improvements in weight status category.

This childhood obesity initiative represented an effort to change policies, environments, and patterns of behavior. The cohort data demonstrate the success of the initiative as illustrated in the behaviors and resultant weight status categories of a representative group of children from each project. Particularly encouraging is the evidence that small changes in daily consumption and physical activity patterns appear to result in weight stabilization in a significant percentage of children. Notably, 90% of children stayed in the same weight status category or improved, while 51% of children who were overweight or obese improved their weight status category. These findings suggest that inappropriate or excessive weight gain may be positively influenced in a significant percentage of children through the consistent application of nutrition and physical activity interventions in the environments where children spend most of their time. An additional insight derived from this evaluation is that children are willing and able to make behavioral changes to achieve or maintain a healthy weight.

These findings illustrate the successful changes that can be realized from the investment of resources focused specially to address childhood obesity. The results of this outcome evaluation suggest that these programs should be sustained and expanded throughout the state of North Carolina.

There are limitations in the design and implementation of the cohort study. The participants are a convenience sample of the total group of children who participated in grant funded activities. In addition, there was not a control group of children who did not participate in these grant funded activities, thus limiting our ability to attribute significant changes exclusively to the childhood obesity grant program. Many changes are occurring both in North Carolina and in the United States that may have contributed to changes in behavior.

Recommendations

The strategies used to achieve these outcomes are not complex or difficult to do with planning and some resources. Program activities such as exposing children to new fruits and vegetables, providing fruits, vegetables, and healthy recipes to children to take home, and on incorporating physical activity into the existing school curriculum can be implemented in a variety of settings. These simple programs, if consistently implemented, suggest that unhealthy weight gain in children can be effectively prevented in a significant percentage of children through the consistent application of nutrition and physical activity interventions. The elements of these programs that contributed to slowing the growth of obesity among children in North Carolina need to be sustained and implemented throughout the state.

References

1. Overweight and Obesity: Economic Consequences http://www.cdc.gov/nccdphp/dnpa/obesity/economic_consequences.htm. Accessed December 5, 2006.
2. Ogden, CL, Carroll, MD, Curtin, LR, McDowell, MA, Tabak, CJ, and Flegal, KM. Prevalence of overweight and obesity in the United States, 1999-2004. *JAMA*. 2006; 295:1549-1555.
3. Daniels, SR. The consequences of childhood overweight and obesity. *The Future of Children*. 2006;16.1:47-67.
4. U.S. Surgeon General. Overweight and Obesity: Health Consequences. Web site accessed April 14, 2008.
5. Olshansky SJ, Passaro DJ, Hershow RC, et al. A potential decline in life expectancy in the United States in the 21st century. *N Engl J Med.* 2005;352(11):1138-1145.
6. Healthy People 2010 Nutrition and Overweight http://www.healthypeople.gov/Document/HTML/Volume2/19Nutrition.htm#_Toc490383123 Accessed February 5, 2007.
7. Committee on Progress in Preventing Childhood Obesity. Institute of Medicine. Progress in preventing childhood obesity: How do we measure up? 2006.
8. North Carolina Nutrition and Physical Activity Surveillance System (NC-NPASS), Division of Public Health, Women's and Children's Health Section, Nutrition Services Division. www.nchealthyweight.com
9. North Carolina Institute of Medicine, North Carolina Child Advocacy Institute. North Carolina 2001 child health report card. www.nciom.org
10. Trust for America's Health. F as in Fat: How obesity policies are failing in America. 2007. http://healthyamericans.org/reports/obesity2007/Obesity2007Report.pdf
11. http://www.eatsmartmovemorenc.com/stateplan/index.html
12. American Heart Association, Gidding, SS, Dennison, BA, Birch, LL, Daniels, SR, Gilman, MW, Lichtenstein, AH, Rattay, KT, Steinberger, J, Stettler, N, Van Horn, L. Dietary recommendations for children and adolescents: A guide for practitioners. *Pediatrics*. 2006;117(2):544-559.
13. USDA. Continuing Survey of Food Intakes by Individuals http://www.ars.usda.gov/Services/docs.htm?docid=7797
14. Barlowe, SE & Dietz, WH Obesity Evaluation and Treatment: Expert Committee Recommendations *Pediatrics*. 1998;102(3):e29.
15. Arkansas Center for Health Improvement. Year four assessment of childhood and adolescent obesity in Arkansas (Fall 2006–Spring 2007), Little Rock, AR: ACHI, September 2007.
16. Blue Cross Blue Shield of North Carolina. State of preventive health: Reality check. November, 2006. http://www.bcbsnc.com/pdfs/reports/SPH_report_2006.pdf
17. National Center for Chronic Disease Prevention and Health Promotion Division of Nutrition and Physical Activity, Centers for Disease Control and Prevention. Can

eating fruits and vegetables help people to manage their weight? Research to Practice Series, No.1. http://www.cdc.gov/nccdphp/dnpa/nutrition/health_professionals/practice/index.htm

18. National Center for Chronic Disease Prevention and Health Promotion Division of Nutrition and Physical Activity, Centers for Disease Control and Prevention. Does Drinking Beverages with Added Sugars Increase the Risk of Overweight? Research to Practice Series No. 3 http://www.cdc.gov/nccdphp/dnpa/nutrition/pdf/r2p_sweetend_beverages.pdf

Appendix A

Fit Together Progress Check

The Progress ✓Check System is a MS Access based evaluation tool used by the Diabetes Prevention and Control, Heart Disease and Stroke Prevention, and Physical Activity and Nutrition Branches of the Division of Public Health. The original Progress ✓Check is an adaptation of progress documentation systems that were used by the North Carolina Cardiovascular Health Program, now known as the NC Heart Disease and Stroke Prevention Program, and the New York State Department of Health, which were based on the framework developed by the Kansas Workgroup on Health Promotion and Community Development and the Centers for Disease Control and Prevention.[i]

Progress Check was developed to support the North Carolina Blue Prints for Changing Policies and Environments in Support of Healthy Eating; and also in Support of Physical Activity. The items have been developed and tested at the local level. The existence of a statewide system, along with the technical assistance available to county level projects from other public health professionals made this an attractive system to use for this evaluation project. The Fit Together Progress ✓Check System was adapted from the original and used to collect extensive information on all project activities related to the goals and objectives of the Initiative. The system was customized so that grantees entered their cohort data into Progress Check and submitted them to ECU. BMI percentile was calculated for each respondent using Centers for Disease Control (CDC) methodology.

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.

Appendix B

Summary of annual and six-month reports for the period June – December 2007

Twelve grantees completed annual (n=10) or six month (n=2) reports covering the period ending December 31, 2007. The annual or six month reports for the remaining grantees were summarized on the last ECU report (January – June 2007). Ten grantees submitted action plan summaries with their annual reports during the last reporting period.

Each grantee developed their action plans incorporating 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

The action plans revealed that most grantees continued to focus their efforts on goals 1 and 2. None of the grantees focused on goal 3 for this time period and only two focused on goal 4.

The number of grantees working on each goal is shown in Figure 16 along with the associated number of objectives and strategies in Figure 17.

Figure 16: Number of grantees focusing on each Fit Together goal

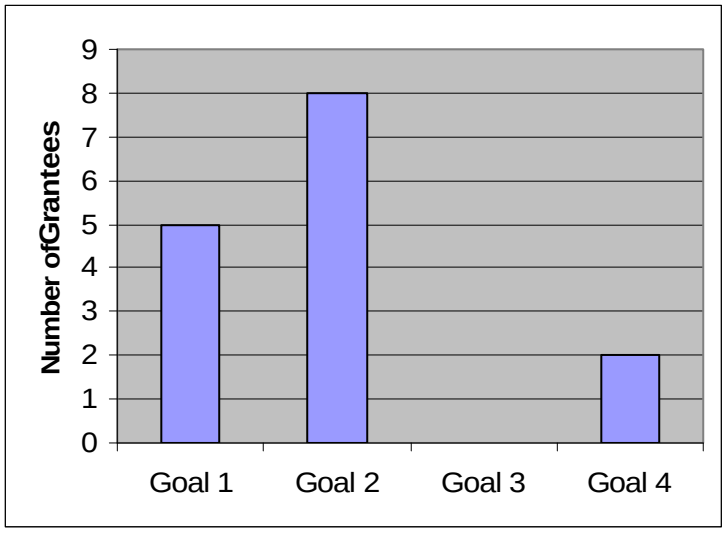
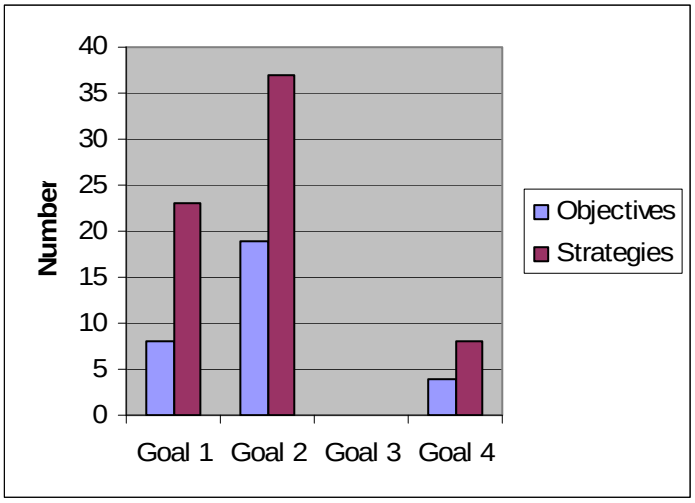


Figure 17: Number of objectives and strategies per Fit Together goal



Progress toward accomplishing goals

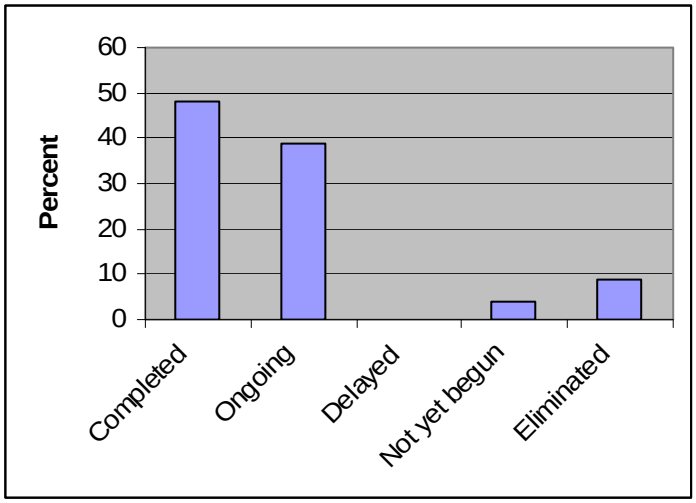
As a part of their annual reports and action plan summaries, grantees were asked to report on progress toward each strategy specified in their action plans by selecting one of the following:

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.

Figures 18 through 20 summarize progress toward the three goals that grantees reported activities for during the last reporting period (goals 1, 2 and 4). Since none of the grantees focused on goal 3 during the last reporting period, a table is not provided for this goal.

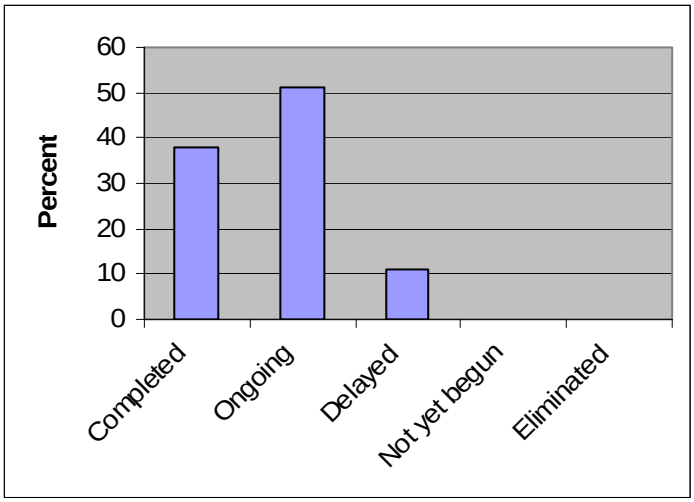
Figure 18: Progress toward Goal 1: Percent of strategies by status (n = 23)



For goal l, all but three strategies were completed or ongoing as planned. Only one strategy had not yet begun and two were eliminated. Reasons for eliminating or not beginning strategies included:

- A strategy to offer a recap of program results for participants and their families had not yet begun since data analysis, while in progress, was not yet complete.
- A strategy to submit newsletter articles to local schools was eliminated since the schools were only sporadically publishing the articles.
- A strategy to have a family reunion for program participants and their families was eliminated due to time and space constraints.

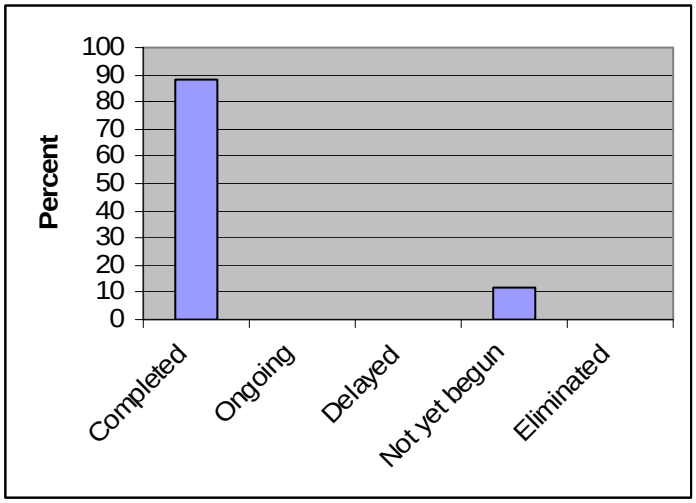
Figure 19: Progress toward Goal 2: Percent of strategies by status (n=36)



For goal 2, all but four strategies were completed or ongoing as planned; these four strategies were ongoing but delayed. None of the grantees reported eliminating strategies or not yet beginning them. Reasons for delaying strategies included:

- A strategy to establish a follow-up visit with each school to determine if project goals were met was delayed due to the absence of a lead teacher at one of the schools.
- A strategy to evaluate the implementation of Energizers in K-8 classrooms was delayed since data analysis was not complete.
- A strategy to post school resources online on the program web site was delayed so the resources could be posted at the same time as child development center resources.
- A strategy to provide a nutrition curriculum to K-5 teachers was delayed because it took longer than anticipated for the project to receive the curriculum from the NC Department of Public Instruction and to distribute it to the classrooms.

Figure 20: Progress toward Goal 4: Percent of strategies by status (n = 8)



For goal 4, all but one strategy was completed; this one strategy was not yet begun. The strategy, to implement the “Way to Go Kids” program and manage pediatric referrals had not been started because the program was still trying to hire a nutritionist to implement the strategy.

The majority of projects reported they anticipated the strategies that were delayed or not yet begun would take place in the near future and prior to the end of the projects.

Ratings for program objectives, partnerships and technical assistance

In the annual and six month reports, grantees were asked to rate their ability to achieve program objectives, collaborate with partners and evaluate the helpfulness of the technical assistance they received from Duke University. Tables 15 through 17 summarize these ratings by providing the mean ratings and range for each item.

Table 15: Progress toward program objectives (annual & six month reports)

During the past 6 months	Mean	Range (1-10)*	N
Achieved program objectives	8.6	6-10	12
Encountered significant barriers to program objectives	3.3	1-9	12
Utilized media advocacy techniques to promote program objectives	6.2	2-10	12
Believe community views childhood overweight as a serious health problem	8.1	5-10	12

* Scale 1 (Not at all) – 10 (To a large extent)

For the most part, grantees rated their ability to achieve program objectives highly, with a mean rating of 8.6. Only one program provided a rating less than 7. This grantee reported difficulty in meeting program objectives due the project coordinator transitioning into a new job at the local health department. The program coordinator's added responsibilities, in addition to undergoing the state's accreditation process at the health department, made it difficult to accomplish program objectives within the original time frames.

Most grantees reported few serious barriers although the project that rated their achievement of goals a 6 encountered significant barriers as reflected by a rating of 9. As explained above, their staff changes and health department accreditation process made accomplishment of project goals within the original time frames difficult. Another grantee commented "The recognition of childhood overweight as a health concern was a key obstacle during this reporting period."

Utilization of media during the past six months to a year varied, with a few projects reporting frequent use of the media (ratings of 8 or higher), and others reporting very little use (rating of 1) of the media. One grantee reported fourteen media events and stated, "The high number of media requests and opportunities show increased community concern for the rising rates of childhood obesity."

Most grantees reported their local communities believe childhood obesity is a serious problem (mean rating 8.1) although one grantee rated this factor a 5 and stated, “Most people still consider childhood overweight to be a social problem.”

Table 16: Partnerships (annual & six month reports)

During the past 6 months	Mean	Range (1-10)*	N
Able to use existing community partnerships to assist in meeting program objectives	8.9	7-10	12
Encountered significant barriers with project partners	1.8	1-6	12
Partnerships been working	9.0	7-10	12
Able to develop new community partnerships to assist in meeting program objectives	7.0	1-10	12
Partners discussed sustaining efforts after this grant	8.8	6-10	12

* Scale 1 (Not at all) – 10 (To a large extent)

All of the grantees rated their ability to use existing community partnerships to meet program objectives highly, with a mean score of 8.9. They also thought their partnerships were working well as indicated by a mean rating of 9.0. One grantee remarked, “Partnerships have been very helpful in offering comments and recommendations. Relationships have been good with partners, with most being successful.” All but one grantee encountered very few barriers in working with their partners, providing ratings of 3 or lower. In the narrative for their annual report, the grantee that rated their barriers as a 6 reported problems securing additional funding to maintain their program in the future. The grantees varied in their ability to develop new partnerships during the past six months or year. The mean for this question was 7.0 with a range of 1 to 10, indicating some grantees were unable or did not need to develop new partnerships while others continued to develop new partners as the grants continued over time. Most grantees have had discussions about project sustainability with their partners (mean: 8.8).

Table 17: Grantee assessment of Duke technical assistance (annual reports)

During the past 6 months	Mean	Range (1-10)*	N
Helpful was the Duke TA Team when requested information or assistance	9.3	6-10	12
Helpful has the Duke TA Team been in providing tools and guidance regarding sustainability	8.6	5-10	12
Helpful were the tools and resources that the Duke TA Team provided to assist with sustainability planning	8.3	5-10	12

Scale 1 (Not at all) – 10 (To a large extent)

The majority of grantees found the Duke Technical assistance very helpful, as indicated by the mean rating of 9.3. Two grantees commented their "lower" scores did not indicate the Duke team was less helpful or professional in their service; rather that the grantee needed less assistance. This fact is illustrated by the following quotation: *"I thought the sustainability workshop held about a year ago was incredibly helpful. I really haven't had to ask for much more help…My scores above do not really reflect less helpful support, rather less need for support in the past six months."* Another grantee stated, *"Resources provided over the project period have provided many valuable ideas and processes for establishing a sustainability plan."*

Grantee 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 previous six months.

"The coolest thing that has happened to me is to be recognized as the healthy guy. It does not matter where I go within our surrounding area I see the school children and they refer to me as the "healthy guy". Of all the ways I have ever been referred to before, this is positive. I appreciate the fact that they look up to me and watch what I am doing and they will be able to see that I have chosen to live well."

"In the last six months, I would have to say that the 'best story' involves a great result mistaken for a "problem." One of our physical education teachers (and this has happened in the past) told us that his students were 'cheating' when using pedometers. For us, we thought that meant the student was shaking the pedometer. We came to find out that during a relay race, each of the students was wearing a pedometer. The race was created according to our guidelines and the goal was to get as many steps as possible. As it turns out, the "cheating" was actually several students doing jumping jacks in line while waiting their turn to run!"

"The coolest thing is still [our project] incentive program. [S]tudents [in the program] continued to work hard to redeem Activity Bucks for sports equipment."

"The project team leader for [our county] and the coordinator for the health department recently relayed a story about the third grade curriculum expansion in our county schools. Eight elementary schools implemented the program in all Grade 3 classrooms in September 2007. The resources are now in 140 Kindergarten—Grade 3 classrooms across the county. "

"I feel certain that our teachers are using the materials we provided to them at our training at the beginning of the school year. I received a package in the mail several weeks ago. You'll never guess what I found! Beautiful thank you letters. Not only from the teachers, but from the students as well. I couldn't believe it. They drew pictures and wrote special notes to me. "Dear Ms. [name], thank you for giving me the nice workbook about how to make my body healthy. I loved it. You friend [name]." I know they are using the fitness dice because many of them mentioned using them. I hung all the cards on my office door and I plan to keep them. These students and teachers appreciate my time and attention. They are finding ways to incorporate our recommended resources into their lesson plans and the children are learning that being healthy is a positive thing. I am so happy to continue working with this project through the Health Department and the Kate B. Reynolds Charitable Trust."

"One of the coolest things that we did this past six months was an event associated with Halloween and Fall Festivals. This is the time of year that children receive so much candy and sweetened treats at school, church, home, and friend's houses. We wanted to provide the children with an opportunity to be rewarded for making a healthy choice during the holiday. The day after Halloween we hosted "The Big Candy Buy-Back." [C]hildren [from our program] brought back as much candy as they wanted to. We encouraged parents to sit with the children and pick there top few pieces and bag up the rest. They then could bring it to [our] class, weight it, and pick up some rewards. The prizes were based on the amount of candy they brought in. Prizes included erasers, pencils, mind bender games, playground balls, jump ropes, workout bags, and other "physically active related" prizes. We had all but 2 children participate. Between 11 children, they donated 26lbs of candy to the program. That is 26lbs of candy that these children would have eaten otherwise. We considered this event very successful and look to improve upon it for next year."

"Our coolest story was part of the plan to provide $100.00 checks to each elementary school to be used for the enhancement of their physical education program. We planned to present the funds at the school board meetings. We have three school systems in [local] county, the largest school system is [local county] Schools. We worked with the county's nine elementary schools throughout this project. In the planning of the presentation, I worked through the central office and on the night of the board meeting all of the elementary school principals attended, but had no idea why they were there. All of the principals were very pleasantly surprised to receive the funds, as we called them up individually by school and recognized their individual accomplishments. This offered a great opportunity for us to highlight the project accomplishments for all of the school board members and to strengthen our partnership with the schools. "

"Our program has been influential in changing the nutrition and physical activity environment for children in our county attending child development centers. The Program Coordinator/Nutritionist worked with county Child Care Resources to select child development centers eligible to receive funds for the implementation of Nutrition and Physical Activity Projects. 100 centers with children attending from low-income, minority, abused and/or criminal households were eligible to apply for project funding. Ten centers applied for the project funds and 6 were selected based on their project goals and objectives. The projects resulted in 10 environmental changes and 5 policy changes in addition to numerous promotional and educational activities. Please see the action plan summary section below for teacher and students comments.

Childcare Network:

- *Created a nutrition classroom extension box containing items that teachers can use in each center that relate to a nutrition theme. Supplies being used include diverse play foods, puzzles, games, measuring items, puppets, books, word cards, food group sorting, etc.*

- *Created a physical activity classroom extension box that teachers can use in the centers and for inclement weather days.*
- *Created a parent lending box that parents can check out, take home and use as interaction with their children.*
- *Implemented the Families Eating Smart and Moving More classes for parents and staff.*

Childcare Site #1:
- *Displayed monthly physical activity and nutrition bulletin board messages and healthy recipes.*
- *Distributed parent newsletters with physical activity and nutrition tips*
- *Hosted a family fitness night with games, taste-tests and prizes to promote healthy living.*
- *Incorporated the Color Me Healthy nutrition and physical activity curriculum into the classroom instruction.*
- *Designed a classroom container garden project.*

Childcare Site #2:
- *Displayed monthly physical activity and nutrition bulletin board messages and healthy recipes.*
- *Distributed parent newsletters with physical activity and nutrition tips*
- *Implemented the Families Eating Smart and Moving More classes for parents and staff.*
- *Incorporated the Color Me Healthy nutrition and physical activity curriculum into the classroom instruction.*
- *Changed menu to include more nutritious meals, snacks and beverages.*
- *Developed a physical activity and nutrition policy for the center.*

Childcare Site #3:
- *Distributed parent surveys to determine nutrition and physical activity priorities*
- *Implemented the Families Eating Smart and Moving More classes for parents and staff.*
- *Incorporated the Color Me Healthy nutrition and physical activity curriculum into the classroom instruction.*

Childcare Site #4:
- *Displayed monthly physical activity and nutrition bulletin board messages and healthy recipes.*
- *Distributed parent newsletters with physical activity and nutrition tips*
- *Incorporated the Color Me Healthy nutrition and physical activity curriculum into the classroom instruction.*
- *Conducted classroom healthy taste-test activities.*
- *Changed menu to include more nutritious meals, snacks and beverages.*
- *Developed a physical activity and nutrition policy for the center.*

- *Created a nutrition classroom extension box containing items that teachers can use in each center that relate to a nutrition theme. Supplies being used include diverse play foods, puzzles, games, measuring items, puppets, books, word cards, food group sorting, etc.*
- *Created a physical activity classroom extension box that teachers can use in the centers and for inclement weather days.*
- *Adopted a policy where classroom physical activity has to be included on each teacher's daily lesson plan (this physical activity is in addition to the daily outdoor activity already required).*
- *Hosted the Fun Bus for physical activity games and activities.*

Childcare Site #5:

- *Implemented Yoga for Kids to increase classroom physical activity and decrease behavioral challenges.*
- *Conducted classroom healthy taste-test activities."*

"In [local] county, we are already seeing the relationship between the physician and agent being sustained. Through this initiative the physician has developed collaborations with the local cooperative extension agent, local school nurses and individuals from the health department. Over the summer they planned a series of Families Eating Smart Moving More classes that took place in the fall. They each had a part in the planning process and hosted a kickoff for the series in August before school started back. From there they have further developed their relationship. The health education supervisor at the [local] Health Department came to the group with an idea to apply for a diabetes prevention grant using the models they were already implementing. With letters of support from everyone involved they received a grant from The WakeMed Pediatric Diabetes Program. The health department received $27,000 in funding for their community-based intensive education and lifestyle change program. One key component of the project that will continue with the new grant is using the physician referral model. The local physician continues to update project staff on the happenings in [loca] County and is thankful to have this collaboration to tie her obesity prevention work into."

"Just last month I was in Chick-fil-A with my daughter and I was wearing a sweatshirt for [program name]. A young mother with four children came up to my table and asked me if I worked with [program name]. When I told her that I did she said "I love that program. We use the cards all the time. We love our free fruit cup from Chick-fil-A and our skating passes from Skate World. We think the program is great!" It was very cool to have such unsolicited praise and it illustrated that [program name] is making a real difference in the lives of families [in our community]."

"Our "coolest story" that has happened as a result of our project would be we were asked by the Health and Wellness Trust Fund to be a part of a video that showcased

all of the different program areas that have been funded by the HWTF. This video was to be shown at the HWTF commission meeting. We were able to get footage of a couple of our programs (Taste Explorers, Walking Trails, and Eat Smart Information Boards). It was indeed an honor and it generated a lot of interest, enthusiasm, and pride for our program."

"There are many activities and products we are proud of. One project product in general is [local] County Community Day. This was a day dedicated to increasing awareness on a community level. We invited all community agencies and programs to come together and share information and free screenings to everyone who could come out. Through this event we reached over 40 households. Because this was the end of the project, we wanted to increase awareness on a larger scale. It was a great event. The [local] County Community Day was held on Saturday, December 1, 2007, in [town name]. Being World AIDs Day, the Health-in-Motion Wellness van and staff assisted in this community day. The [local] County Community Day was sponsored by Project FIT, the School Health Advisory Council, and the [local] Healthy Carolinians Partnership. We are hopeful this will become an annual event.

(1) ACHIEVE Grant:

The [local] Health Department and the [local] YMCA collaborated in writing a grant from the Centers for Disease Control's Chronic Disease Prevention branch. The grant aims to focus on linking the local health department and the local YMCA together to facilitate environmental and policy changes within the community that focus on healthy lifestyles. Particular focus areas include tobacco prevention and overweight/obesity prevention. [County name] was one of just ten nationwide grantees selected—and the only one in North Carolina—to participate in the nationwide ACHIEVE project.

(2) School-Based Nutrition Intervention:

One of the carry forward year objectives included the pilot implementation of a new BMI/nutrition curriculum into the 8th grade at 1 local middle school. An 8-day curriculum was developed to be implemented in the health classes at [School name] Middle School. In efforts to support this objective, and to move into a new arena of obesity prevention in [local county] after the Fit Together funding ends, the Health Director (with approval from the local Board of Health) selected a committee at the health department to launch a proposed nutrition education program. This program will involve a nutrition curriculum to be implemented in 6th, 7th, 8th, and 9th grades at 4 middle schools and 4 high schools in the county, and will serve to link the students in the classroom with the food in their respective cafeterias by highlighting the nutrition information of all cafeteria food choices via electronic nutrition boards. The supplemental curriculum will prepare students with the nutrition information and skills needed to understand the message boards and to be able to perform basic activities associated with nutrition and calories. Activities are built into the curriculum and will engage students to study the information presented on the electronic boards, and

allow them to put the information and skills gained into practical application and use. This has been a collaborative planning process with the health department, local Board of Health, Alliance for Health, Superintendent of the [local] County Schools, and the [local] County Board of Education. If funded, this will be the first project using electronic nutrition boards in the school setting in the entire country.

"The most exciting aspect of the project so far is the work in the pilot practices. We are seeing total practice by-in in all of the practices and all staff understands the project and wants to help to make change happen. In the initial meetings with each practice it was good to see that each staff person felt a responsibility to make the project work. Everyone tried to come up with ideas and creative ways to meet more of the CLAS Standards. They were receptive to the feedback from the medical students and ready to work on their action plan. In one pilot practice they are working to make small changes such as putting signage up in Spanish saying that interpreter services are available. They are also reformatting their patient questionnaire to include language preferred, country of origin and a multiple choice race question. Another practice started with an initial training session where all staff was educated on the CLAS standards. One objective of the training was to make sure that everyone understood the intent of the project and thought it was important to address these issues. One practice is having a lunch and learn to share staff experiences from their native country or from experiences traveling abroad. They are also bringing an authentic dish to share from the country they are discussing."

Quarterly Report to the 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

REPORTING PERIOD: July - September 2007

Our activities this quarter were focused on final cohort report and mid-year report. Details of this work follow.

Final cohort report

Final cohort data were analyzed and a draft of the cohort report was prepared and shared with HWTF staff. Revisions have been made and will be submitted to HWTF staff. A draft press release was prepared by the News and Information office at ECU and has been shared with HWTF staff for their review. The results of the cohort study were presented to the Obesity Task Force and at the full commission meeting.

Mid-year report

Data was collected from active grantees for the mid-year report. The data were analyzed for the report which was written and submitted to the HWTF for review.

Timeline

Below is a timeline detailing some of our activities:

July

- Met with Lori Edwards (Duke) regarding project and APHA abstract submissions
- Conference call with HWTF re: final cohort report
- Monthly conference call with Duke

August

- Monthly conference call with Duke
- Meeting with HWTF to discuss final cohort report

September

- Monthly conference call with Duke
- Conference call with Duke re: APHA presentation and grantee meeting
- Participated in the conference call with the Obesity Task force to present final cohort study results
- Presentation of final cohort study results at the HWTF full commission meeting

REPORTING PERIOD: October - December 2007

Our activities this quarter were focused on sharing the final results of the cohort study. Details of this work follow.

Data from the final cohort report were summarized in a presentation entitled “Celebrating our Successes: Statewide Impact of the Childhood Obesity Initiative”. This was presented at the final Childhood Obesity Initiative grantee meeting in November.

A press release was prepared by the Office of News and Information at ECU and was issued on November 15th. A press release was also issued by the HWTF the same day. These press releases resulted in one radio interview with the North Carolina News Network and an interview for the student newspaper – The East Carolinian – at ECU. This story was the headline story on the opening web page for the Brody School of Medicine for several weeks.

Two oral presentations using final cohort data were made at the annual North American Primary Care Research Group meeting in Vancouver, British Columbia. The two presentations were titled "Youth's assessment of their own weight status and related weight management intentions" and "Regional differences in Childhood Obesity: Examples from North Carolina". The presentation that was shared with the grantees was also presented at the annual Family Medicine Scholarship Day at ECU in December.

Timeline

Below is a timeline detailing some of our activities this quarter:

October

- Monthly coding conference call with Duke
- Conference call with Duke regarding November grantee meeting agenda
- Oral presentation at North American Primary Care Research Group (NAPCRG) annual meeting entitled "Youth's assessment of their own weight status and related weight management intentions" using cohort data
- Oral presentation at NAPCRG annual meeting entitled "Regional differences in Childhood Obesity: Examples from North Carolina".
- Prepared grantee annual report and final report templates
- Worked on press release regarding final cohort report with ECU Office of News and Information

November

- Monthly coding conference call with Duke
- Conference call with Duke regarding upcoming grantee meeting agenda, roles and responsibilities
- Participated in Fit Together meeting: Sharing our Efforts, Celebrating our Successes. Presented final cohort data.
- Press release with ECU Office of News and Information
- Radio interview with the North Carolina News Network
- Interview with student reporter at ECU

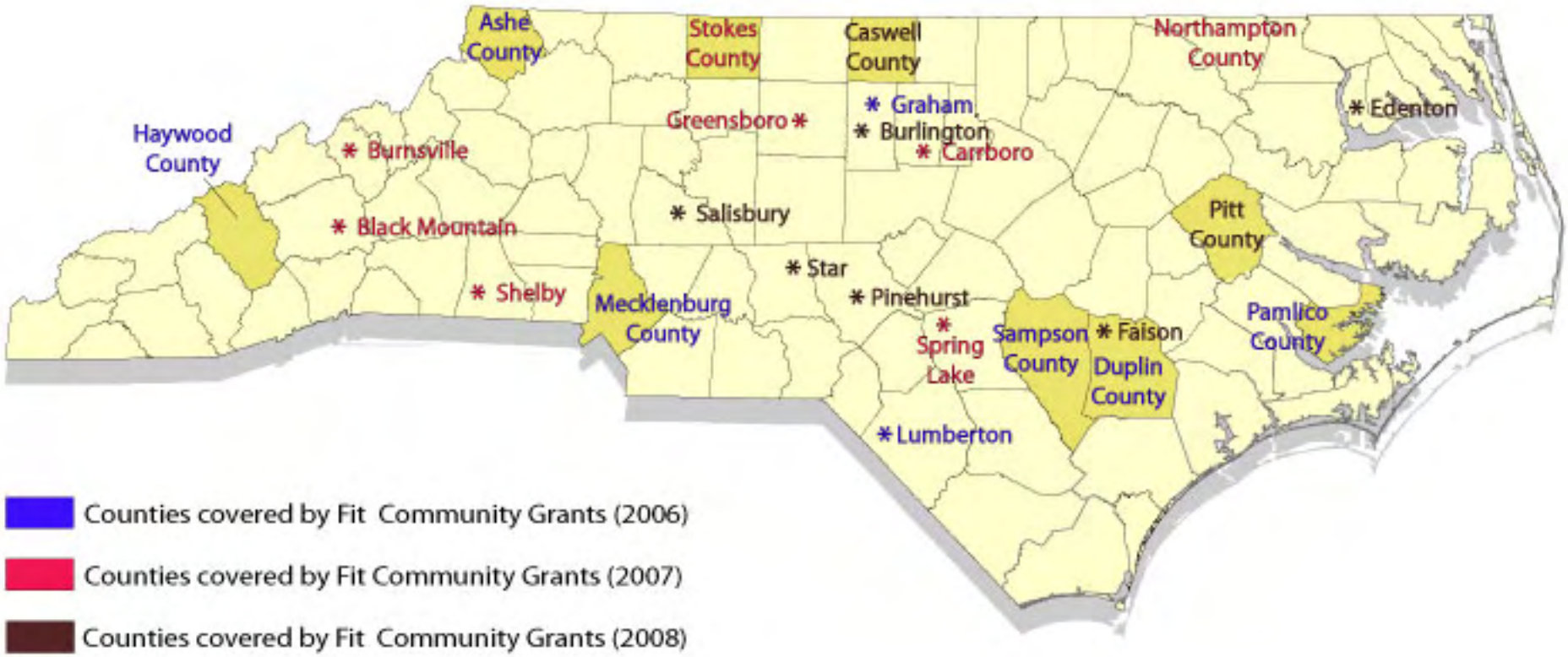
December

- Monthly coding conference call with Duke
- Presented results of cohort data to department faculty and residents at the annual Scholarship Day in Family Medicine.


Mount Airy
Greensboro
Carrboro
Chapel Hill
Durham
Tarboro
Edenton
Asheville
Black Mountain
Salisbury
Cary
Shelby
Cramerton
Pitt County
Mecklenburg County
Jacksonville
Wilmington
Oak Island
Fit Community Designees 2008
Fit Community Designees 2007
Fit Community Designees 2006

fitcommunity

Grantees



NORTH CAROLINA Health Wellness TRUST FUND

Updated 11-01-06

Fit Community Designees

2006 - 2009

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 promte 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 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 conjuntion 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 it 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. 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 affilitate 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 representating the private, govenmental, 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 excercise 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 representating the private, govenmental, 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 excercise behaviors.

Fit Community Designees

2007 – 2010

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 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

Fit Community Designees

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 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.

2008 – 2011

Town of Black Mountain
Thanks to the leadership of a diverse, collaborative partnership, Black Mountain's community garden initiative visibly supports healthy eating. At the three gardens (two located at elementary schools), children and adults grow fresh produce and learn about healthy food preparation. More than 9,000 pounds of produce was distributed to local families in 2007. The two major grocery stores provide regular nutrition education and promote healthy choices, while Parks and

Fit Community Designees

Recreation requires its events to provide healthy food options. Town policies ensure compact development and a connected network of sidewalks and greenways, enabling residents to be physically active. Additionally, more than 75 percent of local restaurants are voluntarily tobacco-free.

City of Jacksonville
Jacksonville has worked for years to build an interconnected pedestrian and bicycle network. In 1989, the Trails and Greenways Commission adopted an 80-mile greenway plan and most recently completed a rail-trail link between downtown and Camp Lejune. The city supports active lifestyles via sidewalk requirements for all new construction and a comprehensive public transit system, in addition to many parks and recreation opportunities. The local health partnership brought schools and grocery stores together to create a logo campaign that identifies healthy products, helping students and their parents choose nutritious foods. Local schools also use proactive support and educational programs to help students who use tobacco better understand the benefits of quitting.

Town of Tarboro — 2008-2011 Fit Community
The small town of Tarboro plans to enable residents to bypass the "car culture" and instead routinely walk and bicycle to local destinations. The diverse partnership created and adopted a Comprehensive Bicycle Plan in 2006 to link neighborhoods, parks, schools, grocery stores and other key destinations. The town works with the N.C. Department of Transportation and developers to implement their ambitious 50-mile plan. Partners encourage active travel with programs like bicycle rodeos and school safety clinics for children, and bicycling clubs for adults. Residents enjoy many other opportunities to be healthy and active. The historic and walkable downtown hosts a farmer's market; free healthy cooking lessons are widely available; all homes are located within one-half mile of a park; and more than 50 percent of local restaurants are voluntarily tobacco-free.

Fit Community Grantees

2006-2008

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%.

2007-2009

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.

Fit Community Grantees

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.

2008-2010

The City of Burlington Recreation and Parks requests $54,000 for the "Bringing Active Leisure Living Into a Neighborhood" (B.A.L.L.I.N) initiative, which aims to increase physical fitness among 115 families living at East Brooke Apartments, starting with a new walking track.

The Caswell County Parks and Recreation Department requests $60,000 for the "Caswell Seniors Moving More" (CSMM) project aimed at making it easy for seniors to be more physically active on a daily basis with a new trail being the centerpiece.

The Town of Edenton requests $60,000 to develop "Project TRACK" (Teaching, Reaching, And Collaborating for Knowledge), which will increase routine physical activity primarily via two interlocking paved tracks adjacent to two schools, White Oak Elementary School and DF Walker Elementary School.

The Town of Faison requests $60,000 for the "Faison Fosters Fitness" project to equip a newly renovated historic gym with physical fitness equipment, provide a walking trail, resurface two tennis courts, providing easy access to quality health and fitness opportunities in the town.

FirstHealth of the Carolinas (Town of Pinehurst) requests $57,000 to implement "Pinehurst Walks!" designed to facilitate community walkability in the Village of Pinehurst through greenway enhancements to encourage walking to and from an elementary school.

Pitt County Government requests $54,000 for the "Making Pitt Fit" project which aims to increase routine physical activity by extending the distance of a walking trail at the County's first district park; constructing an interpretive center (kiosk); a community-wide walking program; and connecting adjacent neighborhoods.

Fit Community Grantees

Salisbury Land Management and Development (Town of Salisbury) requests $60,000 for the "North Main Street Neighborhood… Enjoying the Journey" initiative, which will increase routine physical activity among the neighborhood's residents by providing a safe 1.5-mile extension of the Salisbury Greenway linking them to nearby parks and healthcare facilities.

Yadkin-Pee Dee Lakes Project dba Central Park NC (Town of Star, Montgomery County) requests $54,000 to fund construction of a half-mile “Star Walking Trail” at the STARworks Center for Creative Enterprise as well as programs that will help develop healthy lifestyle options for the residents in the Town of Star.

Fit Community Grant and Designation Program Outcomes
July 1, 2007- June 30, 2008
Collected by the University of North Carolina at Chapel Hill's Active Living by Design

HWTF has invested $1.5 million in helping 24 communities become healthier places to live. The University of North Carolina's Active Living by Design has been collecting key data to help inform an evaluation of the Fit Community program. This data is organized by the 5 P Model, which increase the chance for project success and sustainability. Additionally, a survey was developed in June 2008 in order to assess the impact of the designation program, and the results of that survey are included below.

1. ***Preparation*** strategies involve setting the groundwork for successful community-wide action related to physical activity and/or healthy eating. It is important to create a partnership (if one does not already exist) with representatives from local organizations and the target population who can help identify and address current barriers to, as well as new opportunities for, increasing routine physical activity and/or healthy eating. Additional preparation activities include, but are not limited to: conducting a formal assessment of opportunities and barriers, conducting surveys or focus groups within the target population to better understand attitudes and perceptions, identifying additional and sustainable sources of financial and in-kind support, and finalizing project plans.
   - $408,000 of direct and indirect funding has been leveraged by the Fit Community grantees in order to contribute and ensure the continued success of these communities.
   - Ashe County: 1) Secured a commitment from a local landowner to donate land for park. 2) Arranged survey and site plan development of Lansing Park. 3) Identified a vacant building adjacent to the park for possible public bathrooms in the future
   - City of Lumberton: Scheduled regular monthly "Friends of Luther Britt Park" meetings (comprised of individuals in the West Lumberton community), but attendance has been low.
   - Town of Black Mountain: 1) Held meetings of the Garden Advisory Committee and developed a sustainability plan for the community garden. 2) Held one meeting of the Nutrition Advisory Committee, and finalized the purpose and mission statement for the committee. 3) Administered surveys at Swannanoa Valley Montessori School, the Learning Community School, Black Mountain Primary and Elementary schools to assess the needs, barriers and opportunities of schools and teachers. Parent surveys were also administered at Swannanoa Valley Montessori School and yielded a 75% response rate.
2. ***Promotion*** strategies should increase understanding of the benefits of routine physical activity and/or healthy eating, *and* highlight recommendations, publicize existing local opportunities, and communicate the need for additional community supports. In a well-integrated plan, promotional tactics and activities should link with and support programs, policy, and physical project strategies.
   - 13 grantees held community-wide events to publicize their programs, and physical projects and received media publicity through town newsletters, local papers, public service announcements on the radio, and/ or through flyers that were handed out at health departments

- Graham Children's Health: Received local newspaper coverage about the "ground-breaking" of the Burnsville gym, which gave a blanket solicitation to businesses and individuals for funding contributions.
- Haywood County: Presented to 30 members of the Beaverdam Community Development Association about the planned RC Watershed Trail on October 8, 2007.
- Mecklenburg County: Conducted a successful media promotions campaign by earning in-kind media via WSOC radio interview with PD, an Eat Smart Move More feature article, and in-depth television interview with PC on News 14 Carolina. 3) Worked on promotion plan for a new "Worksite Wellness Challenge" (to be released in January 2008), which is envisioned as a marketing tool to encourage employers to sign up for a worksite assessment. 4) Received mentioning during three separate community presentations given by the Parks and Recreation Department partner.

3. ***Programs*** strategies are designed to provide ongoing, structured opportunities for physical activity and/or healthy eating. They should complement policy and the physical environment changes. Unlike one-time events, programs are organized over periods of time. They might also offer organized activities to engage individuals in policy, environmental or behavioral change. Specific tactics may include developing a walking club to utilize new trails or walking routes, developing a walk-to-school program, or organizing classes, clubs or support groups designed to encourage lifelong physical activity and/or healthy eating.
   - 2 Grantees established community gardens in elementary school programs that encouraged healthy eating habits and fresh produce for the children and their families
   - Town of Black Mountain: Extensive community garden program that has distributed over 9,000 pounds of fresh produce
   - Stokes Reynolds Memorial Hospital: Supported continuation of the employee wellness incentive program: 1) Engaged 16% of all employees (project goal = 20%) in the monthly educational programs. 2) Supported 24% of the program participants (goal = 20%) in maintaining monthly records to track their physical activity. 3) Supported 24% of the participants (goal = 20%) in keeping monthly records to track their consumption of fruit and vegetables. 4) Measured the progress of employees who participated in the mid-year weigh-in (16% of total employees) and achieved a total weight loss of 114.5 pounds. 5) Tracked active participation in the wellness program with 50% of the program participants earning wellness incentive points. 6) Recognized top point achievers and provided incentives for continued motivation and achievement.
   - Sampson County: 1) Created logistical tools such as walking logs for participants, and an incentives system. 2) Created a resource binder for the 'community champion' walking club leaders, and distributed copies during a September training event; 15 volunteers completed the training, and the PD will begin to match participants with community champions in their area as soon as promotional materials are published and participants begin to join.
4. ***Policy*** strategies influence public decisions, such as the creation or change of regulations, guidelines, or local policies that promote routine physical activity and/or healthy eating. Policy work may also include changes in standard practice of organizations, agencies and professionals that result in increased routine physical activity and healthy eating. Examples include requiring sidewalks in all new developments, creating mixed-use zoning ordinances to put more daily trips within walking/bicycling distance, changing school policies to require

more daily physical activity and healthy food options for all children, and implementing changes in worksite or church policies to promote physical activity and/or healthy eating.
- Six grantees established worksite wellness policies with a local business, hospital or other organization in their community
- Town of Shelby: Has a Comprehensive Pedestrian Plan that prioritizes sidewalk and greenway connections
- Duplin Partners for Health: 1) Initiated draft of wellness policy that targets increase in physical activity and healthy eating for county employees. 2) Accepted offer from County Manager that a $100 monetary award will be given to all participating employees.
- Greensboro: Initiated an easement document which will allow Greensboro College to provide public access on their property.

5. ***Physical Projects*** strategies involve changes that make the physical environment more conducive to routine physical activity and/or healthy eating. Specific tactics may include the (partial) construction of walking trails, parks, or greenways; working with officials to implement traffic-calming measures such as crosswalks or roundabouts; and improving access to destinations such as grocery stores, farmers' markets, or community gardens. Physical environments that are altered or built with Fit Community grant funding should be accessible and free to the public. Because the costs for such capital projects can be very high, applicants are encouraged to leverage other funds in addition to Fit Community funds. Applicants are discouraged from proposing the use of an entire Fit Community grant towards the construction of a single physical project.
   - 11 Fit Community grantees created walking trails, paths, and greenways in their communities
   - City of Greensboro: Has 89 miles of new sidewalks, over 80 miles of trails, and 20 planned trail miles in the works
   - Pitt County: Has achieved an extensive parks and trails network- 85% of residents live within 2 miles of a park
   - Northampton: Purchased and installed new basketball court and tennis equipment for new recreation facility.

Fit Community Survey Results (collected in August 2008)
Fit Community Program: Survey of Fit Community Applicants 2006-2008

Survey Overview: With the Fit Community program in existence for three years, HWTF sought opinions from community representatives about the program. Representatives responded to questions designed to elicit insight into the strengths and weaknesses in the Fit Community program, in order to uncover themes and information that could help shape the future of the initiative and add value to the process for communities.

Questions were created to gauge responses from designee, applicant, and non-applicant communities. On-line surveys were sent to a 'distribution list' of key individuals/organizations that have disseminated information about Fit Community to their community constituents in the past. A total of 100 respondents started, and 40 completed the survey. Questions were asked in quantitative (yes / no; likert scale) and open-ended format. Results are summarized by key theme, below.

Fit Community Grant and Designation Program Outcomes (July 1, 2007- June 30, 2008)

I. Why have communities applied or not applied?

Key themes for applying among designees and applicants:

- Funding
- Recognition (i.e., resulting in economic development and/or community awareness of commitment to health and wellness).

II. Value of the designation award

The designation award already appears to be valued, especially by communities that are designated or have applied to be designated. Among all three types of communities, the large majority of respondents (approximately 75%) indicated that the designation was "very valuable" (61%) or "somewhat valuable" (28%). Only 11% of respondents felt the designation was "slightly valuable" or "not very valuable."

However, respondents perceived that the level of awareness about the designation among community members remains relatively low. Predictably, the lowest awareness was perceived in non-applicant communities, but even nearly 40% of designee respondents indicated residents were only "slightly aware" or "not very aware" of the Fit Community designation.

III. Increasing the designation award value

When asked about **specific resources** that would make the designation more valuable, community responses generally fell into the following categories:

- Grant funding and/or resources to fund specific needs in the community (most commonly mentioned).
- Outreach to community leaders and residents (i.e., to increase recognition of the designation)
- Assistance with marketing and PR to leverage the designation / maximize benefit
- Consultation and/or technical assistance was valued across the board

Value of a tiered approach: based on responses, a tiered award approach appears likely increase the value of the designation. Some communities expressed hesitation about the potential of diluting the value of the award, but many more respondents indicated a tiered system would give communities "something to shoot for." All respondents indicated the tiered system would not affect their desire to apply for a designation.

A commonly held **belief emerged that the designation doesn't apply to rural communities**, or they can't compete with larger, more resourced communities. This is despite efforts to make the questions and scoring relevant to urban as well as rural communities by consulting professionals in a variety of communities when revising the designation. This may indicate the need for special efforts / outreach to increase the perceived value of the designation in rural communities.

IV. Community needs and priorities

Communities overwhelmingly expressed that residents desire increase opportunities / amenities to promote healthy lifestyles. Most commonly mentioned:

- Greenway trails / walking trails (mentioned by far the most frequently).
- Sidewalks and bicycle lanes
- Community gardens

- Parks and recreation – facilities and programs

V. Application process

- No consensus emerged about the best and worst times to apply. Responses ranged across the calendar year, with virtually every season and/or month mentioned as a best or worst time to apply.
- Three months was the most common preference for time needed to apply. Several communities who have never applied indicated a preference of 6-12 months.
- Taken together, these responses may indicate that a 'rolling' application process may best serve communities needs, although this question was not posed to respondents.

VI. Other insights / themes

Several other insightful comments and thoughts emerged in the survey which may help to inform future shaping of the designation initiative, or may help direct marketing and promotional efforts:

- One respondent noted that efforts could be made to reduce duplicity among similar efforts to reduce obesity, stating: "It would be nice if everyone were on the same page – ESMM, Fit Community, America on the Move, Be Active NC, ALbD, Winners Circle…so many programs to promote – it is confusing for the public and exhausting for us…my constituents want one message."
- One community indicated they simply needed the money to get physical projects, such as greenways, on the ground. They preferred autonomy over technical assistance and other "hoops" to jump through.
- While the often-suggested need for increased funding was mostly stated in general terms, one respondent gave a very specific suggestion of a way to coordinate Fit Community efforts with outside funding sources: "NCDOT bike ped funding eligibility: have a new category of funds for active living – walking and biking."

In your community, did the Fit Community Designation application process result in:
More communication among different agencies and/or organizations?
75% said "Yes"

More collaboration among different agencies and/or organizations?
58.3% (14) said "Yes"

Do you think your community will use the Self-Assessment as an informational resource in the future?
90% of respondents (n=24) said "Yes."

A NATIONAL PROGRAM OF THE ROBERT WOOD JOHNSON FOUNDATION

School of Public Health - The University of North Carolina at Chapel Hill
400 Market Street, Suite 205 Chapel Hill, North Carolina 27516
P: 919-843-2523 F: 919-843-3083 E: info@activelivingbydesign.org
www.activelivingbydesign.org

FIT COMMUNITY
PROGRESS REPORTS TO HWTF

YEAR 3, 2ND QUARTER PROGRESS REPORT TO HWTF
JULY 1 – SEPTEMBER 30, 2007

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, 2007) of our third yearly contract with the NC 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, ALbD continued technical assistance (TA) for the Round I and Round II grantees, planned and organized the 2nd Fit Community Grantee Meeting, and prepared documents for the Round III Fit Community RFP release. 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**
   - Planned and organized for the October 15, 2007 grantee meeting, including finalizing the agenda, confirming speakers and consultants, creating participant meeting packets, and arranging lodging and other logistics for the Friday Center in Chapel Hill.
   - Gathered measurable data across the 5P strategy areas that represents Round I grantees' progress made in the first year of their projects (see attached).
   - Presented to the HWTF Obesity Task Force on Round I progress (September 11).
   - Presented to HWTF Commission on Round I progress (September 24).
   - Prepared for Round III of Fit Community, including improved RFP, grant application, and designation application. Major changes include: 1) new policy measures in the Physical Activity section concerning the Community component; 2) new Tobacco Use Prevention sections to the designation Self-Assessment concerning the Community and Worksite components; and 3) the addition of three regional information workshops for applicants. The release date is set for October 15, 2007.
   - Met with HWTF and MarketSmart staff to discuss the Fit Community brochure and website; provided feedback on layout and copy content.
   - Participated in informal brainstorming sessions with HWTF and NC Prevention Partners on bringing the Fit Community program to scale in North Carolina.
2. **Technical Assistance (TA)**

- Provided ongoing TA to Round I and Round II grantees, including monthly calls with each Project Director and/or Project Coordinator, review/approval of monthly expense reports (MERs), and quarterly progress reports.
- Provided TA to Round I grantees on financial carryover and budget amendments.
- Conducted initial site visit with Round II grantee, Northampton County (July 19).
- Conducted site visit with Round I grantee, City of Lumberton, to assist with Project Director transition (August 15).
- Attended the first Advisory Committee meeting for the Orange County grantee partnership (September 11).
- Provided feedback to the City of Durham on its Round II grant application.
- Provided feedback to Gaston County on its Round II designation application.

3. Outreach

- Cara Crisler and Eric Wild presented "Becoming a Fit Community" at the annual NC Recreation and Park Association's Citizen Board Members Conference in Greensboro (August 3, 2007).

4. Professional Development Activities

- Joanne Lee became a member of the Eat Smart Move More (ESMM) Implementation Committee of the NC Division of Public Health, and participated in the first meeting on August 7. The purpose of the ESMM Implementation Committee is to support and promote programs and efforts that enhance physical activity and healthy eating opportunities in North Carolina. As such, her participation as a committee member will inform and enhance ALbD's TA capacity as it relates to the work of the Fit Community grantees.
- Joanne Lee served as a grants reviewer for the 2007-2008 ESMM Community Grants. Reviewing the proposals for physical activity and healthy eating projects provided further understanding and insight about North Carolina communities that enhances ALbD's TA capacity.
- Cara Crisler became an Advisory Committee member of the Be Active—Appalachian Partnership and participated in her first meeting on August 24. Her role is to assist with the addition of policy strategies related to the overall goal of increasing physical activity in 20 western counties of North Carolina. As such, her participation as a committee member will inform and enhance ALbD's TA capacity as it relates to the work of the Fit Community grantees.
- Cara Crisler and Joanne Lee participated in the ALbD-sponsored national learning network conference call on the subject of Health Impact Assessments (August 21).
- Cara Crisler and Joanne Lee participated in the ALbD-sponsored national learning network conference call on the subject of Community-Based Problem Solving. Meredith Emmett of NC Community Solutions Network conducted the informative presentation and led an interactive discussion (September 18).
- Cara Crisler, Joanne Lee, and Jen Gilchrist Walker facilitated sessions at the CDC-sponsored 2007 Obesity Prevention in Public Health Course for State Physical Activity Coordinators. Other ALbD staff members played a major role in developing the course (September 25-28).

Discuss any findings or lessons learned that will help inform our work going forward.

The lessons we learned this past quarter pertain primarily to our direct TA work with the 16 grantees. These will be discussed in the forthcoming First Quarter Grantee Progress Report (for both Year II and Year 1 grantees).

Describe any challenges you have faced and how HWTF staff might work with you to address them.
The only challenge at this time is one on the horizon, which entails the transition period between Eric Wild and the new Obesity Program Officer, Cameron Graham. With good communication and patience (on the part of both ALbD and HWTF), this transition will likely take place in a smooth manner. The Fit Community team at ALbD is prepared to meet with Cameron in the near future to relay all pertinent information about the current 16 grantees, and to discuss administrative processes such as reporting and approvals.

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 Round I and Round II grantees, including monthly calls, review/approval of monthly expense reports (MERs), and quarterly progress reports.
- Host the 2007 Fit Community Grantee Meeting at the Friday Center in Chapel Hill, October 15.
- Finalize all documents related to the Round III Fit Community RFP release, set for October 15, 2007.
- Respond to all calls/emails for technical assistance from potential applicants.
- Conduct an information conference call for applicants in mid-November, and make recording available to those who can not make the call.
- Conduct three regional information workshops for applicants in November and December (Asheville, Greensboro, and Greenville).
- Conduct initial site visits with three Round II grantees (all dates TBD): Spring Lake, Black Mountain, and tokes County.

YEAR 3, 3RD QUARTER PROGRESS REPORT TO HWTF
OCTOBER 1 – DECEMBER 31, 2007

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, 2007) of our third yearly contract with the NC 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, ALbD continued technical assistance (TA) for all Round I and Round II grantees (16), hosted the 2nd Fit Community Grantee Meeting, finalized documents for the Round III Fit Community RFP release, and hosted information sessions for applicants. Additional details are provided below in the following categories: *Programmatic Work, Direct Technical Assistance, Professional Development / Networking Activities,* and *Miscellaneous.*

1. Programmatic Work

- Revised the following documents (provided to and posted by HWTF):
  - Request for Proposals
  - Application for Fit Community designation (including an improved self-assessment document – please refer to last quarterly report for details on improvements)
  - Application for Fit Community grant funding

- List of Resources for applying for a Fit Community grant
- FAQ list

- Distributed the Round III press release on November 14 and again on December 12 to a broad email distribution list, including 75 individuals and 80 organizations with the request to forward broadly via listservs and post in newsletters and on web sites.

2. Direct Technical Assistance (TA)

- Provided ongoing TA to Round I and Round II grantees, including monthly calls with each Project Director and/or Project Coordinator, review/approval of monthly expense reports (MERs), and quarterly progress reports.
- Conducted the October 15, 2007 grantee meeting at the Friday Center in Chapel Hill.
- Provided TA to new applicants immediately following the release of the Fit Community RFP, including a conference call for applicants (November 28) which was recorded and made available for playback.
- Conducted three regional information workshops (Asheville on December 10 with 12 participants; Greensboro on December 14 with 18 participants; Greenville on December 18 with 15 participants).
- Conducted initial site visit with Round II grantee, Black Mountain (November 8-9).
- Conducted site visit with Round I grantee, City of Lumberton, to assist new Project Director with assessment activity (focus group) (November 13).
- Conducted initial site visit with Round II grantee, Spring Lake (November 14).
- Conducted site visit with Round I grantee, Sampson County, to assist with partnership development (December 13)

3. Professional Development / Networking* Activities

- Joanne Lee participated in the Robert Wood Johnson Foundation (RWJF)-sponsored meeting in Minnesota for Healthy Eating Research grantees and partners (October 3-5).
- Joanne Lee co-planned and participated in the Blue Cross and Blue Shield of North Carolina Foundation-sponsored communications workshop for Fit Together grantee partnerships (October 16).
- Joanne Lee participated in the ALBD-sponsored national learning network conference call on the subject of integrating “active living” efforts with “community and regional food planning” efforts to build healthier communities (October 23).
- Joanne Lee presented at and participated in the American Public Health Association 135th Annual Meeting & Exposition in Washington DC (November 5).
- Cara Crisler attended NC Prevention Partners 2007 Prevention Institute (November 12).
- Sarah Strunk and Joanne Lee participated in the RWJF-sponsored Childhood Obesity Grantee Meeting in New Orleans (November 14-16).
- Joanne Lee participated in the ALBD-sponsored national learning network conference call on the subject of effective partnerships and policies for increasing park use (November 20).

4. Miscellaneous

Another client of ALbD, Blue Cross Blue Shield of Minnesota (BCBSMN), adopted the Fit Community Designation Self-Assessment tool (PA portion only) for use in a recent RFP, which was released December 17. Fit Community and the HWTF are referenced in the document, “Physical Activity Promotion: Active Living Minnesota RFP #599,” which can be found at: http://www.preventionminnesota.com/objects/Funding/599/ALMN-RFP599.pdf. BCBSMN’s funding program will “support interdisciplinary partnerships to plan for and implement a comprehensive approach to encourage active living among community residents, with a focus on environmental and policy change efforts.”

Discuss any findings or lessons learned that will help inform our work going forward.

This round of Fit Community was the first for which we provided regional workshops for applicants. It is a bit premature to know if these make a difference in the quality of applications that we receive, but that is certainly the expectation. Based on feedback we've received, the workshops have been very valuable to applicants in that they provide much more detailed information about the 5P model and other application details than the RFP is capable of doing alone. Other lessons learned this past quarter pertain primarily to our direct TA work with the 16 grantees. These will be discussed in the forthcoming Second Quarter Grantee Progress Report (for both Round I and Round II grantees).

Describe any challenges you have faced and how HWTF staff might work with you to address them.

As anticipated, the biggest challenge we have faced concerned the Obesity Program Officer staff transition. This of course involves time on behalf of both organizations to come to mutual understanding about the program and each grantee. Cameron hit the ground running and has

**In many cases, professional development activities provided good opportunities for networking that included informal conversations with various people about the Fit Community program.*

worked hard to become well informed about the Fit Community grantees, including attending site visits when possible, which is extremely helpful. A "bump in the road" occurred this quarter that involved a grantee's request for approval to purchase program incentives. ALbD staff was required to contribute a significant amount of unanticipated time to bring the matter to a conclusion. This was discussed in detail with Cameron and she was very amenable to setting up a meeting between ALbD and HWTF that includes the two directors to further discuss how we can better streamline such processes. This meeting will take place January 11, 2008.

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 Round I and Round II grantees, including monthly calls, review/approval of monthly expense reports (MERs), and quarterly progress reports
- Provide TA to 2008 applicants (January 2 – February 1)
- Establish Expert Advisory Panel (early January)
- Meet with HWTF Director and Obesity Program Officer to discuss protocols, budget issues, and next steps for planning / program development of the next iteration of the Fit Community program (January 11)
- Undergo Fit Community budget negotiations and receive approval for the next quarter (by March 1)
- Submit grantee progress report to HWTF (mid-January)
- Conduct second site visit with Round II grantee, Greensboro, to assist with Project Director transition (January 9)
- Conduct initial site visit with Round II grantees: Stokes County (Stokes-Reynolds Memorial Hospital, January 16) and Burnsville (Graham Children's Health Services of Toe River, February 6)
- Log, sort, file, initially review grant applications (February 2-7)
- Review (internally) qualified grant applications (February 8-28)
- Hold meeting to select top 12 grant proposals (February 29)
- Conduct coaching calls for grant finalists and set up 12 reverse site visits (March 3-14)
- Review/score (internally) designation applications (March 3–25)
- Provide TA to grant finalists/help prepare them for reverse site visit (March 17 – April 3)
- Conduct reviewer training via conference call for EAP members (March 27)
- Present designation scoring results to HWTF and BCBSNC staff (March 28)

YEAR 3, 4TH QUARTER & YEAR 4, 1ST QUARTER
PROGRESS REPORT TO HWTF
JANUARY 1 – JUNE 30, 2008

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, 2008) of our Year 3 contract, and in the first quarter of our Year 4 contract (April 1 – June 30, 2008) 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 these quarters, the primary focus of ALbD's work was to provide technical assistance to applicants of the Fit Community designation and grants program (Round III), as well as manage the review and selection process for Round III grantees and designees. Additional details are provided below in the following categories: Fit Community Programmatic Work, Technical Assistance (TA), and Professional Development / Networking Activities.

1. Fit Community Programmatic Work

- Submitted quarterly grantee progress report to HWTF;
- Held meeting with HWTF and ALbD Directors and program staff to develop streamlined processes for routine procedures (e.g., grantee purchase and media requests) (January 11th);
- Drafted scope of work, budget and carryover estimates for potential Year 4 Fit Community work;
- Established an External Advisory Panel (EAP) to help review grant applicant finalists;
- Secured the involvement of ALbD staff in the review process. In addition to Cara Crisler, Jen Walker, and Joanne Lee, ALbD staff also included Mark Dessauer, Danielle Spurlock, and Jessica Hughes;
- Completed grant review process:
    - ALbD scored proposals March 8-4th and held all-day meeting with HWTF staff to select top applicants on March 7th;
    - Conducted coaching calls with 10 grant finalists;
    - Scheduled reverse site visits;
    - Delivered packets for EAP members and conducted reviewer training via conference call for EAP members: March 10-28th;
    - Held Reverse Site Visits with the top 10 applicants at the Friday Center April 9 - 11th;
    - Obtained letters of amendment, letters of support from partners, and revised budgets from provisional grant applicants;
- Determined with HWTF staff 8 grantees for recommendation to HWTFC (April 11th);
- Completed designation review process:
    - Scored applications on March 3 – 25th;

    - Conducted validation process with top candidates;
    - Presented designation scoring results to HWTF staff April 3rd;
- Presented program update and 2008 designation and grant recommendations to HWTF Obesity Task Force (May 1st) and HWTF Commission (May 14th);
- Participated in media event for 2008-2010 Fit Community designees and grantees (June 10th);
- Scheduled July 9th teleconference calls to discuss budget and carryover issues with Round II and Round III grantees;
- Conducted interviews with potential candidates for Fit Community Project Manager position. Hired new Project Manager as of June 23rd (Walker);
- Created "tiered designation scenarios" white paper and held meeting with HWTF to begin the process of moving to a tiered designation award in future rounds of Fit Community;
- Initiated planning for September 25, 2008 grantee meeting (created work plan).

2. Technical Assistance (TA)

- Provided ongoing TA to **2006-2008 (Round I) and 2007-2009 (Round II) grantees**, including monthly calls with each Project Director/Coordinator and review/approval of monthly expense reports (MERs);
- Offered TA to **new applicants** from January 2nd – February 1st, and all 10 grant finalists to assist in preparation for reverse site visits March 10th – 14th;
- Provided focused TA to two 2006 – 2008 grantees **(Mecklenburg County and Sampson County)** on the development of grant extension action plans and budget justifications;
- Provided TA to all 2007 – 2009 grantees on the development of Year Two action plans and budget justifications;
- Provided TA to all 2008 – 2010 grantees on the development of Year One action plans and budget justifications;
- Conducted a **second site visit** (to assist with Project Director transition) in **Greensboro** (January 9th);
- Conducted an **initial site visit** with Round II grantee **Stokes-Reynolds Memorial Hospital** in Stokes County (January 16th);
- Conducted an **initial site visit** with Round II grantee **Graham Children's Health Services of Toe River** in Burnsville (February 5-6th);
- Conducted two **site visits** with Round II grantee **Orange County Partnership for Young Children,** to assist with the transition of the new Project Director (April 22nd) and attend a special event to celebrate the partnership's new initiatives (June 7th);
- Assisted HWTF with grant contract issues as needed;
- Provided feedback on applications to one unsuccessful designee applicant.

3. Professional Development / Networking[1] Activities

- ALbD staff, including Crisler, Walker and Lee, attended professional development trainings to build/enhance skills and competencies in working with diverse and multicultural communities and in working across differences, led by consultant "Visions, Inc" (March 3rd and May 5th);
- Presented (Crisler) and attended (Lee) the Active Recreation Counts Summit presented by NC State University, College of Natural Resources, Parks, Recreation, and Tourism

[1] In many cases, professional development activities provided good opportunities for networking that included informal conversations with various people about the Fit Community program.

Management, IPARC (Investigating Places for Active Recreation in Communities) (April 3rd) in Raleigh;
- Presented (Lee) at the American Planning Association 2008 National Planning Conference (April 17th – 20th) in Las Vegas;
- Assisted in planning and convening (Lee) a Blue Cross Blue Shield of North Carolina Foundation workshop for Fit Together grantees on outcomes reporting (May 15th) in Durham;
- Participated (Sarah Strunk; Lee) in the CDC-sponsored National Summit on Legal Preparedness for Obesity Prevention and Control (June 16th -18th) in Atlanta.

Discuss any findings or lessons learned that will help inform our work going forward.

In the past, the approval process for purchase and media request has at times generated confusion and/or miscommunication between grantees, ALbD, or HWTF. Because of such experiences, ALbD created a new 'approval request form' to encourage grantees to communicate in advance all of the information that HWTF needs in order to make an approval decision. Although the form could be seen as an added layer of paperwork, it has greatly expedited the approval request process. ALbD recommends continued use of the form as an imperative part of the communication process which contributes to shared understanding and efficiency. ALbD will continue to identify potential mechanisms to improve other grant administration processes.

Describe any challenges you have faced and how HWTF staff might work with you to address them.

The process of Year 2 action planning and budgeting would be more efficient if the grantees could take their carryover funds into account at the time of budget planning. From the TA provider's perspective, this could alleviate the confusion experienced by many grantees in the Year 2 planning process and streamline the process of carrying funds forward.

Describe the work you plan to complete during the next quarter regarding the Fit Community program. Provide time frames and deliverables where feasible.

- Schedule site visits with each of the Round III grantees, to take place before the end of 2008;
- Participate /assist in facilitating Fit Community teleconference calls to discuss budget and carryover issues with Round II and Round III grantees on July 9th;
- Work with Round II grantees on financial carryover and budget amendments;
- Conduct monthly coaching calls with each of the 18 grantees and provide ongoing TA;
- Continue planning for the September 25, 2008 Fit Community Grantee Meeting;
- Prepare for the release of RFP for Fit Community, Round IV *(date TBD by HWTF)*;
- Work with HWTF to determine and implement "close-out" procedures for Round I grantees that are concluding their grant periods, including a post-grant evaluation survey.

NORTH CAROLINA HEALTH AND WELLNESS TRUST FUND
Annual Report

Center of Excellence for Research, Teaching, & Learning
Wake Forest University School of Medicine

REPORTING PERIOD: July 2007-December 2007

Describe the objectives that were achieved during the past year:
During the past year (July 2007- December 2007), Wake Forest University School of Medicine completed the following activities:

1. Provided input for web site development
    A. Managed teacher accounts and teacher issues
    B. Attended meetings with Market Smart to prioritize web site progress and to give feedback on web site progress
    C. Conducted multiple site reviews to determine progress on Market Smart deliverables
    D. Provided troubleshooting of admin tool to increase accuracy of site reporting
    E. Suggested field revisions to aid in gathering data needed for site evaluation
2. Provided content for the At School section of the Fit Kids web site
    A. Linked additional Energizers to recess subject field
    B. Facilitated the development of 38 elementary and middle school activities focusing on recess and social studies content
    C. Added 31 additional activities piloted and approved from CEU program
    D. Recruited a group of 14 elementary and middle school teachers to develop Fit Kids activities during the fall case writing group
    E. Conducted training to inform teachers about the Healthy Active Children Policy and to train teachers to create a Fit Kids Activity
    F. Managed communication between teachers to improve collaboration of activity development
    G. Established a spring and fall pilot group to review content provided by teachers through the CEU program
    H. Created congratulatory letter to be sent to teachers when activities are approved and added to the Fit Kids Web site
    I. Created a process for reviewing and editing current content on Fit Kids Web site
3. Organized taping for streaming video
    A. Selected teachers and additional activities for video streaming
    B. Helped to develop and edit scripts
    C. Worked with teachers and students to prepare for video shoot
    D. Attended tapings and offered suggestions for filming
    E. Reviewed and edited video clips for content
4. Assisted in developing CEU concept for Fit Kids web site
    A. Revised components of CEU program requirements
    B. Modified evaluation piece to include a pre and post evaluation
    C. Managed issues related to individual teacher accounts
5. Assisted in promotion of Fit Kids program
    A. Assisted in creating and revising script for Fit Kids DVD
    B. Provided teacher spokesperson for Fit Kids DVD
    C. Worked with NCAE to organize taping of President Eddie Davis

D. Organized distribution of Fit Kids DVD by working with NCAE administrative officers and NCAE school representatives
E. Created materials for NCAE school representatives to use in explaining the Fit Kids program
F. Worked with NCAE to coordinate viewing of the Fit Kids DVD at NCAE annual meeting

6. Assisted with program development, evaluation and sustainability
   A. Met with UNCG group to determine value of additional external evaluation
   B. Developed teacher survey to determine success of Fit Kids DVD and brochure
   C. Summarized results of teacher surveys to develop additional project objectives
   D. Reviewed Be Active Kids Science resource as a possible source for additional web site content
   E. Created Fit Kids Program Power Point used at September HWTF Commission Meeting to summarize program success and to outline upcoming objectives
   F. Conducted teacher focus groups to determine targets for future activity development
   G. Developed Fit Schools program to promote and sustain the successes achieved through the Fit Kids program
   H. Met with PAN Branch, DPI and NCAE to secure support for Fit School program

REPORTING PERIOD: January 2008 – June 2008

During the six month period of January 2008-June 2008, Wake Forest University School of Medicine completed the following activities:

1. Managed process for the development and piloting of Fit Kids activities
   A. Recruited and organized teachers into grade level groups for activity writing purposes
   B. Conducted nine training sessions to familiarize teachers with Healthy Active Children requirements to ensure that all activities produced provide a minimum of 30 minutes of moderate to vigorous physical activity.
   C. Conducted mid-cycle meetings to ensure progress towards objectives
   D. Met with individual teachers as needed
   E. Conducted email and phone coaching as needed for activity development
2. Managed Fit Kids Website
   A. Activated Fit Kids content
      1. Activated 15 Fit Kids activities by March 20th, 2008
      2. Activated additional 34 Fit Kids Activities by May 31st , 2008
      3. Activated additional 28 activities by June 17th, 2008
   B. Reviewed and made suggestions for improvements to admin tool to monitor activity organization
   C. Utilized admin tool to review activities submitted to Fit Kids Website to recommend for pilot process

D. Monitored and made suggestions to improvement of layout for activities with video streaming
E. Monitored for Word 2007 compatibility issues on user end
F. Reviewed and made suggestions regarding unresolved website issues

3. Managed Fit Kids CEU process
   A. Assisted in resolving district issues for Pasquotank County
   B. Assisted in resolving individual teachers issues for CEU credit process
   C. Made recommendations for improvement to CEU page to improve usability for participating teachers
4. Project Sustainability
   1. Met with UNCG evaluators to analyze evaluations results.
   2. Made suggestions for improved evaluation measures for upcoming evaluation efforts
   3. Met with HWTF and Be Active North Caroline to evaluate project and to make recommendations for upcoming trainings
   4. Contacted NCAE to determine timing of for DVD distribution
   5. Worked with NCAE to utilize NCAE newsletter to recruit teachers statewide to participate in Fit Kids activity development and piloting

NORTH CAROLINA HEALTH AND WELLNESS TRUST FUND

Be Active North Carolina
QUARTERLY REPORTS

REPORTING PERIOD: July 2007 through September 2007

Describe the objectives that were achieved during the past quarter:
During the third 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).
    a. With support from Eric Wild, Laurie began creating a template media release for all LEAs that complete the HAC Training. It is currently mid-edits for release in late October or early November. Be Active will coach local LEAs in its release to local media sources.
    b. 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. The third quarter of the year included approximately 45 days of low activity, due to the majority of NC schools' summer vaction. However, late August and September saw a sharp rise in the scheduling and execution of trainings. The school-by-school training method continues to show high participation rates, consistently near 100% participation in each school, with additional attendance including administrators and support staff.
    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, or 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 September 30, 24,515 teachers have been trained (or 53% of the target)

   g. Throughout April, Laurie and intern Sarah Caudle took control of confirming all HAC trainings on the FitKids website. As of September, 2007, all teachers had either been confirmed or could not be found in the system (likely meaning that they had not attended HAC Training.) Updates to the admin site continue to increase its usability.
3. Evaluate training and FitKids Program impact on knowledge, attitudes and behaviors of teachers and students towards active classrooms via FitKids initiative
   a. New timeline has been put in motion for HAC evaluation, which will allow for data collection throughout the summer and fall, followed by data analysis and reporting in December of 2007.
   b. General evaluation of trainer competence continues. However, the new evaluation has begun at 24 sites. Pre and post surveys were provided to all teachers as well as a survey for the trainer. The next several months will see follow-up surveys to test policy compliance and training retention.
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.
   a. During the third quarter, no new LEAs completed training. This is due largely in part to trainings later in the quarter, followed by a time lag while trainers compile their paperwork and return it to us. The 4th quarter of the year should yield new LEA completions.
   b. As of September 30, 2007, 43 LEAS (or 37%) 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 all staff development days and after school windows. Employ and intern from the UNC-G MPH program to continue outreach beginning in late 2007 and throughout the spring of 2008.
   b. Continually update teachers' training status on the FitKids website.
   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. In coordination with HWTF, a statewide release is expected to go out during the 4th quarter.
   d. Continue to update BANC workshop websites. Seek pictures and quotes from trainers. Post stories and testimonials. Website updates are a target for the last quarter of 2007.
   e. Support evaluation through work with trainers. Ensure that data is collected properly and returned promptly for organization and analysis.

REPORTING PERIOD: October 2007 through December 2007

Describe the objectives that were achieved during the past quarter:

During the fourth 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).
    a. Cameron Graham and Laurie finalized the statewide media release for HAC trainings. Coverage was achieved in all major markets including Asheville, Charlotte and the Triangle.
    b. Laurie sent the local version of the media release to the 42 counties who had completed training. Heard positive feedback but only saw print in Asheville/Buncombe media market.
    c. 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. In 2008, a website adjustment will allow principals and/or school leaders to request specific training dates.
2. Organize scheduling of trainings, tracking and resource shipment to provide training for a target of 70% of NC classroom teachers
    a. The final quarter of the year saw a steady number of trainings, though the holidays in November and December reduced activity significantly. Be Active Staff member Lesley Richmond was hired to support the final push for January 2008 through June 2008.
    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, or 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 December 31st, 26,107 teachers have been trained (or 57% of the target)
    g. As of December 31st, all teachers attempting a CEU on the FitKids website have been confirmed or placed in the 'unknown' category.
3. Evaluate training and FitKids Program impact on knowledge, attitudes and behaviors of teachers and students towards active classrooms via FitKids initiative
    a. Data collection occurred in three time frames. Teachers were surveyed immediately before training to capture a snapshot of their activities prior to HAC training. Teachers were then surveyed immediately following training, with a focus on change in knowledge, attitudes and intentions. The final survey was completed a minimum of 30 and a maximum of 90 days following training, to look at retention of

knowledge, changes in attitude and changes in classroom behavior (i.e., physical activity minutes.) Classroom teachers were also observed transitioning in and out of Energizers. Analysis continued through January and the final summary report is included with this Quarterly report.

b. General evaluation of trainer competence continues, teacher satisfaction remains near 100%.

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.
    a. During the fourth quarter, Nash County completed training and received both their $1,000 stipend and a local media release template.
    b. As of September 30, 2007, 43 LEAS (or 37%) 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 all staff development days and after school windows. Employ and intern from the UNC-G MPH program to continue outreach beginning in late 2007 and throughout the spring of 2008.
    b. Continually update teachers' training status on the FitKids website.
    c. Increase public awareness of HAC/FitKids Initiative via local media outreach. Support each LEA in seeking media attention as training is completed.
    d. Continue to update BANC workshop websites. Seek pictures and quotes from trainers. Post stories and testimonials. With a new and extremely active Communication Manager, the website improvements will happen more rapidly in 2008.
    e. Share evaluation results with HWTF. Upon approval, seek opportunity to present findings with state and local organizations. Seek publications in well respected journals. Discuss possibility of statewide press release with HWTF.
    f. Begin calling campaign to increase scheduling of trainings. Enlist support of local community members to ensure that each K-8 teacher has the opportunity to attend a training before June 2008.

REPORTING PERIOD: January 2008 through March 2008

Describe the objectives that were achieved during the past quarter:

During the first quarter of 2008, 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 2008 Action Plan as approved by Cameron Graham.

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:

BeActive NC Quarterly Reports

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. Laurie, Lesley and intern Pooja Verma began a calling campaign to energizer principals and teachers in untrained or low trained counties.
    b. 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. As of Feb. 1, 2008, principals can request training dates and place their Energizer orders from the website.
    c. Lesley began working on a condensed PowerPoint that can be presented to principals during LEA principal meetings to encourage scheduling of future trainings.
    d. Be Active began a trainer incentive program to encourage trainers to schedule trainings and to return any and all paperwork collected. More than 20 sets of paperwork from as far back as 2006 were collected and we consider this initial effort a success.
2. Organize scheduling of trainings, tracking and resource shipment to provide training for a target of 70% of NC classroom teachers
    a. Lesley began to be the driving force behind scheduling, tracking and resource shipping.
    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, or 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, 28,200 teachers have been trained (or 61% of the target)
    g. As of March 31st, all teachers attempting a CEU on the FitKids website have been confirmed or placed in the 'unknown' category.
3. Evaluate training and FitKids Program impact on knowledge, attitudes and behaviors of teachers and students towards active classrooms via FitKids initiative
    a. In initial data collection completed during the final weeks of January. The evaluation team completed an initial summary of findings that was submitted to HWTF and findings were presented on March 28. It was decided that further data should be collected and the report revised before shared.
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.
    a. During the fourth quarter, Nash County completed training and received both their $1,000 stipend and a local media release template.
    b. As of March 31, 2007, 45 LEAS (or 39%) 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 all staff development days and after school windows.
    b. Continually update teachers' training status on the FitKids website.
    c. Increase public awareness of HAC/FitKids Initiative via local media outreach. Support each LEA in seeking media attention as training is completed.
    d. Continue to update BANC workshop websites. Seek pictures and quotes from trainers. Post stories and testimonials. Our new Communications Manager was swamped during the first part of 2008 and is expected to be more highly involved with the HAC portion of Be Active's website.
    e. Resubmit evaluation results to HWTF by mid-June. Upon approval, seek opportunity to present findings with state and local organizations. Seek publications in well respected journals. Discuss possibility of statewide press release with HWTF.
    f. Continue calling campaign to increase scheduling of trainings. Enlist support of local community members to ensure that each K-8 teacher has the opportunity to attend a training before June 2009.

REPORTING PERIOD: April 2008 through June 2008

Describe the objectives that were achieved during the past quarter:

During the second quarter of 2008, 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 2008 Action Plan as approved by Cameron Graham.

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. Laurie, Lesley and intern Pooja Verma continued a calling campaign to energizer principals and teachers in untrained or low trained counties. This exercise will be suspended, for the most part, during July, as most staff turnover (especially Principals) occurs during this time.
    b. The Workshop website (www.beactiveworkshops.org) is currently under construction. This site will be fully functional no later than July 30, 2008. The option to request trainings from the site remains operational, and we will continue to refer interested parties to the sight through all of Be Active programming.

   c. Lesley and Laurie each presented to one end-of-year principal's meeting (in Asheboro City Schools and Mooresville Schools). Both were positive, and we expect to see an increase in trainings scheduled in these school districts.
   d. Be Active continued a trainer incentive program to encourage trainers to schedule trainings and to return any and all paperwork collected. We received a packet of training paperwork from 2006 that allowed one county to surge to more than 70% complete and eligible for their $1,000 incentive check.
2. Organize scheduling of trainings, tracking and resource shipment to provide training for a target of 70% of NC classroom teachers
   a. Lesley began to be the driving force behind scheduling, tracking and resource shipping.
   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, letters are mailed to trainers requesting necessary paperwork. Lesley has begun completing this one to two times per month, to ensure the highest possible return rate. Timely receipt of training paperwork has increased significantly.
   e. All Energizer Booklets have arrived on time and at the right location for trainings.
   f. As of June 30, 2008, 32,059 teachers have been trained (or 69% of the target)
   g. As of June 30, 2008, all teachers attempting a CEU on the FitKids website have been confirmed or placed in the 'unknown' category. Lesley updates this data a minimum of twice per week.
3. Evaluate training and FitKids Program impact on knowledge, attitudes and behaviors of teachers and students towards active classrooms via FitKids initiative
   a. Final revisions of the program evaluation are complete and are attached with this report. The evaluators stated that they had never seen a program show as many positive outcomes as this one has.
   b. Some highlights include:
      - ❖ significant increases in knowledge of brain function, obesity and Healthy Active Children policy
      - ❖ a 12% improvement in use of physical activity as a punishment
      - ❖ an 8% increase in teachers reporting that are participating in classroom based physical activity (not including recess and PE)
      - ❖ a 14% increase in use of FitKids activities
      - ❖ a 24% increase in use of Energizer activities
      - ❖ more than 30% of teachers reported that physical activity engages and motivates their students.
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.
   a. During the fourth quarter, Nash County completed training and received both their $1,000 stipend and a local media release template.

   b. As of June 30, 49 LEAS (or 43%) of 115 LEAS had completed minimal training standards.

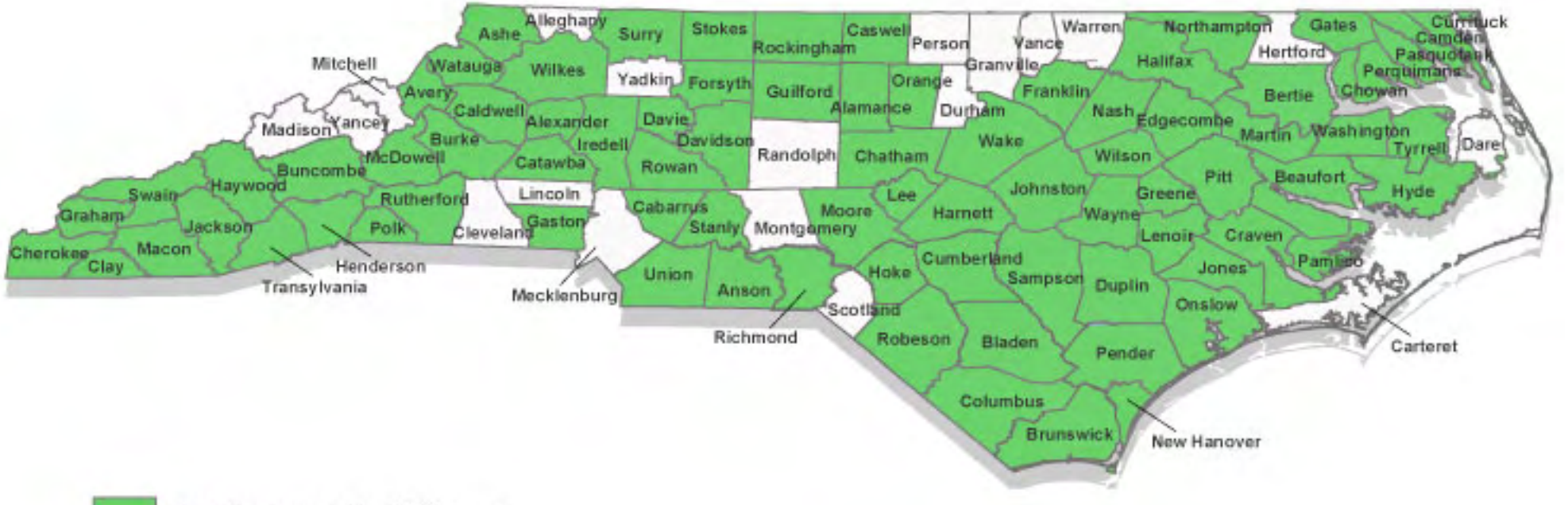
5. Next Steps
   a. Continue follow-up with non-responsive LEAs. Request support from trainers by region by supplying them with updated information on which schools have and have not been trained. Actively seek scheduling for all staff development days and after school windows.
   b. Continually update teachers' training status on the FitKids website.
   c. Increase public awareness of HAC/FitKids Initiative via local media outreach. Support each LEA in seeking media attention as training is completed.
   d. Continue to update BANC workshop websites. Seek pictures and quotes from trainers. Post stories and testimonials. Refresh look and links to FitKids website.
   e. Upon approval from HWTF, share outcomes of HAC Training evaluation. Work with evaluation team to publish in well respected peer reviewed journals.
   f. Continue calling campaign to increase scheduling of trainings. Enlist support of local community members to ensure that each K-8 teacher has the opportunity to attend a training before June 2009.
   g. Investigate 'webinar' version of training. It could offer training to teachers who have uninterested principals. It could also offer a post-funding solution to continue offering training throughout the state, while keeping overhead costs low.

Medication Assistance Program (MAP)

NORTH CAROLINA Health Wellness TRUST FUND

Medication Assistance Program (MAP)

Counties Covered by Grants (FY 2007-2008)



Counties covered by MAP grants

Counties currently not covered by MAP services

Updated: 11-01-08

HWTF MEDICATION ASSISTANCE PROGRAM
GRANT AWARDS
FY 07-08

	LOCAL and STATEWIDE GRANTS	COUNTIES SERVED	PHASE III FUNDING Jan 06 - Dec 07	PHASE IV FUNDING Jan 08 - June 08
1	Albemarle Hospital Foundation	Camden, Chowan, Currituck, Gates, Pasquotank, Perquimans	$ 40,000	$ 40,000
2	Angel Medical Center	Macon	$ 40,000	$ 40,000
3	Ashe Memorial Hospital	Ashe	$ 40,000	$ 40,000
4	Asheville-Buncombe Community Christian Ministry	Buncombe	$ 80,000	$ 60,000
5	Betsy Johnson Regional Hospital	Harnett	$ 40,000	$ 40,000
6	Bladen HealthWatch	Bladen		$ 40,000
7	Boomer Medical Center	Wilkes		$ 30,000
8	Brunswick Senior Services, Inc.	Brunswick	$ 40,000	$ 40,000
9	Cabarrus Health Alliance	Cabarrus	$ 40,000	
10	Cabarrus Memorial Hospital dba NorthEast Medical Center	Cabarrus, Rowan, Stanley	$ 40,000	
11	Caldwell Senior Center, Inc.	Caldwell	$ 40,000	$ 40,000
12	Cape Fear Council of Government AAA	New Hanover, Brunswick, Columbus, Pender		
13	Cape Fear Valley Medical Foundation, Inc. (CCMAP)	Cumberland, Harnett, Sampson	$ 50,000	$ 50,000
14	Carolina Family Health Centers, Inc. (Wilson Community)	Edgecombe, Nash, Wilson	$ 40,000	$ 70,000
15	Clay Comprehensive Health Services, Inc. (CHATUGE)	Cherokee, Clay, Graham	$ 40,000	$ 40,000
16	Columbus County Department of Aging	Columbus	$ 40,000	$ 40,000
17	Community Care Center of Forsyth County (Community Care Center/ Doctors Care Inc.)	Davie, Forsyth, Stokes	$ 25,000	$ 40,000
18	Community Care Clinic of Rowan County	Rowan	$ 40,000	$ 40,000
19	Community Free Clinic of Cabarrus	Cabarrus	$ 30,000	$ 70,000
20	Crisis Control Ministry	Davie, Forsyth, Stokes	$ 40,000	$ 40,000
21	Diakonos, Inc. / Fifth Street Ministries	Iredell	$ 40,000	$ 35,000
22	Duplin Medical Association	Duplin, Sampson	$ 40,000	
23	FirstHealth of the Carolinas	Moore		$ 40,000
24	Franklin County Volunteers in Medicine	Franklin		$ 38,000
25	Gaston Family Health Services, Inc.	Gaston	$ 30,000	$ 35,000
26	Good Samaritan Clinic, Inc.	Burke	$ 40,000	$ 35,000
27	Greater Hickory Cooperative Christian Ministry	Catawba	$ 40,000	$ 55,000
28	Guilford County Department of Public Health	Guilford	$ 40,000	$ 55,000
29	HealthQuest of Union County, Inc.	Anson, Union	$ 40,000	$ 40,000
30	Helping Hands Clinic, Inc.	Caldwell	$ 40,000	$ 40,000
31	Hoke County Senior Services	Hoke	$ 12,000	$ 27,000

HWTF MEDICATION ASSISTANCE PROGRAM
GRANT AWARDS
FY 07-08

	LOCAL and STATEWIDE GRANTS	COUNTIES SERVED	PHASE III FUNDING Jan 06 - Dec 07	PHASE IV FUNDING Jan 08 - June 08
32	Hunger Coalition	Avery, Watauga	$ 40,000	$ 27,000
33	Hyde County Health Department	Beaufort, Hyde	$ 20,000	$ 24,000
34	Isothermal Planning AAA	McDowell, Rutherford	$ 60,000	$ 50,000
35	Kinston Community Health Center, Inc.	Craven, Duplin, Greene, Jones, Lenoir, Onslow, Pitt, Wayne	$ 37,700	$ 40,000
36	Martin-Tyrrell-Washington District Health Department	Washington, Martin, Tyrrell		$ 40,000
37	Metropolitan Community Health Services	Beaufort, Pitt	$ 40,000	$ 40,000
38	Mid-East Commission AAA	Beaufort, Bertie, Martin	$ 60,000	
39	New Hanover Regional Medical Center	Brunswick, New Hanover, Pender		$ 40,000
40	Pamlico County Senior Services	Pamlico	$ 25,000	
41	Pender Adult Services, Inc.	Pender	$ 40,000	$ 35,000
42	Piedmont Health Services	Alamance, Caswell, Chatham, Orange	$ 40,000	
43	Pitt County Council on Aging, Inc.	Pitt	$ 40,000	
44	Resources for Seniors, Inc. (MEDS Program)	Lee, Wake	$ 60,000	
45	Richmond County Health Department	Richmond	$ 40,000	$ 40,000
46	Rockingham County Health Dept	Rockingham		$ 40,000
47	Saluda Medical Center, Inc.	Buncombe, Henderson, Polk, Rutherford, Transylvania	$ 30,000	$ 40,000
48	Scotland Neck Family Medical Center	Halifax	$ 25,000	$ 40,000
49	Servant's House Ministry	Davidson		$ 40,000
50	Southeastern Regional Medical Center	Robeson	$ 40,000	$ 40,000
51	Surry County Senior Services	Surry	$ 40,000	$ 40,000
52	Thomasville Medical Center	Davidson	$ 38,500	$ 38,000
53	Transylvania County Volunteers in Medicine	Transylvania		$ 23,000
54	Upper Coastal Plain Council of Governments	Edgecombe, Halifax, Nash, Northampton, Wilson	$ 60,000	
55	Urban Ministries of Wake County, Inc.	Wake	$ 40,000	$ 40,000
56	Watauga Medical Center/ Appalachian Healthcare Project	Avery, Watauga	$ 40,000	$ 40,000
57	Wayne Action Group for Economic Solvency, Inc. (WAGES)	Duplin, Johnston, Lenoir, Wayne, Wilson	$ 40,000	$ 40,000
58	West Caldwell Health Council, Inc.	Alexander, Avery, Burke, Caldwell, Catawba, Watauga, Wilkes	$ 40,000	$ 40,000
59	WestCare, Inc.	Haywood, Jackson, Swain	$ 60,000	$ 40,000
60	Wilkes Regional Medical Center	Wilkes	$ 40,000	
61	Winston-Salem Urban League	Forsyth	$ 40,000	$ 10,000

MEDICATION ASSISTANCE PROGRAM (MAP)
(JULY 2007 – JUNE 2008)

MAP BACKGROUND AND PROGRAM DESIGN

North Carolina citizens that are uninsured or who qualify for Medicare coverage often find that they cannot afford the medications required to treat or ameliorate their chronic health problems. And those folks 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, HWTFC's statewide prescription drug program for low-income seniors, was not a complete solution to these problems that North Carolina seniors and low-income individuals were facing, HWTFC sought to fund a network of medication assistance programs to serve North Carolina's uninsured populations.

NC Institute of Medicine listed HWTFC's statewide MAP program as a "significant safety net for the uninsured" in its NC Healthcare Safety Net Report 2005. Between July 2007 and June 2008, MAP grantee sites delivered over $27 million worth of medications to nearly 100,000 patients, representing an 18 to 1 return on HWTFC's grant investment.

Funding for the Medication Assistance Program began January 1, 2003 and is currently in its fourth phase of funding community level grants. Phase IV grants are set to expire June 30, 2009. A total of 99 NC organizations have received funding under this program that provides financial prescription assistance for low-income individuals of all ages.

- Phase I: 23 local grants totaling over $8.7 million
January 2003 – December 2005 (3 years)
- Phase II: 58 local grants totaling over $6 million
July 2004 – June 2006 (2 years)
- Phase III: 51 local grants totaling over $2 million
July 2006 – December 2007 (18 months)
- Phase IV: 50 local grants totaling over $2 million
January 2008 – June 2009 (18 months)

Most grantees have used the Office of Rural Health and Community Care's (ORHCC) Medication Access and Review Program (MARP) computer software. This program allows grantees to access the pharmaceutical companies' Patient Assistance Programs (PAP) to help poor and uninsured North Carolinians receive free and low-cost drugs. Each pharmaceutical company establishes its own eligibility criteria, which usually covers those below 200% of the federal poverty level (FPL). In addition to populating and generating the completed paperwork for qualified patients, the software also generates renewal forms to re-order medications, usually every 30 to 90 days.

- Grantees serve other low-income patients (including but not limited to seniors)
- Grantees are partially or wholly funded by the HWTF

MEDICATION ASSISTANCE PROGRAM (MAP)
(JULY 2007 – JUNE 2008)

CURRENT PROGRAM

The current fiscal year covers the last 6 months of Phase III (July – December 2007) and the first 6 months of Phase IV (January – June 2008). The results data for each phase will be presented separately.

- 27,418 low-income patients received medication assistance during FY 07-08
- Over $27 million in free medication for patients through approximately $1,487,844 million in grant funding
    - Return on investment for FY 07-08: 18:1
    - Each $1 spent resulted in $18 in free medication

The current fiscal year covers the last 6 months of Phase III (July – December 2007) and the first 6 months of Phase IV (January – June 2008). The data for each phase will be presented separately.

MAP IS VERY COST EFFECTIVE

- The return of investment for FY 07-08 is the highest recorded since the program's inception in 2003. More patients are reached per site and more medication has been dispensed to needy populations who may not have been able to receive medications without this program. While the direct savings in healthcare dollars are not available, the potential healthcare dollars and lives saved through this program are tremendous.

- Based on lessons learned from early grant funding, Phases III and IV grantees utilized funds specifically for Prescription Assistance Coordinators (PAC), whose primary responsibility is to work with low income patients to determine eligibility for pharmaceutical companies' Patient Assistance Programs (PAP). Funding PACs is more cost effective, and allows HWTF to fund more medication assistance programs in more counties. Additionally, PACs are specially trained in this task, and the process of helping patients is also streamlined, therefore potentially allowing greater reach to a greater number of patients.

PHASE III (final 6 months)

- Medication assistance to seniors including:
    - Identification of their optimal federal plan option
    - Assistance for accessing any available Prescription Assistance Program (PAP) programs for donut hole coverage
    - Assistance for seniors who do not enroll in Part D to apply for any available PAP
    - Outreach and application assistance for NCRx program
    - Outreach and application assistance for CheckMeds NC program
- 51 grants representing 74 counties
- The grantees across the state represent many organizational types including:
    - 9 hospitals or hospital foundations
    - 9 community health centers
    - 7 free clinics

  - 6 senior centers
  - 4 health departments
- Services Provided July – December 2007
  - Total patients served: 5096
  - Total number of medications received by patients: 21,986
  - Average wholesale price of medications received: $9,289,786
- Technical Assistance for program and software questions contracted through the DHHS Office of Rural Health
- Demographics of population served:
  - 90% below age 65
  - 60% below 100% poverty level
  - 29% African American
  - 6% Hispanic
  - 60% Caucasian

PHASE IV (first 6 months):

- Specific disease-focused service providers: Grantees that serve clients with specific disease states will be allowed to limit their MAP services to only their current target populations. For example:
  - Mental health clinics
  - Clinics and pharmacists focusing on chronic disease care
- Medication assistance to seniors including:
  - Identification of their optimal federal plan option
  - Assistance for accessing any available Prescription Assistance Program (PAP) programs for donut hole coverage
  - Assistance for seniors who do not enroll in Part D to apply for any available PAP
  - Outreach and application assistance for NCRx program
  - Outreach and application assistance for MedchecK NC program
- Care+Share NC
  - Grantees were asked to become part of the Care+Share NC funded community collaborative for their area, so that they would be easily accessible to all low-income uninsured residents in their community. Care+Share NC is in the process of facilitating the creation of these collaboratives across the state. As part of their grant agreement, grantees were asked to become an integral part of their area collaborative for helping low-income residents with their drug needs. Many grantees were not aware of Care+Share NC prior to submitting their application; many are now working with community groups to form collaboratives to serve the needs of their counties.
- Grantee Organizational type
  - 12 hospitals or hospital foundations
  - 16 community health centers
  - 7 free clinics
  - 8 senior centers
  - 7 health departments
- 50 grants representing 71 counties

MEDICATION ASSISTANCE PROGRAM (MAP)
(JULY 2007 – JUNE 2008)

- Services Provided January - December 2007
  - Over 20,000 patients served
  - Over 41,000 medications received
  - Average wholesale price of medications: $17,601,419
- Technical Assistance for software contracted through the DHHS Office of Rural Health
- Demographics of population served:
  - 95% below age 65
  - 61% below 100% of poverty level
  - 30% African American
  - 8% Hispanic
  - 58% Caucasian

HOW DOES MAP MAKE A DIFFERENCE IN LOCAL COMMUNITIES?

Recent layoff's in several manufacturing based communities have left former employees with no insurance and limited unemployment. MAP grantees have been able to help individuals with their medication through the gap in employment and prescription benefits.

Referrals are made not only through local physicians, dentists and healthcare clinics, but through county departments of Social Services, Social Security Offices, Chamber of Commerce, Ministry and other Faith-based groups and many more community organizations. Although PACs spend their time working directly with patients, other organization staff includes the Medication Assistance Program in their outreach activities such as health fairs, newsletters, television, radio and print advertising. The following quotes from grantees illustrate the impact the program is having in their communities.

> *The relationship with local physicians, health centers, Care+ShareNC and HealthNet networks was the PAC's initial target area in 2005 and the hard work is reaping benefits for the uninsured and underinsured. The relationship with the medical community has blossomed into a collaborative words alone cannot describe. The physicians are provided with the PAC's cell phone number that is available 24/7….The physicians appreciate the simplicity of their role in the process and a partnership relationship benefiting the overall healthcare cost, patients and government.*
>
> Jennifer P. Sherman, PAC, Brunswick Senior Resources, Inc.

> *Prescription medication is an integral part of providing healthcare. For those with low-incomes and no insurance, they often are unable to afford medications or physician visits. Helping Hands Clinic continues to be the primary provider for the uninsured in Caldwell County. In the clinic's 2007 Patient Satisfaction Survey, 71% of patients said they would have nowhere to go if clinic services were not available and 17% said they would have to use the ER as primary care if the clinic closed. Most physician offices will no longer accept patients who do not have insurance and even the hospital's emergency department triages all patients to determine the need for emergent care. The health department has limited resources to provide primary care and cannot provide prescriptions, labs, x-rays or specialty referrals. All of these entities refer patients to*

Helping Hands Clinic. In addition, other human service agencies including Yokefellow and the Department of Social Services regularly refer patients to the Clinic.
The services that Helping Hands Clinic provides are essential. For many, it is a matter of life or death. Most of the patients served at the Clinic suffer from one or more chronic diseases that affect their heart, their lungs, their ability to move, or their ability to regulate blood sugar. Without medical care and prescriptions, these individuals will suffer from heart attack, stroke, respiratory failure, decreased mobility, diabetic coma, limb amputation, loss of vision and even death. The ability to provide medications through grants from funders such as HWTFC is a critical piece to the puzzle.

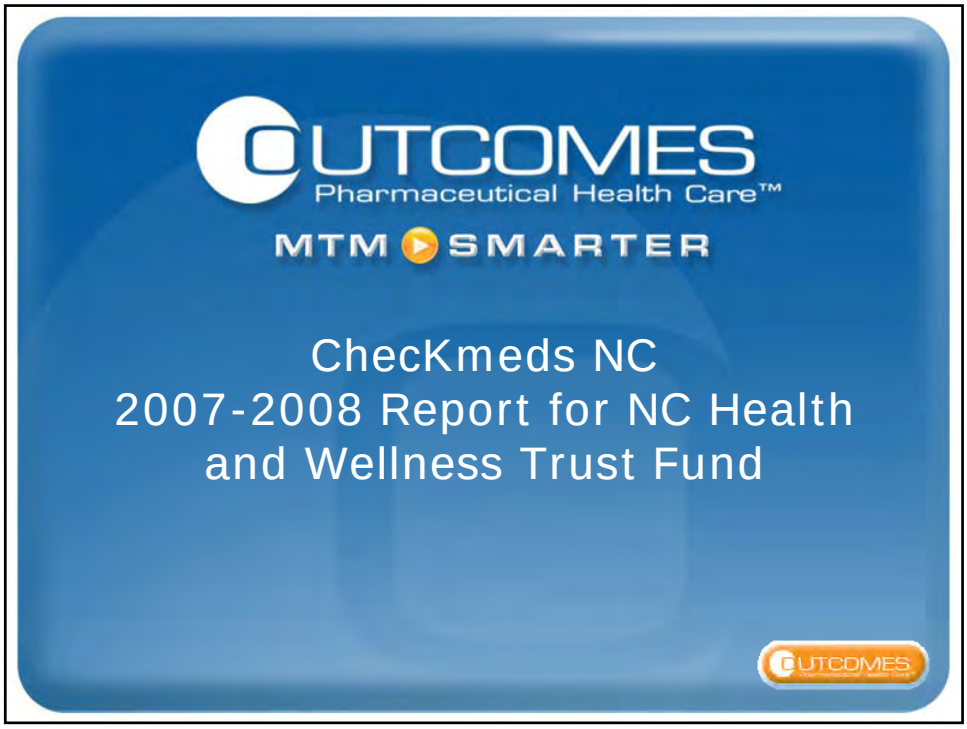
Lou Hill, Executive Director, Helping Hands Clinic, Caldwell County

Rockingham County has been especially hit hard during our present economic situation. The people of our county have not recovered from job losses in our textile, tobacco and furniture industry, which have occurred over the past 10 years. Our Pharmacists and staff have noticed this year an increase in patients immediate and financial needs. More are coming to visits with not only a job losses but also foreclosures on their family homes. Patients are not able to pick-up their refills until they can find transportation. Prescription Assistance is vital in Rockingham County, not just to bridge a gap until a patient can find another resource for their medication, but now in today's economic crisis for the displaced worker, who now because of their age or disability cannot find employment, medication assistance is crucial to prevent that life-threatening heart attack. Furthermore, many individuals in our county cannot read, write, understand, or have access to a computer to fill out the necessary forms needed with each medication. Due to the complexity of the patient's regimen the individual or family member would not know how to substitute brands for generics or ask the physician for therapeutic interchanges to get a medication at no charge. The CPAP Clinical Pharmacist has discovered multiple medication errors upon drug reviews and much needed education in many disease areas such as diabetes. This education would lower ER visits, hospital stays, and disease complications.

Jennifer M. Bayes, Pharm.D., Rockingham County Health Department

NORTH CAROLINA Health Wellness TRUST FUND

ChecKmeds NC


OUTCOMES
Pharmaceutical Health Care™
MTM SMARTER
ChecKmeds NC
2007-2008 Report for NC Health and Wellness Trust Fund
OUTCOMES


ChecKmeds NC
Medication Therapy Management ("MTM") Program to help NC seniors appropriately utilize medications
Avoid costs and health complications associated with inappropriate medication use
Achieve positive health outcomes
Control medication costs
2
OUTCOMES

ChecKmeds NC

- Engages NC pharmacists to consult with seniors and prescribers
- Funded by NC Health and Wellness Trust Fund
  - RFP for network development, pharmacist training and claims processing issued in 2007
  - Outcomes Pharmaceutical Health Care (Outcomes) selected through competitive bid process.

3

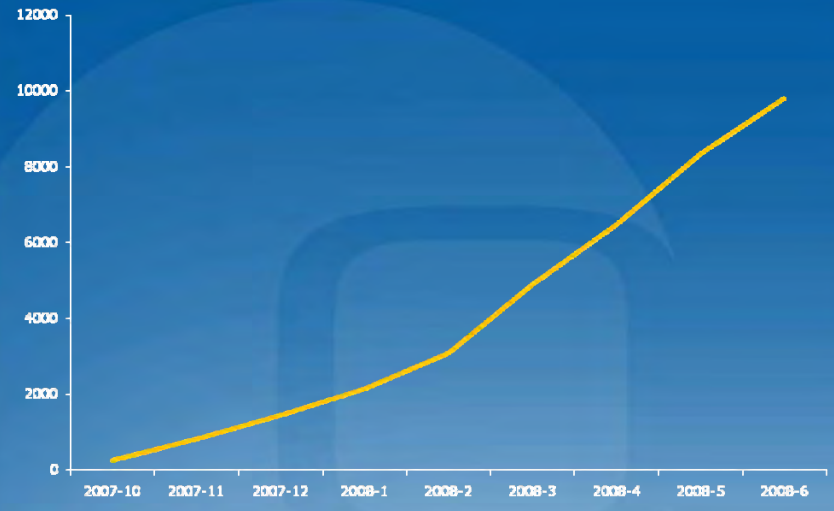
Covered Services Menu

- Comprehensive Medication Review (Medication Check-Up™)
- Prescriber Consultation
  - Cost Efficacy Management
  - Drug Therapy Problem Resolution
- Patient Compliance Consultation
- Patient Education & Monitoring

Estimated Cost Avoidance Model

- Estimated Cost Avoidance (ECA) is a model to estimate the Rx, medical and/or hospital-related costs avoided as a result of an MTM service
- Pharmacists assign a severity rating to each MTM claim:
  - Level 1 – Improved Quality of Care
  - Level 2 – Drug Product Costs
  - Level 3 – Additional Physician Visit
  - Level 4 – Additional Prescription Order
  - Level 5 – Emergency Room Visit
  - Level 6 – Hospital Admission
  - Level 7 – Life Threatening

CheckMeds NC Enrollment

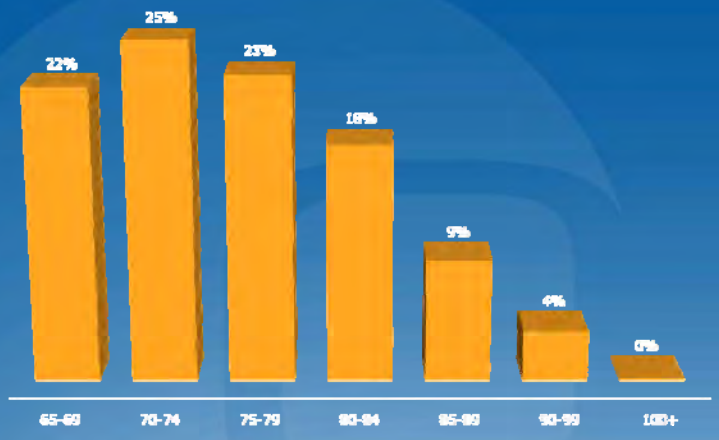


- Seniors Enrolled by Month

ChecKmeds NC Demographics

- Enrolled Seniors by County

ChecKmeds NC Demographics



- Age Distribution of Seniors

ChecKmeds NC MTM Summary

- Patients served
  - 9,715 Total
- MTM Claims
  - 18,632 Total
- Estimated Cost Avoidance
  - $4,997,984 Total
  - $514 per patient served
  - $268 per MTM claim/intervention
  - $7.59 per $1.00 program fees (Admin +Provider Fees)

- October thru 06.30.2008

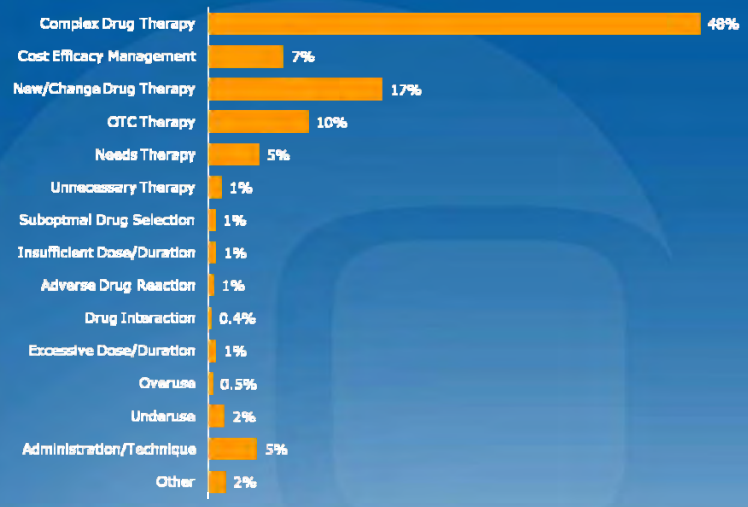
ChecKmeds NC MTM Claims

- ChecKmeds NC MTM Claim Volume

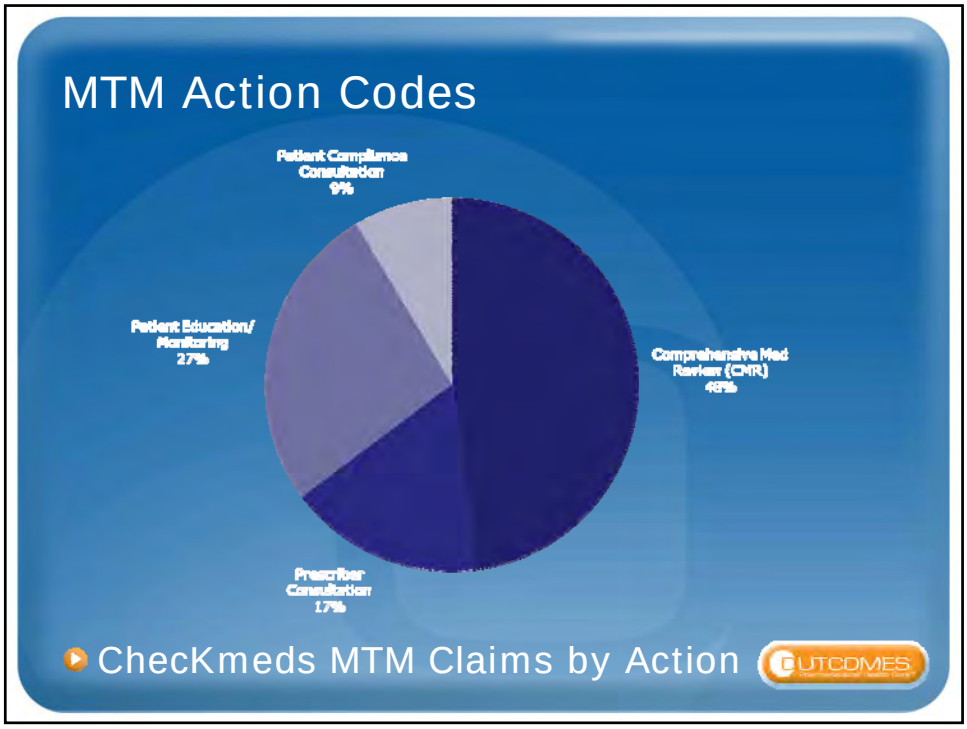
CheckMeds NC MTM Claims

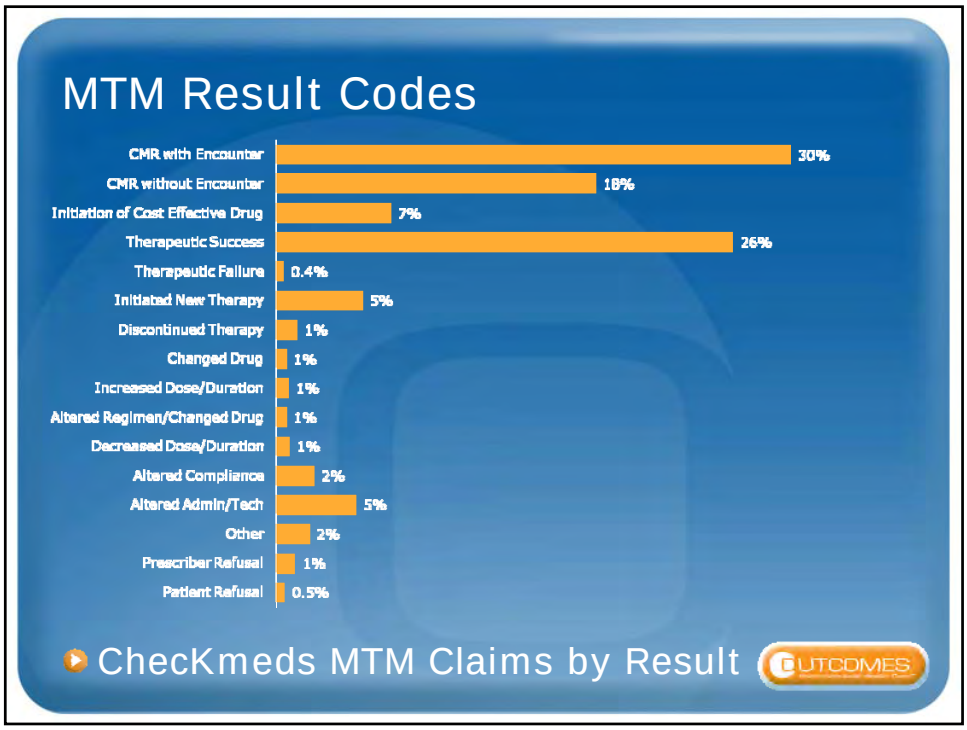
- MTM Claims Distribution by County

MTM Reason Codes



- CheckMeds MTM Claims by Reason


MTM Action Codes
Patient Compliance Consultation 9%
Patient Education/ Monitoring 27%
Comprehensive Med Review (CMR) 48%
Prescriber Consultation 17%
CheckMeds MTM Claims by Action
OUTCOMES


MTM Result Codes
CMR with Encounter 30%
CMR without Encounter 18%
Initiation of Cost Effective Drug 7%
Therapeutic Success 26%
Therapeutic Failure 0.4%
Initiated New Therapy 5%
Discontinued Therapy 1%
Changed Drug 1%
Increased Dose/Duration 1%
Altered Regimen/Changed Drug 1%
Decreased Dose/Duration 1%
Altered Compliance 2%
Altered Admin/Tech 5%
Other 2%
Prescriber Refusal 1%
Patient Refusal 0.5%
CheckMeds MTM Claims by Result
OUTCOMES

Comprehensive Medication Reviews

- CMR with Encounter = 62%
  - Drug therapy problem(s) identified
  - Additional intervention(s) performed
- CMR without Encounter = 38%
  - Pharmacist verified there were no problems
  - Organized patient's medications
  - Educated patient on appropriate use

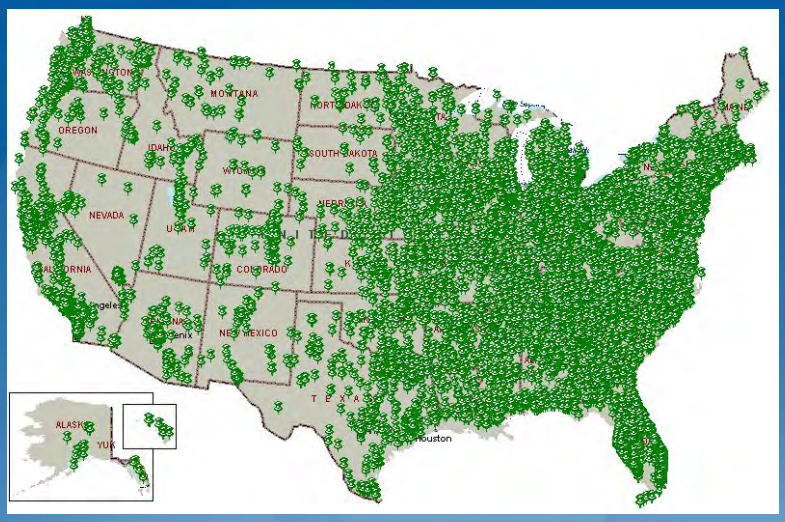
Estimated Cost Avoidance Model

TOTAL ECA:	$4,519,419
Level 1 Improved Quality of Care	$0.00
Level 2 Drug Product Costs	$904,766
Level 3 Additional Physician Visit	$584,058
Level 4 Additional Prescription Order	$114,065
Level 5 ER Visit	$149,315
Level 6 Hospitalization	$2,025,646
Level 7 Life Threatening	$741,569

ROI (Total ECA: Program Costs)	$7.59:$1
ROI (ECA Level 2 Only: Program Costs)	$1.37:$1

Program Costs = Outcomes Admin + Provider Fees

National MTM Network



200809 Contracted and Trained MTM Network

NC MTM Network

- NC Contracted Outcomes MTM Centers (10/2008)

Feature Encounter

- **#105266 – Asthma Management**

  Upon consultation with a CheckKmeds NC covered senior at **Moose Professional Pharmacy** in **Concord, NC,** Outcomes Personal Pharmacist, **Kyle Yoder**, discovered the patient had been underutilizing her asthma prevention inhaler. The pharmacist educated the patient on the difference between her "preventative" inhaler and her "rescue" inhaler, and stressed the importance of using the preventative medication to reduce the need for the rescue drug. The pharmacist followed-up with the patient one week later and the patient reported she had been using her preventative inhaler as prescribed and had not experienced any wheezing or shortness of breath. The pharmacist helped this patient to achieve better control of her breathing condition through education and follow-up. The pharmacy was compensated $20 for the pharmacist's time.

Feature Encounter

- **#200002 – Medication Allergy**

  While filling an antibiotic prescription for a CheckKmeds NC covered senior at **Clark's Pharmacy** in **Williamston, NC,** Outcomes Personal pharmacist, **Brooks Smith**, discovered the patient had previously experienced a life-threatening allergic reaction to that particular antibiotic. With the patient's consent, the pharmacist contacted the doctor and recommended an alternative antibiotic. The doctor agreed and the patient successfully initiated the new therapy. The pharmacist's intervention prevented a potentially serious drug-related complication. The pharmacy was compensated $20 for the pharmacist's time.


Outcomes Pharmaceutical Health Care
601 E Locust, Suite 200
Des Moines, IA 50309-1946
voice 515.237.0001
fax 515.237.0002
www.getoutcomes.com
OUTCOMES

NCRx

NCRx Data Sheet 2007-2008

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

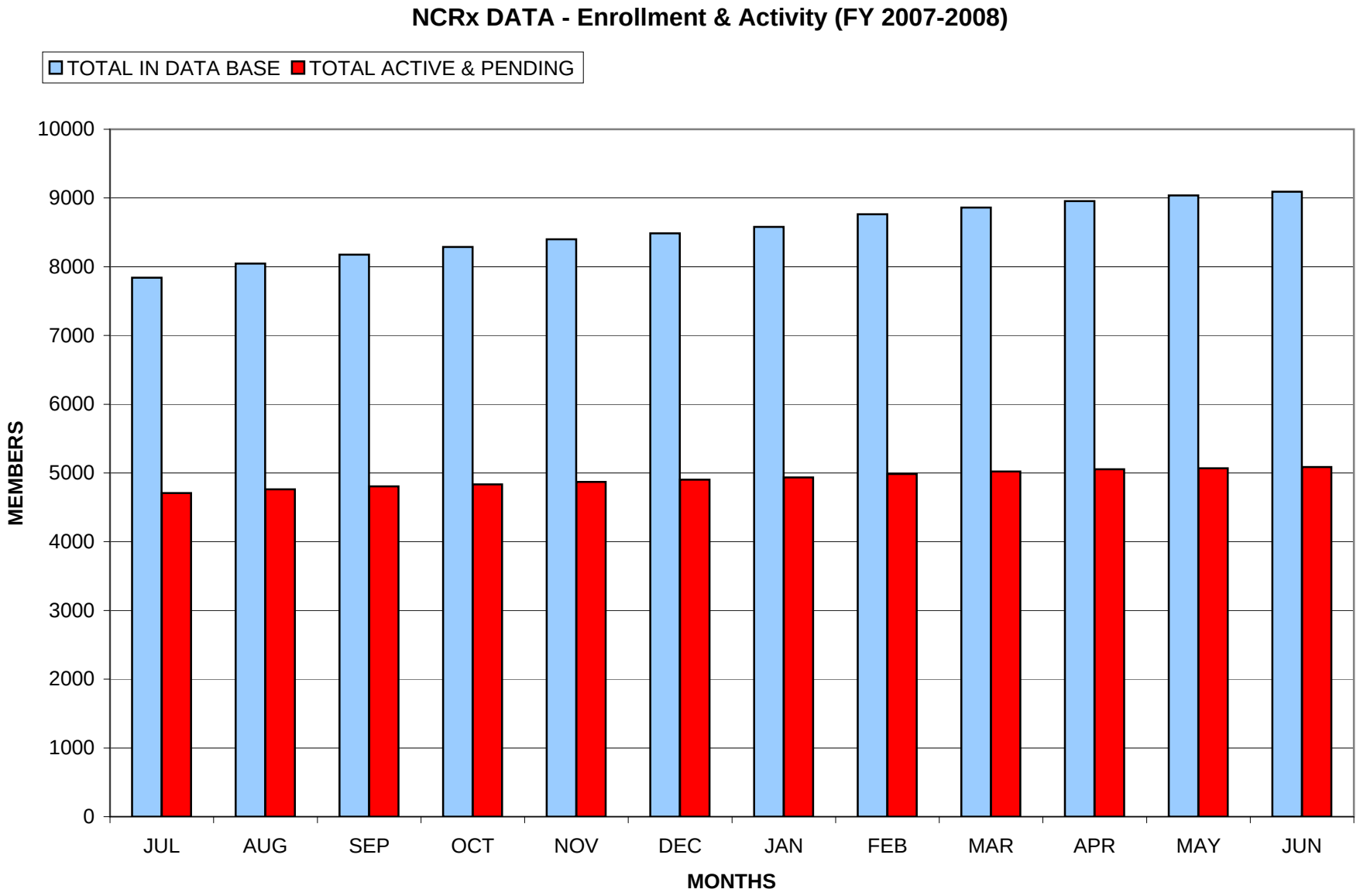
EXPENDITURES AND ENROLLMENT

- $1.5M July 2007 – June 2008
- 5,085 enrollees through June 2008
- Average annual cost per enrollee: $295
- Average monthly cost per enrollee: $24.58

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 DATA - Enrollment & Activity (FY 2007-2008)
TOTAL IN DATA BASE
TOTAL ACTIVE & PENDING
MEMBERS
10000
9000
8000
7000
6000
5000
4000
3000
2000
1000
0
JUL
AUG
SEP
OCT
NOV
DEC
JAN
FEB
MAR
APR
MAY
JUN
MONTHS

Task Force for a Healthier North Carolina

UNC
COLLEGE OF
ARTS & SCIENCES

THE UNIVERSITY
of NORTH CAROLINA
at CHAPEL HILL

DEPARTMENT OF PUBLIC POLICY

CAMPUS BOX 3435
ABERNETHY HALL
CHAPEL HILL, NC 27599-3435

T 919.962.1600
F 919.962.5824
www.unc.edu/depts/pubpol

TASK FORCE FOR A HEALTHIER NORTH CAROLINA
FINAL REPORT (JULY 2006 TO DECEMBER 2007)

BACKGROUND

Per a letter of invitation (June 21, 2006), the University of North Carolina at Chapel Hill entered into a partnership with the N.C. Health and Wellness Trust Fund Commission to create the *Task Force for a Healthier North Carolina*. The *Task Force* was given a formal charge to examine access to health care for vulnerable and underserved population including:

1. Access to prescription drug coverage for seniors
2. Access to public-sponsored health insurance for children
3. Access to health benefits for employees in small businesses

The HWTF letter of invitation extended a budget of $300,000 to support the work of the task force. UNC-CH entered into a subcontract with The Lewin Group, a national health care and human services consulting firm, to provide additional analytical support to UNC-CH staff and the task force. The performance period for the HWTF contract began July 15, 2006 and extended through December 31, 2007.

PROJECT DETAILS

The *Task Force for a Healthier North Carolina* held public forums and made recommendations on strategies to improve access to health insurance for the three specific populations. The three substantive policy topics of focus were:

1. **Medicare Part D Program and Supporting Prescription Drug Coverage for Seniors**: Explore how the state and the HWTF can provide financial and/or other forms of assistance to Medicare drug coverage beneficiaries.
2. **Enrollment in and Access to Public-Sponsored Health Coverage and Federal/State Tax Credits for Working Families**: Explore ways to improve access to and enrollment in public sector health programs for children (Medicaid, S-CHIP) and to provide mechanisms to support and assist taxpayers in claiming (income and health-related) federal and state income tax benefits (i.e., credits).
3. **Small Business, Employer-Sponsored Health Insurance and the Underinsured**: Explore public and private strategies to strengthen employer provision of health insurance; improve small business access to affordable group health insurance coverage; improve employee access to health insurance coverage in the individual and/or group market during employment transitions; and limit financial exposure for the underinsured.

GOALS & DELIVERABLES

In order to provide background information to the *Task Force*, the Lewin Group crafted reports on each of the three areas. These reports offered data on the relevant populations and existing programs, described trends and key issues, and offered some potential policy-related strategies for making improvements. They are posted on the HWTF Web site at www.HealthWellNC.com.

The *Task Force* then held meetings on each issue in order to hear comments and proposals from interested groups and individuals. The *Task Force* sponsored a public forum to discuss prescription drug coverage for seniors on November 16, 2006 in Chapel Hill, NC in order to hear from advocates and individuals working at the state level. The first official task force meeting on this topic was held on December 13, 2006 in Raleigh, NC. This meeting included information from Part D plan administrators, pharmacists, pharmaceutical companies as well as the director of the newly created NCRx program.

The second meeting on children's health insurance was held on March 26, 2007 in Winston-Salem, NC. This meeting included information from administrators of the state children's health insurance program (in NC, these programs are known as Health Check/Medicaid and Health Check/SCHIP), child advocates, directors in the CCNC network, pediatricians and researchers on child health.

The final *Task Force* meeting on employees of small businesses was held on June 8, 2007 in RTP, NC. This meeting included perspectives from advocates, state program leaders, directors of small employer pools, insurance companies and leaders in the private sector. These forums offered opportunities to hear from experts and advocates on the most critical problems facing each population and on potential recommendations.

The *Task Force* then offered a report on each of the three areas. The reports described the critical issues to be addressed and a set of recommendations to help strengthen existing programs as well as identifying new opportunities to improve access to health insurance. The final reports were circulated to interested groups and posted on www.HealthWellNC.com.

KEY FINDINGS FOR THE *TASK FORCE*

Along with assistance from many groups and individuals working on these issues, several of the task force recommendations have been implemented.

Prescription Drug Coverage for Seniors

The task force called for increased outreach efforts to individuals who were eligible for, but not enrolled in, existing assistance programs. In September 2007, the general assembly approved $250,000 to the Seniors Health Insurance Information Program (SHIIP) to provide grants to the direct service agencies working with seniors and enrolling them into existing assistance programs (both NCRx and the federal Low-Income Subsidy program).

The task force also recommended increasing the premium assistance offered in the NCRx program. Initially, the premium assistance amount was set at $18 per month which was just

enough to fully cover the premium amount of the least expensive plan. That plan, however, carried a $265 annual deductible. The NCRx premium assistance has now been raised to $29 which fully covers several plans that offer a $0 deductible.

Children's Health Insurance:
The task force called for increased outreach and enrollment efforts for Health Check/Health Choice including strengthening the involvement of outreach coordinators, school-based clinics, hospital emergency rooms as well as working through existing programs with similar eligibility criteria. Due in part to this recommendation, outreach agencies have strengthened their focus on these entry points to help get eligible children enrolled in the programs.

The task force also recommended expanding health coverage for children in families with incomes between 200% and 300% of the federal poverty level. Many advocates had been working on the NC Kids' Care proposal to expand coverage to this population and the task force reaffirmed these efforts. The task force recommended including additional funding in order to cover the appropriate outreach and enrollment support necessary to reach newly eligible families.

Additionally, the task force recommended strengthening the process of linking children to a primary care provider through the CCNC network. A follow up report, as requested by task force member Dr. Olson Huff, followed up on the findings and recommendations related to the transition of children ages 0 to 5 years old from Health Choice into Medicaid and the linkage to a primary care provider. This supplemental report has been circulated among many stakeholders involved in the linkage process. Some additional funding for data gathering for this report was provided by the Kate B. Reynolds Charitable Trust.

Health Insurance Coverage for Small Businesses:
The task force recommended the creation of a state-wide Office of Small Business Health Insurance Partnerships (OSBHIP) to serve the major needs of small employers and employees including: 1) provide a single source of information on and portal to purchase private health plans; and 2) direct technical and financial assistance for small employers who wish to offer flexible and portable health insurance coverage to their employees. The task force also recommended that OSBHIP offer information and assistance to small employers that wish to offer workplace wellness programs as well as employers that wish to offer benefits such as pre-tax deductions for health expenses, child care and dependent care.

In conjunction with the work of the task force, UNC and the NC Rural Center conducted a survey of small employers to better understand their views on health insurance and the tax credit available to small businesses that offer coverage to their employees. The survey results indicated that many small employers were unaware of the tax credit and that the current benefit level ($250 per year) was too small to encourage them to offer coverage.

The First Year for Seniors: Medicare Prescription Drug Coverage in North Carolina, 2006

Prepared for:

North Carolina Health & Wellness Trust Fund (HWTF)

Lieutenant Governor Beverly E. Perdue, HWTF Commission Chair

and

University of North Carolina at Chapel Hill

Daniel P. Gitterman, Ph.D., Principal Investigator

Prepared by:

The Lewin Group

Aaron McKethan
Christina Koster
Wes Joines

November 15, 2006

TABLE OF CONTENTS

KEY FINDINGS

- Of the approximately 1.3 million Medicare beneficiaries in North Carolina, about 716,000 (54%) receive prescription drug benefits through Medicare prescription drug plans (PDPs) or Medicare Advantage prescription drug (MA-PDs) plans.

- About 500,000 (38%) Medicare beneficiaries that did not enroll in a Medicare PDP or MA-PD have prescription drug coverage from other sources, such as through employer-based plans or other government programs.

- About 102,000 Medicare beneficiaries (8%) either do not have prescription drug coverage or the coverage that they do have is not at least comparable to the standard Medicare Part D benefit.

- The Medicare PDP with the highest enrollment in the state is the United AARP MedicareRx Plan; this PDP has 116,700 enrollees, representing about 20% of total PDP enrollment in the state. The United AARP MedicareRx Plan is one of 5 PDPs offered in North Carolina by the same plan sponsor, United-PacifiCare.

- The four plan sponsors with the greatest Part D enrollment account for 66% of PDP enrollment in North Carolina: United-PacifiCare (27%), Humana (21%), Member Health/Community Care Rx (10%), and Blue Cross and Blue Shield of North Carolina (8%).

- The average enrollment-weighted PDP premium in North Carolina is $31.95, which is slightly higher than that of North Carolina's neighboring states.

- In 2007, Part D participants will have more PDP options in 2007 than are currently available in 2006. Many plans in North Carolina have re-configured benefit packages and premiums and more will include zero deductibles and gap coverage than in 2006.

- If current Part D participants stay in the same PDPs for 2007, their monthly premiums will increase in January 2007 by 7.8%, on average. The monthly premium of the AARP MedicareRx Plan (which has the highest enrollment of any PDP in North Carolina in 2006) is set to increase to $30.00 per month for 2007, a 6.1% increase over the 2006 premium of $28.27.

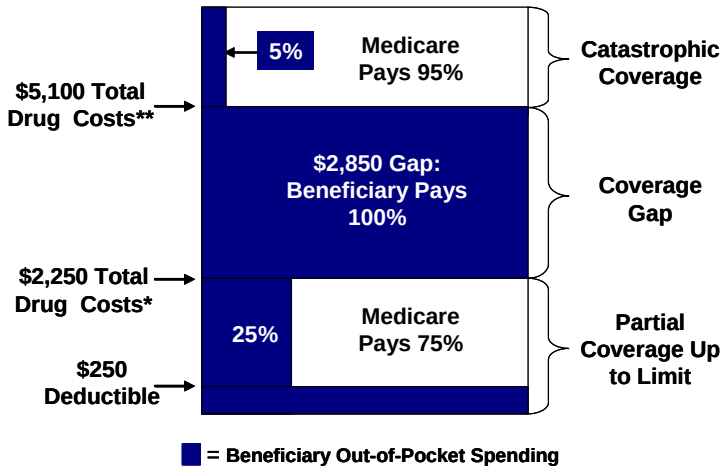
- Medicare Part D includes a low-income subsidy program (LIS) that subsidizes Part D coverage for certain low-income beneficiaries with limited assets. As of July 2006, about 91,600 North Carolina residents were receiving LIS assistance. Another 91,700 North Carolinians are estimated to be eligible for these benefits, but have not enrolled in the LIS program (as of June 2006).

I. INTRODUCTION

The 2003 Medicare Prescription Drug Improvement and Modernization Act (MMA) made voluntary prescription drug coverage available to all 43 million Medicare beneficiaries. Beginning in January 2006, millions of Medicare beneficiaries, including 1.3 million in North Carolina, began to enroll in a Medicare prescription drug plan (Medicare Part D). Beneficiaries choosing to participate in the program had the option of enrolling in stand-alone prescription drug plans (PDPs) providing drug coverage independent of other Medicare medical benefits. Alternatively, beneficiaries could enroll in Medicare Advantage (Medicare Part C) prescription drug plans that combine medical and drug benefits (MA-PDs).

The private plans available to Medicare beneficiaries can have different benefit designs and cost sharing arrangements, but all must be at least actuarially equivalent to the standard Medicare benefit. In 2006, the standard Medicare benefit includes a $250 deductible and 75% coverage once the deductible is reached up to $2,250 annually. The standard benefit also includes catastrophic coverage (95% paid by the plan or Medicare and 5% paid by the beneficiary) that becomes effective once the beneficiary exceeds more than $3,600 per year in out-of-pocket drug spending. Exhibit 1 provides a graphical depiction of the Part D coverage dynamics.

Exhibit 1: Medicare Standard Drug Benefit Guidelines, 2006



**Equivalent to $750 in out-of-pocket spending*
***Equivalent to $3,600 in out-of-pocket spending*

An important feature of the standard benefit is the coverage gap that exists between $2,250 and $5,100 in total drug spending. Most beneficiaries are responsible for all of their own drug costs within this "doughnut hole." Some plans offer alternative benefit designs or more comprehensive benefits, such as zero-deductible plans or coverage to fill in some or the entire coverage gap.

Medicare beneficiaries that enrolled in Part D during the initial enrollment period for 2006 (between November 15, 2005 and May 15, 2006) who want to switch to other plans may do so between November 15 and December 31 in 2006.[1] These changes will be effective beginning January 1, 2007. Beneficiaries that are satisfied with their current coverage will not have to take any action for 2007. However, beneficiaries that were eligible for but did not enroll in Medicare Part D in the 2006 enrollment period will face late-enrollment penalties in the form of higher premiums. Those qualifying for both Medicare and Medicaid (dual eligibles) are eligible to enroll or switch plans outside of annual enrollment periods without penalty.

This background report provides an overview of 2006 Medicare enrollment trends in North Carolina. We include information about the benefit structures of prescription drug plans offered within the state, including a preliminary look at 2007 premium and deductible changes. We also describe the provisions included in the MMA that provide "Extra Help" subsidies to beneficiaries with low incomes and limited assets.

Enrollment and plan-level benefit design and formulary information are based on data collected from the Medicare Personal PlanFinder by staff from The Lewin Group. Medicare state and county enrollment data are based on an enrollment report released by the Centers for Medicare and Medicaid Services (CMS) on June 11, 2006. Lewin estimates of employer-sponsored coverage and other creditable coverage are based on data from several sources including CMS, the Current Population Survey, Kaiser State Health Fact Sheets, and the National Conference of State Legislatures.

This report was prepared by Aaron McKethan, Wes Joines, and Christina Koster from The Lewin Group. We gratefully acknowledge the assistance of Stephanie Coplin and Jessica Dorrance (University of North Carolina at Chapel Hill), who helped prepare this report.

II. PART D PLANS

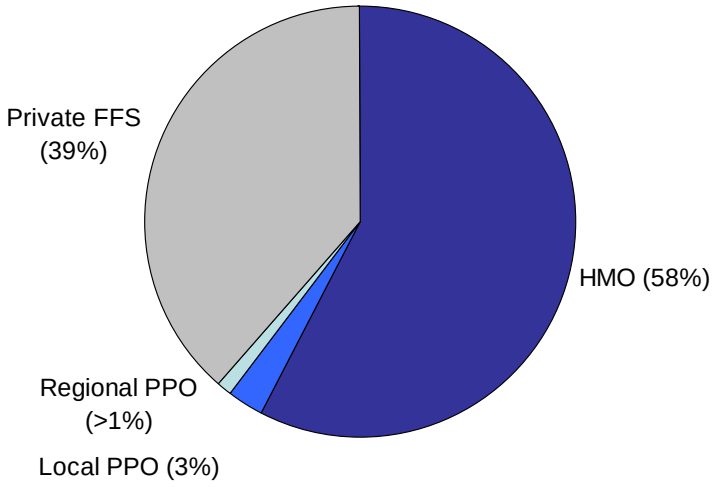
How many Part D plans are available in North Carolina?

In the 2006 enrollment period, North Carolina Medicare beneficiaries had the option of selecting from among 38 PDPs and 16 MA-PDs. Despite the many options available, a large proportion of beneficiaries receiving drug benefits tended to select from a small number of plan options available (discussed in greater detail below).

MA-PDs are distributed among several plan types: traditional health maintenance organizations (HMOs), local or regional preferred provider organizations (PPOs), and private fee-for-service (FFS) plans. The distribution of MA-PD plan types in North Carolina is consistent with national trends. The majority of beneficiaries (58%) enrolled in an MA-PD are enrolled in an HMO. Exhibit 2 displays the distribution of MA-PDs plan types in North Carolina, by percent of beneficiaries.

[1] This same enrollment period will also be in effect for future years.

Exhibit 2: MA-PD Enrollment by Type of Plans in North Carolina, 2006



III. PART D ENROLLMENT

What Part D enrollment trends have emerged in North Carolina?

The most recent enrollment estimates provided by the CMS indicate that of the approximately 1,318,800 Medicare beneficiaries in North Carolina, about 716,400 (54%) receive prescription drug benefits through the Medicare program's new Part D coverage.

This figure includes:

- 376,800 beneficiaries (29% of the total North Carolina Medicare population) who enrolled in PDPs
- An additional 230,000 beneficiaries (17%) eligible for both Medicaid and Medicare (dual eligibles) that were automatically enrolled in PDPs
- An additional 109,600 beneficiaries (8%) that are enrolled in MA-PDs[2]

About 500,100 (38%) North Carolina Medicare beneficiaries that did not enroll in a Medicare PDP or MA-PD have creditable[3] prescription drug coverage through other sources. This includes:

- 418,200 Medicare-eligible seniors (32%) whose employer-sponsored retiree coverage includes prescription drug benefits[4] (just over half of these beneficiaries are enrolled in

---

[2] This figure includes some dual-eligibles that were previously enrolled in Medicare Advantage/Part C that were automatically enrolled in an MA-PD when Medicare Part D was implemented.

[3] Prescription drug coverage is said to be "creditable" if it is at least actuarially equivalent to the standard Medicare prescription drug plan.

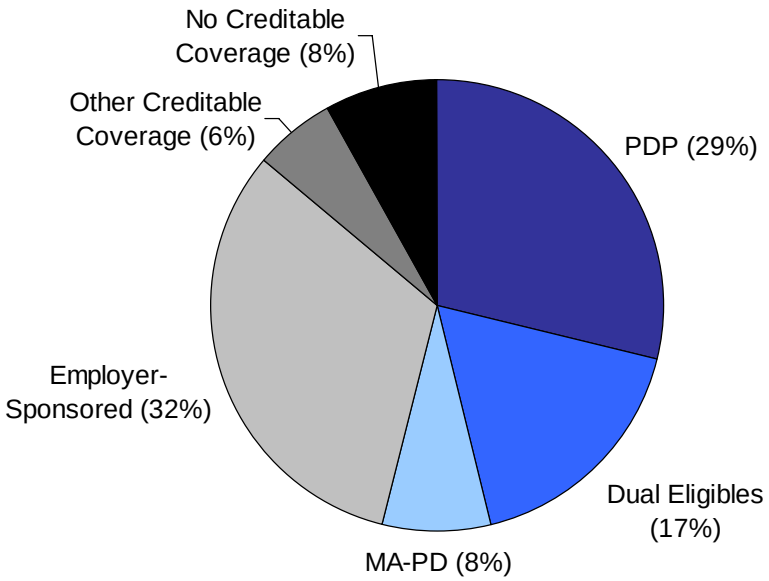
[4] Based on Lewin estimates.

employer-based plans for which Medicare subsidizes coverage through its Retiree Drug Subsidy, RDS)

- Another 81,900 beneficiaries (6%) with other sources of creditable coverage, including coverage through the Department of Veterans Affairs and the Indian Health Service

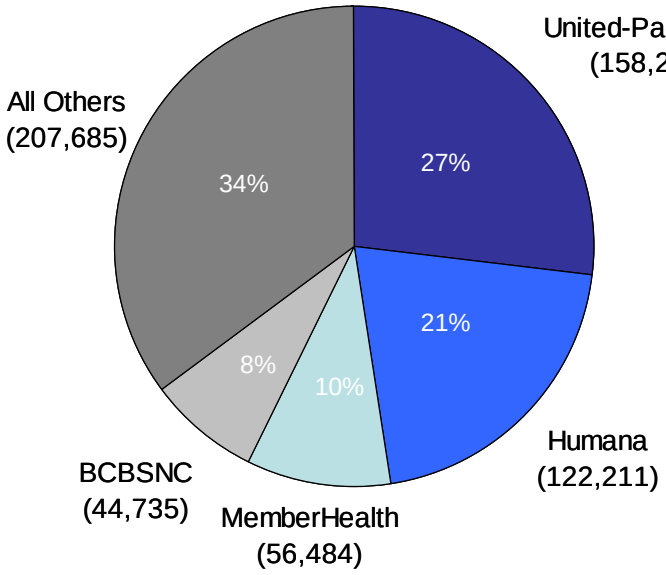
Lewin estimates that about 102,300 North Carolina Medicare beneficiaries (8%) either do not have a source of prescription drug coverage or do not have coverage that is at least comparable to the standard Medicare Part D benefit. See Exhibit 3.

Exhibit 3: Estimates of Creditable Prescription Drug Coverage among North Carolina Medicare Beneficiaries, 2006



Consistent with national enrollment patterns, a small number of plan sponsors in North Carolina account for a large share of Part D enrollment. Among the Medicare beneficiaries enrolled in PDPs (including dual-eligibles that were automatically enrolled), about 65% are enrolled in plans offered by one of just four plan sponsors: United-PacifiCare (accounting for 27% of total PDP enrollment), Humana (21%), MemberHealth/Community Care Rx (10%), and Blue Cross and Blue Shield of North Carolina (8%). On the other end of the spectrum, ten of the PDPs offered in North Carolina each have less than 1,000 members enrolled. See Exhibit 4 below.

Exhibit 4: PDP Enrollment in North Carolina, 2006



The most popular individual PDP selected in North Carolina is the United AARP MedicareRx Plan. This PDP has 116,700 enrollees, representing about 20% of total PDP enrollment in the state for 2006.

How do Medicare Part D enrollment patterns vary across the state?

Enrollment percentages vary considerably across counties. Hoke County has the highest Part D enrollment in the state with nearly three-fourths (74%) of Medicare-eligible individuals enrolled in a PDP or MA-PD. Currituck and Dare Counties have the lowest Part D enrollment, with only 39% of Medicare-eligible individuals enrolled in a PDP or MA-PD. See Appendix A for prescription drug enrollment figures by county.

Medicare prescription drug plan enrollment varies slightly depending on a county's rural or metro status.[5] On average, about 57% of Medicare-eligible individuals in rural counties receive prescription drug benefits through the Medicare program, compared to 52% living in a metropolitan county. Greater variation can be found by comparing enrollment in major metropolitan areas[6] across the state. For example, metropolitan areas with a major military presence (e.g., Jacksonville and Fayetteville) have a lower percentage of Medicare beneficiaries receiving prescription drugs through Medicare than other major metropolitan areas in the state. This may be largely attributable to military retirees and their families receiving prescription drug coverage through other government sources, such as the Department of Veterans Affairs. Similar patterns have emerged in areas with relatively high concentrations of state retirees, such as in Durham and Raleigh. The North Carolina State Teachers' and Retirees' Health Plan

[5] For this analysis, we used the rural-metro county definitions from the North Carolina Rural Center, available online at: http://www.ncruralcenter.org/databank/rural_county_map.asp.

[6] We used metropolitan statistical area (MSA) definitions maintained by the U.S. Office of Management and Budget (OMB), available online at: http://ww.census.gov/population/www/estimates/metrodef.html.

maintains generous retiree prescription drug coverage for eligible seniors; consequently, many vested state retirees do not receive prescription drug benefits through Medicare.

See the appendices for detailed tables and maps depicting enrollment patterns at county (Appendix A and Appendix B), metropolitan area (C and D), and AHEC region (E and F) levels.

IV. PREMIUMS, BENEFITS, AND FORMULARIES

How do premiums vary by plan and plan type in North Carolina?

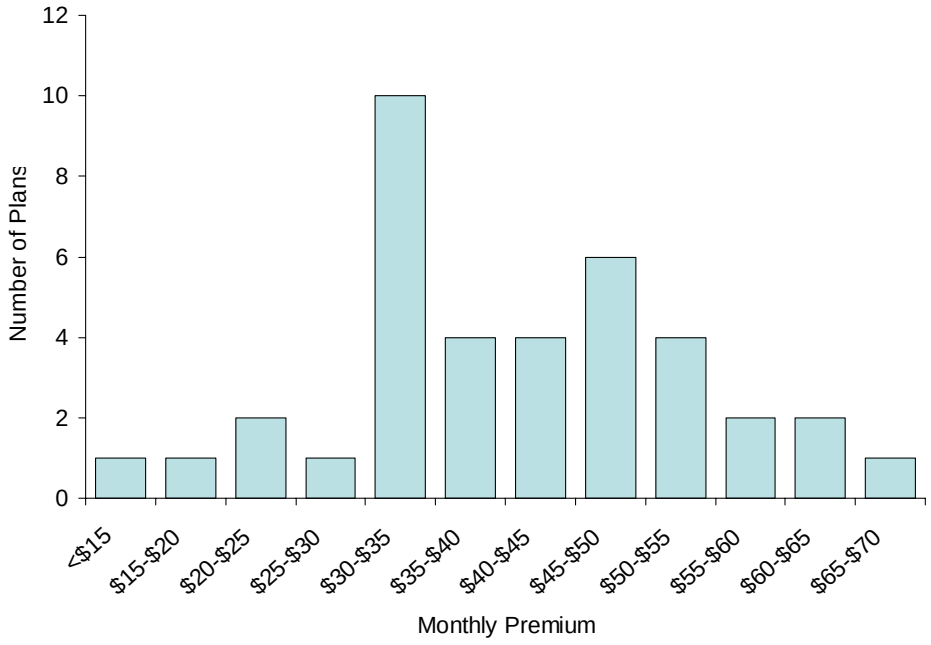
For 2006, Monthly PDP premiums in North Carolina range from $13.27 to $65.03, with an average PDP premium charge of $40.86. Exhibit 5 below displays the range of premiums offered by PDP plans in North Carolina and its neighboring states. Importantly, the far right-hand column displays the average premiums weighted by plan enrollment. This reflects the average premiums that are actually being paid by beneficiaries for 2006, rather than simply those being offered in the marketplace. As would be expected, enrollment is skewed toward plans offering lower premiums. In North Carolina, the average monthly premium being paid (weighted by enrollment) is about $9 below the average amount being charged.

Exhibit 5: PDP Premiums in North Carolina and Neighboring States, 2006

State	Lowest Premium	Highest Premium	Average Premium	Average Premium, Weighted by Enrollment
North Carolina	$13.27	$65.03	$40.86	$31.95
Georgia	$17.91	$73.17	$37.60	$29.92
South Carolina	$16.57	$69.72	$39.39	$30.10
Tennessee	$14.08	$69.98	$40.05	$27.48
Virginia	$8.81	$68.61	$38.12	$28.00

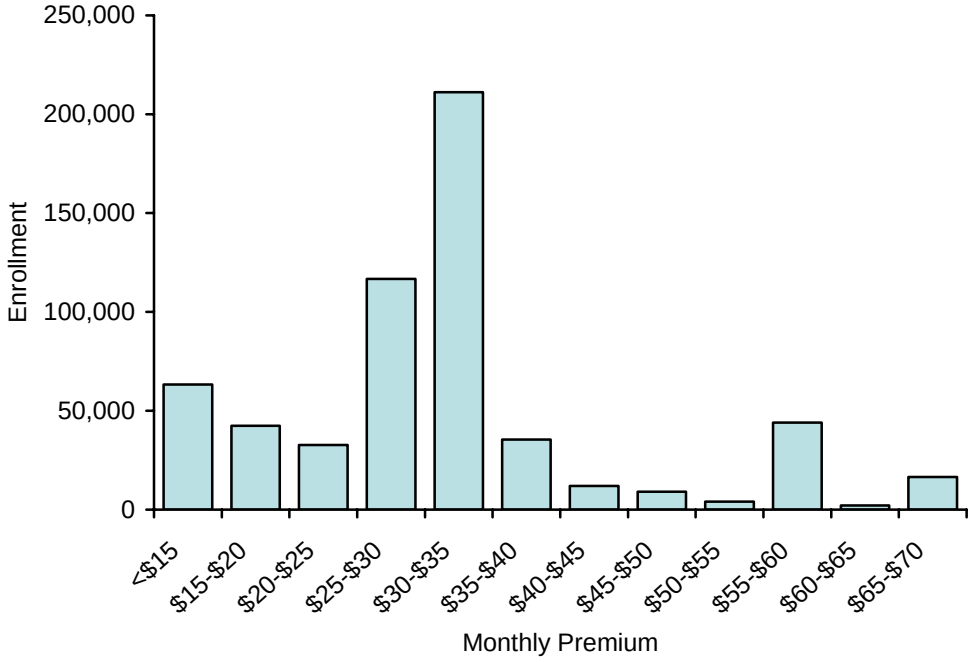
Exhibit 6 displays the distribution of PDP offerings in North Carolina by (unweighted) monthly premium amounts.

Exhibit 6: Distribution of PDPs by Monthly Premium Amount in North Carolina, 2006



As noted above, with numerous plan options providing different levels of benefits and cost sharing arrangements, beneficiaries in North Carolina have disproportionately enrolled in PDPs with lower than average premiums. The state's most popular PDP, the United AARP MedicareRx Plan, includes a monthly premium of $28.27. Exhibit 7 below displays PDP enrollment by monthly premium level.

Exhibit 7: PDP Enrollment by Premium Level in North Carolina, 2006



Generally, MA-PDs can offer lower premiums than PDPs to the extent that they are able to offset the cost of drug coverage with savings from other medical costs. This is evident in North Carolina as the average MA-PD premium in the state is $20.36 for 2006, compared to the unweighted state average ($40.86) for all PDPs offered in the state. MA-PD premiums range from $0 to $47.29 per month. Like those enrolling in PDPs, beneficiaries selecting MA-PDs tended to enroll in plans with lower than average premiums. The enrollment-weighted average MA-PD premium in North Carolina is $12.11 per month

To what degree is "enhanced coverage" available for plans in North Carolina?

Part D plan sponsors have the flexibility to offer plans that are different than the standard Medicare drug benefit as long as they are at least actuarially equivalent to the standard benefit. This "enhanced coverage" allows plans to design and market drug plans to beneficiaries with different needs or incomes. Enhanced coverage is available to beneficiaries in the form of reduced or zero deductibles or with additional coverage of generic drugs or brand *and* generic drugs in the coverage gap. About 15% of Medicare Part D participants in North Carolina are enrolled in a plan providing some form of gap coverage.

In North Carolina, most Part D participants (56%) are enrolled in PDPs that do not have deductibles. This includes the popular United AARP MedicareRx Plan. Forty-three percent of participants are enrolled in a PDP offering the standard $250 deductible and approximately 1% of participants are enrolled in a PDP offering a "reduced deductible" (between $0 and $250). Among MA-PD beneficiaries, virtually all (99%) are enrolled in plans requiring that

beneficiaries meet the standard $250 deductible. Only 1% of MA-PD participants have a zero deductible and none have reduced deductibles between $0 and $250.

Some PDPs also offer additional coverage in the coverage gap. One plan in North Carolina (Humana Complete, with about 16,500 enrollees statewide) covers both brand and generic drugs through the coverage gap. Six other plans cover only generic drugs in the coverage gap. The remaining 31 plans (including the top-selling United AARP MedicareRx Plan) do not provide any additional coverage in the coverage gap. See Exhibit 8.

Exhibit 8: PDPs with Enhanced Coverage in the Coverage Gap in North Carolina, 2006

Coverage in Gap	Number of Plans	Percent of Plans	Percent of Plans in US
None	31	81.6%	84.4%
Generic Only	6	15.8%	13.2%
Brand & Generic	1	2.6%	2.4%

None of the MA-PDs in North Carolina offers additional coverage in the coverage gap.

How do formularies vary among PDPs in North Carolina in 2006?

A formulary is a list of prescription drugs that a health plan will cover. When selecting plans, it is important that beneficiaries with specific and non-substitutable medication needs enroll in plans with formularies that include those medications. However, not all formularies are the same; the number of drugs covered on PDP formularies varies from plan to plan. PDPs in North Carolina cover, on average, about 1,700 drugs. Some plans cover as few as 879 and as many as 3,107 drugs.

The formularies offered by PDPs in North Carolina cover more drugs, on average, than those in neighboring states (i.e., Virginia, Tennessee, South Carolina, and Georgia), where the average number of drugs covered ranges from 1,609 to 1,635. Because many of the PDPs offered in North Carolina are national plans, and therefore are also offered in other states, many of the same formularies are offered in North Carolina and its neighboring states. For example, each of North Carolina's neighboring states offers a PDP that has 3,107 drugs covered on formulary. PDPs that are only offered in specific states account for the variation across states. For example, while the minimum amount of drugs covered by a North Carolina PDP is 879, PDPs in Georgia and South Carolina cover as few as 592.

A large formulary does not necessarily equate to a "good" plan. Formularies may cover many drugs but may also exclude drugs that are commonly used by beneficiaries. Thus, as noted above, an important part of the plan selection process is to ensure that plans selected do cover needed medications. Since beneficiaries can not always anticipate future prescription needs, this process can be particularly challenging. See Appendix H for plan-specific formulary information.

What types of utilization management efforts are used by PDPs in North Carolina?

In addition to formularies, PDPs may differ by the types of utilization management efforts that are used, including the following:

- Prior authorization (a procedure requiring the physician to obtain authorization from the insurer before prescribing a drug)
- Step therapy (a prescription regimen that requires beneficiaries to first try certain less-expensive drugs before moving to other more-expensive alternatives)
- Quantity limits (a limitation by plans of the number of doses of a particular drug that beneficiaries may receive in a given time period)

The average PDP in North Carolina imposes prior authorization on 120 drugs and step therapy restrictions on 27 drugs. PDPs in North Carolina use these utilization management tools somewhat less frequently than PDPs in neighboring states, as can be seen in Exhibit 9. The average PDP in North Carolina applies prior authorization on 120 drugs, but the maximum number of drugs subject to prior authorization by a North Carolina PDP is 361, significantly lower than some other states.

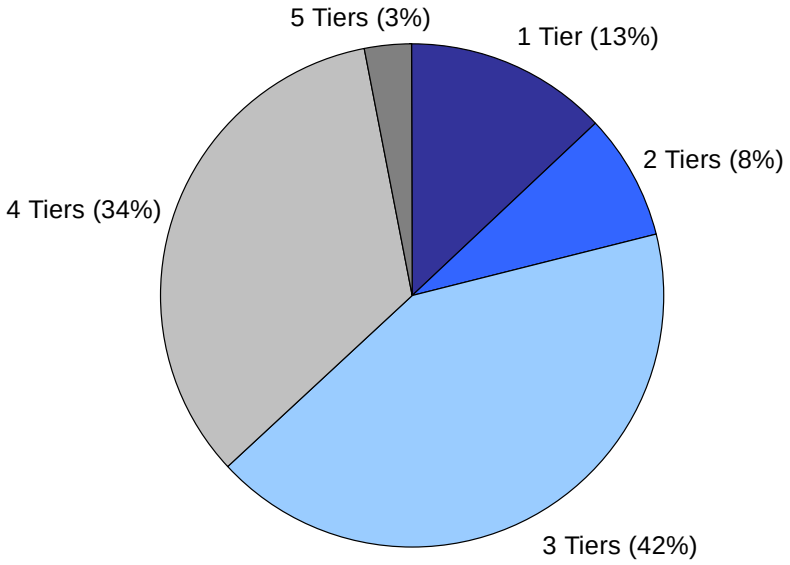
Exhibit 9: Utilization Management in PDPs in North Carolina and Neighboring States

State	Prior Authorization (PA)		Step Therapy (ST)	
	Average # of drugs subject to PA	Maximum # of drugs subject to PA	Average # of drugs subject to ST	Maximum # of drugs subject to ST
North Carolina	120	361	27	107
Georgia	119	361	33	272
South Carolina	128	692	33	272
Tennessee	137	692	29	107
Virginia	129	692	27	107

What types of tier structures are offered by North Carolina PDPs?

In a formulary, drugs are often placed in different tiers to determine the cost-sharing responsibilities of the beneficiary for each drug on the formulary. Tier structures are generally designed to encourage beneficiaries to choose lower-priced drugs when more expensive options are available. For example, in a common three-tier formulary, generic drugs are usually placed on tier 1, preferred brand drugs are placed on tier 2, and non-preferred brand drugs are placed on tier 3. Preferred brand drugs are offered at lower co-payments than non-preferred brand drugs. Three-tier PDPs are currently the most common tier structure among PDPs offered in North Carolina. See Exhibit 10.

Exhibit 10: North Carolina PDPs, by Number of Tiers



Most PDPs in North Carolina use a co-payment structure for tiers 1-3, which means that beneficiaries pay fixed dollar amounts when purchasing prescription medications on each of these tiers. If the plan has more than three tiers, coinsurance is usually in effect for tiers four and above, meaning that the beneficiary pays a percentage of the total cost of the prescription. The United AARP MedicareRx Plan includes four tiers, with a co-pay of $5 on tier 1, $28 on tier 2, $55 on tier 3, and 25% coinsurance on tier 4. Exhibit 11 displays the range of different co-payment amounts for tiers 1-3 and the range of coinsurance options for tiers 4 and 5 for PDPs in the state.

Exhibit 11: Range of Cost-Sharing Arrangements by Tier for PDPs in North Carolina

Tier	Lowest Co-Pay/Coinsurance	Highest Co-Pay/Coinsurance
1	$0	$12
2	$15	$67
3	$40	$67
4	25%	33%
5	30%	30%

How will Part D plans and premiums change in 2007?

The federal government recently released information about the Part D plans that will be available effective January 1, 2007.[7] Part D participants will have more PDP options in 2007 (51 PDPs) than were available in 2006 (38 PDPs). More PDPs will include zero deductibles and coverage in the gap than were offered in 2006. These changes in North Carolina are consistent with national trends for 2007.

If current Part D participants stay in the same PDPs for 2007, their monthly premiums will increase in January 2007 by 7.8%, on average.[8] The monthly premium of the AARP MedicareRx Plan (which has the highest enrollment of any PDP in North Carolina in 2006) is set to increase to $30.00 per month for 2007, a 6.1% increase over the 2006 premium of $28.27.

In 2006, about 40% of all PDP participants were enrolled in plans offering the standard $250 deductible for 2006. About 90% of these beneficiaries will continue to have the standard deductible for 2007 ($265) if they remain in the same plans.[9] The remaining 10% will have lower deductibles for 2007 than the standard deductible if they remain in the same plan.
In 2006, 56% of PDP participants are enrolled in plans with a zero deductible. Virtually all (99%) of these beneficiaries will continue to have a zero deductible for 2007 if they remain in the same plan.

Another change in PDP design from 2006 to 2007 is that more PDPs are offering coverage in the gap. Six new plans will offer some form of gap coverage in 2007, bringing the total number of PDPs offering gap coverage to 15, up from 7 in 2006. Of the 36 plans that are continuing in 2007, three have added gap coverage, one has dropped gap coverage, and one has decreased the level of gap coverage. Appendix I provides details about premium and deductible changes in 2007 for North Carolina PDPs.

To gain a more complete understanding of the Medicare program's overall premium stability in North Carolina, it would be necessary to carefully model current enrollees' 2006 and 2007 premium costs relative to total changes in PDP benefit designs. CMS will be releasing all relevant information in the coming weeks.

---

[7] In September 2006, the Centers for Medicare and Medicaid Services (CMS) announced the Medicare Part D standard benefit for 2007. See: http://www.medicare.gov/medicarereform/local-plans-2007.asp

[8] This average is weighted by 2006 PDP enrollment and thus excludes three PDPs that were offered in 2006 but were not offered as the same plans in 2007. Together, these three plans have 5,470 in total enrollment for 2006.

[9] The standard deductible will increase from $250 for 2006 to $265 for 2007.

V. THE LOW-INCOME SUBSIDY PROGRAM

Medicare Part D includes a low-income subsidy program (LIS) (known as "Extra Help") that pays Part D premium and cost-sharing requirements for certain low-income beneficiaries. Dual-eligible beneficiaries automatically enrolled in Medicare Part D are automatically eligible for the LIS program. Non-dual eligibles that have incomes at or below 135 percent of the Federal Poverty Level (FPL) and have limited assets (described in Exhibit 14 below) are also eligible for "full" LIS benefits. Dual eligibles and non-dual eligibles receiving full LIS benefits pay no monthly premiums or annual deductibles, do not face a coverage gap, and are subject to reduced co-payments.

Beneficiaries with incomes between 135 and 150 percent of FPL and with limited assets can receive partial LIS assistance, although they are expected to pay towards their monthly premiums on a sliding scale basis. See Exhibit 12.

Exhibit 12: Summary of Low-Income Subsidy Eligibility and Benefits, 2006

Low-Income Subsidy Level	Monthly Premium	Annual Deductible	Co-payments	Gap Coverage?
Individuals with Medicaid and Medicare ("dual eligibles")	$0	$0	$1- $2/generic; $3-$5/brand; no co-pays after total drug spending reaches $5,100	Yes
Individuals with income <135% of FPL and limited assets ($6,000/individual; $9,000 couple)	$0	$0	$2/generic; $5 brand; no co-pays after total drug spending reaches $5,100	Yes
Individuals with income 135%-150% of FPL and limited assets ($10,000/individual; $20,000 couple)	Sliding scale up to $32.30*	$50	15% of total costs up to $5,100; $2/generic; $5 brand thereafter	No

Note: Assets do not include $1,500/individual and $3,000/couple for funeral or burial expenses. *$32.30 is the national monthly Part D base beneficiary premium for 2006.
Source: Centers for Medicare and Medicaid Services

Individuals can apply for the LIS at the local Social Security Administration (SSA) office or through their State Medicaid offices. Telephone and Internet-based applications are also accepted through SSA. As of July 2006, the SSA had received about 232,000 applications for LIS assistance from individuals in North Carolina. Of this amount, SSA made eligibility determinations for 183,200 applicants of which 91,600 applicants were accepted for full or

partial LIS assistance. North Carolina's applicant "acceptance" rate of 50% is slightly better than the national average rate of 45.8%.[10]

While many North Carolinians are receiving assistance through LIS, many low-income Medicare beneficiaries do not qualify for these benefits due to assets that exceed the eligibility threshold. A recent study estimated that 2.4 million Medicare beneficiaries with incomes below 150% of FPL would not qualify for LIS assistance in 2006 because their assets exceed the eligibility threshold.[11] The SSA has reported that most (57%) low-income subsidy applicants that were determined to be ineligible would have qualified based on income alone, but were disqualified due to excess assets.[12]

In addition to those who do not qualify for LIS benefits due to the income and/or asset tests, there are many people that are presumed to be eligible but remain unenrolled in the program. Nationally, CMS estimates that 13.2 million individuals are eligible for the LIS, of whom 3.25 million have not yet enrolled.[13] This includes an estimated 91,700 North Carolinians that are eligible but were unenrolled in the LIS program as of June 2006. See Appendix J for county-level estimates of the number of beneficiaries that are presumed eligible but are unenrolled in North Carolina.

---

[10] "Status of Medicare Low Income Subsidy Applications Received," Social Security Administration. Data as of July 14, 2006. URL: http://www.ssa.gov/legislation/statealphasmallfont.html

[11] Rice, Thomas. "Low-Income Subsidies for the Medicare Prescription Drug Benefit: The Impact of the Asset Test." Kaiser Family Foundation, April 2005.

[12] "Medicare: Low-Income Assistance Under the Medicare Drug Benefit" May 2006. Kaiser Family Foundation. URL: http://www.kff.org/medicare/upload/7327.pdf

[13] "Low-Income Subsidy Outreach Targeting Information Number of Unenrolled People who May Be Eligible for the Low-Income Subsidy," CMS. June 29, 2006.

APPENDICES

A. Medicare Beneficiaries with Medicare Prescription Drug Benefits by County, 2006

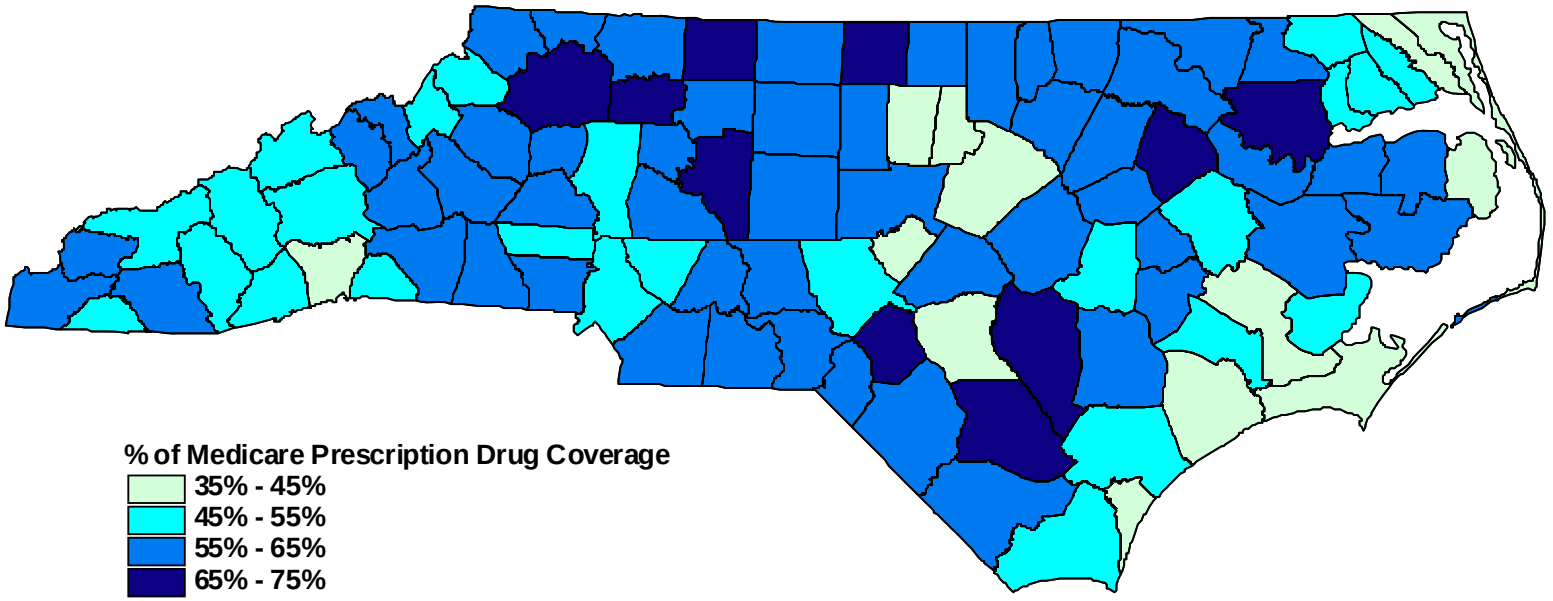
County Name	Stand-Alone PDP	MA-PD	Dual Eligibles*	Total Enrolled in Medicare Part D	% of Medicare-eligibles enrolled in Medicare Part D
Alamance	5,672	4,282	3,639	13,593	56.0%
Alexander	2,096	285	913	3,294	60.1%
Alleghany	747	306	516	1,569	58.2%
Anson	1,495	10	1,191	2,696	59.4%
Ashe	2,049	357	1,150	3,556	63.0%
Avery	1,034	157	635	1,826	47.9%
Beaufort	3,153	165	2,142	5,460	55.3%
Bertie	1,543	39	1,565	3,147	68.2%
Bladen	1,966	47	1,933	3,946	67.4%
Brunswick	5,680	854	2,247	8,781	45.7%
Buncombe	12,163	1,608	6,096	19,867	48.3%
Burke	5,356	257	2,978	8,591	56.4%
Cabarrus	7,160	1,307	2,927	11,394	50.8%
Caldwell	5,797	507	2,546	8,850	63.4%
Camden	313	62	179	554	43.4%
Carteret	3,554	73	1,520	5,147	44.0%
Caswell	1,172	364	1,041	2,577	67.1%
Catawba	9,764	863	3,515	14,142	58.3%
Chatham	3,009	803	1,165	4,977	64.3%
Cherokee	1,956	438	1,246	3,640	55.3%
Chowan	1,042	52	637	1,731	55.0%
Clay	804	99	407	1,310	52.5%
Cleveland	6,806	387	3,601	10,794	57.6%
Columbus	3,783	77	3,305	7,165	62.9%
Craven	4,609	67	2,547	7,223	41.5%
Cumberland	6,521	1,345	6,530	14,396	40.2%
Currituck	800	82	317	1,199	38.6%
Dare	1,497	47	369	1,913	38.6%
Davidson	6,474	5,759	3,491	15,724	70.5%
Davie	1,315	1,748	768	3,831	58.4%
Duplin	2,704	56	2,299	5,059	62.2%
Durham	6,394	1,074	4,546	12,014	42.0%
Edgecombe	3,159	268	2,933	6,360	68.3%
Forsyth	7,590	16,381	5,954	29,925	57.7%
Franklin	1,998	528	1,723	4,249	61.4%
Gaston	10,485	2,677	5,793	18,955	58.5%
Gates	537	106	393	1,036	53.6%
Graham	494	90	479	1,063	59.2%
Granville	1,916	422	2,043	4,381	58.2%
Greene	858	20	718	1,596	64.7%

County Name	Stand-Alone PDP	MA-PD	Dual Eligibles*	Total Enrolled in Medicare Part D	% of Medicare-eligibles enrolled in Medicare Part D
Guilford	15,115	13,632	8,705	37,452	57.7%
Halifax	3,565	687	3,894	8,146	65.0%
Harnett	4,104	155	2,807	7,066	62.1%
Haywood	3,272	668	1,998	5,938	45.5%
Henderson	6,710	1,247	2,403	10,360	42.8%
Hertford	1,382	93	1,374	2,849	63.9%
Hoke	994	164	1,158	2,316	74.0%
Hyde	251	5	317	573	59.2%
Iredell	7,579	1,176	3,012	11,767	55.0%
Jackson	1,625	257	930	2,812	50.0%
Johnston	5,261	1,005	3,978	10,244	60.7%
Jones	625	10	478	1,113	54.1%
Lee	2,743	218	1,465	4,426	44.4%
Lenoir	3,938	23	3,148	7,109	57.1%
Lincoln	4,072	189	1,563	5,824	54.2%
McDowell	2,671	684	1,564	4,919	58.4%
Macon	2,791	256	1,049	4,096	49.5%
Madison	1,164	200	1,068	2,432	59.0%
Martin	1,666	63	1,310	3,039	58.2%
Mecklenburg	22,969	6,734	12,173	41,876	50.4%
Mitchell	1,102	303	788	2,193	60.2%
Montgomery	1,364	370	1,058	2,792	61.7%
Moore	6,201	674	2,067	8,942	45.1%
Nash	5,254	466	3,493	9,213	58.1%
New Hanover	8,263	985	3,917	13,165	45.0%
Northampton	1,430	262	1,463	3,155	63.3%
Onslow	3,436	134	2,270	5,840	39.7%
Orange	2,949	941	1,599	5,489	39.6%
Pamlico	901	20	482	1,403	51.8%
Pasquotank	1,508	250	1,169	2,927	47.9%
Pender	2,175	391	1,393	3,959	50.1%
Perquimans	852	93	456	1,401	49.8%
Person	2,023	459	1,368	3,850	64.9%
Pitt	5,596	214	4,503	10,313	53.8%
Polk	1,714	145	499	2,358	48.5%
Randolph	6,476	4,297	3,154	13,927	63.7%
Richmond	3,477	59	2,217	5,753	62.8%
Robeson	5,494	74	6,481	12,049	58.8%
Rockingham	4,711	3,638	3,246	11,595	64.5%
Rowan	6,619	2,481	3,489	12,589	60.4%
Rutherford	4,618	737	2,374	7,729	61.4%
Sampson	3,393	574	2,765	6,732	69.9%
Scotland	2,031	41	1,847	3,919	64.1%
Stanly	4,301	54	1,677	6,032	55.5%

County Name	Stand-Alone PDP	MA-PD	Dual Eligibles*	Total Enrolled in Medicare Part D	% of Medicare-eligibles enrolled in Medicare Part D
Stokes	1,266	2,736	1,153	5,155	72.6%
Surry	3,054	3,461	2,560	9,075	60.0%
Swain	681	124	754	1,559	55.0%
Transylvania	2,711	478	755	3,944	50.2%
Tyrrell	241	19	194	454	61.8%
Union	6,315	222	2,202	8,739	58.0%
Vance	2,183	711	2,189	5,083	62.8%
Wake	16,921	6,595	9,233	32,749	44.0%
Warren	855	316	1,117	2,288	61.1%
Washington	1,039	33	641	1,713	62.0%
Watauga	2,014	208	872	3,094	53.4%
Wayne	4,642	493	4,423	9,558	50.2%
Wilkes	3,554	2,358	2,651	8,563	69.6%
Wilson	4,920	107	3,170	8,197	62.5%
Yadkin	1,226	2,291	1,095	4,612	66.2%
Yancey	1,292	215	866	2,373	56.6%
Total	376,764	109,564	230,041	716,369	54.3%

* Dual Eligibles were automatically enrolled into a PDP and are counted as “dual eligibles” above. However, beneficiaries that were previously enrolled in a Medicare Advantage plan were automatically enrolled into a MA-PD and are counted in the MA-PD column above.

B. Map: Percentage of Medicare Beneficiaries with Medicare Prescription Drug Benefits, by County (2006)

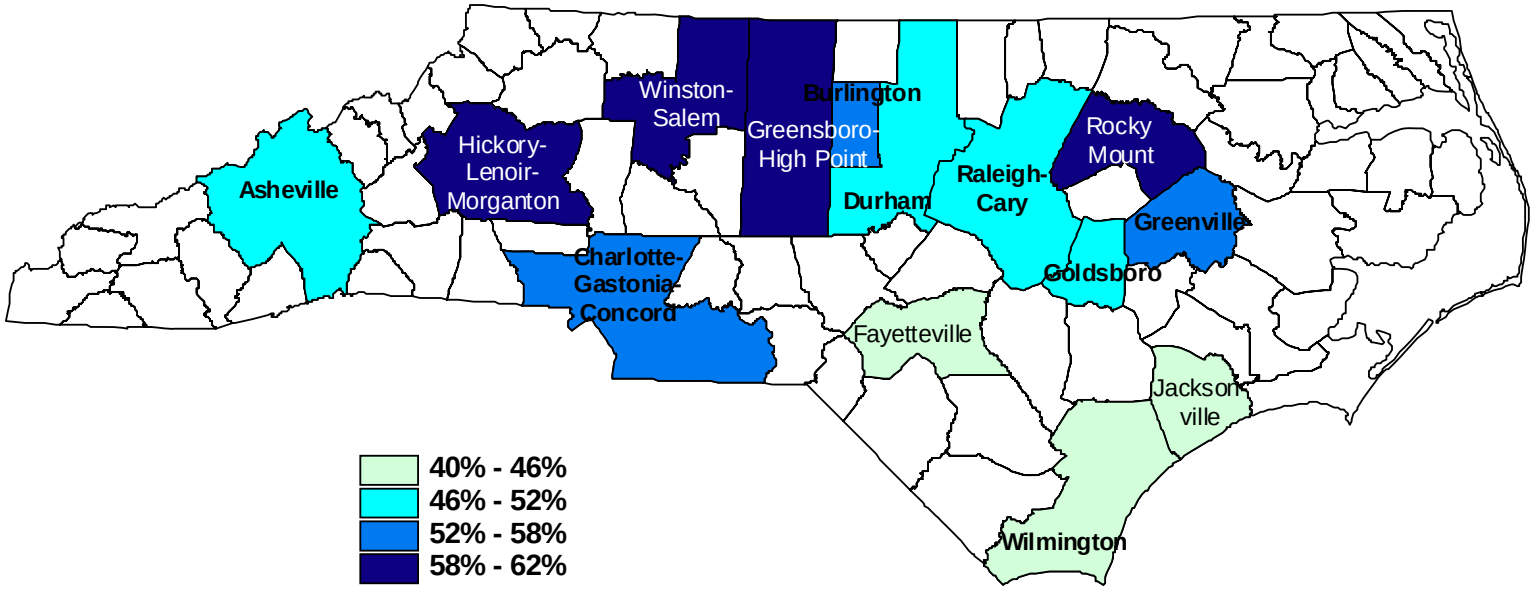


C. Medicare Beneficiaries with Medicare Prescription Drug Benefits, by MSA (2006)

MSA	Stand-Alone PDP	MA-PD	Dual Eligibles*	Total Enrolled in Medicare Prescription Drug Plans	% of Medicare-eligibles enrolled in Medicare Part D
Asheville	23,309	3,723	11,565	38,597	46.8%
Burlington	5,672	4,282	3,639	13,593	56.0%
Charlotte-Gastonia-Concord	48,424	10,950	24,286	83,660	53.1%
Durham	14,375	3,277	8,678	26,330	46.9%
Fayetteville	7,515	1,509	7,688	16,712	42.9%
Goldsboro	4,642	493	4,423	9,558	50.2%
Greensboro-High Point	26,302	21,567	15,105	62,974	60.1%
Greenville	6,454	234	5,221	11,909	55.1%
Hickory-Lenoir-Morganton	23,013	1,912	9,952	34,877	59.1%
Jacksonville	3,436	134	2,270	5,840	39.7%
Raleigh-Cary	24,180	8,128	14,934	47,242	48.1%
Rocky Mount	8,413	734	6,426	15,573	61.9%
Wilmington	16,118	2,230	7,557	25,905	46.0%
Winston-Salem	11,397	23,156	8,970	43,523	60.1%
Other	153,514	27,235	99,327	280,076	57.4%
Total	376,764	109,564	230,041	716,369	54.3%

* Dual Eligibles were automatically enrolled into a PDP and are counted as “dual eligibles” above. However, beneficiaries that were previously enrolled in a Medicare Advantage plan were automatically enrolled into a MA-PD and are counted in the MA-PD column above.

D. Percentage of Medicare Beneficiaries with Medicare Prescription Drug Benefits, by MSA (2006)

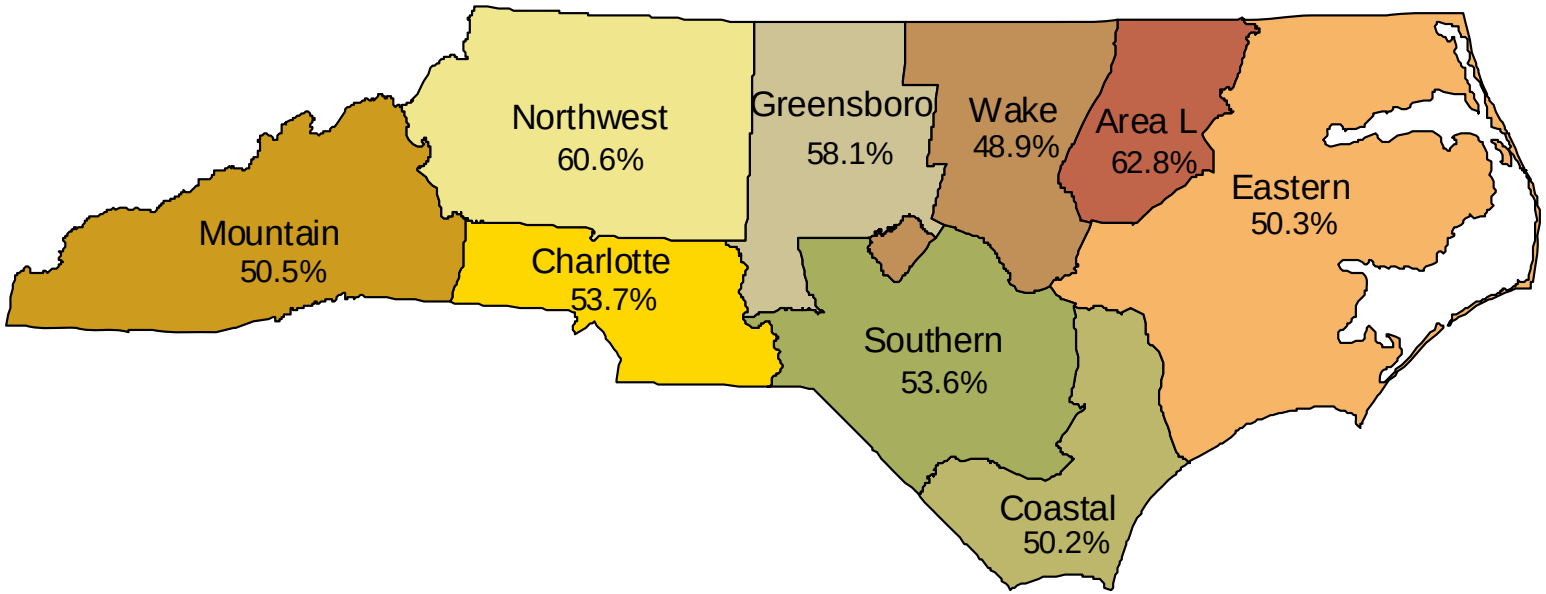


E. Medicare Beneficiaries with Medicare Prescription Drug Benefits, by AHEC Region (2006)

AHEC	Stand-Alone PDP	MA-PD	Dual Eligibles*	Total Enrolled in Medicare Prescription Drug Plans	% of Medicare-eligibles enrolled in Medicare Part D
Greensboro	40,468	28,327	23,607	92,402	58.1%
Northwest	67,534	41,331	37,298	146,163	60.6%
Charlotte	63,603	11,580	31,127	106,310	53.7%
Eastern	43,983	2,163	31,152	77,298	50.3%
Southern	34,181	3,133	27,805	65,119	53.6%
Coastal	22,605	2,363	13,161	38,129	50.2%
Mountain	45,768	7,549	23,276	76,593	50.5%
Area L	18,328	1,790	14,953	35,071	62.8%
Wake	40,294	11,328	27,662	79,284	48.9%
Total	376,764	109,564	230,041	716,369	54.3%

* Dual Eligibles were automatically enrolled into a PDP and are counted as “dual eligibles” above. However, beneficiaries that were previously enrolled in a Medicare Advantage plan were automatically enrolled into a MA-PD and are counted in the MA-PD column above.

F. Map: Percentage of Medicare Beneficiaries with Medicare Prescription Drug Benefits, by AHEC Region (2006)



G. Enrollment in North Carolina PDPs by Plan Sponsor, 2006

Plan Sponsor	PDP	Enrollment
United HealthCare Insurance Company	AARP MedicareRx Plan	116,654
Humana Inc.	Humana PDP Standard	63,316
Member Health/Community Care Rx	CCRX BASIC	47,041
Blue Cross Blue Shield of North Carolina	Medicare Prescription Drug Plan - Plus	43,854
Humana Inc.	Humana PDP Enhanced	42,384
WellCare	WellCare Signature	29,538
CIGNA HealthCare	Plan 00308	27,049
PacifiCare Life and Health Insurance Company	PacifiCare Saver Plan	25,227
YOURx PLAN	Medco Prescription Savings Plan	22,573
Prescription Pathway	Pennsylvania Life Standard Defined	20,575
Unicare	Medicare RX Rewards	19,309
SilverScript	SilverScript	19,271
RxAmerica	RxAmerica Standard - Open Formulary	17,808
Humana Inc.	Humana PDP Complete	16,511
Coventry AdvantraRx	AdvantraRx Premier	15,599
United HealthCare Insurance Company	United Medicare Rx - B	14,105
RxAmerica	RxAmerica $2.00 Generic Co-pay	9,598
United American Insurance Company	UA Medicare Part D Prescription Drug Cov	7,019
Coventry AdvantraRx	AdvantraRx Premier Plus	5,536
Member Health/Community Care Rx	CCRX GOLD	5,043
Community Care Rx	CCRX CHOICE	4,400
Coventry AdvantraRx	AdvantraRx Value	3,127
CIGNA HealthCare	Plan 00508	2,233
Aetna Life Insurance Company	Aetna Medicare Prescription Premier Plan	2,068
PacifiCare Life and Health Insurance Company	PacifiCare Comprehensive Plan	1,544
Other		8,021

H. Number of Drugs Covered on Formularies of North Carolina PDPs

Plan Sponsor	PDP Name	Number of Drugs on Formulary
RxAmerica	RxAmerica $2.00 Generic Co-pay	3,107
RxAmerica	RxAmerica Standard - Open Formulary	3,107
Blue Cross Blue Shield of North Carolina	Medicare Prescription Drug Plan - Plus	2,887
Humana Inc.	Humana PDP Standard	2,785
Humana Inc.	Humana PDP Complete	2,785
Humana Inc.	Humana PDP Enhanced	2,785
Aetna Life Insurance Company	Aetna Medicare Prescription Premier Plan	2,344
Unicare	Medicare RX Rewards Premier	2,218
CIGNA HealthCare	Plan 00508	2,091
CIGNA HealthCare	Plan 00608	2,091
CIGNA HealthCare	Plan 00308	2,091
Blue Cross Blue Shield of North Carolina	Medicare Prescription Drug Plan - Standard	2,071
United HealthCare Insurance Company	United Medicare Rx - B	1,900
United HealthCare Insurance Company	AARP MedicareRx Plan	1,900
Coventry AdvantraRx	AdvantraRx Premier Plus	1,715
Coventry AdvantraRx	AdvantraRx Premier	1,715
United American Insurance Company	UA Medicare Part D Prescription Drug Cov	1,617
YOURx PLAN	Medco Prescription Savings Plan	1,605
Member Health/Community Care Rx	CCRX BASIC	1,426
Member Health/Community Care Rx	CCRX CHOICE	1,426
Member Health/Community Care Rx	CCRX GOLD	1,426
Prescription Pathway	Pennsylvania Life Act. Equ. Standard	1,376
Prescription Pathway	Pennsylvania Life Enhanced #1	1,376
Prescription Pathway	Pennsylvania Life Standard Defined	1,376
Aetna Life Insurance Company	Aetna Medicare Prescription Basic Plan	1,278
Aetna Life Insurance Company	Aetna Medicare Prescription Standard Plan	1,278
SilverScript	SilverScript Plus	1,244
Unicare	Medicare RX Rewards Plus	1,239
Unicare	Medicare RX Rewards	1,239
Sterling Prescription Drug Plan	Sterling Prescription Drug Plan	1,207
Coventry AdvantraRx	AdvantraRx Value	1,159
SilverScript	SilverScript	1,141
PacifiCare Life and Health Insurance Company	PacifiCare Saver Plan	955
PacifiCare Life and Health Insurance Company	PacifiCare Select Plan	955
PacifiCare Life and Health Insurance Company	PacifiCare Comprehensive Plan	955
WellCare	WellCare Complete	879
WellCare	WellCare Premier	879
WellCare	WellCare Signature	879

I. Comparison of PDP Premium and Deductible Information (2006-2007), by 2006 PDP Enrollment

Company Name	Plan Name	2006 Enrollment	Premiums		Premium Change (%)	Deductibles	
			2006	2007		2006	2007
UnitedHealthcare	AARP MedicareRx Plan	116,654	$28.27	$30.00	6.1%	$0	$0
Humana Insurance Company	Humana PDP Standard S5884-066	63,316	$13.27	$17.80	34.1%	$250	$265
MEMBERHEALTH	Community Care Rx BASIC	47,041	$32.24	$33.30	3.3%	$250	$265
Blue Cross Blue Shield of North Carolina	BCBSNC Plus Plan	43,854	$59.60	$65.00	9.1%	$0	$0
Humana Insurance Company	Humana PDP Enhanced S5884-007	42,384	$18.05	$26.20	45.2%	$0	$0
WellCare	WellCare Signature	29,538	$24.87	$27.70	11.4%	$0	$0
CIGNA HealthCare	CIGNATURE Rx Value Plan	27,049	$35.53	$27.10	-23.7%	$250	$265
UnitedHealthcare	UnitedHealth Rx Basic	25,227	$31.56	$32.30	2.3%	$0	$0
Medco YOURx PLAN	Medco YOURx PLAN	22,573	$34.32	$34.30	-0.1%	$250	$100
Pennsylvania Life Insurance Company	Prescription Pathway Bronze Plan Reg 8	20,575	$32.19	$27.60	-14.3%	$250	$265
Unicare	MedicareRx Rewards Value	19,309	$31.30	$33.10	5.8%	$250	$265
SilverScript	SilverScript	19,271	$30.90	$29.90	-3.2%	$250	$265
RxAmerica	Advantage Freedom Plan by RxAmerica	17,808	$34.95	$33.50	-4.1%	$250	$265
Humana Insurance Company	Humana PDP Complete S5884-036	16,511	$65.03	$85.90	32.1%	$0	$0
Coventry AdvantraRx	AdvantraRx Premier	15,599	$33.95	$37.80	11.3%	$0	$0
UnitedHealthcare	UnitedHealth Rx Extended	14,105	$31.53	$44.70	41.8%	$0	$0
RxAmerica	Advantage Star Plan by RxAmerica	9,598	$32.27	$28.60	-11.4%	$250	$265
United American Insurance Company	UA Medicare Part D Prescription Drug Coverage	7,019	$38.59	$41.80	8.3%	$0	$0
Coventry AdvantraRx	AdvantraRx Premier Plus	5,536	$46.62	$51.00	9.4%	$0	$0
MEMBERHEALTH	Community Care Rx CHOICE	4,400	$40.34	$41.90	3.9%	$250	$0
Coventry AdvantraRx	AdvantraRx Value	3,127	$23.23	$26.50	14.1%	$0	$0
CIGNA HealthCare	CIGNATURE Rx Plus Plan	2,233	$40.65	$36.00	-11.4%	$0	$0
Aetna Medicare	Aetna Medicare Rx Premier	2,068	$64.48	$73.20	13.5%	$0	$0
UnitedHealthcare	AARP MedicareRx Plan - Enhanced	1,544	$52.68	$49.10	-6.8%	$0	$0
Pennsylvania Life Insurance Company	Prescription Pathway Gold Plan Reg 8	1,234	$52.54	$25.30	-51.8%	$0	$0

Company Name	Plan Name	2006 Enrollment	Premiums		Premium Change (%)	Deductibles	
			2006	2007		2006	2007
WellCare	WellCare Complete	1,208	$45.22	$47.90	5.9%	$0	$0
CIGNA HealthCare	CIGNATURE Rx Complete Plan	1,064	$48.69	$47.40	-2.6%	$0	$0
Blue Cross Blue Shield of North Carolina	BCBSNC Standard Plan	881	$52.03	$49.00	-5.8%	$250	$265
Unicare	MedicareRx Rewards Plus	879	$38.73	$36.10	-6.8%	$0	$0
UnitedHealthcare	AARP MedicareRx Plan - Saver	758	$47.10	$24.70	-47.6%	$0	$265
Aetna Medicare	Aetna Medicare Rx Essentials	529	$37.24	$30.20	-18.9%	$250	$210
Aetna Medicare	Aetna Medicare Rx Plus	454	$48.45	$43.00	-11.2%	$0	$0
Unicare	MedicareRx Rewards Premier	402	$51.67	$51.00	-1.3%	$0	$0
SilverScript	SilverScript Plus	168	$59.71	$40.60	-32.0%	$100	$0
Sterling Prescription Drug Plan	Sterling Rx	17	$60.04	$33.60	-44.0%	$100	$100
Average Premiums for 2006 and 2007 and % Change (Weighted by 2006 Enrollment)			**$18,587,084**	**$20,034,164**	**7.8%**		

J. Estimated Number of Unenrolled Individuals That May Be Eligible for the Low-Income Subsidy in North Carolina, by County (As of June 29, 2006)

County	Estimate of Remaining LIS
Alamance	1,678
Alexander	521
Alleghany	185
Anson	423
Ashe	394
Avery	199
Beaufort	750
Bertie	386
Bladen	526
Brunswick	1,272
Buncombe	2,916
Burke	1,314
Cabarrus	1,626
Caldwell	1,241
Camden	107
Carteret	629
Caswell	350
Catawba	1,918
Chatham	711
Cherokee	541
Chowan	201
Clay	196
Cleveland	1,394
Columbus	940
Craven	778
Cumberland	1,052
Currituck	197
Dare	274
Davidson	1,963
Davie	434
Duplin	624
Durham	2,082
Edgecombe	719
Forsyth	2,855
Franklin	544
Gaston	2,574
Gates	168
Graham	153
Granville	590
Greene	214
Guilford	3,741
Halifax	798
Harnett	1,034

County	Estimate of Remaining LIS
Haywood	823
Henderson	1,326
Hertford	315
Hoke	323
Hyde	65
Iredell	1,897
Jackson	428
Johnston	1,589
Jones	58
Lee	595
Lenoir	774
Lincoln	855
McDowell	663
Macon	600
Madison	378
Martin	350
Mecklenburg	5,463
Mitchell	273
Montgomery	288
Moore	998
Nash	1,118
New Hanover	1,693
Northampton	327
Onslow	594
Orange	782
Pamlico	145
Pasquotank	324
Pender	624
Perquimans	169
Person	544
Pitt	1,495
Polk	299
Randolph	1,747
Richmond	851
Robeson	1,454
Rockingham	1,263
Rowan	1,730
Rutherford	969
Sampson	789
Scotland	625
Stanly	835
Stokes	513
Surry	981

County	Estimate of Remaining LIS
Swain	332
Transylvania	418
Tyrrell	52
Union	1,673
Vance	618
Wake	4,158
Warren	281
Washington	201
Watauga	447
Wayne	1,079
Wilkes	1,148
Wilson	1,310
Yadkin	463
Yancey	362
Total	**91,688**

Task Force *for a* Healthier North Carolina

A Final Report on Findings and Recommendations on

Medicare Part D and Access to Prescription Drug Coverage for

North Carolina's Seniors

March 2007

Lieutenant Governor Beverly Perdue
Chair, Health and Wellness Trust Fund Commission

Task Force Co-Chairs

Senator Bill Purcell
Representative Verla Insko
Carole Bruce, HWTF Commissioner

University of North Carolina at Chapel Hill

Dr. Daniel Gitterman, Assistant Professor of Public Policy
Stephanie Coplin, Research Associate
Jessica Dorrance, Research Associate

Funding for UNC to support the Task Force is provided by the NC Health and Wellness Trust Fund

THE UNIVERSITY of NORTH CAROLINA at CHAPEL HILL

The Task Force respectfully submits the following recommendations on strategies to improve access to prescription drug coverage for North Carolina seniors.

Co-Chairs

Bill Purcell, North Carolina Senator, 25th District

Verla Insko, North Carolina Representative, 56th District

Carole Bruce, HWTF Commissioner**,** Attorney, Smith Moore LLP

Members

Bill Farmer, Vice President of Corporate Development, Time Warner Cable *(new member as of March 2007)*

Dr. Olson Huff, HWTF Commissioner

Dr. Jim Jones, Medical Director, Black River Health Services *(new member as of March 2007)*

H. Kel Landis III, Principal, Plexus Capital

Valeria Lee, President, Golden LEAF Foundation

Vernon Malone, North Carolina Senator, 14th District

Daniel McComas, North Carolina Representative, 19th District

Dr. Karen McNeil-Miller, President, Kate B. Reynolds Charitable Trust

Norma Mills, Lecturer, University of North Carolina, School of Government

Dr. Daniel Gitterman, Director (Ex Officio), Assistant Professor of Public Policy, UNC-CH

BACKGROUND

On November 16, 2006, Lieutenant Governor Beverly Perdue, Chair of the Health and Wellness Trust Fund Commission, announced the formation of the Task Force *for a* Healthier North Carolina. The Task Force was given the specific charge to hold public forums and make recommendations on strategies to improve access to health insurance coverage in North Carolina, including: access to prescription drug coverage for seniors; access to public health insurance for children; and access to health benefits for employees in small businesses. The Task Force for a Healthier North Carolina was created by a grant from the NC Health and Wellness Trust Fund Commission (HWTF). The Lewin Group was commissioned to prepare background policy briefings and to provide analytical support.[1]

The Task Force *for a* Healthier North Carolina sponsored two public meetings to explore strategies to improve access to prescription drug coverage for North Carolina's seniors. An initial public forum was held on November 16, 2006 in Chapel Hill, and an official Task Force meeting was held on December 13, 2006 in Raleigh. The Task Force invited formal presentations and written statements from the following individuals or organizations:

- **Rob Bizzell**, Owner, Realo Discount Drugs
- **Chris Bowen**, Pharmacist, Kerr Drug
- **Marlowe Foster**, Assistant Director, Government Relations and Public Affairs, Pfizer
- **Mark Gregory**, Vice President of Pharmacy, Kerr Drugs
- **James Hayes**, Citizen Advocate, HIV/AIDS Drug Assistance Programs
- **Becky Hunter**, Member, AARP Advocacy Council
- **Michael Keough**, Director, NC Rx, Office of Rural Health, Department of Health and Human Services
- **Dr. Ted Marmor**, Professor of Public Policy and Management, Yale University
- **Kevin Meriwether**, East Region Market President, Humana
- **Marjorie Morris**, Chief, Medicaid Eligibility Unit, Division of Medical Assistance, Department of Health and Human Services
- **Carla Obiol**, Deputy Commissioner, NC SHIIP, Department of Insurance
- **Phyllis Rogers**, Local Senior, Employee at Courtyard Marriott
- **Gary Salamido**, Director, State Government Affairs, GlaxoSmithKline
- **Alan Scantland**, Senior Vice President, Corporate Development, MemberHealth

- **Vandana Shah**, Policy Director, Health and Wellness Trust Fund Commission
- **Brian Shank**, Director, State Government Affairs, AstraZeneca
- **Steve Sherman**, AIDS Policy/ADAP Coordinator, Division of Public Health, Department of Health and Human Services
- **Gina Upchurch**, Executive Director, Senior PHARM*Assist*
- **Kathlyn Wee**, Director, State Public Affairs, UnitedHealthcare

Key findings from the Lewin Group's first background report to the Task Force, "The First Year for Seniors: Medicare Prescription Drug Coverage in North Carolina, 2006,"[2] are briefly summarized:

- Distribution of NC Medicare beneficiaries in 2006:
  - 32% (418,200) had retiree health insurance through an employer;
  - 29% (376,800) enrolled in a Medicare Part D plan;
  - 17% (230,000) were enrolled in both Medicare and Medicaid;[3]
  - 8% (102,300) had no "credible" coverage;[4,5]
  - 8% (109,600) were enrolled in a Medicare Part C plan;[6]
  - 6% (81,900) had some other form of "credible" coverage.

- Distribution of NC Part D beneficiaries by plan sponsor in 2006 (16 plans in total):
  - 27% (158,288): United-Pacificare
  - 21% (122,211): Humana
  - 10% (56,484): MemberHealth
  - 8% (44,735): Blue Cross Blue Shield North Carolina
  - 5% (29,538): WellCare
  - 5% (29,279): CIGNA
  - 24% (148,868): All other plans

- Medicare Part D beneficiaries in North Carolina will experience an average weighted premium increase of 7.8% in 2007.[7,8]

- Medicare Part D includes a low-income subsidy program (LIS) (known as "Extra Help"). As of June 2006, an estimated 91,700 North Carolinians are eligible but were not enrolled in the LIS program.[9,10]

- In 2006, seven PDP plans offered some coverage during the "doughnut hole" gap, but only Humana offered gap coverage for both generic and preferred brand-name drugs. In 2007, the total number of plans offering some gap coverage increased to fifteen; however, none of these plans offers coverage for preferred-brand drugs.[11]

For other key findings, see the full Lewin/HWTF/UNC-CH report at: http://www.healthwellnc.org/LewinPartD06report.pdf.

FINDINGS AND RECOMMENDATIONS

Finding 1: Improving Outreach and Enrollment for Federal "Extra Help" Low Income Subsidy (LIS) Premium Subsidies and NCRx

The Lewin Group reports that approximately 102,000 Medicare beneficiaries in North Carolina either do not have prescription drug coverage or do not have coverage that is as good as the standard Medicare benefit. In addition, as of July 2006, about 91,000 North Carolina seniors eligible for federal "Extra Help" had not enrolled in the program.[12] Finally, there are over 11,000 North Carolinians eligible for both Medicaid and Medicare who are expected to lose their automatic qualification for "Extra Help" for 2007.

In October 2006, Governor Easley announced NCRx, a premium assistance program to help lower-income seniors participate in the Medicare Part D prescription drug program.[13] NCRx offers an $18-per-month premium subsidy for eligible seniors. The Health and Wellness Trust Fund Commission (HWTF) approved $24 million in funding over three years (2007-09) to support the new program.[14] North Carolina seniors began applying for NCRx during the Medicare Part D enrollment period (November 15-December 31, 2006) and the premium assistance became available in January 2007.

NCRx is a qualified State Pharmaceutical Assistance Program (SPAP). SPAPs are state-funded programs that provide financial assistance for prescription drug coverage for low-income seniors and the disabled.[15] North Carolina's previous SPAP, Senior Care, ended in January 2006 when Medicare prescription drug coverage began. Prior to June 2006, HWTF invested $78 million to fund this prescription drug assistance program. Twenty-two states, including North Carolina, operate qualified SPAPs.[16] Of these, six (Delaware, Indiana, Nevada, Pennsylvania, North Carolina, and South Carolina) are supported in full or in part through tobacco settlement funds, and two (Massachusetts and Montana) are supported in part through a tobacco tax. The majority of SPAPs are funded through a mix of revenue and budget outlays including annual state allocations, lottery funds, casino taxes, fees, and general revenue.[17] Indiana's SPAP, known as HoosierRx, is the only other program that is fully funded by tobacco settlement funds.

With the implementation of the Medicare prescription drug benefit in 2006, SPAPs were provided with an opportunity to reevaluate their programs. Some states made the decision to terminate their SPAPs, while several states decided to wrap around the coverage provided by Medicare Part D and the low-income subsidies offered through the Medicare drug benefit. SPAPs have taken several approaches to fill the gaps in the Medicare drug benefit, including paying the premiums and cost-sharing requirements for members, covering the drugs that are not covered by Medicare Part D, and covering the "doughnut hole."

NCRx set forth the following eligibility criteria for its new program:

- North Carolina residency;
- Medicare beneficiary;
- age 65 or older;
- income at or below $17,150 for individuals and $23,100 for married couples (175% of the federal poverty level, FPL);

- combined savings, investments, and real estate (other than home, car, and $1,500 per person to cover burial expenses) of $20,000 or less for individuals and $30,000 or less for married couples;
- enrolled or will enroll in a Medicare Part D Prescription Drug Plan that participates with NCRx;
- no other prescription drug coverage that is as good as or better than Medicare Part D;
- not eligible for the full federal "Extra Help" subsidy for Medicare Part D.[18]

In addition to the premium assistance, enrolling in NCRx allows individuals to take advantage of a "special enrollment period" for Part D prescription drug plans. Ordinarily, once an individual enrolls in a Part D plan they are locked into it for a year, until the next enrollment/plan switching period (November 15-December 31). Enrolling in NCRx, however, allows individuals to enroll in or switch their Part D plan at the time of NCRx enrollment. This may be particularly beneficial for individuals who are eligible for but not enrolled in a prescription drug plan or for individuals in a plan that does not offer the best coverage for them (e.g., a plan in which the formulary has changed and no longer includes some or all of their medications).

Seniors enrolled in Medicare Part C/Medicare Advantage (Medicare plans that generally cover hospital, doctor, and prescription drug benefits all through one health plan) are excluded from participating in NCRx. However, 45.5% of Medicare Part C plan options in North Carolina charge an additional drug premium. Those individuals with Part C drug coverage pay an average of $26.36 per month in 2007.[19]

NCRx Enrollment Status and Outreach Activities

As of March 2007 and still very early in the enrollment process, NCRx had approved 3,849 applications. An additional 932 applications are being processed or are waiting for additional information. The enrollment period for NCRx was originally scheduled to coincide with the federal Part D enrollment period (November 15-December 31, 2006), but it has been extended without a formal deadline.

The majority of the NCRx budget is directed toward premium assistance for seniors. There is an administrative budget, about 9%, none of which is committed to outreach and enrollment activities per se. Within the current administrative budget for NCRx, funds for outreach and enrollment included a line item for printing and postage for a mailing to individuals, many of whom were enrolled in the Senior Care program. The Easley administration has set up a toll-free line, 1-888-488-NCRX (6279), and a Web site, www.ncrx.gov, so seniors can get information on NCRx and the Medicare plans.

The governor spent about $100,000 of leftover campaign money to air a television advertisement across the state announcing the prescription drug assistance plan for low-income senior citizens. The ad was aired as a free public service announcement in some areas. Governor Easley also distributed a radio ad to stations and asked them to air it as a free public service.[20] Posters announcing the program exist on the Web site.

On the Front Lines of Enrollment and Outreach Activities in North Carolina

North Carolina Seniors Health Insurance Information Program (SHIIP)
State Health Insurance Assistance Programs (SHIPs) provide personalized counseling and assistance to over 43 million Medicare beneficiaries and their caregivers nationwide who need help navigating the increasingly complex health care system, including the Medicare program. SHIPs are designed to provide accurate, understandable, and objective information, counseling, and assistance to Medicare beneficiaries on a wide range of health insurance issues, including Medicare, Medicaid, long-term care, and prescription drugs. While many local offices are located in Area Agencies on Aging, SHIPs also are located in other community-based organizations that serve older adults and people living with disabilities, such as senior centers and hospitals. Research has consistently found that Medicare beneficiaries prefer to receive information about Medicare through one-on-one assistance rather than through other means, such as written materials, mass media, or the Internet.

The Seniors Health Insurance Information Program (SHIIP) is North Carolina's lead state agency for answering questions and counseling Medicare beneficiaries and their caregivers about Medicare, Medicare Part D, and other health insurance concerns. SHIIP is a division of the Department of Insurance and has coordinators (both paid staff and volunteers) located in all 100 North Carolina counties. These coordinators help Medicare beneficiaries enroll in Part D plans, apply for the federal low-income subsidy (LIS), and respond to related questions and concerns.

Funding for SHIIP—which comes from both state and federal dollars—helps pay for the coordinators and helpline staff positions to assist with Medicare Part D enrollment. Historically, SHIPs have been funded by a growing, but inadequate amount of federal support that has been supplemented, in some instances, by state appropriations and local philanthropy. SHIP funding has historically been low: federal funding for the national network has remained relatively low and stable since the program began in 1991, when $10 million was allocated among the states in the form of grants. For the next 12 years, federal funding ranged from $10 million to $16 million per year. Following the enactment of the Medicare Modernization Act in December 2003, SHIP funding increased to $21.1 million in 2004 and $31.7 million in 2005. In 2006, funding decreased slightly to $30 million—about 70 cents per Medicare beneficiary.[21]

Prior to the implementation of the Medicare Modernization Act (MMA) and Medicare Part D, NC SHIIP received approximately $400,000 per year in federal funding. After the MMA, however, federal funding to all SHIPs was increased to assist with outreach and enrollment in Part D and with the general increased demand for services. In 2006, SHIIP in North Carolina received $871,625 in funding from the Centers for Medicare and Medicaid Services (CMS). The SHIIP office also received federal dollars from a one-time grant administered through the North Carolina Department of Health and Human Services in the amount of $444,088 to provide additional resources toward assistance with the transition to Medicare Part D. It is expected that the annual federal funding will eventually return to the original level (although it is not clear when this will happen), resulting in a decrease in funding of about $400,000 for North Carolina.

During the last enrollment period (November 15-December 31, 2006), SHIIP received 6,917 calls on their helpline. During the 2005 enrollment period, they received nearly twice as many

calls. In addition, they received close to 3,000 calls specifically related to NCRx. Over the course of a year from July 1, 2005 to June 30, 2006, they received over 80,000 calls.

Local Pharmacies
Pharmacies and pharmacists report being on the front lines of Medicare Part D. Many beneficiaries sought information about their prescriptions and their Part D plan directly from their pharmacist. One North Carolina pharmacist reported that customers often complain they do not receive helpful responses to enrollment and other questions from Part D plan hotlines. This is supported by a recent report from the Government Accountability Office (GAO) that documented the quality of service and information provided to Medicare beneficiaries by Prescription Drug Program (PDP) sponsor call centers. CMS requires each PDP to staff a toll-free call center that can provide information about the sponsor's plans. The report found that although calls were being answered quickly, the information provided was often not accurate or was incomplete. The GAO only obtained accurate and complete responses to their questions about one third of the time.[22]

Community-Based Organizations
In addition to SHIIP and pharmacies, a variety of community-based organizations play a role in providing information about Medicare Part D and assisting beneficiaries with navigating the doughnut hole. These agencies, which include senior centers, community centers, and other nonprofit agencies, reach out to individuals who may not be aware of other existing resources (such as SHIIP). Working with community-based organizations can be particularly effective because clients sometimes feel more comfortable receiving assistance from a provider they know and trust or from an agency they already visit for other services. In North Carolina, SHIIP operates "train-the-trainer" sessions every year throughout the state to educate and update providers who work with seniors about Medicare Part D and LIS enrollment.

Existing Models for Enrollment and Outreach Activities

Outreach and enrollment activities are critical to the success of any public program, and states have used several effective strategies to reach out to target populations for assistance programs. For example, many states have made significant investments in outreach and enrollment activities for their State Children's Health Insurance Programs (SCHIP). Some examples of successful outreach and enrollment strategies in SCHIP programs include: working with schools and other organizations and institutions already serving the target population; coordinating with community- and faith-based organizations; partnering with corporate sponsors; employing individuals as community outreach workers; funding monetary incentives to organizations; asking celebrities to promote the program; and advertising in the media. [23]

As previously mentioned, collaboration with community-based organizations can be very effective in cutting through consumer barriers. It can reduce stigma by associating the program with trusted organizations, increase awareness by providing information through trusted sources, facilitate the difficult application by providing assistance, and break down language and cultural barriers by engaging people through members of their own community.[24]

There is little experiential data on the success of specific outreach efforts related to SPAP premium assistance programs. There is literature, however, from related organizations outlining suggested outreach strategies. In 2005 and 2006, CMS provided guidance to SPAPs that received transitional grant funds. CMS recommended that SPAPs provide education via mailings, the Internet, public service announcements, and handbooks to Part D beneficiaries. CMS also recommended establishing a test population for future marketing strategies.[25]

The American Public Human Services Association (APHSA) referred to the states' role in Part D as "information intermediaries." While their recommendations are not specific to SPAPs, some of the same outreach efforts may translate to SPAP enrollment. The APHSA recommended public service announcements, posters, calendars, newspapers, interest group listservs, and mailings.[26]

Recommendation 1: Improving Outreach and Enrollment for Federal "Extra Help" Low Income Subsidy (LIS) Premium Subsidies and NCRx

The Task Force offers the following immediate recommendations to improve outreach and enrollment for Medicare Part D Extra Help and NCRx:

1.1 In order to meet the ongoing demand for enrollment, outreach, and Medicare Part D counseling, the SHIIP program will need consistent future funding. The Task Force supports reliable and sustainable federal as well as state funding to allow SHIIP to engage in strategic and long-term planning to meet the growing needs of the North Carolina Medicare population now and in the future. Through federal grants directed to state health insurance programs and with additional state funding to make up for any federal shortfall, SHIIP must have the resources to continue to provide free counseling and assistance via telephone and face-to-face interactive sessions, public education presentations and programs, and media activities.

1.2 The Task Force recommends committing resources (potentially from within the existing NCRx administrative or program budget) toward additional community-based outreach and enrollment efforts. For example, small mini-grants ($2500 to $5000) could be made available to community-based organizations that serve seniors in an effort to assist with both the NCRx and Medicare Part D open enrollment period. Currently, there are more than 20 organizations comprising the Medicare Partners State-Level Coordinating Committee, a group of public and private entities with an interest in ensuring that as many North Carolinians as possible enroll in a Part D plan and that low-income people sign up for the subsidy program. A subcommittee of the Medicare Partners State-Level Coordinating Committee, which would include the Seniors Health Insurance Information Program (SHIIP) director, the NCRx director, a HWTF senior staff member, and two members of the senior community-based organizations community, could serve to solicit, award, and monitor innovative community-based NCRx outreach and enrollment grants.

1.3 The Task Force recommends targeting additional resources from the existing NCRx (administrative) budget to those counties with the greatest under-enrollment in "Extra

Help" as well as those counties that operate with volunteer rather than paid SHIIP staff coordinators.

1.4 The Task Force recommends that SHIIP outreach coordinators collaborate with local retail and independent pharmacies to provide outreach and enrollment assistance and activities within dispensing pharmacies. Many Medicare Part D beneficiaries request information directly from their pharmacist, which makes the pharmacy an appropriate setting for targeted enrollment and outreach efforts. For example, Kerr Drug, a retail pharmacy chain in the Carolinas, operates "Health Care Centers" in several of their store locations, offering some clinical services and basic counseling on insurance-related issues. By placing SHIIP volunteers in these and other existing in-house settings, the pharmacy can become a one-stop location for many seniors who are in need of additional assistance. For example, SHIIP staff or volunteers could make use of the Benefits Checkup, a Web-based decision support tool that helps beneficiaries and those who serve them, understand and assess their current situation before enrolling in an appropriate Medicare Prescription Drug plan. At the pharmacy counter, Benefits Checkup can be used to help determine if seniors qualify for Medicare's Extra Help or other prescription savings programs and allow them to apply for many of these programs on line.

1.5 The Task Force recommends that NCRx pilot an online application process during the next federal Medicare Part D (2008) open enrollment period and evaluate its impact on program enrollment. In other states, electronic applications have been shown to increase program enrollment. SHIIP coordinators and volunteers, as well as some community-based organizations, currently provide Web-based assistance for seniors who are enrolling directly in Medicare Part D (see Medicare Drug Plan Finder, http://www.medicare.gov). Evaluations of electronic application procedures conclude that:

- applying online is quicker (the time between application submission and eligibility determination is reduced compared to paper applications);
- there is increased consumer satisfaction;
- application errors are reduced because applicants are required to complete all necessary information before proceeding to the next screen or are prompted when data is missing;
- because information is collected electronically, the process may improve an agency's ability to efficiently access data.

Some online application systems have "application assisters" who can work with beneficiaries to input data. This could be a particularly useful feature for seniors who may not be familiar with Web-based applications.

Finding 2: Strengthening NCRx

The $18-per-month premium assistance available through NCRx is an important step toward helping low-income seniors gain access to affordable prescription drug coverage. As previously mentioned, enrolling in NCRx also allows beneficiaries to take advantage of a special enrollment

period for Part D plans. For those who are eligible, the benefit amount offered by NCRx is sufficient to cover the full premium cost of the least expensive PDP offered in North Carolina in 2007 ($17.80). This financial assistance is critical for seniors who are not eligible for the federal LIS but may not be able to afford the cost of a prescription drug plan on their own. This least expensive plan, however, carries with it a $265 deductible that individuals are expected to pay out of pocket before their benefits begin.

In order to be eligible for this premium assistance, individuals must meet the eligibility criteria mentioned in the previous section. These include income requirements as well as an asset test. While the asset test for NCRx eligibility is relatively simple for the applicant, asset tests by nature penalize savings and discourage low-income individuals from building wealth. Requiring an asset test also adds staff time and contributes to the overall administrative costs of operating a program.[27] In addition, NCRx benefits are only available to seniors. This excludes an entire segment of the Medicare population—those under 65 years of age who are disabled and receive Social Security Disability Insurance (SSDI).

Recommendation 2: Strengthening NCRx

The Task Force encourages state policy makers to monitor enrollment trends during the first year of NCRx program operation. The following recommendations for the second year of the program are contingent upon availability of funds on January 1, 2008:

Strengthening NCRx Benefit Design

2.1 For new Medicare Part D enrollees, the current $18 monthly premium assistance available through NCRx provides financial support to cover the full premium cost ($17.80) for only the least expensive Prescription Drug Plan (PDP) in North Carolina, which carries a $265 annual deductible. If funding is available, the Task Force recommends consideration of an increase in premium assistance ($7.30-per-member-per-month increase in 2007) to cover the full premium cost of the least expensive plan that does not carry a $265 deductible ($25.30 per month in 2007).

2.2 Currently, the NCRx program pays premium assistance directly to the Part D plan on behalf on the beneficiary. For those seniors already enrolled in a Part D plan, participation in NCRx requires a senior to stop automatic deduction of their Part D premium from their social security checks. The Part D plan charges those who have selected a higher-premium plan for the difference between the monthly plan premium and the state's $18 premium contribution. The Task Force recommends consideration of additional benefit designs, including the offering of a "debit card," in addition to the direct premium payment options. The state would contribute a fixed annual amount to a senior's prescription drug spending account, equal to the current premium assistance amount (i.e., $18 per month x 12). This benefit would operate similar to the current "flexible health spending account" debit cards that are available to state employees through a contract with AON consulting. Seniors could use the card to pay coinsurance, co-pays, or other costs at the pharmacy counter.

Expanding NCRx Eligibility

If funding is available in year 2, the Task Force recommends the following:

2.3 Consider eliminating the asset test, (currently set at $20,000 for individuals and $30,000 for married couples) which could boost enrollment and reduce overall administrative costs.

2.4 Consider expanding the eligibility threshold from 175% FPL (federal poverty line) to 200% FPL ($19,600 for individuals and $26,400 for married couples).

2.5 Consider expanding NCRx to cover all Medicare Part D beneficiaries under 200% FPL, including eligible Social Security Disability Income (SSDI) beneficiaries under age 65.

Finding 3: Navigating the Gaps in Part D Coverage

The doughnut hole is the gap in Medicare Part D coverage during which the beneficiary is responsible for 100% of their prescription drug costs. Once the beneficiary reaches the initial coverage limit of $2,400, coverage stops completely and they must spend $3,850 in true out-of-pocket expenses (TrOOP) before Medicare Part D catastrophic coverage begins.

The Role of the Health and Wellness Trust Fund

Over the last four years, the Health and Wellness Trust Fund has taken several significant steps to provide a safety net for seniors and other low income populations. Recognizing that Senior Care, HWTF's former statewide prescription drug program for low-income seniors, was not a complete solution to the problems that North Carolina seniors and low-income individuals under 65 were facing, HWTF created a network of Medication Assistance Programs (MAP) to serve the underserved populations without access to prescription drugs. Since 2003, HWTF has provided over $17 million in funding to MAP grantees to help seniors and other low-income individuals identify and apply for the lowest-cost prescription drugs available through public and private programs, including Patient Assistance Programs and discount card programs offered by pharmaceutical companies. In order to simplify the application process, HWTF equipped each grantee with computers and custom-design software (MARP) that had been developed by the NC Office of Research, Demonstrations and Rural Health Development (ORDRHD).

In addition to helping beneficiaries locate free or low-cost prescriptions, many MAP grantees also contract with local pharmacists to counsel seniors in identifying drug utilization issues such as drug-to-drug interactions and duplicative therapies. MAP grantee sites provided over $68.8 million worth of free medications to nearly 40,000 patients from January 2003 to December 2005, representing a 6:1 return on HWTF's grant investment. More than 8,000 of these patients also received medication management (MM) services during this period. Because of their leadership in the medication access field, MAP grantees have also stepped in to provide critical assistance to seniors facing the doughnut hole.

The Role of Patient Assistance Programs (PAPs)

Patient Assistance Programs (PAPs), often sponsored by pharmaceutical companies, provide free or low-cost prescription drugs to people with limited finances. Each company develops its own program structure and eligibility criteria. They only offer assistance with medication produced by their own company (for example, Pfizer's PAP only offers assistance with Pfizer products). At the Task Force public meeting, representatives from three of the leaders in patient assistance—Astra Zeneca, GlaxoSmithKline, Pfizer—presented information on their respective programs. Each includes some assistance for individuals with Medicare Part D. The details are briefly described below.

- AstraZeneca
  Prescription assistance is available to Part D beneficiaries through AstraZeneca's "AZ Medicine and Me" program. Enrollees will pay no more than $25 for a typical 30-day supply of AstraZeneca medicines. This program has no enrollment fee and is available at most local pharmacies. To be eligible, individuals must have an annual income below $30,000 (couples must earn less than $40,000 per year), must be taking a listed AstraZeneca product, and must have spent at least 3% of their annual household income on prescription drugs during the current year.[28]

- GlaxoSmithKline
  Prescriptions are available to Part D beneficiaries through GSK's Access program. To be eligible, individuals must have an income below 250% FPL, live in one of the 50 states or District of Columbia, and provide proof that they already have spent $600 on outpatient medicines in the current calendar year. Oncology patients who are enrolled in Part D plans will be able to receive their medicines through GSK's existing Commitment to Access patient assistance program by meeting the following criteria: income below 350% FPL, residence in one of the 50 states or District of Columbia, and proof that the patient has already spent $600 on outpatient medicines in the current calendar year.[29]

- Pzifer
  Pfizer's PAP, known as Connection to Care, is aimed primarily at those without any form of insurance or prescription drug coverage; however, Part D beneficiaries can apply for a "Hardship Exemption" in order to qualify for assistance. To be eligible, individuals must have an income below 200% FPL and the patient and the patient's physician must complete and sign the application form. Hardship exemption requests are reviewed on a case-by-case basis. If approved, the patient will receive their approved Pfizer medicines at no charge. The 90-day supply of medicine is shipped to the physician's office for pickup by the patient.[30]

These three companies are considered leaders in patient assistance programs. Many other pharmaceutical companies do not offer PAPs or offer only very limited assistance to individuals with insurance coverage. PAPs also may restrict which drugs are covered in their program. For instance, they may not include assistance toward medications for certain illnesses, such as cancer and HIV/AIDS. Finally, prescription medications provided through PAPs do not count toward a Medicare beneficiary's true out-of-pocket costs (TrOOP). See Appendix A for a full listing of

companies that offer patient assistance to Part D beneficiaries and Appendix B for additional information about PAPs and the TrOOP.

Recommendation 3: Navigating the Gaps in Part D Coverage

The Task Force offers the following strategies to continue helping seniors navigate the gaps in Medicare Part D coverage:

3.1 The Task Force recommends that SHIIP and other community-based outreach organizations continue to encourage seniors with significant prescription drug needs to enroll in a Part D plan that offers some doughnut hole coverage. Currently, the least expensive Part D plan premium for coverage during the gap is $42.90. Although the coverage only applies to generic prescriptions, this would ensure that seniors receive some financial assistance for approved medications.

3.2 If the NCRx premium assistance is increased to $25.30 (or to the cost of the least expensive Part D plan with no deductible in 2007), the state, in promoting the expanded benefit, would contribute more than 50% of the cost of the least expensive plan that offers doughnut hole coverage ($42.90 in 2007).

3.3 The HWTF MAP grantees should continue outreach efforts to assist those seniors affected by the doughnut hole. Additionally, the pharmacists providing medication therapy management (MTM) services available through the new NCRx Care initiative (described further in recommendation 4) should coordinate with MAP grantee organizations and refer those seniors facing the doughnut hole to additional assistance in locating free or low-cost medications.

3.4 GlaxoSmithKline, AstraZeneca, and Pfizer, leaders in offering Patient Assistance Programs (PAPs), are all members of the Pharmaceutical Research and Manufacturers of America (PhRMA). The Task Force encourages GlaxoSmithKline, as a North Carolina-based company, to work with state leaders to showcase the important role of the private sector in providing prescription drug assistance for low-income Medicare Part D beneficiaries facing the doughnut hole**.**

Finding 4: The Design of NCRx Care and Managing Out-of-Pocket Drug Costs

In October 2006, the Health and Wellness Trust Fund Commission announced NCRx Care, a medication therapy management (MTM) program.[31] Building upon its Medication Assistance Program (MAP), established in 2002, the Office of Rural Health, through an agreement with HWTF, will contract with retail and community pharmacists to provide MTM services, which include counseling Medicare enrollees on the most appropriate and cost-effective use of their federal drug coverage benefit, helping monitor health status, and identifying potentially harmful drug-to-drug interactions. The HWTF has approved $2 million over three years to compensate

pharmacists who counsel eligible seniors. The Office of Rural Health is currently soliciting public bids for the administration of NCRx Care.

By providing multiple services, MTM has been viewed as an effective method for helping save lives and reduce overall healthcare costs.[32] This type of service can be crucial for seniors and those with chronic illnesses, who often must take multiple medications.

MTM Under Medicare Part D

Currently, under the federal Medicare Part D benefit, the Centers for Medicare and Medicaid Services define MTM-eligible individuals as those who:

- have multiple chronic diseases, such as, but not limited to, diabetes, asthma, hypertension, hyperlipidemia, and congestive heart failure;
- are taking multiple covered Part D drugs; AND
- are identified as likely to incur annual costs for covered Part D drugs that exceed the level specified by the Secretary of Health and Human Services.

CMS set a $4,000 threshold of annual costs that PDPs are to use for identifying targeted beneficiaries eligible for MTM services; this amount was published on the Medicare.gov Web site in a document for plan sponsors submitting a bid to become a PDP. Further clarification by CMS staff notes that the $4,000 takes into account all true-out-of-pocket spending for covered Part D drugs. The statutory language notes that MTM services may be provided by a pharmacist or other qualified provider.[33]

Large MTM programs from Medicare Part D plans like Humana and Blue Cross Blue Shield do not typically deviate from the aforementioned federal guidelines. Humana's MTM program, for example, requires that patients have at least two chronic illnesses, take five or more systemic medications, and expect to spend more than $4,000. The MTM program offered through Blue Cross Blue Shield of North Carolina requires that eligible Medicare beneficiaries meet the following criteria: 1) they must suffer from at least five chronic diseases, with at least two of the following: hypertension, high cholesterol, congestive heart failure, diabetes, or asthma; 2) they must have claims for at least six different covered PDP medications within a 12-month period or less; 3) they are likely to incur annual costs of at least $4,000 for PDP-covered medications.[34]

Other organizations, including the American Pharmacists Association (APhA), have developed a more comprehensive definition of what constitutes MTM. Some key components, according to AphA, are:

- performing or obtaining necessary assessments of the patient's health status;
- formulating a medication treatment plan;
- selecting, initiating, modifying, or administering medication therapy;
- monitoring and evaluating the patient's response to therapy, including safety and effectiveness;
- performing a comprehensive medication review to identify, resolve, and prevent medication-related problems, including adverse drug events;

- documenting the care delivered and communicating essential information to the patient's other primary care providers;
- providing verbal education and training designed to enhance patient understanding and appropriate use of medications;
- providing information, support services, and resources designed to enhance patient adherence to therapeutic regimens;
- coordinating and integrating medication therapy management services within the broader health care management services being provided to the patient.[35]

MTM Services in North Carolina

Efforts to offer MTM services in North Carolina have already been implemented and can provide insights for the design of NCRx Care. Four examples of existing MTM programs include:

- Senior PHARM*Assist*
  Senior PHARM*Assist* works closely with participants' healthcare and social service providers to ensure the best pharmaceutical care possible. Seniors enrolled in the prescription card program are seen every six months for recertification and medication therapy management. A pharmacist works one on one with each senior to review every medication (prescription, over-the-counter, and herbal) that he or she is taking. The pharmacist also assesses whether a participant can properly perform any tasks associated with taking those medications (i.e., drawing up insulin, using an inhaler, or administering eye drops). Finally, the pharmacist discusses health promotion strategies with the patient and makes referrals to other relevant programs, such as medical transportation, home-delivered meals, and senior centers. After 24 months in the program, the rate of participants reporting any hospitalizations decreased by 51%**,** and the rate of participants reporting any emergency department visits declined by 27%**.**

- AlaMAP
  Alamance Medication Assistance Program (AlaMAP) has provided MTM services for more than five years. Since the inception of Medicare Part D, the AlaMAP MTM program has focused primarily on seniors; most clients are referred to the program through their physician or through local agencies. AlaMAP received a one-time MAP grant from the HWTF, and most of the MTM services continue to be grant funded. The program is looking into the possibility of charging small sliding-scale fees for these services in the future. Some of its many accomplishments include documented declines in emergency room visits and more appropriate medication regimens for participants. Like some other MTM programs across the state, AlaMAP tracks clients, services provided, and client outcomes in a database. AlaMAP also has dispensed more than $7 million in PAP medications since July 2001.

- North Carolina Department of Health and Human Services, Division of Medical Assistance (DMA)
  DMA reimburses pharmacists who provide medication management assistance to Medicaid patients across the state. It is important to note that DMA's program is not a medication therapy management program as defined by CMS and does not provide some

of the key MTM components as defined by the APhA MTM working group. When a Medicaid patient reaches 12 prescriptions, they are offered the services by the pharmacist. During the first six months, the pharmacist requests that the patient transfer all the prescriptions to one pharmacy, there is a consultation between the pharmacist and the patient's physicians, and the pharmacist reviews medication utilization with the patient. The goal at the end of the six-month review is to do one or more of the following: reduce the overall number of medications taken, change the dosage or type of medications taken to increase effectiveness or decrease unfavorable interactions, and reduce the total medical costs incurred by the patient. In return for these services, DMA pays the pharmacist $10 per enrollee per month. The $10 figure was reached through actuarial estimates. Quality control for this program is limited. A section within DMA regularly audits a portion of the pharmacists' billings for the services. A section chief reported that there have been a few cases in which DMA has had to reclaim overpaid monies. At some point, DMA would like to measure the patients' overall health care spending as a determinant of success for the program. The program began in June 2006, and many of the details, including quality control, are still being established.[36]

- University of North Carolina, School of Pharmacy Medication Management Program for Older Adults
  This program, which is part of the UNC School of Pharmacy, provides MTM services to seniors living in Orange County, North Carolina. Individuals aged 60 years and older can join by contacting the program directly. The first visit usually takes approximately one hour, and follow-up visits are based on the individual's needs. The pharmacist obtains consent from the senior to review his or her medical record and to discuss the medication evaluation and recommendations with his or her physician. The pharmacist works with the physician to optimize medication therapy and provides the individual with a written summary of the medication evaluation. The pharmacist documents all medication evaluations and recommendations and shares the records with the physician and other health care providers. In addition, one of the UNC clinical pharmacists currently provides MTM and other education services to patients at Chapel Hill Internal Medicine (CHIM). The pharmacist works one day a week at CHIM and sees patients of all ages who are in need of MTM-type services. Patients can request these services on their own or be referred by their physician at CHIM.

As the NCRx Care program begins designing its benefits, lessons from these types of programs can be used to create a new program that best meets the needs of seniors and other Medicare Part D beneficiaries.

Vendors to Manage MTM

The HWTF, through the Office of Rural Health, is currently soliciting bids for the administration of NCRx Care. A number of private companies have designed innovative systems for MTM. One of the leading vendors in administering MTM services is Outcomes Pharmaceutical Care.

Outcomes is a privately held limited liability company that administers MTM services. With Outcomes, pharmacists can document and be reimbursed for MTM services via the Web. As of

October 2006, four Medicare Part D plans had contracted with the administrator of this program to provide MTM services. The company has been working with employer groups, health plans, union funds, Medicaid, and others since 1999. Using such services provides the conveniences of a standardized reporting mechanism, data-collection efforts, and quality-control parameters.[37] Once a year, patients may receive a "comprehensive medication review" in which a pharmacist meets face to face with the patient for a full consultation. If in the same year, the patient experiences a circumstance that warrants an additional review (hospitalization, changes in medication, etc.), the individual pharmacist retains the autonomy to make that decision. For each consultation, the pharmacist submits a claim to Outcomes for $50. Additional claims may apply if the pharmacist must complete follow-up action, such as contacting the patient's physician. Outcomes pay the pharmacist in one of two ways depending upon the preference of the contracting program: 1) through a fee-for-service operation in which they bill the organization monthly for pharmacy claims or 2) the contracting organization's payment of a specific amount per member per month.

Outcomes monitors service quality by utilizing an outside committee that reviews pharmacist claims and ensures that the appropriate actions were taken, and that the billed amount was equal to the services rendered.

Recommendation 4: The Design of NCRx Care and Managing Out-of-Pocket Drug Costs

The Task Force views NCRx Care and appropriate brown-bag counseling by dispensing and non-dispensing clinical pharmacists as an important additional benefit offered as a companion program to NCRx.

The Task Force offers the following recommendations to aid in the design of NCRx Care and to help seniors manage out-of-pocket drug costs:

4.1 As one of the first steps in designing the new assistance program, NCRx Care will need to establish "eligibility" criteria for its beneficiaries. The program should use the NCRx criteria as a base and build in additional eligibility requirements specific to those most in need of MTM services. NCRx Care would become an added benefit to the NCRx $18 monthly premium assistance. In addition to those who are eligible for NCRx, NCRx Care should consider offering the benefit to all Medicare beneficiaries who receive the federal low-income subsidy (also known as "Extra Help").

4.2 The Task Force recommends that NCRx Care use the definition and standards of MTM provided by the APhA (American Pharmacists Association) as a guide for designing the services to be provided. This would ensure that beneficiaries receive comprehensive medication management services that include monitoring health status, providing one-on-one counseling, collaborating with physicians, and documenting action and health outcomes. At a minimum, NCRx Care should use the eligibility guidelines provided by the Centers for Medicare and Medicaid Services (CMS) for MTM.

4.3 The Task Force recommends that NCRx Care make dispensing and non-dispensing (for example, community based pharmacists) pharmacists eligible for reimbursement.

4.4 The Task Force recommends that NCRx Care take active and immediate outreach and enrollment steps to begin educating beneficiaries as well as pharmacists about the available services and how they might participate in the program.

Finding 5: Improving the Coordination of Health Care Delivery for Seniors

Several Task Force members and advocates for seniors expressed concern that low- to moderate-income Medicare beneficiaries must navigate a confusing network of prescription drug plans, health care and other service providers, and other public programs. There is a growing need for community-based organizations that can meet a variety of needs and challenges for seniors.

There are organizations currently providing this kind of coordination. For example, Senior PHARM*Assist*, a nonprofit organization in Durham, NC, promotes healthier living for Durham seniors by helping them obtain and better manage needed medications and by providing health education**,** community referral**,** and advocacy. In most cases, Senior PHARM*Assist* provides tailored, hands-on assistance for seniors and younger Medicare beneficiaries (people with disabilities) including help finding a Medicare prescription drug plan that works best for them, applying for the low-income subsidy, medication management services, and help locating other resources such as transportation assistance and home-delivered meal services. Through its prescription drug card program, Senior PHARM*Assist* also acts as a secondary payer. This helps participants meet their deductibles and cost-sharing related to Medicare drug plans.

In addition to these types of organizations, North Carolina has a rich history of developing community-based health care systems, and the Task Force expressed particular interest in initiatives that create community-care networks for seniors, similar to the infrastructure of the Community Care of North Carolina Program (CCNC).

For example, the physicians who participate in CCNC felt the need to encourage providers to take an informed look at their prescribing habits for their Medicaid patients. They felt the need to evaluate the relative costs of medicines prescribed in key therapeutic categories. They identified the top 100 drugs by Medicaid expenditures in North Carolina and then arranged those compounds in a tiered fashion by average wholesale price (AWP), where Tier 1 drugs offer the greatest potential cost savings to the Medicaid program. The tiered list is shared with providers throughout the CCNC network via posters, pocket-sized reference cards, and an electronic drug reference entitled ePocrates. As a result of this voluntary, provider-driven effort, preliminary findings show the post-rollout period of February 2003-March 2003 had 22% lower expenditures compared to a pre-rollout period of September 2002-October 2002. The actual savings equals approximately $640,000.[38]

Additionally, the CCNC infrastructure has allowed the state to develop and implement a nursing home polypharmacy initiative that creates pharmacist and physician teams to review drug profiles and medical records for Medicaid patients in nursing homes. They determine if a drug

therapy problem exists and then recommend a change and perform follow-up. Approximately 9,208 nursing home residents used more than 18 drugs within a 90-day period. The criteria used to identify individuals for the initiative included: inappropriate drugs for the elderly known as "Beers drugs"; drugs used beyond usual time limit; drug use warnings and precautions; the prescription advantage list; and potential therapeutic duplication. Of the 9,208 patients, recommendations were made on 8,559 of them and 74% or 6,359 had recommendations implemented. This initiative has proven that the pharmacist-and-physician team approach reduces costs and improves quality of care.

In 2005, the North Carolina General Assembly passed legislation to expand the scope of the CCNC managed care network to include aged, blind, and disabled populations. Implementation has recently begun. North Carolina has also applied for a Medicare Redesign Demonstration Waiver that would allow for a joint agreement between CMS and the North Carolina Community Care Network (a nonprofit organization that represents all the CCNC networks) to help manage recipients dually eligible for both Medicare and Medicaid.

A NC Pilot for Collaboration and Coordination of Care

Another example of coordinated care efforts is the Program of All-Inclusive Care for the Elderly (PACE), a unique, capitated managed care benefit for the frail elderly that seeks to provide better care and cost savings by integrating preventive, acute, and long-term care into one package. For most participants, the program provides needed services through an adult day care center to enable them to live at home, rather than in a nursing home or other institution. This coordinated-care model began as a federally supported demonstration project but, as part of the Balanced Budget Act of 1997 (BBA), PACE was made a permanent provider under Medicare and a state option under Medicaid. PACE features an integrated financing system through both Medicare and Medicaid.

There are nearly 40 PACE programs in 19 states that are serving approximately 17,000 Medicare and Medicaid beneficiaries. PACE serves individuals who are age 55 or older, certified by their state to need nursing home care, able to live safely in the community at the time of enrollment and live in a PACE service area. Although all PACE participants must be certified to need nursing home care, only about 7% nationally reside in a nursing home. If a PACE enrollee does need nursing home care, the program pays for it and continues to coordinate the enrollee's care. By delivering all needed medical and supportive services, PACE is able to provide the entire continuum of care and services to seniors with chronic-care needs while maintaining their independence in their homes for as long as possible. Care and services include:

- adult day care that offers nursing, physical, occupational and recreational therapies, meals, nutritional counseling, social work, and personal care;
- medical care provided by a PACE physician familiar with the history, needs, and preferences of each participant;
- home health care and personal care;
- all necessary prescription drugs;
- social services;
- medical specialists such as audiology, dentistry, optometry, podiatry, and speech therapy;

- respite care;
- hospital and nursing home care when necessary.

In 2004, the North Carolina General Assembly passed legislation to develop two pilot PACE programs (see Appendix C). One is being developed by Elderhaus, a daytime care facility for seniors based in Wilmington, NC. The second is being developed by Piedmont Health Services, which operates six community health centers throughout the state. This second pilot program has received some start-up funding through CMS as part of a new initiative to develop PACE programs in rural areas.

Creating a new PACE program is an in-depth process that requires the completion of an extensive provider application, access to start-up funds, and development of the infrastructure needed to provide services. A prospective PACE-sponsoring organization must work with state and federal agencies, internal and external funding sources, community organizations, and health care providers to assemble an operational program. PACE provider applications are submitted to the state Division of Medical Assistance (DMA) before being passed to the Centers for Medicare and Medicaid Services for final approval. The approval process typically requires twelve months. In North Carolina, the two programs are in the process of creating the PACE infrastructure and completing applications. They are tentatively scheduled to be operational by fall 2007 (Elderhaus) and summer 2008 (Piedmont Health Services).

Although the PACE designation as a permanent provider allowed for rapid expansion nationwide, growth has been slower than expected. Some recent research has presented explanations for possible barriers to expansion. These include issues of competition between PACE programs and other state-sponsored programs for the same population, poor understanding of the program, and a lack of financing.

With funding from the Centers for Medicare and Medicaid Services, Mathematica Policy Research is evaluating the PACE program. Its evaluation is estimating the program's impact on beneficiaries in their first through fourth years of enrollment, as well as trying to understand how the program has changed now that it is a permanent component of the Medicare program. In particular, the evaluation is answering these four questions:

- What are the effects of PACE on quality of care, as measured by mortality, self-reported health, and physical functioning of enrollees after their first full year of enrollment?
- How do Medicare and Medicaid outlays for PACE enrollees compare with outlays that would have been made in the absence of the PACE program?
- How did the Balanced Budget Act, which made PACE a permanent part of the Medicare program, affect PACE operations?
- How well does a community-based physician model operate in two current PACE sites and at a non-PACE site that serves a similar population?

The analysis includes two parts based on different data sources. A study of the effects on quality of care relies on a telephone and in-person survey of Medicare beneficiaries who entered PACE and home- and-community-based waiver programs in seven states between 2001 and 2003. A study of the effects on Medicare and Medicaid expenditures analyzes a cohort who entered

PACE in 1999, using Medicare and Medicaid claims supplemented by data from PACE sites on hospital and nursing home utilization by enrollees.

Recommendation 5: Improving the Coordination of Health Care Delivery for Seniors

5.1 The Task Force encourages continued exploration of whether the PACE program is an effective model for coordinated care for seniors. The Task Force believes that the results of a pending federal evaluation as well as further monitoring of the two pilot sites in North Carolina could provide policy makers with valuable information on models to coordinate care for the state's most vulnerable seniors. For example, policy makers might want to support a future evaluation of how the community-based physician model operates in the current pilot PACE sites and at a non-PACE site that serves a similar population.

Other Strategies to Access Prescription Drug Assistance in NC

While beyond the scope of the Task Force's formal charge, the Task Force acknowledges two important additional programs for accessing prescription drugs. These federally funded programs—340B pricing and the Aids Drug Assistance Program (ADAP)—provide assistance for low-income seniors as well as low-income individuals under age 65.

340B

340B pricing refers to a federal designation given to facilities that serve very low-income individuals. States offer discounts through the 340B drug pricing program, which requires pharmaceutical manufacturers participating in Medicaid to offer drug discounts to federal and state-supported facilities that serve the most vulnerable populations. Receiving lower-cost medications through one of North Carolina's qualified facilities is likely much more affordable for those with very low incomes than purchasing a Medicare Part D prescription drug plan. As of July 2006, 309 facilities in North Carolina had 340B discount status.[39]

Covered facilities include nonprofit disproportionate-share hospitals owned by or under contract with state or local governments; federally qualified health centers (FQHCs); AIDS Drug Assistance Programs (ADAPs); Ryan White CARE Act Title I, Title II, and Title III programs; and clinics for tuberculosis, black lung, family planning, sexually transmitted diseases, hemophilia, public housing, homeless, urban Indian and native Hawaiian populations.[40]

Aids Drug Assistance Programs (ADAPs)

The North Carolina AIDS Drug Assistance Program (ADAP), also know as the HIV Medications Program, uses a combination of state and federal funds to provide low-income residents with assistance in obtaining essential, life-sustaining medications to fight HIV/AIDS and the opportunistic infections that often accompany the disease. The program purchases the medications in bulk from a pharmaceutical wholesaler, and a central pharmacy dispenses and sends the prescriptions for each client. There is no cost to the individual covered under this

program for the drugs that are on the program's formulary. The individual is responsible for the cost of other drugs that they receive that are not covered by the program.

Individuals living with HIV/AIDS typically have extremely high prescription drug costs and many of the necessary medications do not have a generic equivalent. For those with HIV/AIDS who have prescription drug coverage through Medicare Part D as SSDI recipients, North Carolina ADAP has paid the cost of the drugs while in the doughnut hole. Similar to prescription drugs available through PAPs, these medications do not count toward the true-out-of-pocket costs that Medicare beneficiaries must pay in order to qualify for catastrophic coverage.

Further exploration of a range of community-based outreach and enrollment strategies as well as additional state assistance to address some of the gaps in the Medicare Part D benefit remain critically important to ensure access to affordable prescription drug coverage for all of North Carolina's seniors.

Conclusion

Many of the problems Medicare beneficiaries face stem from larger, systemic issues that no single authority can fully address. The Task Force would like to recognize the impact that programmatic complexity has on individual beneficiaries, and urges leaders at the state and federal level to push for a more user-friendly version of the Part D program and the health care system for seniors in general. We believe that less complexity and more coordination will lead to better health care and therefore, better health outcomes for all Medicare beneficiaries. Further, we hope that the recommendations put forth by this document will help to make North Carolinians' experience with Medicare better, and contribute to the overall discussion of reform.

Appendix A

Patient Assistance Program Eligibility Criteria and Medicare Part D

Will your Medicare patients be eligible for Patient Assistance Programs?
Updates are made as they are received. Last updated March 21, 2007.

No Medicare Patients may apply for PAPs		
Actelion	**Dermik**	**Salix**
American Regent	**Eisai**	**Savient**
Axcan	**IVAX**	**Sciele Pharma**
Biogen	**MedImmune**	**Scios**
Boehringer Ingleheim	**Millenium**	**Teva/Gate**
Cangene	**Mylan**	**Watson**
Celgene	**PDL Biopharm**	
Cephalon	**Purdue**	
Medicare Patients without a Part D plan may apply for PAPs		
Alpharma	**Endo**	**Novo-Nordisk**
Amgen (Part D see below)	**Enzon**	**Ortho-Biotech** (Part D see below)
Amylin	**ESP**	**Reckett Benckiser**
Astellas Pharma (Part D see below)	**Forest**	**Reliant**
	Galderma	**Roche** (Part D see below)
Bayer	**Genentech**	**Serono**
Berlex	**Genzyme** (Part D see below)	**Shire** (Part D see below)
Biovail	**Graceway**	**Solvay**
Bradley Pharmaceuticals	**Intermune**	**TAP** (Part D see below)
Centocor	**King**	**UCB**
Daiichi Sankyo	**MedPointe**	**Upsher-Smith**
Duramed	**MGI**	**Valeant** (Part D see below)
Eli Lilly (Part D see below)	**NitroMed**	**Vistakon**
All Medicare Patients may apply for PAPs		
Abbott *	**Digestive Care**	**Novartis**
Alcon (Part D enrollees must submit a hardship letter)	**Eytech**	**Pfizer*** (Some medications may not be available to Part D enrollees)
	Gilead*	**Procter & Gamble** (Cannot be LIS eligible)
Allergan*	**GlaxoSmithKline—**Part D enrollees use GSK Access program	**Sanofi-Aventis** (Appeal process for financially needed patients who have a life threatening condition confirmed by physician)
AstraZeneca—Part D enrollees use AZ Medicines & Me	**Johnson & Johnson***	
	Kos	
Bristol Myer Squibb* Berlex/Beta Seron Fnd. (Cannot be LIS eligible)	**Merck***	**Schering-Plough**
	Merck/Schering Plough *	**Takeda***
	NABI (Cannot be LIS eligible)	

Chiron/TOBI—Part D enrollees may be eligible for product or co-pay assistance		**Wyeth** (Part D enrollees must submit a hardship letter or LIS denial letter)
Medicare Part D patients may apply for selected medications		
Amgen—Sensipar and Enbrel only **Astellas Pharma—**Prograf only **Eli Lilly—**Zyprexa, Forteo and Humatrope only	**Genzyme—**Renagel only through Renagel Part D PAP **Ligand—**only if drugs not in patient's Part D plan **Ortho-Biotech—**Only if drugs not in patient's Part D plan **Roche—**Only if drugs not in patient's Part D plan	**Shire—**Fosrenol, only if drug not in patient's Part D plan **TAP—**Prevacid Only **Valeant—**Only if drugs not in patient's Part D plan; Part D enrollees ineligible for Infergen PAP

LIS = Low-Income Subsidy within Part D
*Will consider consider allowing some Part D enrollees to apply for PAPs; contact the company for more information.

Appendix B

Patient Assistance Programs (PAPs)

What are patient assistance programs?
Patient assistance programs (PAPs) are programs set up by drug companies that offer free or low-cost drugs to individuals who are unable to pay for their medication. These programs may also be called indigent drug programs, charitable drug programs, or medication assistance programs. Most of the best known and most prescribed drugs are included. All of the major drug companies have patient assistance programs, although every company has different eligibility and application requirements. Companies offer these programs voluntarily; the government does not require them to provide free medicine.

How do patient assistance programs work?
The patient applies for the drug company program that has the needed medicine. Information on medication available through patient assistance programs and the company programs offering these drugs may be found on the RxAssist.org Web site. Many application forms are available and can be filled out online or printed out. Some companies' programs require that a physician or heath care advocate (someone working in a physician's office or in a clinic) get the form by calling the program. Many times in these cases, the patient assistance program will screen for eligibility before sending the form. The form that is sent will have a patient-specific identification number on it. After it is filled out and submitted, the drug company will decide whether the patient is eligible to receive the medication for free. If the patient is eligible, the medication may be sent to the patient's home, the physician's office, or a local pharmacy, depending on the program. Some, but not all companies send letters informing patients and/or physicians about whether the patient has been approved for their patient assistance program.

What are the eligibility requirements for patient assistance programs?
Eligibility varies program by program. Generally, individuals must have incomes under 200% of the federal poverty level (below $25,660 for a family of two people), cannot have prescription coverage from any public or private source, and must be a U.S. resident or citizen. Some companies require that the patient have no health insurance.

For a list of program decisions regarding Medicare and patient assistance program eligibility, see http://www.rxassist.org/docs/medicare-and-paps.cfm.

PAPs and True-Out-of-Pocket Expenses (TrOOP)
The monetary value of free or low-cost drugs provided through PAPs cannot be counted toward an individual's true-out-of-pocket expenses (TrOOP). TrOOP costs are the expenses that count toward the annual Medicare drug plan threshold (also known as the doughnut hole) of $3,850 (in 2007) for the year.

Information adapted from: http://www.rxassist.org/faqs/default.cfm#3 and http://www.oig.hhs.gov/fraud/docs/advisoryopinions/2006/AdvOpn06-03F.pdf

Although many pharmaceutical companies operate PAPs, they face one main barrier to providing assistance to Part D beneficiaries—the federal anti-kickback statute. When companies offer people free or reduced cost medications or financial assistance toward particular prescription drugs, these actions may be viewed as inducements toward the purchase of specific drugs from specific companies as well as rewarding businesses reimbursable by a federal health care program. The following rules currently guide the actions of PAPs:

Prohibited:

- Cannot "offer, pay, solicit, or receive any remuneration to induce or reward the referral or generation of business reimbursable by any federal health care program."
- Assistance that has a monetary value cannot be counted toward an individual's true-out-of-pocket costs (TrOOP), the expenses that count toward the annual Medicare drug plan threshold (also known as the doughnut hole) of $3,850 (in 2007) for the year.

Permissible:

- Pharmaceutical manufacturers may make cash donations to independent charities that provide financial assistance to Part D beneficiaries.
- PAPs may elect to provide free drugs to financially needy Medicare Part D enrollees outside the Part D benefit.
- Pharmaceutical manufacturers may be able to join together in a collaborative PAP if safeguards are put in place to avoid steering and kickback issues as illustrated by the Office of Inspector General.

Appendix C

PACE

The Program of All-Inclusive Care for the Elderly (PACE) is a capitated benefit authorized by the Balanced Budget Act of 1997 (BBA) that features a comprehensive service delivery system and integrated Medicare and Medicaid financing. The program is modeled on the system of acute and long-term care services developed by On Lok Senior Health Services in San Francisco, California. The model was tested through CMS (then HCFA) demonstration projects that began in the mid-1980s. The PACE model was developed to address the needs of long-term care clients, providers, and payers. For most participants, the comprehensive service package permits them to continue living at home while receiving services rather than be institutionalized. Capitated financing allows providers to deliver all services that participants need rather than be limited to those reimbursable under the Medicare and Medicaid fee-for-service systems.

The BBA established the PACE model of care as a permanent entity within the Medicare program and enables states to provide PACE services to Medicaid beneficiaries as a state option. The state plan must include PACE as an optional Medicaid benefit before the state and the Secretary of the Department of Health and Human Services (DHHS) can enter into program agreements with PACE providers.

Participants must be at least 55 years old, live in the PACE service area, and be certified as eligible for nursing home care by the appropriate state agency. The PACE program becomes the sole source of services for Medicare-and Medicaid-eligible enrollees.

An interdisciplinary team consisting of professional and paraprofessional staff assesses participants' needs, develops care plans, and delivers all services (including acute care services and, when necessary, nursing facility services), which are integrated for a seamless provision of total care. PACE programs provide social and medical services primarily in an adult day health center, supplemented by in-home and referral services in accordance with the participant's needs. The PACE service package must include all Medicare- and Medicaid-covered services, and other services determined necessary by the interdisciplinary team for the care of the participant. PACE providers receive monthly Medicare and Medicaid capitation payments for each eligible enrollee. Medicare-eligible participants who are not eligible for Medicaid pay monthly premiums equal to the Medicaid capitation amount, but no deductibles, coinsurance, or other type of Medicare or Medicaid cost-sharing applies. PACE providers assume full financial risk for participants' care without limits on amount, duration, or scope of services.[41]

PACE PILOT PROGRAM FUNDS FROM HOUSE BILL 1414 (2004)

SECTION 10.12.(a) The Department of Health and Human Services, Division of Medical Assistance, shall develop a pilot program to implement the Program for All-Inclusive Care for the Elderly (PACE). One pilot site shall be planned for the southeastern area of the state and the other pilot site shall be planned for the western area of the state. The division shall design the pilot program to access federal Medicaid and Medicare dollars to provide acute and long-term care services for older patients through the use of interdisciplinary teams. When implemented,

services provided through the PACE pilot program may include physician visits, drugs, rehabilitation services, personal care services, hospitalization, and nursing home care. The PACE pilot program may also offer social services intervention, case management, respite care, or extended home care nursing.

SECTION 10.12.(b) Of the funds appropriated to the Department of Health and Human Services, Division of Medical Assistance, for the 2004-2005 fiscal year, the sum of one hundred twenty-three thousand one hundred fifty-six dollars ($123,156) shall be used to support two positions in the Division of Medical Assistance to develop the pilot programs in accordance with subsection (a) of this section. These funds may also be used to contract for actuarial analysis as part of the development of the pilot programs.

SECTION 10.12.(c) The Department of Health and Human Services shall report to the House of Representatives Appropriations Subcommittee on Health and Human Services and the Senate Appropriations Committee on Health and Human Services on March 1, 2005, on PACE pilot program development. The report shall include services proposed to be offered under the pilot program, administrative structure of the pilot program, number of Medicare and Medicaid eligible recipients anticipated to receive services from the PACE pilot sites, and the projected savings to the state from PACE pilot program implementation.

SECTION 10.12.(d) Nothing in this section obligates the General Assembly to appropriate funds to implement the PACE program statewide.

[1] http://www.unc.edu/news/archives/nov06/taskforcegitterman111606.htm.
[2] The Lewin Group. "The First Year for Seniors: Medicare Prescription Drug Coverage in North Carolina, 2006." 15 November 2006. *North Carolina Health and Wellness Trust Fund* <http://www.healthwellnc.com/LewinPartD06report.pdf> (accessed December 2006).
[3] These individuals are also known as dual eligibles and they were automatically enrolled into a Medicare Part D plan. Full-benefit dual eligibles qualify for the low-income subsidy and therefore, pay no premiums or deductibles and have copayments usually ranging from about $1.00 to just over $3.00. This population is not subject to the doughnut hole.
[4] "Medicare Factsheet: The Medicare Prescription Drug Benefit." November 2006. *The Kaiser Family Foundation.* <http://www.kff.org/medicare/upload/7044-05.pdf> (accessed December 2006).
[5] Credible coverage is defined as coverage that is at least as good as the standard Medicare drug benefit. Individuals that do not enroll in Medicare Part D once they become eligible and have not had credible coverage prior to enrolling face a penalty equal to 1% of the national average monthly premium for each month they delay enrollment.
[6] The Medicare Part D benefit is offered through two types of private plans: stand-alone PDPs for people who receive other Medicare benefits through the fee-for-service program, and Medicare Advantage plans (MA-PDs, also known as Medicare Part C), such as HMOs or PPOs, that cover drugs and other Medicare benefits.
[7] The Lewin Group. "The First Year for Seniors: Medicare Prescription Drug Coverage in North Carolina, 2006." 15 November 2006. *North Carolina Health and Wellness Trust Fund.* <http://www.healthwellnc.com/LewinPartD06report.pdf> (accessed December 2006).
[8] This average is weighted by 2006 PDP enrollment and thus excludes three PDPs that were offered in 2006 but were not offered as the same plans in 2007. Together, these three plans have 5,470 in total enrollment for 2006.
[9] "Medicare Factsheet: Low-Income Assistance Under the Medicare Drug Benefit." May 2006. *The Kaiser Family Foundation.* <http://www.kff.org/medicare/upload/7327.pdf> (accessed December 2006).
[10] The LIS is substantial premium and cost-sharing subsidies for Medicare beneficiaries with low incomes and modest resources. These subsidies are intended to reduce or eliminate enrollees' out-of-pocket expenses associated with the drug benefit, including premiums, deductibles, copayments, and costs in the coverage gap (doughnut hole).
[11] Some PDPs offer additional coverage for medications (either generics only or preferred and generic drugs) during the doughnut hole. These plans usually require a higher monthly premium.
The Lewin Group. "The First Year for Seniors: Medicare Prescription Drug Coverage in North Carolina, 2006." 15 November 2006. *North Carolina Health and Wellness Trust Fund.* <http://www.healthwellnc.com/LewinPartD06report.pdf> (accessed December 2006).
[13] "Gov. Easley Outlines Prescription Drug Assistance for Seniors: *'North Carolina Rx' Will Help Provide Low-income Elderly the Medications They Need."* 18 October 2006. *North Carolina Office of The Governor.* <http://www.governor.state.nc.us/News_FullStory.asp> (accessed December 2006).
[14] "Gov. Easley Outlines Prescription Drug Assistance for Seniors: *'North Carolina Rx' Will Help Provide Low-income Elderly the Medications They Need*." 18 October 2006. *North Carolina Office of The Governor.* <http://www.governor.state.nc.us/News_FullStory.asp> (accessed December 2006).
[15] "State Pharmaceutical Assistance Programs." 1 August 2006. *US Department of Health and Human Services, Centers for Medicare and Medicaid.* <http://www.cms.hhs.gov/States/07_SPAPs.asp> (accessed December 2006).
[16] "State Pharmaceutical Assistance Programs in 2006-07: Helping to Make Medicare Part D Easier and More Affordable." 10 January 2007. *National Conference of State Legislatures.* <http://www.ncsl.org/programs/health/SPAPCoordination.htm> (accessed December 2006).
[17] "State Pharmaceutical Assistance Programs in 2006-07: Helping to Make Medicare Part D Easier and More Affordable." 10 January 2007. *National Conference of State Legislatures.* <http://www.ncsl.org/programs/health/SPAPCoordination.htm> (accessed December 2006).
[18] The federal "Extra Help" benefit offers assistance to Medicare beneficiaries up to 150% of the federal poverty level (FPL) ($14,700 for individuals and $19,800 for married couples) who pass the asset test of $10,000 for individuals and $20,000 for married couples. NCRx offers assistance to seniors (age 65+) up to 175% FPL ($17,500/individuals and $23,100/married couples) and increases the asset limits to $20,000 for individuals and $30,000 for married couples.
[19] "Landscape of Local Plans State-by-State Breakdown." 5 January 2007. *US Department of Health and Human Services.* < http://www.medicare.gov/medicarereform/local-plans-2007.asp#NC> (accessed December 2006).
[20] http://www.newsobserver.com/659/story/525234.html.

[21] Health Assistance Partnership, "State Health Insurance Assistance Programs: A Critical Resource for Medicare Benefiaries." May, 2006. <http://www.hapnetwork.org/assets/pdfs/HAP-SHIP-Issue-Brief-2006-Final-May-2006.pdf>.
[22] United States. Government Accountability Office. "Medicare Part D: Prescription Drug Plan Sponsor Call Center Responses Were Prompt, but Not Consistently Accurate and Complete." June 2006. <http://www.gao.gov/new.items/d06710.pdf> (accessed December 2006).
[23] "State Children's Health Insurance Program (SCHIP): Outreach and Enrollment." *National Conference of State Legislatures.* January 2000. <http://www.ncsl.org/programs/health/outenrol.htm>.
[24] "Recommendations for Creating a Sustainable Approach to Healthy Start Plus® Outreach in Franklin County." A report to Access Health Columbus. *Children's Defense Fund-Ohio*. November 2001. <http://www.cdfohio.org/publications_research/pub_library/access_health/pdfs/access_health_cols.pdf>.
[25] http://www.cms.hhs.gov/States/Downloads/SPAPGrantGuidance.pdf.
[26] http://cwd.aphsa.org/confs_calls_events/docs/Gale-Arden.pdf.
[27] Summer, Laura, and Lee Thompson. "How Asset Tests Block Low-Income Medicare Beneficiaries from Needed Benefits." May 2004. *The Alliance for Health Reform.* <http://www.allhealth.org/briefingmaterials/HowAssettestsblocklow-incomebeneficiaries-310.pdf> (accessed December 2006).
[28] "AZ Medicine & Me™ for People in Medicare Part D Program." *AstraZeneca.* http://www.astrazeneca-us.com/content/patientAssistance/astrazeneca-medicine-and-me.asp.
[29] "GlaxoSmithKline Announces New Patient Assistance Programs for Low-Income Medicare Part D Patients." GlaxoSmithKline. <http://www.bridgestoaccess.com/pdfs/PressRelease12072006.pdf> (accessed December 2006).
[30]"Pharmaceutical Assistance Program Drug Details." *US Department of Health and Human Services.* <http://www.medicare.gov/pap/drugdetails.asp?drug_id=13987&drug_name=Ogen>.
[31] "Lt. Governor Perdue Announces a Unique Senior Drug Program to Save Money and Lives." 13 October 2006. North Carolina Health and Wellness Trust Fund. <http://www.healthwellnc.com/hwtfc/pdffiles/PressNCRxCare-10-13-06.pdf>.
[32] The Lewin Group. "Medication Therapy Management Services: A Critical Review; Executive Summary Report." May 17, 2005. *American College of Clinical Pharmacy*. <http://www.accp.com/position/mtms.pdf> (accessed December 2006).
[33] "A Summary of Medication Therapy Management Programs in the Medicare Modernization Act and the Center for Medicare and Medicaid Services' Implementing Regulations." April 2005. *American Society of Health-System Pharmacists.* <http://pharmacy.rutgers.edu/725/584/MTM%20Reading.pdf> (accessed December 2006). Federal guidance on MTM can be found online at United States. Department of Health and Human Services. Centers for Medicare and Medicaid Services. "Medicare Program; Medicare Prescription Drug Benefit." 28 January 2005. <http://a257.g.akamaitech.net/7/257/2422/01jan20051800/edocket.access.gpo.gov/2005/pdf/05-1321.pdf> (accessed December 2006).
[34] "Medicare Prescription—Quality Assurance Policies and Procedures." 29 September 2006. *Blue Cross Blue Shield of North Carolina.* 23 February 2007. <http://www.bcbsnc.com/plans/medicareprescription/quality-assurance.cfm#medtherapy>.
[35] Medication Therapy Management Services Definition and Program Criteria. APha MTM Working Group. July 2004.
[36] Interview. January 12, 2007. Thomas D'Andrea, RPH, MBA, Section Chief, Pharmacy and Ancillary Services, NC DHHS, Division of Medical Assistance.
[37] Jeffrey Brewer, Pharm.D., BCPS; Patty Kumbera. "Establishing a Web-based Program for Reimbursement for Medication Therapy Management Services." *American Journal Health-System Pharmacists* 63 (19) (2006): 1806-1809. Posted 10.31.2006. Found online at www.medscape.com/viewarticle/545490.
[38] "Evaluating Coordination of Care in Medicaid: Improving Quality and Clinical Outcomes." Prepared Witness Testimony, Mr. Jeffrey Simms, Assistant Director, North Carolina Division of Medical Assistance. <http://energycommerce.house.gov/reparchives/108/Hearings/10152003hearing1111/Simms1739.htm>.
[39] "States and the 340B Drug Pricing Program" 4 January 2007. *National Conference of State Legislatures*. <http://www.ncsl.org/programs/health/drug340b.htm>.
[40] "Discount Drug Pricing Program Eligibility." 2004. *US Dept. of Health and Human Services, Pharmacy Services Support Center.* <http://pssc.aphanet.org/about/whoiseligible.htm>.

[41] Overview of "The Program of All-Inclusive Care for the Elderly (PACE)." *Centers for Medicare and Medicaid Services.* <http://www.cms.hhs.gov/pace/>.

SCHIP in North Carolina: Evolution and Reauthorization Challenges and Opportunities

Prepared for:

North Carolina Health & Wellness Trust Fund (HWTF)

Lieutenant Governor Beverly E. Perdue, HWTF Commission Chair

and

University of North Carolina at Chapel Hill

Daniel P. Gitterman, Ph.D., Principal Investigator

Prepared by:

The Lewin Group

Aaron McKethan
Wes Joines
Christina Koster

March 2007

EXECUTIVE SUMMARY

Since the State Children's Health Insurance Program (SCHIP) was established by Congress in 1997, the state of North Carolina has taken advantage of federal matching funding and program flexibility to expand public health insurance coverage to thousands of previously uninsured children. The North Carolina Health Choice for Children program has grown steadily, with approximately 110,000 children enrolled as of 2006.

This report explores the history of the Health Choice for Children program over the last decade, focusing on some of the major issues and challenges that have characterized the program to date. The report also summarizes the perspectives of several key stakeholders and experts about the major issues that will be discussed at the federal and state levels during the SCHIP reauthorization process, which is set to be completed before the end of Fiscal Year (FY) 2007 on September 30, 2007.

The Health Choice program has gained strong popularity among beneficiaries and their families, providers, and policymakers. Key factors that contribute to the popularity of the program include:

- The political consensus to make coverage available to uninsured children
- The program's non-entitlement structure (making it a program for which policymakers can exercise budget control)
- The relatively generous federal matching rate (making it an unattractive target for state budget cuts)
- The program's success in expanding health care coverage for thousands of low-income children in North Carolina

Despite being regarded as a successful program, particularly in terms of enrollment and outreach, Health Choice has faced funding shortfalls (at both the federal and state levels) that have contributed to instability in the program. For example, in 2001 North Carolina was the first state in the country to "freeze" enrollment in SCHIP.

The SCHIP reauthorization process that will take place in Washington, D.C. in 2007 will provide an important opportunity for federal policymakers to re-examine the federal role to assist states providing health care coverage for low-income uninsured children. At the same time, North Carolina leaders can use the reauthorization debates taking place at the federal level to examine the experience of Health Choice and evaluate their own commitments to the program's objectives.

The issues identified in this report that are likely to frame the reauthorization discussions at the federal level include the following:

- The amount of federal funding that will be made available to states
- The methods used to derive federal funding allocations
- The allocation formula itself
- The distribution and use of reallocated federal funds
- Broader discussions about the government's role in health care

Opportunities to expand or greatly modify Health Choice will be highly contingent on the level and form of funding made available at the federal level. However, this report also outlines several issues that state leaders in North Carolina can consider that may affect the stability and experience of the program in the future. These include the following:

- State funding sources
- Enrollment and outreach
- Evaluating Health Choice's new primary care management system
- Administrative structure
- Expanding Health Choice to include additional sub-populations of uninsured children

ACKNOWLEDGMENTS

The authors offer special thanks to the following individuals for their helpful insights, suggestions, and recollections: William Brandon, David Bruton, Lanier Cansler, Allen Feezor, Gary Fuquay, Patricia Garrett, Mark Holmes, Ann Lore, June Milby, Adam Searing, Steve Shore, Pam Silberman, Jeffrey Simms, Rebecca Slifkin, Dan Soper, Torlen Wade, Charles Willson, Tom Vitaglione.

These stakeholders and experts helped to identify and frame the key issues discussed in this report. In addition, they also provided comments on early drafts of the document. We also want to express our appreciation to Daniel Gitterman, Jessica Dorrance, and Stephanie Coplin for their very helpful assistance and guidance.

The authors take full responsibility for any errors.

TABLE OF CONTENTS

I. BACKGROUND: THE LEGISLATIVE ORIGINS OF SCHIP

The large number of low-income children without health insurance coverage was a widely discussed policy issue in the 1990s. Nationally, the rate of uninsured children increased from 13.0% in 1990 to 15.0% by 1998.[1] The rate of uninsured children is even higher among families with low-incomes.[2] Growing public concern about the uninsured, along with the failure in 1994 of the comprehensive health care reform legislation promoted by the Clinton Administration, set the stage for the passage of a significant federal health insurance coverage expansion for uninsured children.

The Balanced Budget Act of 1997 (BBA) authorized the largest expansion of publicly-sponsored health insurance coverage since the creation of Medicare and Medicaid in 1965. The BBA amended the Social Security Act by adding Title XXI, also known as the State Children's Health Insurance Program (SCHIP). Under SCHIP, states and territories receive federal matching funds to provide comprehensive health care benefits for the uninsured children of low-income families. In response to the passage of the BBA, all fifty states, the District of Columbia, and five territories established child health insurance programs or expansions.

The BBA gave states discretion to design their own programs according to their specific needs, contexts, and capacities. For example, the BBA allowed states to expand their Medicaid programs, design new and separate child health care programs, or use a combination of the two approaches. As of 2006, 11 states and the District of Columbia had Medicaid SCHIP programs, 18 states had separate programs, and 21 states had a combination of the two approaches.[3] Within federal guidelines, states administer the program and determine eligibility standards, benefit packages, payments levels, and enrollment and other procedures.

The BBA authorized nearly $40 billion in federal funds to states over a ten-year period (FY 1998-2007). States can combine state funds and federal matching funds to extend coverage to low-income uninsured children whose families earn too much to qualify for Medicaid.[4] Thus, like Medicaid, SCHIP financing is a joint state/federal responsibility. However, Medicaid is an entitlement program, whereby those eligible for the program receive its benefits as long as they meet program eligibility guidelines. There is no cap on matching federal contributions. By contrast, federal policymakers that designed the SCHIP program favored a non-entitlement approach that would set an initial ten-year ceiling on federal financing responsibilities for the program. Accordingly, federal matching funds are available to states based on a formula-driven allotment system.

The statutory formula defining the federal government's SCHIP matching rate for each state is based on the number of low-income and uninsured children in each state, as determined by the Current Population Survey (CPS), as well as a cost factor representing the average wages in the state compared to the national average. Each state can receive federal matching funds up to its allotment amount and can retain

federal allocations for a period of three years.[5] If a state spends more than its budgeted allotment in a given year, it can draw upon any of its unspent federal allotment funds from previous years. At the end of the three-year period, however, all remaining funds from federal allotments are returned to the federal government to be reallocated among those states that spent beyond their earlier allocations.

On a matching rate basis, the federal government contributes relatively more to states for SCHIP than for Medicaid. To encourage state participation, federal policymakers set states' federal matching rates at 30 percentage points above 70 percent of their existing Medicaid matching rates, with an upper limit of 85 percent.[6] Thus, while the Medicaid federal medical assistance percentage (FMAP) ranged from 50% to 76% in FY 2006, the enhanced SCHIP FMAP ranged from 65% to 83% across states. In FY 2006, for every $1 spent on state child health insurance programs, the federal government share was $0.72 of spending, on average. This compares to an average federal share of $0.63 for every $1 spent on Medicaid. In North Carolina, the federal matching rate for Medicaid is 63.49% while the federal matching rate for SCHIP is 74.44% (FY 2006).[7]

Under SCHIP, states may design member cost-sharing arrangements to resemble the out-of-pocket payments made by enrollees in private health insurance plans. States that chose to implement SCHIP benefits through a Medicaid expansion must follow the cost-sharing rules of the Medicaid program. States that implement SCHIP through a separate state program must comply with maximum cost-sharing amounts based on a sliding scale that, in turn, is based on family income. The total annual aggregate cost sharing (including payments for premiums, deductibles, and co-payments) for SCHIP families may not exceed five percent of total family income in any given year.

SCHIP's initial period of authorization is scheduled to expire in September 2007. Thus, the program's future is an important item on the current federal policy agenda. The SCHIP reauthorization process will provide an important opportunity for federal policymakers to re-examine the federal role to assist states in providing health care coverage to low-income uninsured children. At the same time, states can use the reauthorization debates taking place in Washington, DC to examine the experience of their own programs and evaluate their own commitments to the same goal.

This report briefly outlines the legislative origins and some of the key features of the SCHIP experience in North Carolina (called "Health Choice for Children"). Based on a review of secondary literature and informal interviews with several stakeholders, advocates, and experts in North Carolina, the report also describes some of the key successes and challenges of the Health Choice program to date. The report concludes with several key funding-related issues that will be considered at the federal level during the federal reauthorization process. It also highlights several policy areas for consideration at the state level that may help the program to further achieve its objective to expand health care coverage opportunities for uninsured children in North Carolina.

II. BRIEF HISTORY OF HEALTH CHOICE FOR CHILDREN

Legislative Origins of Health Choice for Children

Even before federal policymakers settled on final provisions of the Balanced Budget Act that would establish SCHIP, policy officials and health care leaders in North Carolina were actively considering policy solutions to expand coverage to low-income uninsured children in the state. Aware that Congress would likely soon pass a significant appropriation for states for this purpose, the state Department of Health and Human Services (DHHS) in July 1997 asked the North Carolina Institute of Medicine (NCIOM) to co-sponsor a task force to explore numerous policy options. The list of policy alternatives produced by this task force included expanding Medicaid, establishing a separate state children's health insurance program, implementing a combination of both, and initiating a voucher system for families to purchase insurance for their children.

A bipartisan legislative task force chaired by Lieutenant Governor Dennis Wicker convened to consider the task force's recommendations and later to consider the details of Governor James Hunt's legislative proposal. In December 1997, Governor Hunt presented his proposal to develop a children's health insurance program that would take advantage of SCHIP funding made available at the federal level. The Governor's initial proposal was to expand eligibility in the state's Medicaid program from 100% of the federal poverty level (FPL) for uninsured children up to 200% of the FPL.[8] Families would not pay premiums for SCHIP coverage but would be responsible for modest co-payments for physician office visits, hospital visits, and prescription drugs.[9]

In February 1998, Governor Hunt called a special session of the General Assembly to enact the new program. During the special session, which began in March 1998, the Senate, controlled by Democrats, quickly embraced the Governor's plan. The Republican-led House, concerned that a new Medicaid expansion would limit future cost containment options, promoted a different plan for the program. The House proposal used the North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan (also referred to as the "State Health Plan", SHP) as the platform for the new program. The House version also called for the upper income threshold for eligibility determinations to be 185% of the FPL (rather than 200% as in the Governor's plan). It included slightly higher co-payments than the Senate's plan, an enrollment waiting period to discourage parents from dropping existing coverage and shifting responsibility for their children's coverage to the state, and modest sliding scale premiums to be paid by the families of enrolled children between 133% and 185% of the FPL.[10]

Both chambers passed competing bills in the opening days of the special session. Over the next six weeks, House and Senate negotiators struggled to reach consensus on the features of the new program. The resulting compromise, announced on April 28, 1998, arranged for the program to be jointly administered by the state's DHHS and the SHP. DHHS would maintain overall responsibility for ensuring that the program operates within state and federal budget guidelines.

Within DHHS, the Division of Medical Assistance (DMA) was appointed the lead agency for policy and for eligibility determination and the Department of Public Health (DPH) was made responsible for outreach and for the development of the special needs criteria to mirror the State's Title V program. Outreach was to be delivered at the local level through a partnership between county departments of health and social services and public health. The SHP would administer benefits and process claims through a traditional indemnity plan administered by Blue Cross Blue Shield of North Carolina (BCBSNC), which pays "any willing provider" on a fee-for service basis.

The compromise legislation extended eligibility to uninsured children in families with incomes of up to 200% of the FPL (or $32,900 for a family of four in 1998). Benefits for the program were to be tied to the SHP's package of benefits, with added benefits for vision, hearing, and dental care. Children with special health care needs would have access to benefits that essentially matched those under Medicaid. In addition, well-baby, well-child, and immunizations were also to be covered by the plan, and as required, there were no co-pays for preventive services.

The compromise bill did not require that families pay monthly premiums, but did require modest co-payments for families with incomes between 150% and 200% of the FPL. The SHP became responsible for paying providers at rates established for the SHP, which at the time exceeded prevailing Medicaid rates. The SHP was responsible for administering co-payments for covered families with incomes between 150% and 200% of the FPL. The compromise bill also assessed an annual enrollment fee of $50 per child up to $100 per family (for families with incomes between 150% and 200% of the FPL). The proceeds from annual enrollment fees are distributed to the county departments of social services to help offset the costs for their role in conducting outreach and making eligibility determinations.

House negotiators ensured that the final bill included "waiting period" provisions designed to deter families from dropping private insurance to sign up for the new public program. The initial waiting period was six months, although this dropped to only two months after program implementation began. Children would have to be uninsured for at least the duration of the waiting period prior to enrolling in Health Choice.[11]

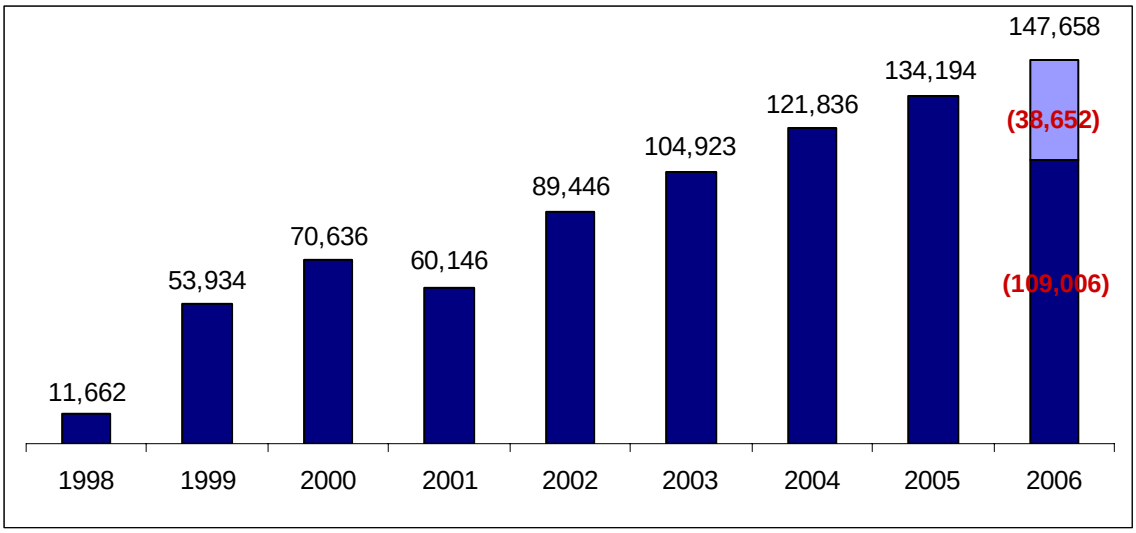
On April 30, 1998, the compromise bill passed the Senate 45-1 and the House 99-12. The new Health Choice program was formally approved by the federal government on July 14, 1998 and began enrolling children on October 1 of the same year.

The Early Years of Health Choice

The early years of Health Choice were focused primarily on outreach and enrollment. Unlike most states, North Carolina officials elected not to sponsor major television or radio advertisements encouraging families to enroll in the new program.[12] Instead, the state favored a novel approach that promoted county-based grassroots outreach. As noted, the legislation establishing Health Choice authorized enrollment to be conducted through county departments of social services and public health. Existing relationships between Medicaid program managers, local social services departments, and close networks of local non-profit and volunteer organizations across the state contributed to the state's local grassroots outreach program.

The DHHS, using the original enrollment projections provided by the federal government, had initially projected that about 71,000 uninsured children statewide would qualify for and enroll in the program. However, almost immediately upon the program's implementation, enrollment grew more rapidly than expected. In its first month of operation, Health Choice enrolled nearly 6,000 children, surpassing the state's projections. After three months of enrolling children, nearly 18,000 children were enrolled in the program. By July 1999, after the program had been in operation for less than a year, enrollment climbed to 45,245, already 64% of the projected target of 71,000 children. By the end of 2000, more than 72,000 children were enrolled. By 2006, the program provides benefits to nearly 148,000 children. See Exhibit 1.

Exhibit 1: Total Enrollment in Health Choice for Children (1998 – 2006)



Note: Figures displayed are based on point-in-time enrollment statistics (December of each year). For 2006, the total column (147,658) represents children receiving benefits through the program. However, the light blue portion (38,652) reflects those children (ages 0-5) that were transitioned to Medicaid effective January 1, 2006, making Health Choice a "combination" program. This transition is discussed in more detail below.
Source: North Carolina Department of Health and Human Services, Division of Medical Assistance, Health Choice for Children Enrollment, URL: http://www.ncdhhs.gov/dma/elig/elig.html

Early success was attributable to several factors. First, the state's grassroots outreach coalition strategy has been highly effective in taking advantage of existing organizations and networks at the local level.[13] Funding to select local coalitions through grants from The Robert Wood Johnson Foundation and The Duke Endowment assisted the outreach efforts by testing specific efforts to minority groups, businesses, church groups, and local government groups, giving counties the ability to use locally developed and tested success stories to design their own campaigns. Local coalitions have been supported by state organizations, such as the North Carolina Healthy Start Foundation, that produce and distribute promotional materials across the state. The Foundation has also sponsored a "Family Health Resource Line" that fields approximately 3,000 calls per month, with the vast majority of calls concerning public children's health insurance issues.[14]

Second, early Health Choice enrollment benefited from the decision of Blue Cross Blue Shield of North Carolina (BCBSNC) to terminate its own non-profit program (Caring Program for Children) when Health Choice was established. The program had enrolled approximately 8,000 uninsured children; BCBSNC suggested that affected families seek coverage in the state's new Health Choice program.

Third, the state made a simple enrollment form widely available in numerous settings. This form is used to determine eligibility for both Health Choice and Medicaid. If applicants are determined to be eligible for Medicaid, they are enrolled in that program. Applicants determined to be ineligible for Medicaid but eligible for Health Choice are enrolled in Health Choice.

Fourth, institutional providers have also grown increasingly proactive in helping to ensure that children eligible for Medicaid or SCHIP are enrolled in these programs at the point of service. This helps reduce uncompensated care incurred by hospitals and other provider groups while also ensuring that eligible children receive and maintain access to program coverage.

Fifth, from the program's inception, Health Choice has been popular among health care providers. Popularity among providers was due in part to relatively generous provider reimbursement, which has resulted in broad provider participation in the Health Choice program across the state. The program's structure ensured that providers would be reimbursed through the SEHP's BCBSNC rates instead of lower Medicaid rates. However, as will be discussed in greater detail below, the General Assembly effectively lowered Health Choice rates to Medicaid rates in 2005.

Finally, state officials contend that enrollment growth rapidly eclipsing the state's original enrollment projections resulted from underestimating the number of children that would qualify and thereby enroll in the program. As noted previously, original estimates projected that 71,000 children would qualify for and enroll in Health Choice. Both the federal allotments for North Carolina and the state's own appropriations for Health Choice were based on this original number. However, as is discussed below, this figure proved to be an underestimate and has contributed to instability in the program.

Enrollment Freeze

By late 2000, while the state was in the midst of a budget shortfall, DHHS determined that by the end of the state fiscal year (June 30, 2001), DHHS would effectively run out of state funds that the General Assembly had appropriated to finance the Health Choice program. Accordingly, the state submitted a state plan amendment to the federal government to close SCHIP to new enrollment effective January 1, 2001. The federal government approved this plan amendment on February 16, 2001.[15] North Carolina thereby became the first state in the country to "freeze" new enrollment in their SCHIP program.[16]

Under the freeze, existing enrollees continued to receive coverage. However, several categories of children who were determined to be eligible for Health Choice were placed on a waiting list. This included children who were no longer eligible for

Medicaid due to increases in family income or because they "aged" out of Medicaid coverage (that is, became eligible for Health Choice when their age exceeded the eligibility threshold of Medicaid). The wait list also included children whose parents did not seek to re-enroll in the program within a specified period. The waiting list peaked at over 34,000 children.[17] As a result of the enrollment freeze, enrollment in Health Choice dropped from a high of 72,024 in January of 2001 to 59,294 children by June of that same year, a 29 percentage decline.[18]

The program was partially re-opened starting in July 2001 as the Governor authorized the DHHS to begin lifting the enrollment cap. Since the number of enrolled children had dropped enough so that the state had enough funds to cover some of the children on the waiting list, the DHHS first began to enroll wait-listed children without yet fully opening the program to new applicants. However, total enrollment continued to decline until it reached a low of 51,294 by October of 2001. The enrollment freeze was lifted for *new* applicants on October 8, 2001 as the General Assembly appropriated new funding for the program. Enrollment grew rapidly once the program was fully re-opened; by July 2002, enrollment in the program climbed to over 84,000.

The 2001 enrollment freeze occurred because as program spending was projected to increase, the DHHS faced a shortage of appropriated state funds that could be used to generate federal matching funds. The DHHS did not have the authority to reduce provider reimbursement since payment rates were tied to an existing contract between the SHP and BCBSNC. Since the program's benefit package was legislatively mandated by the General Assembly, the DHHS also did not have the discretion to cut services in order to contain costs that might avoid or delay the enrollment freeze. Moreover, the DHHS did not (then) have the authority to draw upon additional state funds beyond what had been originally budgeted by the General Assembly. Thus, a freeze on enrollment was the only viable option that DHHS could consider in the short-term, absent action by the General Assembly (which was not in session at the time).

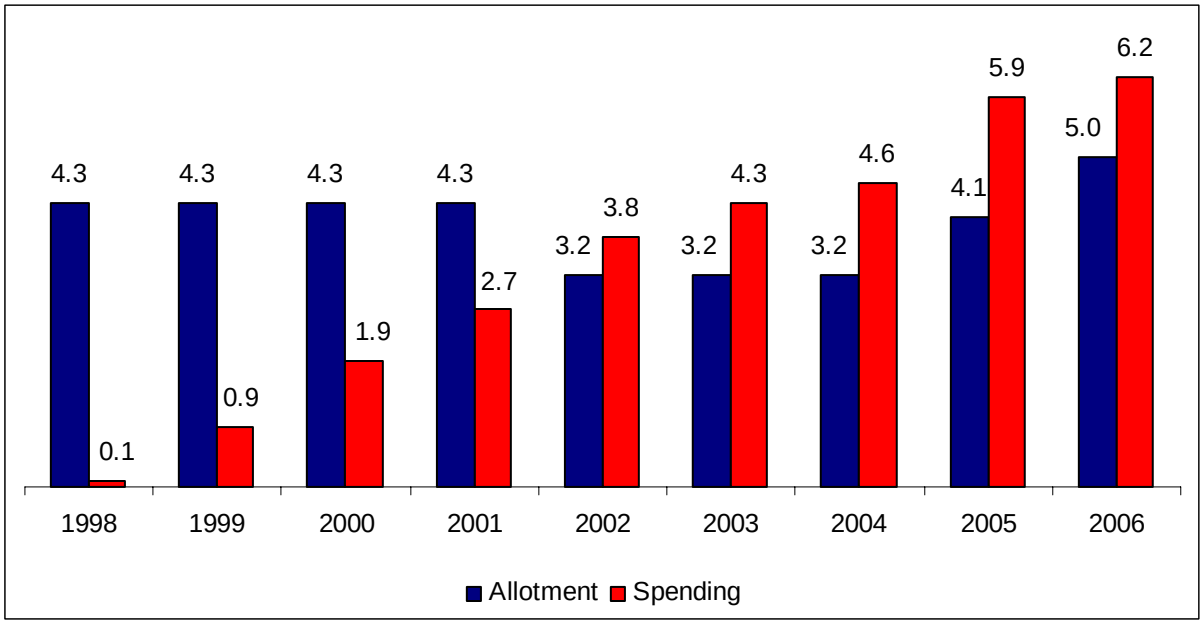
Since the enrollment freeze of 2001, DHHS has faced similar challenges of program costs exceeding appropriated state funds. In fact, the DHHS has considered freezing SCHIP enrollment on several different occasions since 2001. However, as is discussed in more detail below, the General Assembly has periodically requested and received guidance from the NCIOM about measures to avoid new enrollment freezes. The General Assembly has also added sufficient funding to temporarily avoid new enrollment freezes. Moreover, in 2003, the General Assembly granted the DHHS the authority to transfer necessary funds within DHHS into the Health Choice program to help prevent future freezes absent direct General Assembly action.

Health Choice and Reallocated Federal Funds

While the enrollment freeze of 2001 was associated with a lack of appropriated state funds, the Health Choice program is also increasingly challenged by the reduced availability of federal matching funds to finance the program.

Historically, North Carolina has used all of its original federal allotments to fund the program.[19] On an aggregate national level, total SCHIP spending was less than total allotment levels in the early years of the program. This created opportunities for states like North Carolina to receive reallocated federal funds that had been originally allocated (but were unspent by) other states. However, as other states enrolled more children and expanded eligibility and/or benefits, excess allotments declined, making fewer reallocated funds available to states like North Carolina that have regularly spent more than their annual allotments. Total SCHIP annual spending across the fifty states (in absolute dollars and as a proportion of the allotted funds that were made available in the BBA) has increased sharply during the program's tenure, more than tripling since 2001. See Exhibit 2.

Exhibit 2: SCHIP Federal Allotments and Aggregate State Spending (All States), in billions



Source: Centers for Medicare and Medicaid Services.

In addition to providing additional state funds to support the growing Health Choice program, the state has taken other measures to avert additional enrollment freezes. The General Assembly took many of these measures in response to the recommendations of

the NCIOM, which issued several policy recommendations in 2003 as directed by the General Assembly.[20] In state budget discussions in August 2005, for example, the General Assembly shifted Health Choice children ages five and younger to the Medicaid program by extending Medicaid eligibility to this sub-population. This strategy created a coverage "entitlement" for affected children newly enrolled in Medicaid. The strategy also temporarily averted the possibility of another SCHIP enrollment freeze by taking advantage of "savings" available from lower provider reimbursement rates paid to Medicaid providers relative to the rates paid to providers on behalf of Health Choice and SHP beneficiaries.

Summary of Health Choice Evolution

Several key issues have characterized the experience of the Health Choice program in North Carolina. The plight of low-income uninsured children reached the political and policy agenda in North Carolina before passage of the BBA that would establish SCHIP. However, the federal government's role in making funding available has been critical in helping North Carolina policymakers and advocates to achieve their goal of expanding public coverage. The administration of the Health Choice program, including its innovative grassroots outreach program, has also succeeded in enrolling low-income children in the state. As the reauthorization debate draws near, ensuring the availability of additional state and federal funds will remain critical for the state's ability to put its successful outreach program to work to not only enroll more eligible but unenrolled children, but also to consider any policy proposals that might expand eligibility to additional sub-populations of low-income uninsured children.

III. PREPARING FOR REAUTHORIZATION

SCHIP's initial period of federal authorization will expire on September 30, 2007. Congress and the President will determine the conditions under which the program will be reauthorized. The debate over reauthorization will take place at a time when the uninsured rate for children is once again on the rise and budget pressures are contributing to constraints on publicly financed health care coverage.[21]

The reauthorization debate will be dominated by the level and form of federal funding that will be committed to states. States' recent experiences with the program underscore the importance of federal financing considerations in the reauthorization process. For example, in FY 2006, 38 states' SCHIP spending exceeded their federal allotments.[22] Funds available to redistribute from FY 2003 unspent funding was insufficient to fill this gap. This led Congress to include $283 million in the Deficit Reduction Act of 2005 (P.L. 109-171) to temporarily fill these gaps.[23] In FY 2007, an estimated 17 states (including North Carolina) face financial shortfalls totaling over $1 billion.[24] After Congress modified the redistribution formula in December 2006 (P.L.

109-432), the total estimated shortfall is $920 million, including $17.6 million for North Carolina.[25]

Federal policymakers are likely to approach the reauthorization debates with several key priorities in mind. First, policymakers will seek to ensure that children currently enrolled in SCHIP keep their coverage. Second, policymakers may also seek to provide sufficient funding that would allow states to conduct further outreach to currently eligible but uninsured children. Finally, policymakers may promote opportunities to expand eligibility to additional low-income children without a current source of health care coverage. Underlying each of these likely policy priorities will be the federal government's role in providing funding to states.

In North Carolina, policy discussions concerning the reauthorization debate are already taking place among key program stakeholders, advocates, and policymakers. Based on a high-level review of the history of the Health Choice program in North Carolina and interviews with several program stakeholders, this section outlines some of the key components of the federal reauthorization debate that will directly affect the states' Health Choice program. Also included is a discussion of several issues that state leaders may consider to help improve the program's ability to meet its objectives.

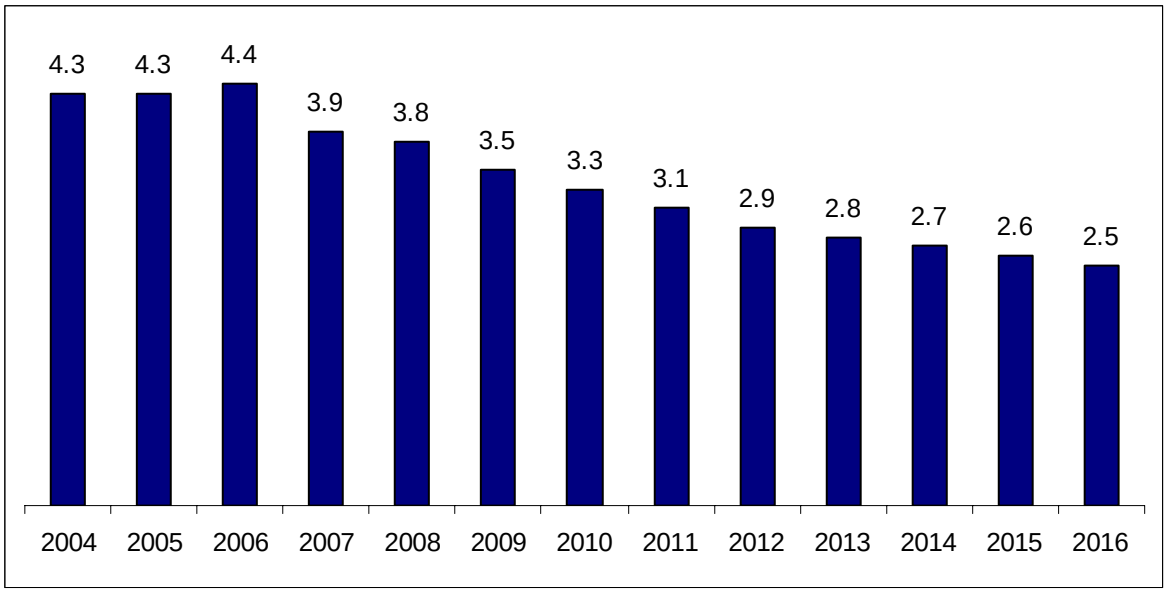
Issues for Consideration at the Federal Level

Several aspects of SCHIP's financing arrangements will be considered in the reauthorization process. The most important aspect of the reauthorization debate for North Carolina, as for all states, is the actual amount of federal funding that will be made available to support the program in future years.

The Congressional Budget Office (CBO) assumes that Congress will reauthorize SCHIP at FY 2007 funding levels.[26] Thus, CBO budget forecasting begins with a baseline assumption that the program will be effectively "frozen" for the next several years at $5 billion per year. This is consistent with the President's FY 2008 Budget, which set aside approximately $5 billion over five years for additional SCHIP allotment funds.[27]

However, some analysts predict that reauthorizing SCHIP at 2007 funding levels would result in program shortfalls in North Carolina of $54.9 million by 2008 and $199.3 million by 2012 (assuming moderate expenditure growth and no change to rules for allocating and redistributing federal funds).[28] Such funding shortfalls would likely result in declining enrollment if the state is unable or unwilling to keep up with annual increases in enrollment and overall health care costs. According to the Kaiser Commission on Medicaid and the Uninsured, holding federal SCHIP allotments fixed at $5 billion after FY 2007 would result in steady declines in SCHIP enrollment nationwide.[29] See Exhibit 3.

Exhibit 3: Projected SCHIP Enrollment Based on Current Funding Levels (in millions, 2004 – 2016)



Source: The Kaiser Commission on Medicaid and the Uninsured. (Assuming federal SCHIP allotments remain at $5 billion after FY 2007).

In addition to the actual amount of funds that the federal government will make available to states, stakeholders and experts interviewed identified several additional issues related to program financing that are likely to be considered in federal discussions about SCHIP reauthorization. These include the data used to derive federal funding allocations, the allocation formula itself, and the distribution and use of reallocated federal funds. These issues are discussed below.

Data Used to Derive Federal Funding Distribution

As noted previously, the amount of matching funds that the federal government has allocated to North Carolina is determined by an allocation formula. This formula, in turn, is based on information obtained from the Current Population Survey (CPS), a monthly survey of 60,000 households conducted by the U.S. Bureau of Labor Statistics (BLS). The CPS compiles information on insurance coverage for children and the number of children from low-income families (defined by BLS as those earning less than 200% of the FPL). State officials in North Carolina contend that the CPS underestimated the number of uninsured children in the state. This does not appear to be a North Carolina-specific issue. Indeed, the CPS has been criticized for its insufficient sample size in small states, its unstable estimates from year to year, and its inadequate questions about individuals' insurance status.[30] In 1999, Congress acted to limit large annual changes in allotments and bolster the sample size in the survey to ameliorate these problems (P.L. 106-113). However, state leaders we interviewed suggest that the reauthorization debate should include a discussion about alternative

ways to improve the reliability and accuracy of the estimates used as the basis for SCHIP's funding formula.

Allocation Formula

SCHIP's formula for determining federal allocations to states does not allow flexibility to accommodate changes that affect demand for the program, such as changes in the number of uninsured children in the state. The state's share of the total federal allotment is based in part on its share of low-income children and low-income uninsured children. However, the allocation formula is designed such that the only way the state can receive a larger allocation is if the rate of increase in uninsured children in North Carolina exceeds that of the nation as a whole.

Thus, an increase in the actual number of uninsured children in the state does not necessarily translate into larger federal allocations to support the program. Our interviewees noted that states are effectively "punished" by withdrawn federal funds for succeeding in insuring children, which presents an illogical cycle since if available federal funds are depleted, these same children may become uninsured again. Moreover, the formula is based on a three-year average, which reduces flexibility for states to respond to any major economic cycles and other changes that may affect demand for the program.

Stakeholders interviewed cited the program's allocation formula as a challenge for North Carolina in recent years. Even in times of increasing need (e.g., economic recessions, increases in plant closings or business downsizings), the state has been unable to receive additional federal allocations.

The Distribution and Use of Reallocated Federal Funds

As noted above, states can retain their federal allotments for a period of three years before reverting unused funds back to the federal government. Funds left over from states that did not fully expend their allocation have been collected and re-distributed to those states that overspent their allocations. North Carolina has historically been on the receiving end of this arrangement.

However, states receiving reallocated federal funds only have one year in which to spend these redistributed funds before the funds revert again back to the federal government. The unpredictability of the amount and timing of reallocations gives states inadequate time to obtain necessary matching state funds to trigger the flow of reallocated federal funds.

Our interviewees suggested that extending the time during which redistributed funds can be used would provide the necessary flexibility for state officials to use reallocated funds appropriately and efficiently while still providing the federal government with budgetary predictability and a ceiling on total costs.

Each of the above issues is likely to play an important role in the reauthorization debate at the federal level. However, the underlying pressure that drives each of these issues is the allotment structure of the program itself. In a capped block grant program, a fixed amount of dollars being distributed over a fixed number of states and territories is likely to generate persistent conflicts over resources and funding formulas. Within this structure, the issue with the greatest impact on the future of the program is the actual amount of funding that will be made available to states.

Moreover, in advance of the 2008 presidential and congressional elections, candidates, advocates, and policymakers are developing health coverage reform proposals that may affect health care coverage for children and adults. To the extent that these health policy discussions and debates continue to accelerate in 2007, SCHIP reauthorization discussions may also be framed within the broader discussion about the government's role in health care financing and delivery.

Issues for Consideration at the State Level

State leaders may use the reauthorization discussion taking place at the federal level as an opportunity to engage in state-level policy discussions to consider opportunities to further advance the program's objective of reducing the number of uninsured children in low-income families. This section provides examples of issues for consideration at the state level.

Exhibit 4: State Funding of Health Choice for Children

SFY 98-99	SFY 99-00	SFY 00-01	SFY 01-02	SFY 02-03
$7,491,362	$21,812,862	$26,207,471	$27,927,830	$43,753,153
SFY 03-04	**SFY 04-05**	**SFY 05-06**	**SFY 06-07**	
$53,867,815	$69,965,357	$67,553,586	$25,140,369	

Source: Office of the Governor.
Notes: NCHC became effective on October 1, 1998.
SFY 2006-07 expenditures only include 6 months of data.

State Funding Sources

State leaders could pursue creative strategies or opportunities to ensure the availability of sufficient state funding to generate federal matching contributions. The enrollment freeze of 2001 occurred because the state could not quickly make state funds available to generate federal matching contributions. While the DHHS now has greater discretion to draw upon its available funds to avoid enrollment freezes, North Carolina policymakers may also explore other innovative approaches that could further ensure that sufficient funding is available if warranted. This could include establishing or re-directing "rainy day" or other dedicated funding streams that may be made available to ensure the continued success and stability of the Health Choice program. Dedicated

funding streams may also provide enhanced opportunities to expand the program to other uninsured populations.

Outreach

Since the inception of Health Choice, North Carolina has been seen as a national leader in outreach and enrollment efforts.[31] Despite this success, our interviewees believe there are still thousands of children that are eligible but are unenrolled in Health Choice and Medicaid. In fact, Action for Children North Carolina (ACNC), a non-profit child advocacy organization, cites census estimates that approximately 177,000 children are income-eligible for Medicaid or Health Choice, but are not enrolled and remain uninsured.[32,33]

Thus, notwithstanding the financing challenges discussed in this report, there is still room for more outreach to help these children enroll. Assuming sufficient state and federal funds are available to support greater enrollment, several options have been suggested to reach out to children that are eligible for the program, but not currently enrolled. For example, practicing physicians could be better encouraged and equipped to help children enroll in Medicaid or SCHIP at the point of service. Physicians could also help to ensure that children actively reenroll in Health Choice, which is required every twelve months for ongoing enrollment. Continuous enrollment, assuming eligibility remains constant, provides children with more stability and continuity of care over time and provides physicians with financial reimbursement for providing care.

Evaluating Health Choice Program's New Primary Care Management System

Providing a usual source of care has been an important policy goal for children's health care for many decades.[34] Having a usual source of care has been linked to many positive outcomes, such as increased use of preventive care, decreased use of emergency room care, and better continuity of care.[35]

In 1998, the state's Medicaid program established pilot community-based medical care management programs called Community Care of North Carolina (CCNC).[36] The CCNC program is a system of local networks of primary care providers coordinating prevention, treatment, referral, and institutional services for Medicaid beneficiaries. In addition, participating providers serve as gatekeepers to other needed health care services. In 2002, the General Assembly legislated a statewide expansion of the CCNC program.[37]

Starting in 2005, Health Choice children ages five and under who were transferred to the Medicaid program now have the added benefit of being enrolled in Medicaid's CCNC program. Beginning in March 2007, children (ages 6-18) enrolled in Health Choice will also be eligible to select primary care physicians from the CCNC program. For the first time in the Health Choice program, this will provide dedicated case

management for covered children. However, there will be some differences with the community care network in the Medicaid program. For example, in Health Choice the assigned primary care provider will not have the authority to act as a gatekeeper in referring enrollees to specialists as they do in CCNC. State officials should closely monitor the experience of new Health Choice children enrolled in the community care network and identify any opportunities to improve the program.

Administrative Structure

When SCHIP was authorized in 1997, the North Carolina General Assembly decided to make the Health Choice program a stand-alone program tied to the SHP.[38] With several years of experience with the program, policymakers can now evaluate the costs and benefits of the program's current administrative structure and consider whether other structures may be more appropriate.

One option available to states is to establish a Medicaid expansion program. The primary advantage of a Medicaid expansion program is that there would be a continuous source of income from the federal government, even after Health Choice federal matching funds run out. Since Medicaid "entitles" eligible children to coverage, children in states that use Medicaid for SCHIP remain eligible for coverage even if SCHIP funding runs out. Medicaid funding remains available at its lower matching rate once all SCHIP funds have been used. This may prevent the disruption of enrollment and outreach that North Carolina has experienced with the Health Choice enrollment freeze of 2001.

One possible reason that has been considered for structuring Health Choice as a Medicaid expansion is that, historically, Medicaid pays providers less than Health Choice. Thus, some savings opportunities may be associated with structuring Health Choice as a Medicaid expansion program. However, in the state budget that passed in 2005, the General Assembly cut Health Choice provider reimbursement rates down to prevailing Medicaid rates. Thus, a Medicaid expansion program would not be able to generate additional state savings through lower provider reimbursements.

It is also worth noting that lowering provider fees may have the indirect costs and risks associated with potentially making health care providers more reluctant to serve Health Choice. Several stakeholders who were interviewed acknowledged that, in an environment where Health Choice reimbursement had been cut, it is important to conduct continual monitoring of health care access issues in light of receive reimbursement changes.

Another issue associated with structuring the program as a Medicaid expansion is the potential public stigma associated with Medicaid as a "welfare" program, which could affect enrollment and outreach. The families of children enrolled in Health Choice carry a standard BCBSNC insurance card (since BCBSNC provides administrative services for

the SHP). By contrast, Medicaid recipients have a distinct Medicaid card that may deter enrollment of some families. According to a study conducted by the Cecil G. Sheps Center in 2003, parents of Health Choice children reported in focus groups that Health Choice is more "dignified" than Medicaid for these reasons.[39]

A third issue associated with structuring the program as a Medicaid expansion is that counties in the state are responsible for paying a portion of Medicaid costs. Shifting all Health Choice children to the Medicaid program would likely exacerbate the already challenging financial burden that is placed on the counties to fund a portion of the state's Medicaid costs.

Finally, while a Medicaid expansion program may offer benefits from the standpoint of avoiding enrollment freezes and ensuring continuous care for eligible beneficiaries, under a Medicaid expansion program, the state would lose some of its cost containment flexibility that is associated with Health Choice operating as a standalone program.

Expanding the Health Choice Program

Despite the success of Health Choice in enrolling low-income and previously uninsured children, state policymakers continue to monitor coverage rates for low-income children that currently do not qualify for public coverage. According to ACNC, approximately 38,000 children in families falling just outside the eligibility threshold for Health Choice (between 200-300% of the FPL) are uninsured.[40] Further, approximately 49,000 children in families making above 300% of the FPL are also uninsured.[41]

As of July 2006, 24 states have chosen to make SCHIP eligibility available for uninsured children in families earning less than 200% of the FPL. However, 17 states have chosen to expand eligibility to families greater than 200% of the FPL.[42] The upper income eligibility limit under SCHIP has reached as high as 350% of the FPL in one state.

Notwithstanding the financial challenges that are discussed in this report, state policymakers may open the Health Choice program to additional uninsured children. Several policy proposals to achieve these goals are likely to be considered in the coming year in North Carolina. For example, ACNC has developed a proposal ("Carolina Cares for Children") that would further extend public coverage to low-income uninsured children up to 300% of the FPL. Under the proposal, the state would provide a sliding scale premium subsidy for eligible working families with incomes between 200-300% of the FPL. Families with incomes above 300% of the FPL would be eligible to buy into the program at full premium cost. ACNC estimates annual public subsidy expenses for the program of $21 million.[43]

Another proposal under consideration in North Carolina would impact children's health care coverage, but also coverage for low-income adults. Specifically, the Medicaid "Light" proposal, which has recently emerged from a NCIOM Task Force on

Covering the Uninsured, would add to existing Medicaid coverage for parents and children earning up to 300% of the FPL but not currently qualifying for other public coverage.

The focus of the Task Force's proposal is to expand access to primary care and preventative services rather than more comprehensive coverage (for budget reasons). If approved by the General Assembly, the resulting Medicaid "Light" proposal would take the form of a Medicaid waiver that would then be considered by CMS. Under the waiver, a limited non-entitlement Medicaid expansion would draw down additional federal funds to add to state funds.

While this and other policy proposals will continue to be considered at the state level, the feasibility and implementation of such proposals are likely to be highly contingent on the level and form of federal funding made available for SCHIP though the reauthorization process.

IV. CONCLUSION

Since its creation in 1997, SCHIP has become an important source of health care coverage for children in the United States. SCHIP enrollment has increased steadily to 6.1 million children by FY 2005.[44] SCHIP has also had important positive impacts on Medicaid enrollment as well. For example, the same law that established SCHIP also allowed states to simplify and extend eligibility for children in Medicaid. Between 1997 and 2004, 6.8 million additional children enrolled in Medicaid. The creation of SCHIP as well as enrollment gains in Medicaid have both contributed to declines in the rate of uninsured children, from 13.9% in 1997 to 8.9% by 2005.[45] Among children in families earning less than 200% of the FPL, the percentage of children without health insurance dropped from 23% to 14%.[46]

A federally funded evaluation conducted by Mathematica Policy Research found SCHIP to be successful in nearly all of the areas examined.[47] Studies of SCHIP have found that, just like having health insurance coverage generally, enrollment improves access to health care. Relative to uninsured children, children enrolled in Medicaid or SCHIP reported much lower unmet health care needs (2% vs. 11%).[48]

Since the federal SCHIP program was established, the state of North Carolina has taken advantage of federal matching funds and program flexibility to expand public health insurance coverage to thousands of previously uninsured children in the state. The program has gained strong popularity among beneficiaries and their families, providers, and policymakers. Key factors that contribute to the popularity of the program include the political consensus to make coverage available to uninsured children, the program's non-entitlement structure (making it a program for which

policymakers can exercise some measure of budget control, relative to Medicaid), the relatively generous federal matching rate (making it an unattractive target for budget cuts), and the program's success in expanding health care coverage for thousands of low income children in North Carolina.

SCHIP's initial period of authorization is scheduled to expire on September 30, 2007. As reauthorization nears, policymakers at both the state and federal levels have begun to focus on areas of concern within the program and to identify recommendations for program changes. To be sure, the level of the federal government's funding of SCHIP will dominate the reauthorization process.

Beyond the sheer dollars that will be allocated to states, federal policy discussions regarding the allotment structure and funding formula and how they might be changed are key to the future of the Health Choice program (and any possible expansions to the program) in North Carolina. While much depends on the outcome of the reauthorization process that will take place in Washington, D.C., this report outlines several issues that state leaders in North Carolina can consider that may affect the stability and experience of the program in the future.

References

[1] "Trends in the Well-being of America's Children and Youth, 2001." Tables HC 11.A and HC 11.C. U.S. Department of Health and Human Services. Office of the Assistant Secretary for Planning and Evaluation. URL: http://www.childtrendsdatabank.org/figures/26-Figure-1.gif

[2] Current Population Survey Annual Social and Economic Supplement. Table H08. URL: http://www.childtrendsdatabank.org/figures/26-Figure-3.gif

[3] M. McClellan, Testimony Before the Senate Finance Subcommittee on Healthcare, Hearing on the State Children's Health Insurance Program (Washington, D.C.: U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, July 25, 2006).

[4] States in which the maximum Medicaid income threshold for children was already 200% of FPL before SCHIP was established could increase this income level by 50 additional percentage points above the level used to make qualification determinations for the state Medicaid program.

[5] However, in some cases this three-year period has been extended.

[6] J. Lambrew, January 2007. "The State Children's Health Insurance Program: Past, Present, and Future. The Commonwealth Fund Commission on a High Performance Health System. URL: http://www.cmwf.org/usr_doc/991_Lambrew_SCHIP_past_present_future.pdf

[7] "Federal Matching Rate (FMAP) for SCHIP." State Health Facts. Henry J. Kaiser Family Foundation. URL: http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=compare&category=Medicaid+%26+SCHIP&subcategory=SCHIP&topic=Federal+Matching+Rate&link_category=&link_subcategory=&linkf_topic=&printerfriendly=0&viewas=table

[8] "History of North Carolina Medicaid Program, State Fiscal Years 1970-2005." North Carolina Department of Health and Human Services. URL: http://www.dhhs.state.nc.us/dma/historyofmedicaid.pdf.

[9] W. Brandon, R. Chaudry, and A. Sardell. "Launching SCHIP: The States and Children's Health Insurance." In R. Hackey and D. Rochefort, eds. The New Politics of State Health Policy, Lawrence: University of Kansas Press, 2001.

[10] Brandon et al. (2001)

[11] The bill also included the state's first refundable tax credit that was available to North Carolina families whose adjusted gross annual household incomes were $100,000 or less, much higher than the income threshold for Health Choice. Under the agreement, the credit was worth $300 per year for families earning less than 225% of the FPL (then roughly $37,015 for a family of four) and $100 for families earning less than $100,000 and above 225% of the FPL.

[12] Brandon et al. (2001)

[13] Brandon et al. (2001)

[14] Correspondence with Pat Garrett, NC Pediatric Society Foundation (December 2006)

[15] P. Silberman, J. Walsh, R. Slifkin, S. Poley. January 2003. "The North Carolina Health Choice Enrollment Freeze of 2001," Kaiser Commission on Medicaid and the Uninsured. http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14314

[16] Seven of the thirty-nine states with separate SCHIP programs, including North Carolina, capped SCHIP enrollment during 2001-2003. During these years, most states experienced budget deficits which exacerbated states' SCHIP financing challenges.

[17] I. Hill, B. Courtot, and J. Sullivan. January/February 2007. "Coping with SCHIP Enrollment Caps: Lessons from Seven States' Experiences," *Health Affairs*.

[18] I. Hill et al. (January/February 2007).

[19] Part of North Carolina's 1999 allocation was initially returned to the federal government, but these funds were later returned to the state and used completely.

[20] "North Carolina Health Choice: 2003." February 2003. Report of the North Carolina Institute of Medicine Task Force on the North Carolina Health Choice Program. Submitted to the North Carolina Department of Health and Human Services and the North Carolina General Assembly. http://www.nciom.org/docs/nchcreport.pdf

[21] J. Lambrew (January 2007)

[22] C. Peterson. April 18, 2006. "SCHIP Original Allotments: Funding Formula Issues and Options." Congressional Research Services Report for Congress. Congressional Research Service.

[23] J. Lambrew (January 2007)

[24] M. Broaddus and E. Park. September 21, 2006. "SCHIP Financing Update: In 2007, 17 States Will Face Federal Funding Shortfalls of $800 Million in Their SCHIP Programs." Center on Budget and Policy Priorities. URL: http://www.cbpp.org/6-5-06health2.htm.

[25] M. Broaddus and E. Park (September 21, 2006)

[26] "SCHIP's Financing Structure." October 2006. Center for Children and Families, Georgetown University Health Policy Institute.

[27] "Budget in Brief: FY 2008." Department of Health and Human Services.

[28] M. Broaddus and E. Park. November 28, 2006. "Freezing SCHIP Funding in Coming Years Would Reverse Recent Gains in Children's Health Coverage." Center on Budget and Policy Priorities. URL: http://www.cbpp.org/6-5-06health.htm

[29] The Kaiser Commission on Medicaid and the Uninsured. Additional Detail of the FY 2007 Budget from the Office of the Actuary at CMS.

[30] D. Bergman, June 2005. "Perspectives on Reauthorization: SCHIP Directors Weigh In." National Academy for State Health Policy. http://www.nashp.org/Files/CHIP25_final.pdf

[31] W. Brandon et al. (2001)

[32] This figure likely includes thousands of children whose immigration status precludes their eligibility.

[33] North Carolina Action for Children. 2006.

[34] C. Sia, T. Tonniges, E. Osterhus, and S. Taba. May 2004. "History of the Medical Home Concept." *Pediatrics*, vol. 113, no. 5, pp. 1473–1478.

[35] J. Woolridge, G. Kenney, C. Trenholm et al. 2005. "Congressionally Mandated Evaluation of the State Children's Health Insurance Program: Final Report to Congress." Mathematica Policy Research and The Urban Institute.

[36] CCNC, in turn, grew out of another primary care case management (PCCM) program (Carolina ACCESS) that was established in 1991.

[37] T. Ricketts, S. Greene, P. Silberman, H. Howard, and S. Poley. April 15, 2004. "Evaluation of Community Care of North Carolina Asthma and Diabetes Management Initiatives: January 2000-December 2002." North Carolina Rural Health Research and Policy Analysis Program. The Cecil G. Sheps Center for Health Services Research. The University of North Carolina at Chapel Hill.

[38] While Health Choice was originally established as a stand-alone program, it is now considered a "combination" program since some children (ages 0 to 5) receive SCHIP benefits through Medicaid.

[39] P. Silberman, J. Walsh, R. Slifkin, and S. Poley. "The North Carolina Health Choice Enrollment Freeze of 2001." Kaiser Commission on Medicaid and the Uninsured, January 2003. URL: http://www.kaisernetwork.org/health_cast/uploaded_files/ACF190.pdf

[40] "Why Health Insurance Is Good for Children," Action for Children North Carolina, January 2007. URL: http://www.ncchild.org/images/stories/Carolina_Cares_for_Childre/Health_Insurance_Good_for_Children.pdf

[41] Action for Children North Carolina (January 2007)

[42] "State Children's Health Insurance Program (SCHIP) At A Glance," Kaiser Commission on Medicaid and the Uninsured, January 2007. URL: http://www.kff.org/medicaid/upload/7610.pdf.

[43] All figures associated with the "Carolina Cares for Children" proposal are taken from a brief primer on the program from North Carolina Action For Children.

[44] Centers for Medicare and Medicaid Services. FY 2005 Annual Enrollment Report.

[45] R. Cohen, M. Martinez. 2005. "Health insurance coverage: Estimates from the National Health Interview Survey." URL: http://www.cdc.gov/nchs/nhis.htm.

[46] L. Ku. August 2005. "Medicaid: Improving Health, Saving Lives," Center on Budget Priorities analysis of National Health Interview Survey Data.

[47] J. Woolridge et al (2005)

[48] B. Bloom and A. Dey, "Summary Health Statistics for U.S. Children: National Health Interview Survey, 2004," *Vital Health Statistics,* Feb. 2006 10(227):1–85.

Task Force *for a* Healthier North Carolina

Key Findings and Final Recommendations on Access to Health Insurance Coverage for North Carolina's Children

JULY 2007

Lieutenant Governor Beverly Perdue
Chair, Health and Wellness Trust Fund Commission

Task Force Co-Chairs

Senator Bill Purcell
Representative Verla Insko
Carole Bruce, HWTF Commissioner

University of North Carolina at Chapel Hill

Dr. Daniel Gitterman, Associate Professor of Public Policy
Stephanie Coplin, Research Associate
Jessica Dorrance, Research Associate

The Task Force is a partnership between the NC Health and Wellness Trust Fund and the University of North Carolina at Chapel Hill

THE UNIVERSITY of NORTH CAROLINA at CHAPEL HILL

Task Force *for a* Healthier North Carolina

The Task Force *for a* Healthier North Carolina sponsored a public forum to explore strategies to improve the health insurance coverage of North Carolina's children. The meeting was held on March 26, 2007 in Winston-Salem. The focus of invited presentations was on outreach and enrollment activities, the emerging role of Community Care of North Carolina in the State Children's Health Insurance Program (SCHIP) program, and proposals to expand health coverage to children in families with incomes between 200% and 300% of the Federal Poverty Level (FPL).

The Task Force respectfully submits the following recommendations on strategies to improve access to health insurance coverage for North Carolina's children.

Co-Chairs

Bill Purcell, North Carolina Senator, 25th District
Verla Insko, North Carolina Representative, 56th District
Carole Bruce, HWTF Commissioner**,** Attorney, Smith Moore LLP

Members

Bill Farmer, Vice President of Corporate Development, Time Warner Cable
Dr. Olson Huff, HWTF Commissioner
Dr. Jim Jones, Medical Director, Black River Health Services
H. Kel Landis III, Principal, Plexus Capital
Valeria Lee, President, Golden LEAF Foundation
Vernon Malone, North Carolina Senator, 14th District
Daniel McComas, North Carolina Representative, 19th District
Dr. Karen McNeil-Miller, President, Kate B. Reynolds Charitable Trust
Norma Mills, Lecturer, University of North Carolina, School of Government
Dr. Daniel Gitterman, Director (Ex Officio), Associate Professor of Public Policy, UNC-CH

The Task Force invited formal presentations from the following individuals:

- **Ania Boer**, Health Check/NC Health Choice Outreach Campaign Coordinator, North Carolina Healthy Start Foundation
- **Christopher Dumas**, Associate Professor of Economics, UNC/Wilmington
- **Jane Foy**, Professor, Department of Pediatrics, Wake Forest University
- **Patricia Garrett**, Director, PMG Associates, LLC
- **Jim Graham**, Executive Director, Northwest Community Care Network
- **Mona Moon**, Senior Advisor, Department of Health and Human Services (DHHS)
- **Carolyn Sexton**, Health Check/NC Health Choice Outreach Consultant, Division of Public Health
- **Jeffrey Simms**, Deputy Director, Community Care of North Carolina (CCNC)
- **Tom Vitaglione**, Fellow, Action for Children North Carolina
- **Steven Wegner**, President and Medical Director, AccessCare

BACKGROUND

In 1997, as part of the Balanced Budget Act (BBA), Congress authorized nearly $40 billion in federal funds over a 10-year period to fund the State Children's Health Insurance Program (SCHIP). This program allows states to provide comprehensive health care coverage for children in working families with incomes between 100% and 200% of the Federal Poverty Level (FPL).

In North Carolina, children are currently offered health insurance coverage through an SCHIP program known as "Health Choice for Children" (children age 6-18 in families with incomes 100% to 200% FPL), and through a Medicaid program known as "Health Check" (children age 5 and under in all families up to 200% FPL; children 6-18 up to 100% FPL).[1]

In North Carolina, children are currently offered access to health insurance coverage through an SCHIP program known as "Health Choice for Children and Health Check (Medicaid). NC Health Choice covers children ages 6-18 whose families fall between 100 and 200% of the federal poverty line. Medicaid's Health Check covers all children in North Carolina ages 0-5 (200% FPL) and children ages 6-18 whose family incomes fall below 100% FPL.[2]

Together these programs provide health insurance to nearly 800,000 North Carolina children who would otherwise be without access to affordable health coverage.[3] It is estimated, however, 177,000 children are eligible but not enrolled in either of these public programs.[4]

Background information on the legislative history of Health Choice and a summary of issues for consideration at the federal and state levels, including the federal reauthorization of funds for SCHIP, can be found in The Lewin Group's report to the Task Force, "SCHIP in North Carolina: Evolution and Reauthorization, Challenges and Opportunities" available at http://www.healthwellnc.com/LewinSCHIP07report.pdf.

FINDINGS AND RECOMMENDATIONS

Finding 1: SCHIP Outreach Efforts

Since the inception of Health Choice, North Carolina has been proactive in reaching out to parents and enrolling children in the program. In fact, outreach efforts were so successful in the early years that North Carolina became the first state forced to freeze enrollment in 2001 due to insufficient funding.[5] Additional funding from the General Assembly was allocated, which allowed enrollment to resume, and steps have been taken to prevent future freezes in enrollment.

Despite ongoing outreach efforts, a large number of eligible children remain uninsured. More than 260,000 children in North Carolina do not have health insurance.[6] Approximately 177,000 of these children are eligible for either Health Choice or Health Check.[7] Estimates suggest that half are eligible for Health Check (family income below 100% FPL), and half are eligible for

Health Choice (family income between 100% and 200% FPL). Approximately 76% of these children live in families where at least one parent is working full-time, and 35% live with a parent who works for a large firm (over 100 employees)—large firms are more likely to offer health insurance to their employees than smaller firms.[8] Additionally, the percentage of North Carolina children who are uninsured has increased from 10.1% in 2000 to 11.9% in 2005.[9] The North Carolina Division of Public Health (DPH) acts as the lead state agency for outreach and has partnered with the NC Healthy Start Foundation to develop and distribute free, bilingual outreach materials and maintain a user-friendly Web site with up-to-date information about Health Choice and Health Check. In addition to printed and Web-based materials, outreach strategies also include targeted TV and radio announcements as well as the NC Family Resource telephone hotline, which answers questions and provides information about Health Choice/Health Check. The Division of Public Health also works with a variety of entities including the Division of Social Services (DSS), the Division of Medical Assistance (DMA), the NC Pediatric Society, and health care providers to reach children.

The North Carolina Healthy Start Foundation is a nationally recognized private, nonprofit organization dedicated to reducing infant death and illness and to improving the health of women and young children in North Carolina. They designed and maintain a first-rate Health Check/Health Choice website which is available at http://www.nchealthystart.org/outreach/index.html.

Covering Kids and Families, a national program of the Robert Wood Johnson Foundation (RWJF), also helps build additional capacity for outreach and enrollment into SCHIP and Health Check in all 50 states. As the lead state organization for *Covering Kids*, the North Carolina Pediatric Society Foundation works with four county coalitions in Buncombe, Moore, New Hanover, and Wake. Each local coalition has a distinct agenda and a work plan tailored to local needs. At the state level, 50 individuals representing 41 organizations, provide guidance to major state initiatives. Their website is available at http://www.ncpeds.org/Covering%20Kids/Covering%20Kids%20Main.htm.

Some of the efforts implemented in North Carolina include tailored outreach materials for specific professional and community agencies (e.g., religious leaders, child care providers, teachers and principals, human resource managers), an emergency room enrollment initiative, and a single application for SCHIP, Health Check, and Food Stamp programs.[10] Some key players and outreach methods for those involved in the state's efforts are described below.

North Carolina Division of Social Services (DSS)

DSS eligibility caseworkers determine Health Check and Health Choice eligibility and help ensure that children select a primary care provider. Caseworkers are responsible for making eligibility determinations in a timely fashion (usually 45 days), which means processing paperwork and verifying the supporting documentation. The addition of new application requirements creates further work necessary to correctly process the materials, often without any additional resources or staff.

Health Check Coordinators

North Carolina has Health Check Coordinators (HCC) who assists with outreach to eligible families and increase awareness of both Health Choice and Health Check. HCC's also educate clients about the benefits of the Community Care of North Carolina (CCNC) network, which links children to a primary care provider (PCP).[11] Coordinators are responsible for assisting eligible children in accessing comprehensive and preventive health care services, and they act as a key liaison between children and physicians, professional organizations, and agencies providing primary and preventive care services.[12]

Currently, HCC's are located in 91 North Carolina counties.[13] The position is primarily funded by DMA but can also be funded through DPH as well as through Smart Start Partnerships or grants. The number of HCC positions for which a county is eligible is based on the number of Health Check-eligible children living in the county.[14] The NC Health Directors Association has endorsed a plan to expand coordinators statewide. This would place HCC's in all counties by relocating existing positions.[15]

School Systems

Working with school systems has emerged as a logical way to reach out to families and children. When the Health Choice program began, outreach materials were sent home to every school-age child. This method was expensive and could not be maintained, but North Carolina continues to work with school professionals, such as school nurses, social workers, and counselors, to convey information about the program. North Carolina's School-Based and School-Linked Health Centers (NCSB/SLHC), health care centers located in or near schools that provide both health care and health education also help recruit uninsured children into Health Choice and Health Check.[16]

Currently, there are more than 53 school-based or school-linked health centers operating in 22 North Carolina counties. The centers are funded through a combination of sources including state, county, or city funding; community health centers; private grants; reimbursements for services from health insurance providers; and out-of-pocket payments from patients.

Another strategy for reaching out to schoolchildren is through the National School Lunch Program (NSLP). This is a federally assisted meal program that provides free or low-cost lunches to more than 29 million children throughout the nation each school day.[17] The income eligibility for NSLP and Health Choice/Health Check is similar, so children eligible for school lunches are likely to be eligible for Health Choice or Health Check as well.[18] Some research has suggested using data verification and certification from programs such as NSLP to target outreach efforts and/or enroll children from NSLP into SCHIP.[19, 20, 21]

Early Intervention

As part of the Individuals with Disabilities Education Act (IEDA), North Carolina created a system of early intervention services directed at children with special needs, birth through age five, and their families.[22] The two parts of this system include a program for infants and toddlers and the preschool program for children between ages 3 and 5. The Infant-Toddler Program and

the Preschool Program each include agencies providing a variety of services and support to children with disabilities. All of these services are managed through Children's Developmental Services Agencies (CDSA's), which serve all 100 NC counties. Children with special health care needs may qualify for additional coverage through Health Choice, which includes some of these early intervention services.[23] The CDSA's are a logical mechanism for making information available about Health Choice and Health Check for eligible children.

Although North Carolina utilizes these strategies to reach families, there is still a lack of knowledge and understanding about the program among those who are eligible but not enrolled. Unfortunately, there are also some lasting effects from the enrollment freeze in 2001. Enrollment was slow to recover once the program reopened. According to numerous individuals who play a role in outreach efforts, applicants continue to ask if the enrollment is still closed and express concern that the program will close again in the future. Currently, Health Choice does limit enrollment growth to 3% per 6-month period in order to continue to control the costs.[24] Health Check, on the other hand, is an entitlement program and therefore does not have a cap on enrollment.

Recommendation 1: Strengthen Outreach Efforts to Parents of Eligible Children

Much of the policy research literature on SCHIP outreach and enrollment indicates that there is no "magic bullet" when it comes to methods for reaching out to the parents of eligible children. North Carolina has already implemented a variety of successful outreach strategies and works with a wide range of partners in order to find and enroll as many children as possible. The Task Force offers the following recommendations to strengthen outreach efforts:

1.1 Health Check Coordinators and DSS eligibility caseworkers play a key role in outreach and enrollment. **The Task Force strongly supports the goal that all NC counties have at least one Health Check Coordinator**.

1.2 **The Task Force concludes that school-based enrollment remains a critical and effective mechanism to reach eligible children. School health clinics must play an enhanced role in strengthening outreach efforts.** Policy makers should continue to encourage adequate state funding for these centers.

1.3 **The Task Force recommends enhanced efforts to target outreach to children enrolled in programs with similar eligibility criteria, such as the school lunch program, and to target outreach through programs already serving children, such as the Early Intervention Programs and NC Smart Start.** Although broad-based outreach methods are essential for reaching out to many children and families, targeted outreach methods can direct efforts to children where they live and attend school. Working through existing structures or programs remains an important way to reach children who are eligible for Health Choice or Health Check.

1.4 **The Task Force recommends the creation of multi-county or regional Health Choice/Health Check coordinating committees that would bring together the variety**

of actors and organizations working to ensure that children have access to affordable health insurance. The committees would agree to meet on a regular basis and to create a method for disseminating information in order to update one another on pertinent issues. Possible members would include representatives from DPH, DMA, DSS, Health Check Coordinators, eligibility caseworkers, CCNC networks, local health care providers, local advocacy organizations, and others. The self-identified person willing to lead outreach efforts in each county is identified at http://www.nchealthystart.org/outreach/county/list.html.

Finding 2: The Enrollment and Annual Renewal Processes

States have flexibility in their enrollment practices, and many have chosen to eliminate some of the more burdensome enrollment procedures, including face-to-face interviews at initial enrollment and/or at time of renewal, short renewal periods, waiting periods, asset tests, and supplemental documentation requirements.

In North Carolina, efforts have been made to create a user-friendly application and renewal process for Health Choice and Health Check. For example, the joint application can be returned by mail or in person to the county Division of Social Services (DSS). North Carolina does not require a face-to-face interview or an asset test, there is no waiting period to become eligible, and once enrolled, children remain eligible for coverage for 12 months despite any changes to family income, known as "continuous eligibility."[25, 26]

The single application is screened by a DSS caseworker for eligibility for Health Check; if ineligible for that program, it is screened for eligibility for Health Choice.[27] Eligibility determination is made within 45 days and, if the application is approved, coverage begins during the month the application was submitted.[28] If a child qualifies for either program, all of the necessary materials are sent to the household by mail.[29]

The renewal application for Health Check or Health Choice is nearly identical to the initial enrollment application, but some of the key demographic information, including the child's name, is preprinted on the renewal form. Reminders about the renewal process are sent to families 2 months before the annual coverage ends. First, a post card is sent indicating that it is time to renew coverage. The renewal form is sent 10 days later with a reminder to return the form to DSS. Another notice is sent if the form is not returned by the twenty-fifth day of the eleventh month (that is, the month before coverage is set to end). If the form is not returned within 10 days, a final notice is sent to the family indicating the eligibility status for the child.[30] There is an additional grace period before termination of coverage if materials are submitted within 10 days of the final deadline.

Extensive policy research highlights the importance of securing and maintaining consistent health care coverage for children and the need for improved retention efforts in programs such as Health Choice and Health Check.[31, 32] Although some children become ineligible due to increases in family income, the renewal process itself can be a significant cause of "drop-off."[33]

Unfortunately, procedural barriers still exist that limit renewals. Examples of additional retention strategies that have been implemented in other states include using fully preprinted renewal forms, enrollment through emergency rooms, allowing families to self-report information rather than having to provide additional documentation**,** verifying information using data from other programs, and using electronic application and renewal systems.

Using Preprinted Forms

Several states use preprinted renewal applications that include all the application information that was submitted the previous year. Families only have to update any information that may have changed. In some states, if no information has changed, the forms do not need to be returned at all; this is sometimes referred to as "passive renewal." Florida has been using both of these methods to improve retention, with much success. The drops in enrollment at the time of renewal were only about 5%, compared to as high as 50% in some other states that do not use these retention strategies.[34] In Florida, families are required to return the preprinted form only if any information has changed. No response is presumed to indicate that all the information is still correct, and the child remains in the program.[35] This could be an especially effective option if coupled with a mechanism for verifying information through other government databases (see below for more information about this possibility). It is important to note that using preprinted forms may require adjustments in the technology systems used to generate and process applications.

Enrollment through Emergency Rooms

As part of the local RWJF Covering Kids and Families project, Buncombe County DSS piloted an enrollment initiative through hospital emergency rooms. Any parent or guardian of an uninsured child treated at the two participating hospitals is given an opportunity to enroll the child in Health Choice or Health Check at the time of hospital discharge. Outreach workers from DSS help train emergency room staff on filling out the application. The staff then helps the family complete a "bare bones" version of the standard application and a DSS caseworker follows up with the family to complete the application by phone.

The collaborative process between DSS and the hospitals was well received, and the hospitals described the project as financially beneficial to them.[36] The number of Health Choice and Health Check applications received from the emergency rooms has increased since the inception of the pilot project, and the program has now been adopted throughout the county.

Self-Reporting Income

Another significant step that some states have taken to ease the renewal process and increase retention is to eliminate the need for supplemental documentation of income. Instead, some states allow families to "self-report" or "self-declare" this information. Like complex application and renewal forms, verification requirements—such as income, citizenship, and residency—can be a significant barrier for some families and may prevent eligible children from applying at all.[37] Although documentation of income is not required under federal law, North Carolina does require income verification for Health Choice and Health Check. Individuals must provide

copies of all paycheck stubs for one month for all workers (adults and children) living in a household, proof of residency for first-time applicants, and proof of citizenship (birth certificate) for those applying for Health Check. The income documentation can be burdensome for some families, depending on the number of workers in the household, the number of jobs that each person holds, and the number of pay periods during a month.

Currently, 9 states allow applicants to self-report their income when they initially apply for and renew benefits for children in SCHIP and Medicaid programs.[38] One additional state allows self-reporting of income, but only for the SCHIP program (not for Health Check) and only at the time of renewal.[39] Self-reported income is generally verified by administrators through post-eligibility audits or by using information available through other government databases, such as the Social Security Administration or state Departments of Labor.[40] Often the social security number for the adult(s) is required for verifying income when it has been self-reported. Some states that allow self-reporting of income give applicants the choice of either submitting the social security number(s) needed for verification or submitting pay stubs and other necessary documentation.[41]

Although federal guidelines have encouraged states to simplify their enrollment and renewal practices, including self-report of income, many states have been hesitant to allow this because of concerns regarding fraud. Research on this topic indicates that error rates in states that allow self-reporting are, for the most part, no higher than in states that do not allow self-reporting.[42, 43] Income verification using other databases like those mentioned above helps create greater safeguards against fraud or abuse. Additionally, states often report some administrative cost savings and a decrease in the time needed to make an eligibility determination as a result of applicants self-reporting income.

Furthermore, the federal Medicaid regulations require states to conduct post-eligibility verification of income using an Income and Eligibility Verification System (IEVS). Some states also monitor quality using the Medicaid Eligibility Quality Control (MEQC) process.[44] These programs help verify income eligibility before or after a determination has been made. Although this is not necessarily required for separate SCHIP's, many states are already going through these or similar steps to ensure the quality of their programs.[45, 46]

The following two examples provide information about self-reporting procedures in other states:

- In Georgia, caseworkers verify income information by reviewing the Department of Labor database and two databases provided by the Social Security Administration.[47] Information received through these databases includes family wages, unemployment benefits, and social security benefits.

- In Michigan, the state conducts a post-eligibility audit of self-reported income on SCHIP applications. The state takes a random sample of applications each month and asks families to provide verification of income. The error rate for applications has been consistently at or below 3%.[48, 49]

Ex-Parte Verification and Streamlining Applications

Other states are also using existing information from other programs or databases to verify continued eligibility for SCHIP and Medicaid. For example, information from Food Stamp applications can be used to confirm Medicaid eligibility so that parents/guardians are not duplicating information and having to provide similar documentation verification for all programs.[50]

This strategy could go a step further to be used to automatically enroll or renew enrollment for children living in families with incomes that continue to meet the eligibility limit for Health Choice or Health Check. The current public benefits model suggests that individuals can receive benefits through public programs, but only with significant administrative effort.[51] Currently, many programs cannot easily collaborate to share pertinent information. Sharing information and/or using existing data to verify eligibility could simplify efforts for both administrators and applicants. However, adequate technology infrastructure is essential for this type of coordination.

Another similar strategy is streamlining applications for use with multiple programs. For instance, The Children's Partnership, a national nonpartisan organization, created "Express Lane Eligibility," which builds multiple doorways for entry into SCHIP and Medicaid by using enrollment information from the National School Lunch Program. This has been implemented in several California school districts. Children are allowed to use the school lunch application to also apply for Medicaid; temporary Medicaid coverage begins while any additional material is submitted in order to finalize eligibility.[52] There is a pending bill in the U.S. Congress to give all states the option of using Express Lane Eligibility and to fund some of the necessary technology improvements.[53]

This type of approach has been piloted in Buncombe County, NC, where representatives from DSS and the county's Food Stamp Program created a joint application and enrollment process for Food Stamps, Health Choice, and Health Check.[54] When a family renewed their Food Stamp benefits, the caseworker checked the Health Choice/Health Check status of any children and if they were not enrolled, referred the family to the new Food Stamp and Health Check team to process a joint application.[55]

Electronic Applications

Many states are also using electronic applications for programs such as SCHIP, Medicaid, Food Stamps, and Temporary Aid to Needy Families (TANF).[56] There are many advantages to using electronic applications including convenience for applicants, cost savings for administrators, and more complete information with fewer errors.[57] In addition, an evaluation of electronic application procedures indicated that going "paperless" is quicker (the time between application submission and eligibility determination is reduced compared to paper applications), there is increased consumer satisfaction, and because information is collected electronically, the process may improve an agency's ability to efficiently access data.[58] There are some disadvantages for both users and administrators. These include potentially high start-up costs for creating the system and developing the necessary interfaces with other systems as well as problems for consumers who prefer not to use an electronic application or have limited Internet access.

Collecting information electronically and sharing information among programs allows states to better track the movement of families between various programs. Research also recommends creating database systems that will automatically allow different programs to share information about enrolled families so that household changes only need to be reported once. This may cut down on the number of renewals in which families must participate, which is likely to lead to higher retention.[59]

Many health care foundations are playing an increasingly important role in improving children's health, including providing funds for technology infrastructure to improve access to health coverage.[60] Foundation funding for child health grew by more than 50% between 1999 and 2003.[61] Total philanthropic giving targeted toward children reached more than $4 billion in 2001; 25% of the foundation grants directed toward children were focused on health.[62] One example of grant-making directed at improving access to health coverage for kids is the California HealthCare Foundation, which invested $3 million over 3 years to help develop Health-e-App,[63] an online application system for California's SCHIP and Medicaid program. After a successful pilot of the system in one county, it was implemented statewide, and additional efforts to create a one-stop electronic enrollment system for multiple programs, known as One-e-App, are under way. *See Appendix A for more information about California's electronic application systems.*

Recommendation 2: Simplify the Enrollment and Renewal Processes

Simplifying the application and renewal procedures for SCHIP is likely to help increase enrollment and retention, reducing the number of children without access to health insurance coverage. The Task Force offers the following recommendations to further simplify the enrollment and renewal process:

2.1 **The Task Force recommends the adoption of a fully preprinted renewal application that includes information from the previous year.** This will allow individuals to simply update information that has changed from the previous year (e.g., address, increase/decrease in income). This will likely decrease the average time needed to complete the renewal application and simplify the process for both applicants and administrators. In order to do this; however, the technology system used to generate the applications and collect data will likely require some adjustments and improvements.

2.2 **The Task Force recommends that the emergency room enrollment initiative that has already been piloted in Buncombe County be extended to additional NC counties and if successful, adopted statewide.** This strategy reaches children and families when they are most in need of assistance and creates an additional doorway to enrollment. The arrangement in place between DSS and local hospitals in Buncombe County can be used as a model for adopting this enrollment initiative throughout the state.

2.3 Some states have begun to streamline the application process for multiple programs in order to simplify the procedures for administrators, avoid duplicating efforts, and ease the process for applicants. **North Carolina must move toward enrolling children into Health Choice or Health Check when they apply for the National School Lunch**

Program and/or the Food Stamp program. The joint application process that has already been implemented in Buncombe County, NC can be used as a model for how to incorporate this strategy throughout the state.

2.4 **The Task Force recommends that DHHS pilot an online application for Health Choice**. Research suggests that the time and start-up costs for implementing such a system vary widely depending on the precise needs and design. Initially, a pilot program could be implemented in select counties to help contain start-up costs and better monitor quality and effectiveness. Further information about the specific considerations, such as implementation costs, training for administrators, how to handle documentation requirements, and applicant signatures would need to be examined.

Finding 3: Transitioning Children (0-5) from SCHIP to Health Check and Linking Them to a CCNC Primary Care Provider

On January 1, 2006, SCHIP children between the ages of 0 and 5 years were transferred from the North Carolina Health Choice program to the Community Care of North Carolina (CCNC)/ Health Check program. The transition enabled North Carolina to avoid enrollment freezes similar to what occurred in 2001. In addition to easing the burden on the Health Choice program, it allowed children who were transferred to CCNC to benefit from its enhanced primary care case management (E-PCCM) structure and services.

The impact of the transition for children less than 6 years of age has not been thoroughly evaluated. Yet an additional 110,000 lower-income children enrolled in NC Health Choice, ages 6 to 18 years, are in the process of being linked with the CCNC networks in 2007. The Kate B. Reynolds Charitable Trust has provided short-term grant support to Dr. Daniel Gitterman and Dr. Julie Jacobson Vann at UNC-Chapel Hill to examine and review the process of the SCHIP to CCNC transition for 0- to 5-year-old children in North Carolina and make policy recommendations to enhance the health care financing and delivery systems for children of low-income families in North Carolina. This evaluation is under way; preliminary findings are presented here as part of the Task Force report.

Enrollment of Children in CCNC Health Check and Linkage with Primary Care Providers

For children who are less than 6 years of age and have been transferred from Health Choice to CCNC Health Check, the primary responsibility for formally linking them with a primary care provider resides with the county-based Department of Social Services (DSS) caseworkers. Yet the DSS caseworkers generally do not have a direct reporting relationship with the CCNC administrative offices or CCNC networks. Therefore, state-level goals are being delegated to employees who are accountable to meet the goals of their respective counties, not of the state. Because the client linkage with PCPs has not been fully successful, other mechanisms were added to increase the proportion of eligible clients who get appropriately linked with a PCP. County-based Health Check Coordinators (HCCs) have been asked to assist with this effort. This supplemental strategy is important given that HCCs are employed by more than 90 NC counties to assist families with obtaining medical benefits and other services needed by their children,

educate families about Health Check and Health Choice, help enroll eligible children, and follow Health Check-enrolled children in their counties to make sure that they are receiving well child check-ups and recommended follow-up care. The third strategy for linking eligible children with CCNC primary care providers involves primary care physician offices. These health care practices have been provided with Carolina ACCESS Enrollment Forms and instructions. Employees of CCNC participating physician practices are asked to work with patient clients to complete the brief forms and then fax them to DSS.

The overall success of these three strategies has not yet been validated with quantitative evidence; however, anecdotal reports and completed key interviews indicate that the results have not met expectations. In addition, the interview data provide initial evidence that the processes to link patients with PCPs vary from network to network and county to county, and that collaboration and communication among all involved entities can be inconsistent. Some CCNC networks and providers seem unaware of the respective roles of those responsible for the linkage process. Enrollment reports that summarize the success of linking children with PCPs are pending.

Data Management

The North Carolina Health Check and Health Choice programs, DSS case workers, Health Check Coordinators, CCNC Networks and case managers, and CCNC participating providers utilize a number of databases. These serve to document and manage Health Check and Health Choice eligibility, enrollment, linkage with PCPs, case management performed by CCNC case managers, case management performed by clinicians, disease management and registry functions, and efforts to facilitate compliance with regular Health Check screenings, immunizations, and referrals for special health care problems.

Based on findings from key interviews, evidence suggests that the existing databases are not integrated to the degree necessary for optimally managing the linkage of children with PCPs, as well as identifying patients (ages 6 to 18 years in Health Choice) in need of case management services. The Health Check eligibility database, used by DSS caseworkers to link children with PCPs during eligibility determinations and re-determinations, is reported to lack real-time tracking, at the client level, of those children who have been linked with a PCP versus those who have not. In addition, the attempted and actual contacts made by DSS caseworkers with parents or guardians to initiate the PCP link are not electronically documented to facilitate monitoring and evaluate the relative success of the various strategies. Access to the Health Check eligibility database for purposes of linking children with PCPs is reported to be restricted to the DSS caseworkers and is not available to Health Check Coordinators, CCNC networks, CCNC case managers, or providers who may assist with the linkage efforts.

A second major database limitation is related to the 6- to 18-year-old Health Choice enrollees who are to be linked with a CCNC primary care provider. Because these children are enrolled in Health Choice, their health care claims are processed by Blue Cross and Blue Shield (BCBS) of North Carolina. The claims files are sent to the North Carolina Division of Medical Assistance on a weekly and monthly basis. However, findings from interviews indicate that the claims data and related case management reports are not readily available to CCNC networks to facilitate

rapid identification of children who are likely to benefit from case management and/or disease management programs.

Recommendation 3: Improving the Linkage of Children and Primary Care Providers

A more fully integrated and collaborative approach to the process of linking children with a primary care provider is likely to improve the overall success of the program. In addition, CCNC case managers need to receive Health Choice claims data and lists of Health Choice enrollees potentially in need of case management services in a timely manner. The Task Force offers the following recommendations to enhance the transition of children aged 0 to 5 years from Health Choice to Health Check and link children with a primary care provider:

Strengthening Collaboration between CCNC, DSS and Health Check Coordinators for SCHIP Kids

3.1 **Encourage the CCNC networks, through future contractual relationships, to work collaboratively with Departments of Social Services and Health Check Coordinators in their geographic service areas to develop annual strategic plans to link children with primary care providers and promote the CCNC systems and medical home concept**. This collaborative plan should also address efforts to educate the participating providers and enrollees about the advantages of the CCNC health care delivery system and the concept of the "medical home." The CCNC network needs to be promoted not only as an approach to managing children with chronic illnesses but also as an integrated health care delivery system that facilitates access to primary and preventive care. The CCNC networks should facilitate this, in part, through orienting and training DSS caseworkers and HCCs about CCNC and the "medical home" concept.

In the interim, until contracts are amended, the CCNC networks should be encouraged to work with other involved agencies on a plan that focuses on linking patients with PCPs and promoting the CCNC and medical home concepts. The voluntary efforts of some CCNC networks to orient DSS caseworkers and HCCs in some counties have been reported to enhance the linkage of clients with PCPs.

3.2 **Develop a mechanism that creates a reporting relationship or accountability between DSS caseworkers and CCNC**. One proposed strategy would involve partial payment of DSS caseworker salaries by CCNC to compensate counties for linking children with primary care providers. An alternative strategy would involve compensating counties on a per case basis for linking children with primary care providers. Because a per case-basis reimbursement potentially provides incentives to link children with PCPs in an expedited way, perhaps without parental buy-in, accountability should be built into the system. Refer to the recommendations listed below concerning data systems, online documentation of linkage attempts, and monitoring systems that are proposed to facilitate accountability.

3.3 **Restructure the outreach strategies of Health Check Coordinators to educate Health Check and Health Choice families about the CCNC networks at the time of enrollment or reenrollment.** The first documented "primary purpose" in the Health Check Coordinator Job Description is to "Increase community and family awareness of the benefits of Carolina ACCESS/Community Care of North Carolina and Health Check and Health Choice program." Ideally, this educational process should occur when children are enrolled in Health Check or Health Choice rather than after a problem is detected (e.g., lack of routine health visits or inappropriate use of emergency department services). The Health Check Coordinators' operational strategies should be restructured so that they meet with Health Check and Health Choice clients shortly after enrollment to discuss the medical home concept, advantages of the CCNC program, and the importance of well child checks, immunizations, and other preventive care, and to verify that the child has been linked with a PCP. If the PCP has not been selected, the HCC should facilitate the link at this meeting. This proposed approach is expected to facilitate more appropriate use of services.

3.4 **Clarify the role of the Health Check Coordinator in linking 6- to 18-year-old children who are enrolled in Health Choice with a CCNC primary care provider**. The current HCC job description lists the following as the "primary purpose of position": "Coordinate the activities of Health Check and Health Choice and serve as a link with existing child health programs, local physicians, Health Check agencies and professional organizations." The specific role of the HCC in linking 6- to 18-year-old children enrolled in Health Choice with a CCNC primary care provider is not clear. This responsibility should be delineated more clearly in the job description and policies and procedures and in the "Suggested Local Orientation Guide for New Health Check Coordinators."

Improving Collaboration by Exploring Options for New Technology to Enhance Existing Information Systems

3.5. **Explore the use of new or enhanced information systems by DSS caseworkers, Health Check Coordinators, and others involved in linking children with CCNC primary care providers to support and facilitate the linkage process, document contacts and linkage attempts, and monitor the relative success of alternative strategies**. Creating a more fully integrated information system that can be used and viewed by all involved with the linkage process is likely to improve communication and collaboration. One proposed approach is to add a PCP linkage tracking component to the State Eligibility Information System (SEIS) used by DSS caseworkers. This proposed tracking system would include a simple data entry screen to document attempted contacts with families (to link patients with PCPs), including the date, time, reason for the contact (other options to be used for other HCC activities), person initiating the contact, and result of the contact. If this component of the system were made available online to all entities involved in the linkage process, a more coordinated effort to link patients could be developed. This proposed tracking system would also include online real-time tracking reports and reminders that list enrollees who have not yet been linked with a PCP. The reports would be automatically updated whenever an enrollee is linked with a PCP. The

proposed system module and data would also be used to generate reports to monitor and evaluate progress and respective success of each strategy used to link children with PCPs.

3.6 Because the Health Check Coordinators utilize the Automated Information and Notification System (AINS) to identify and follow Health Check-eligible children to determine which in their respective counties are receiving regular Health Check screenings, immunizations, and referrals for special health care problems, **the Task Force believes that it would be critical to link the SEIS and AINS databases to optimize the efficient documentation activities of Health Check Coordinators.** The information systems used to monitor the linkage of children with CCNC primary care providers should also include the 6- to 18-year-old children who are enrolled in Health Choice.

Finding 4: Expanding Coverage for Children in Families with Incomes Between 200% and 300% of the Federal Poverty Level (FPL)

Extensive policy research on the topic of children's health documents the countless benefits of ensuring consistent access to high-quality health care. Children with health insurance coverage are more likely to receive vaccinations and other critical preventive services, as well as more timely treatment for illnesses or other special needs.[64] Increasing access to health insurance is also cost-effective for the state and local economies.[65]

A coalition of advocates led by Action for Children, a statewide, nonprofit, nonpartisan organization, worked together to create a plan – NC Kids Care – to make health insurance coverage more affordable for children in North Carolina with assistance from Mercer Government Human Services Consulting. The proposal included a limited benefits package (compared to the traditional Health Check benefits for children), sliding-scale fees for families with incomes between 200% and 300% of the FPL, and an option for families with incomes above 300% to buy in to the program at the full premium cost (approximately $160 per month). *See Appendix B for more information on this proposal.*

Governor Michael Easley also put forth a proposal to expand children's health insurance that is based on previous work done by the NC Institute of Medicine's Task Force on Covering the Uninsured.[66] In his plan, the governor offers a more limited benefits package, known as "Medicaid Lite." It is not an entitlement program for those with family incomes between 200% and 300% of the FPL and it does not include the option for families with incomes above 300% of the FPL to buy in. *See Appendix C for more information on the governor's proposal.*

In their recent budget bills, both the North Carolina House and the Senate included sections on expanding health insurance coverage for children. The version included in the House budget bill is similar to the plan put forth by Action for Children and their coalition, but it does not include the buy in option for families earning more than 300% of the FPL and it gives the DHHS some flexibility in making final decisions about co-payments and other components. The Senate's version proposes to assemble a study commission to further examine the issue of expanding

coverage for children and then, based on its findings; provide funding for an expansion in the second year. *See Appendix D for more information on the House and Senate proposals.*

Several states offer coverage for families with incomes above 200% FPL, and the current debate at the federal level about the reauthorization of funds for SCHIP is prompting more states to evaluate their programs and increase eligibility. Six states (Illinois, Pennsylvania, Massachusetts, Vermont, Maine, and Washington) have enacted universal health coverage for children and several more states have proposed universal coverage or are working to expand coverage eligibility for children.

With the proposed plans for expanding coverage, North Carolina is taking an important step toward reaching more children who are in need of affordable health insurance. However, it is important to point out that the current proposals offer some differences in eligibility, services covered, and cost-sharing arrangements.

Plans to expand Health Check coverage generally require a federal waiver. Section 1115 of the Social Security Act allows states to apply for a waiver to alter the state's Health Check eligibility criteria without loosing federal funds.[67,68] Health Check waivers are often required to be budget neutral, meaning that the federal government's Health Check contribution to the state would not be more with the waiver than it was without the waiver. This is primarily true if the proposed expansion will include individuals who are not ordinarily covered under Health Check.

With the proposed expansions, budget neutrality may not be an issue because Health Check language allows inclusion for "traditional coverage groups," which does include children in families with incomes between 200% and 300% of the FPL. This is an issue that requires further investigation and may depend on the specific details of an expansion plan once (if) it is approved by the North Carolina General Assembly. If budget neutrality rules do apply, North Carolina would have to document projected cost savings in other areas of the Health Check program.

Recommendation 4: Expand Public Health Insurance Coverage for Children in Families with Incomes between 200% and 300% of the FPL

4.1 **The Task Force reaffirms our support for NC Kids' Care** included in the North Carolina General Assembly's House Budget Bill (H1473), to expand health insurance coverage for children living in families with incomes between 200% and 300% of the FPL.

4.2 **Programs for expanding children's health insurance coverage will require additional outreach and enrollment support, and the Task Force recommends adequate funding be directed toward these efforts.** Individuals and organizations currently involved in Health Choice and Health Check outreach should be consulted in order to better evaluate funding needs for any potential expansion programs as well as linkages to the CCNC.

4.3 **Previous recommendations regarding easing the enrollment and renewal process as well as linking children with a PCP would also apply to any expansion programs.** Individuals and organizations involved in the enrollment, application, and renewal process as well as linkage with a PCP should be consulted to better understand the need for easing the process. Additional resources should be made available to facilitate appropriate modifications to current Health Choice and Health Check enrollment and referral efforts.

4.4 The current proposals to expand coverage to children in families with incomes between 200% and 300% of the FPL are an important step in the right direction. **The Task Force recommends that the key stakeholders continue to collaborate on a broader plan to ensure that all children and their parents in North Carolina have affordable and quality health insurance coverage available to them.** RWJF's *Consumer Voices for Coverage: Strengthening State Advocacy Networks to Expand Health Coverage* seeks to strengthen advocacy efforts to promote health care policies that will expand health insurance coverage. **The Task Force strongly recommends that advocacy groups collaborate on one-strong proposal from North Carolina.** *The program will only fund proposals from one registered applicant per state.* All applicant organizations must register online by July 13, 2007 (3 p.m. ET) in order to be eligible.

Conclusion

Access to affordable health insurance coverage for children remains a major issue nationally and statewide. Two recent issues of *Health Affairs* dedicated entirely to child health has documented the need for additional progress in ensuring access to affordable health insurance benefits for all children.[69]

In North Carolina, Health Choice and Health Check provide critical health coverage for low-income children. NC Kids' Care offers the opportunity to take another step toward the goal of making sure every child in North Carolina has access to affordable health insurance. Although North Carolina has taken important steps to enroll all eligible children and keep them enrolled in Health Choice and Health Check, additional areas for improvement remain.

With this report, the Task Force recommends that North Carolina continue outreach and enrollment efforts in order to reach the estimated 177,000 eligible children not yet enrolled in Health Choice or Health Check. The state must also strengthen retention efforts to ensure that no eligible children lose coverage at the time of renewal. Finally, it is also critical that children continue to be linked to a primary care provider and receive the benefits available through the CCNC network.

North Carolina must continue to move forward and be a leader on this issue. The current proposals to expand coverage to children in families with incomes between 200% and 300% of the FPL are an important step in the right direction toward the goal of access to affordable health insurance coverage for all children and their parents.

Appendix A
Examples of Electronic Applications and Other Innovations

Healthy-e-App

Health-e-App is the first fully automated Web-based application in the United States for enrolling low-income children and pregnant women in public health insurance programs. Developed by the California HealthCare Foundation (CHCF), in partnership with Deloitte Consulting LLC, Health-e-App is a real-time ecommerce application. It was developed to demonstrate the impact information technologies could have on improving access to, and the business processes of, government-sponsored health programs.

Health-e-App was developed with the cooperation of the California Health and Human Services Agency, which approved its pilot testing in San Diego County. Subsequently, CHCF licensed Health-e-App to the state of California at no cost. Health-e-App is being implemented throughout California to enroll eligible applicants in Healthy Families and Medi-Cal. It has also been licensed for use in Arizona and Indiana.

Health-e-App offers a faster, more secure, and consumer-friendly way to apply for public health insurance. It provides better quality application data and a more streamlined enrollment process, and it shows promise of increasing program enrollment because it is quick and easy to use.

Source: http://www.chcf.org/topics/medi-cal/index.cfm?itemID=19675

One-e-App

California originally developed Health-e-App, which is now available throughout the state, and is piloting One-e-App, which is available in 7 counties (Alameda, Fresno, Los Angeles, San Joaquin, San Mateo, Santa Clara, Santa Cruz).

One-e-App is a Web-based system for connecting families with a range of publicly funded health and social service programs. This one-stop approach improves the efficiency and user-friendliness of the application process for families seeking health coverage.

One-e-App helps to improve the quality and completeness of applications. As the data are entered, the system performs routine error checks and provides immediate notification when a required field is incomplete or data are incorrectly entered.

Other services are provided in real time, including an instant toggle between English and Spanish versions of the application, real-time selection of a provider and a health plan, and real-time submission of applications for final eligibility determination. The result is a system that is more efficient, cost-effective, and consumer-friendly.

Source: http://www.oneeapp.org/works/

One-e-App offers benefits to a wide range of constituencies, including consumers, county agencies, Healthy Kids programs and sponsors, health plans, and health care providers. These benefits are described below.

Benefits for Consumers

- Provides a one-stop application process for a range of publicly-funded health and social services programs.
- Offers immediate answers about preliminary eligibility and real time electronic submission of applications.
- Gives the ability to select appropriate health plans and doctors in real time when applying for several programs.
- Prints application documents and notification letters in the client's preferred language.
- Simplifies annual renewals for many programs. Eliminates or reduces the need to re-submit verification documents for renewals or future applications; the documentation is already in the system.

Benefits for County Government Agencies

- Helps Counties better serve their clients by providing a one-stop process for preliminary eligibility determination and electronic application submission across multiple programs.
- Interfaces with Statewide Automated Welfare Systems (SAWS) without requiring changes to those systems.
- Eliminates the need for manual data re-entry.
- Improves the quality of applications and decreases the number of incomplete applications through a consumer-friendly, interview style format and built-in error checking features.
- Provides outreach management and retention tools.
- Allows counties to track and support enrollment activities across programs and in the community.
- Protects data security and applicant confidentiality.
- Funds used to implement, maintain and administer One-e-App can be used to leverage federal matching dollars, thereby increasing the value to counties even further.

Benefits for Healthy Kids Programs and Sponsors

- Provides an easy-to-use application and eligibility determination tool for Healthy Kids Programs. As several counties have demonstrated, paper applications are not necessary, and the need for duplicate data entry is eliminated.
- Insures that funding for state and federal health coverage programs is maximized before children and adults are enrolled in programs funded with scarce local dollars.
- Allows Healthy Kids enrollment entities to help families apply for a broad range of programs beyond Healthy Kids, thereby increasing the value of their service to consumers and the community.

Benefits for Health Plans

- Provides an automated, consumer-friendly tool for health plans to conduct the entire Healthy Kids enrollment process, including eligibility determination, enrollment, provider selection, and premium collection.

- Performs preliminary eligibility determination and electronic application submission for parents in Medi-Cal at the same time that their children are being screened and applying for Medi-Cal, Healthy Families or Healthy Kids, thus improving enrollment rates and plan revenues.
- Ensures that complete and consistent information is supplied for every application, saving staff time that would otherwise be required to follow-up.
- Reduces delays associated with mailing and processing paper Medi-Cal and Healthy Families applications.
- Streamlines re-enrollment by notifying plans of Healthy Kids annual renewal dates. Reduces expensive "churn" that undermines continuity of care.

Benefits for Health Care Providers (Hospitals, Clinics, Physicians)

- Increases the number of insured patients, thereby increasing provider revenues.
- Preserves care grants and charity funds for those patients who truly aren't eligible for other coverage.
- Helps providers better serve their patients by assisting them with enrollment in a broad range of health coverage programs.
- Case management tools permit efficient tracking of applications.

Source: http://www.oneeapp.org/works/index.cfm?subclass=CL399&nlvl=1

Express Lane Eligibility

Nearly 7 million children in America are uninsured yet eligible for the federal-state programs Health Check and the State Children's Health Insurance Program (SCHIP). At the same time, over 4 million low-income, uninsured children already participate in public programs with similar income eligibility rules: the National School Lunch Program (NSLP), the Supplemental Nutrition Program for Women, Infants, and Children (WIC), food stamps, and child care programs. To enroll in these programs, families complete an application and submit necessary documentation, providing much of the same information that is required for Health Check and SCHIP enrollment.

California has also used a program called Express Lane Eligibility (ELE) to help identify children who are potentially eligible for Medi-Cal or Healthy Families by targeting children enrolled in the National School Lunch Program. ELE helps to make connections between Health Check and SCHIP and other public programs. At a minimum, ELE can be used to target outreach to the large numbers of uninsured children in public programs. A recent evaluation shows moderate success in identifying uninsured but eligible kids but does support the program as a useful tool in helping reach those in need. The evaluation also highlights the importance of efforts to streamline the application process for families.

Source: http://www.calendow.org/reference/publications/pdf/access/SC_ExpressLane_final.pdf
Dr. Michael R. Cousineau and Erika O. Wada, "Express Lane Eligibility Project: Evaluation Report," The Division of Community Health, University of Southern California, July 2006 (accessed May 31, 2007).
and
http://www.expresslaneinfo.org/AM/Template.cfm?Section=About_Express_Lane_Eligibility

Appendix B
Carolina Cares for Children Proposal
Covered Services and Cost-Sharing Summary

Category of Service	Covered Service	Co-Payment	Coinsurance	Deductible	Benefit Limit
Inpatient Non-Maternity Physical Health	Yes	$0	None	Ded applies, then 100% coverage	
Skilled Nursing Facility	Yes	$0	None	Ded applies, then 100% coverage	
Outpatient Physical Health	Yes				
Medical / Surgery	Yes	$30	None	Waived	
PT, OT, & Speech Therapy	Yes	$30/visit for first 3 visits, may be waived afterwards with OK from medical home	None	Waived	
Emergency Room	Yes	$30, Waived if admitted	None	Waived	
Primary Care Physician	Yes	$10, none if EPSDT or preventive care	None	Waived	
Specialist Physician	Yes	$30	None	Waived	
Inpatient Non-Maternity Behavioral Health	Yes	$0	None	Ded applies, then 100% coverage	
Outpatient Behavioral Health	Yes	$30/visit	None	Waived	6 visits allowed without diagnosis, 26 visits annually
Behavioral Health Other	No				
Pharmacy					
Generic	Yes	$0	None	Waived	
Brand	Yes	$20	None	Waived	
Brand Non-Formulary	Yes	$20	None	Waived	
Family Planning	Yes	$0	None	Ded applies, then 100% coverage	
Case Management	CCNC only	$0	None	Waived	
Home Health	Yes	$0	None	Ded applies, then 100% coverage	
Personal Care	Yes	$0	None	Ded applies, then 100% coverage	210 minutes per day, 60 hours per month
School Based Services	Yes	$0	None	Ded applies, then 100% coverage	
Lab & Radiology	Yes	$0	None	Ded applies, then 100% coverage	
Dental	No				
Vision/Hardware	Yes	$0	None	Ded applies, then 100% coverage	One exam annually; with prior approval, one set of lenses annually and one set of frames every 24 months
DME / Supplies	Yes	$0	None	Ded applies, then 100% coverage	
Preventive Care (EPSDT Services)	Yes	$0	None	Waived	
Ambulance	Yes	$0, $100 if determined non-emergent	None	Ded applies, then 100% coverage	
Maternity	No				

Source: Information available from Action for Children, http://www.ncchild.org/images/stories/Carolina_Cares_for_Children/Carolina_Cares_Services_and_Cost_Sharing_11_2006.pdf

Appendix C
Governor Easley's "Medicaid Light" Proposal

Title of Request: Limited Health Check Benefit Package for Uninsured Children Between 200% and 300% of Poverty

Description of Request: Expand Health Check coverage to provide a limited benefit package, "Health Check Light," to children with incomes between 200% of the federal poverty level (the current Health Check/NCHC eligibility level) and 300%. Services covered will be similar to the current Health Check program, but will require increased coinsurance, co-payments and deductibles depending on the type of service provided. Coverage for inpatient hospitalization (non-maternity/non-behavioral health) will be limited to $10,000. Skilled nursing, home health/personal care services and dental services will not be covered. A federal waiver will be required to implement this limited benefit package. The requested General Fund appropriation will cover the total non-federal cost share (i.e. counties will not cost share the Health Check Light coverage). It will be necessary to contract with a third party to collect premiums as the MMISsystem can not accommodate this component. This request does not include this cost. Effective January 1, 2008.

Purpose of Expansion Request: Provide basic health care coverage to approximately 12,100 additional low-income North Carolinians by expanding the Health Check program to establish a limited benefit package, "Health Check Light." Coverage will be extended to children with incomes between 200% of the federal poverty level (the current Health Check/NCHC eligibility level) and 300%.

Necessary changes in operation: Because the Health Check Light program will offer more limited benefits, focusing on primary and preventive care and limiting inpatient coverage, with increased cost sharing compared to the state's Health Check program, the state will need approval from the Centers for Medicare and Health Check Services (CMS) to waive applicable federal requirements.

Anticipated outcome/impact after implementation of changes: Increase the number of NC residents with health care coverage by an estimated 11,800 children. Improve access to primary and preventive health care services for low income individuals by providing them with a medical home through Community Care of North Carolina (CCNC). Improve the health status of covered children by emphasizing cost-effective primary care and managing chronic conditions in lieu of delayed expensive inpatient services.

Relation to Agency Goals: Supports the division's mission to by increasing access to high-quality, medically necessary health care for North Carolina residents.

Source: Information provided by NC DHHS, Office of State Budget and Management

Appendix D
North Carolina Kids' Care Proposal

NC KIDS' CARE *(from House Bill 1473, p.105-108)*

SECTION 10.48. (a) The Department of Health and Human Services, Division of Medical Assistance, shall develop and implement a limited benefit medical assistance program, NC Kids' Care, to expand health care coverage to children in families with incomes between two hundred percent (200%) and three hundred percent (300%) of the federal poverty guidelines, as revised April 1 of every year. The Department shall apply for any federal Health Check waivers required to implement this section. Eligibility for and benefits under this program are not entitlement and are subject to availability of funds and other changes to State and federal law.

SECTION 10.48. (b) Eligibility.—The Department may enroll eligible children based on the availability of funds. Following are the eligibility and other requirements for participation in NC Kids' Care children must:

(1) Be between the ages of birth and 19 years of age;
(2) Be ineligible for Health Check, Medicare, or other government sponsored health insurance;
(3) Have been uninsured for three months;
(4) Be in a family whose family income is above two hundred percent (200%) through three hundred percent (300%) of the federal poverty level;
(5) Be a resident of this State, meet applicable federal citizenship and immigration requirements, and be eligible under Federal law; and
(6) Have paid the monthly premiums required by NC Kids' Care.

SECTION 10.48.(c) Benefits and Limitations.—Except as otherwise provided, health benefits, including limitations, provided to children shall be as follows:

(1) Excluded benefits:
    a. Dental.
    b. Maternity.
    c. Skilled nursing facility.
    d. Personal care services.
(2) Capped benefits:
    a. Inpatient physical health benefits are limited to two hundred fifty thousand dollars ($250,000) per eligible child.
    b. Inpatient behavioral health benefits are limited to two hundred fifty thousand dollars ($250,000) per eligible child.
    c. Outpatient behavioral health benefits are limited to 26 visits annually.
    d. Primary care and special care physician visits are limited to five annually, except that:
        1. Additional specialty physician visits are allowed if approved by a primary care physician enrolled in Community Care of North Carolina; and

2. Additional wellness visits are allowed according to a predetermined schedule.

e. Prescriptions are limited to six per month, but this limit is waived if the child is participating in a Community Care of North Carolina case or disease management program.

f. Durable medical equipment and supplies are limited to five hundred dollars ($500.00) with prior approval by CCNC, except there is no limit on diabetic supplies.

SECTION 10.48.(d) Community Care of North Carolina.—The Department of Health and Human Services shall provide services to children enrolled in the NC Kids' Care program through Community Care of North Carolina and shall pay Community Care of North Carolina providers for these services as allowed under Health Check.

SECTION 10.48.(e) Cost Sharing.—NC Kids' Care shall require enrollees to contribute to the cost of their care through the use of deductibles, co-payments, coinsurance, and premiums as follows:

(1) A monthly premium is to be charged for each child enrolled in NC Kids' Care.

(2) The premium amount charged for each child shall vary depending on family income between two hundred percent (200%) FPL and three hundred percent (300%) FPL, except that:

a. The average premium charged for a child between two hundred percent (200%) and three hundred percent (300%) FPL shall not be more than sixty-five dollars ($65.00) PM/PM; and

b. The total premium cost shall not exceed two percent (2%) of an individual's annual income and four percent (4%) of a family's annual income.

(3) Coinsurance of not more than twenty percent (20%) may apply to the following benefits:

a. Inpatient physical health;

b. Outpatient physical health;

c. Surgery;

d. Physical therapy, occupational therapy, and speech therapy;

e. Emergency room;

f. Inpatient behavioral health;

g. Laboratory and radiology;

h. Durable medical supplies; and

i. Ambulance services.

(4) The maximum out-of-pocket coinsurance is two thousand five hundred dollars ($2,500) per child annually.

(5) Co-Payments.—NC Kids' Care may require enrollees to pay a co-payment for the following services offered. The co-payment for each service shall not exceed:

a. Twenty dollars ($20.00) for a primary care physician visit;

b. Forty dollars ($40.00) for a specialty care physician visit;

c. One hundred dollars ($100.00) for an emergency room visit, except the co-payment is waived if the enrollee is admitted to the hospital;

d. One hundred fifty dollars ($150.00) for ambulance service, except the co-payment is waived if the enrollee is admitted to the hospital;
e. Prescription drugs, as follows:
1. Five dollars ($5.00) for each generic drug prescription;
2. Thirty dollars ($30.00) for each brand-name drug prescription; and
3. Sixty dollars ($60.00) for each brand-name drug prescription, not on the list of preferred drugs.

SECTION 10.48. (f) Enrollment in NC Kids' Care shall not exceed funds appropriated for the program.

SECTION 10.48.(g) The nonfederal costs of NC Kids' Care shall be paid with State funds and enrollee premiums. Counties shall not be required to share in the nonfederal costs of NC Kids' Care.

SECTION 10.48.(h) Providers of services under NC Kids' Care shall be paid at Medicare rates except that pharmacy providers shall be paid at Health Check rates.

SECTION 10.48.(i) Until such time as the Department of Health and Human Services has an electronic data system that has the ability to collect and accept premiums and provide the other management activities inherent in administering NC Kids' Care, the Department may contract with a third party to administer this program.

SECTION 10.48.(j) This section becomes effective January 1, 2008, or upon approval of all required federal waivers and State Medical Assistance Plan amendments, whichever is later.

NC KIDS' CARE STUDY *(From Senate Finance Subcommittee Substitute for House Bill 1473 p, 107-108)*

SECTION 10.48. The Department of Health and Human Services, Division of Medical Assistance, shall determine the most cost-efficient and cost-effective method for implementing a limited benefit medical assistance program, NC Kids' Care. In developing the Program, the Department shall include the following:

(1) Eligibility for benefits under NC Kids' Care is not an entitlement, is for legal residents of North Carolina, and is subject to availability of funds and State and federal requirements.

(2) NC Kids' Care shall provide health coverage to children whose income is not less than two hundred percent (200%) and not more than two hundred twenty-five percent (225%) of the federal poverty level.

(3) Children enrolled in NC Kids' Care must be ineligible for Health Check, Medicare, or other government-sponsored health insurance.

(4) The premium for enrollment in NC Kids' Care shall be not more than twenty-five dollars ($25.00) per member per month except that the premium for a family shall not exceed seventy-five dollars ($75.00) per family per month.

(5) Providers of services to children enrolled in NC Kids' Care shall be paid at Health Check rates.

The Department of Health and Human Services shall report its findings and recommendations on the scope and benefits of NC Kids' Care to the Senate Appropriations Committee on Health and Human Services, the House of Representatives Appropriations Subcommittee on Health and Human Services, and the Fiscal Research Division not later than April 1, 2008.

Source: Information available from the North Caroling General Assembly Web Site, http://www.ncleg.net/Sessions/2007/Bills/House/PDF/H1473v7.pdf

[1] In North Carolina, Health Check for children is sometimes referred to as Health Check. Health Check covers preventive services including complete medical and dental check-ups, and provides vision and hearing screenings and referrals for treatment. Nationally, Health Check's prevention services for children are provided under Early Periodic Screening, Diagnostic and Treatment (EPSDT). This is the federal law that requires Health Check to provide medically necessary health care services to Health Check-eligible children through the age of 20 even if the services are not normally covered by Health Check or normally only covered for recipients 21 years of age and older.

[2] In North Carolina, Medicaid for children is referred to as Health Check. Health Check covers preventive services including complete medical and dental check-ups, and provides vision and hearing screenings and referrals for treatment. Nationally, Health Check's prevention services for children are provided under Early Periodic Screening, Diagnostic and Treatment (EPSDT). This is the federal law that requires Health Check to provide medically necessary health care services to Health Check-eligible children through the age of 20 even if the services are not normally covered by Health Check or normally only covered for recipients 21 years of age and older.

[3] Data adapted from Annie E. Casey Foundation, *CLIKS Database: Community-Level Information on Kids*, http://www.kidscount.org/cgi-bin/cliks.cgi?action=rank_indicator&subset=NC&areatype=county (accessed June 20, 2007).

[4] Adapted from Carolina Cares for Children (chart) created by Action for Children based on original data from *Federal Register* 71, no. 15 (January 24, 2006): 3848-3849, http://www.ncchild.org/images/stories/Carolina_Cares_for_Children/Childrens_Health_Insurance_Chart.pdf (accessed June 15, 2007).

[5] Data from CPS, which are used to allocate funding for the program, underestimated the number of children who would be eligible. A special session of the General Assembly allocated additional funding for the program and enrollment began to increase again. In 2005, the General Assembly passed legislation to move children under 6 to the Health Check program, helping to prevent another enrollment freeze.

[6] Adapted from "State Health Facts" from the Kaiser Family Foundation based on original data from the Census Bureau's March 2005 and 2006 Current Population Survey (CPS: Annual Social and Economic Supplements), http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=profile&area=North+Carolina&category=Health+Coverage+%26+Uninsured&subcategory=Health+Insurance+Status&topic=Children+%280%2d18%29 (accessed June 22, 2007).

[7] Adapted from Carolina Cares for Children (chart) created by Action for Children based on original data from *Federal Register* 71, no. 15 (January 24, 2006): 3848-3849, http://www.ncchild.org/images/stories/Carolina_Cares_for_Children/Childrens_Health_Insurance_Chart.pdf (accessed June 15, 2007).

[8] Information prepared by Action for Children (in 2007) for the NC Coalition to Promote Health Insurance for Children. Data are based on calculations from the NC Institute of Medicine.

[9] Adapted from "Child Health Report Card" based on original data from "Annual Social and Economic Supplement, Current Population Survey, U.S. Census Bureau and Bureau of Labor Statistics," http://www.ncchild.org/images/stories/2006_Health_Report_Card.pdf (accessed June 7, 2007).

[10] Covering Kids and Families & The Southern Institute on Families, *Promising Practices from the Nation's Single Largest Effort to Insure Eligible Children and Adults Through Public Health Coverage* (April 2007), http://www.thesoutherninstitute.org/docs/publications/CKF%20Promising%20Practices%204-07.pdf (accessed June 14, 2007).

[11] Community Care of North Carolina (CCNC) provides a "medical home" for children enrolled in Health Check. This connects children to a primary care provider who helps coordinate all health care needs for the child. Previously, only children enrolled in Health Check were eligible for this service, but beginning in January 2007, children in the Health Choice program began to be linked to the CCNC network as well.

[12] North Carolina DHHS, Division of Medical Assistance, *Health Check Coordinator Job Description*, http://www.dhhs.state.nc.us/dma/healthcheck/a5.pdf (accessed May 31, 2007).

[13] North Carolina DHHS, Division of Medical Assistance, *Health Check in North Carolina: Annual Report, Fiscal Year 2006*, http://www.dhhs.state.nc.us/dma/2006report/2006report.pdf (accessed June 6, 2007).

[14] North Carolina DHHS, Division of Medical Assistance, *Establishment of New Health Check Outreach Projects*, http://www.dhhs.state.nc.us/dma/healthcheck/n.pdf (accessed June 6, 2007).

[15] North Carolina DHHS, Division of Medical Assistance, *Health Check in North Carolina: Annual Report, Fiscal Year 2006*, http://www.dhhs.state.nc.us/dma/2006report/2006report.pdf (accessed June 6, 2007).
[16] The Center for Health and Health Care in Schools, *School-Based Health Centers*, http://www.healthinschools.org/sbhcs/sbhc.asp (accessed June 6, 2007).
[17] United States Department of Agriculture, Food and Nutrition Service, *National School Lunch Program*, http://www.fns.usda.gov/cnd/lunch/AboutLunch/NSLPFactSheet.pdf (accessed June 6, 2007).
[18] Children from families with incomes at or below 130 percent of the poverty level are eligible for free meals. Those with incomes between 130 percent and 185 percent of the poverty level are eligible for reduced-price meals, for which students can be charged no more than 40 cents.
[19] S. Dorn and G. Kenney, "Automatically Enrolling Eligible Children and Families Into Health Check and SCHIP: Opportunities, Obstacles, and Options for Federal Policymakers," The Commonwealth Fund, June 2002, http://www.allhealth.org/BriefingMaterials/Dorn_auto-enrolling_eligible_children_Health Check_SCHIP-314.pdf (accessed April 20, 2007).
[20] N. Cole and C. Logan, "Data Matching in the National School Lunch Program," Abt Associates (prepared for the USDA, Food and Nutrition Service), March 2007, http://www.fns.usda.gov/oane/MENU/Published/CNP/FILES/DataMatchingGuide.pdf (accessed June 6, 2007).
[21] United States Department of Agriculture, Food and Nutrition Service, "Preliminary Report on the Feasibility of Computer Matching in the National School Lunch Program," http://www.fns.usda.gov/oane/MENU/Published/CNP/FILES/NSLPDataMatchExecSum.htm (accessed June 6, 2007).
[22] North Carolina Early Intervention Services, http://www.ncei.org/ei/index.html (accessed June 19, 2007).
[23] North Carolina DHHS, Division of Medical Assistance, *Information for Children with Special Health Care Needs and Their Families*, June 2005, http://www.dhhs.state.nc.us/dma/CHIP/sn_booklet.pdf (accessed June 20, 2007).
[24] North Carolina General Assembly, Senate Appropriations Bill 622, FY2005, http://www.ncleg.net/Sessions/2005/Bills/Senate/PDF/S622v9.pdf (accessed June 7, 2007).
[25] North Carolina Healthy Start Foundation, The Health Check/Health Choice Outreach Web Site, http://www.nchealthystart.org/outreach/index.html (accessed May 31, 2007).
[26] D. C. Ross and L. Cox, "Resuming the Path to Health Coverage for Children and Parents: A 50 State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Health Check and SCHIP in 2006," Kaiser Family Foundation, January 2007.
[27] North Carolina DHHS, Division of Medical Assistance, "North Carolina Health Choice for Children," http://www.dhhs.state.nc.us/dma/cpcont.htm#howapply (accessed April 19, 2007).
[28] NC Pediatric Society, "DSS Employees: Frequently Asked Questions about Health Check/NC Health Choice," http://www.ncpeds.org/Covering%20Kids/FAQs/DSS%20Employees.pdf (accessed April 19, 2007).
[29] North Carolina DHHS, Division of Medical Assistance, "North Carolina Health Choice for Children," http://www.dhhs.state.nc.us/dma/cpcont.htm#howapply (accessed April 19, 2007).
[30] North Carolina DHHS, Division of Medical Assistance, *North Carolina Health Choice for Children, Annual Report, 2005*, http://www.dhhs.state.nc.us/dma/CHIP/2005annreport.pdf (accessed May 31, 2007).
[31] L. Ku and D. C. Ross. "Staying Covered: The Importance of Retaining Health Insurance for Low-Income Families," Center on Budget and Policy Priorities, 2002, http://www.commonwealthfund.org/usr_doc/ku_stayingcovered_586.pdf?section=4039 (accessed April 20, 2007).
[32] L. Cox, "Allowing Families to Self-Report Income: A Promising Strategy for Simplifying Enrollment in Children's Health Coverage Programs" (Washington, DC: Center on Budget and Policy Priorities, December 2001).
[33] Lake, Snell, Perry and Associations, "Retaining Eligible Children in Health Check and SCHIP: What We Know So Far," prepared for Covering Kids and Families. June 2003.
[34] *Health Insurance for Children* 13, no. 1 (Spring 2003), Future of children.org, http://www.futureofchildren.org/information2827/information_show.htm?doc_id=175451 (accessed May 4, 2007).
[35] Ibid.
[36] "Covering Kids and Families," *Promising Practices from the Nation's Single Largest Effort to Insure Eligible Children and Adults Through Public Health Coverage*, April 2007, http://www.thesoutherninstitute.org/docs/publications/CKF%20Promising%20Practices%204-07.pdf (accessed June 14, 2007).
[37] L. Cox, "Allowing Families to Self-Report Income: A Promising Strategy for Simplifying Enrollment in Children's Health Coverage Programs," (Washington, DC: Center on Budget and Policy Priorities, December 2001).

[38] D. C. Ross and L. Cox, "Resuming the Path to Health Coverage for Children and Parents: A 50 State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Health Check and SCHIP in 2006," Kaiser Family Foundation, January 2007.
[39] Ibid.
[40] L. Cox, "Allowing Families to Self-Report Income: A Promising Strategy for Simplifying Enrollment in Children's Health Coverage Programs" (Washington, DC: Center on Budget and Policy Priorities, December 2001).
[41] Health Management Associates, "Self-Declaration of Income: Options for California," May, 2006, http://www.100percentcampaign.org/assets/pdf/rpt-hma-0605.pdf (accessed May 31, 2007).
[42] Ibid.
[43] D. Holahan and E. Hubert, "Lessons from States with Self-Declaration of Income Policies," United Hospital Fund of New York, 2004, http://www.uhfnyc.org/usr_doc/lessons.pdf. (accessed June 14, 2007).
[44] Ibid.
[45] Ibid.
[46] Health Management Associates, "Self-Declaration of Income: Options for California," May 2006, http://www.100percentcampaign.org/assets/pdf/rpt-hma-0605.pdf (accessed May 31, 2007).
[47] L. Cox, "Allowing Families to Self-Report Income: A Promising Strategy for Simplifying Enrollment in Children's Health Coverage Programs" (Washington, DC: Center on Budget and Policy Priorities, December 2001).
[48] Ibid.
[49] Health Management Associates, "Self-Declaration of Income: Options for California," May 2006. http://www.100percentcampaign.org/assets/pdf/rpt-hma-0605.pdf (accessed May 31, 2007).
[50] D. C. Ross and L. Cox, "Resuming the Path to Health Coverage for Children and Parents: A 50 State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Health Check and SCHIP in 2006," Kaiser Family Foundation, January 2007.
[51] S. Dorn, "Making it Real: Auto-Enrollment into New State Coverage," Urban Institute, SCI Winter Meeting, Powerpoint presentation, January 2007.
[52] The Children's Partnership, *Expresslane Eligibility*, http://www.expresslaneinfo.org/AM/Template.cfm?Section=The_Basics&Template=/CM/ContentDisplay.cfm&ContentID=5894 (accessed June 12, 2007).
[53] The Children's Partnership, "Express Lane Eligibility," http://www.expresslaneinfo.org/Content/NavigationMenu4/PolicyAdvocacy/FederalPolicy/Legislation/default.htm (accessed June 12, 2007).
[54] Covering Kids and Families, "Promising Practices from the Nation's Single Largest Effort to Insure Eligible Children and Adults Through Public Health Coverage," April 2007, http://www.thesoutherninstitute.org/docs/publications/CKF%20Promising%20Practices%204-07.pdf (accessed June 14, 2007).
[55] Ibid.
[56] Several states, including Arizona, California, Florida, Georgia, Hawaii, Indiana, Louisiana, Maryland, Michigan, Nevada, New Jersey, Pennsylvania, Texas, Utah, Washington, and West Virginia, have some online enrollment systems.
[57] K. Wysen, "A State Guide to Online Enrollment for Health Check and SCHIP," National Academy for State Health Policy, January 2003, http://www.nashp.org/Files/guide_to_online_enrollment_kw.pdf (accessed May 4, 2007).
[58] J. Jee and L. Chimento, "TAE Issue Brief: Online Screening and Applications," The Lewin Group, http://www.adrc-tae.org/tiki-page.php?pageName=TAE+Issue+Brief-+Online+Screening+and+Applications (accessed April 23, 2007).
[59] Covering Kids and Families, "Retention: Ideas for Improvement," http://coveringkidsandfamilies.org/actioncenter/module.php?ModuleID=53 (accessed June 12, 2007).
[60] J. Ferris and G. Melnick, "Improving the Health of Californians: Effective Public-Private Strategies for Challenging Times," *Health Affairs* 23, no. 3 (May/June 2004).
[61] The Foundation Center, "Foundations Place Higher Priority on Children's Health" (press release), May 2005, http://foundationcenter.org/media/news/pr_0505a.html (accessed June 12, 2007).
[62] A. Schwartz and L. LeRoy, "Child Health: Fertile Ground for Philanthropic Investment," *Health Affairs* 23, no. 5 (September/October 2004).
[63] Ibid.

[64] E. Schor, M. Abrams, and K. Shea, "Health Check: Health Promotion and Disease Prevention for School Readiness," *Health Affairs* 26, no. 2 (month/year): 410-429.
[65] Analysis from Cameron School of Business at the University of North Carolina-Wilmington as cited by Action for Children in "Fact Sheet: Providing Health Insurance to All North Carolina Children Is Good for Business and Local Economies," January 2007, http://www.ncchild.org/images/stories/Carolina_Cares_for_Children/Health_Insurance_Good_For_Business.pdf (accessed June 7, 2007).
[66] The NCIOM recommendation called for expanding health insurance coverage to adults through a limited Health Check benefits package, known as "Health Check Light." The governor's current proposal takes the benefits recommended by NCIOM but applies them only to children.
[67] C. Milligan, "Section 1115 Waivers and Budget Neutrality: Using Health Check Funds to Expand Coverage," State Coverage Initiatives, May 2001, http://www.statecoverage.net/pdf/issuebrief501.pdf (accessed June 12, 2007).
[68] Kaiser Family Foundation, "Health Check Section 1115 Waivers: Current Issues," January 2005, http://www.kff.org/Health Check/upload/Health Check-Section-1115-Waivers-Current-Issues-pdf.pdf (accessed June 12, 2007).
[69] *Health Affairs*. Special Issue, *Designing Children's Health Care*, 26, no. 2 (March/April 2007): 312-608; *Health Affairs*, Special Issue, *Child Health: A Progress Report*, 23, no. 4 (September 2004): 7-283.

Options to Expand Health Insurance Coverage for Workers in Small Businesses in North Carolina

Prepared for:

North Carolina Health & Wellness Trust Fund (HWTF)
Lieutenant Governor Beverly E. Perdue, HWTF Commission Chair

and

University of North Carolina at Chapel Hill
Daniel P. Gitterman, Ph.D., Principal Investigator

Prepared by:

The Lewin Group

Aaron McKethan
Adam Wilk
Wes Joines

June 2007(September 2007 as amended)

OVERVIEW

This brief highlights policy options that encourage small employers to provide or subsidize health care benefits for their employees. The first section provides background for understanding the key challenges that small employers face in the private health insurance market. The second section provides a snapshot of current coverage trends in North Carolina's small group market in recent years. The final section summarizes common policy approaches that states have considered or have used to reduce the number of individuals without health insurance in the small group market.

BACKGROUND

Overview of Employer-Based Health Insurance Trends in North Carolina

About 4.5 million North Carolinians receive employer-based health care benefits.[1] While the proportion of people receiving health care benefits through their job has declined in recent decades, the system of employer-sponsored health insurance continues to provide coverage to the majority (nearly 57%) of the state's non-elderly population.[2]

In general, workers in smaller firms are less likely to be offered employer-based health insurance than those working in larger firm, both in North Carolina and nationally. In 2005, consistent with national trends, only about 42% of North Carolina firms with less than 50 employees offered employer-based health insurance, compared to over 95% for firms with more than 50 employees.[3] The exhibit below displays recent comparisons of employer-based coverage trends, by firm size, in North Carolina and the United States.

Percentage of private sector employers by firm size in NC and the US that *offer* health insurance coverage (2005)

Firm Size	2005	
	NC	US
1-9 employees	37.2%	35.7%
10-24	49.9%	64.0%
25-99	84.4%	82.6%
100-999	92.6%	94.2%
1000+	100.0%	98.9%
TOTAL	**56.7%**	**56.3%**

Source: Medical Expenditure Panel Survey, MEPSnet/IC Trend Query: Percent of private-sector establishments that offer health insurance by firm size (2005).

Some small business workers who do not get coverage through their employer may be able to access health insurance through a family member's employer or through a public program (e.g.,

Medicaid). They may also seek individual coverage in the private market. However, many workers of small firms simply go without coverage. Approximately half (55.3%) of the state's uninsured population is employed by, or is a family member of someone who works for, a firm with fewer than 25 employees.[4] Between 2001 and 2006, the total uninsured population grew by three percentage points nationally. During that time, the percentage of individuals without insurance working for firms with fewer than 25 workers jumped 8-percentage points nationally.[5] In North Carolina over the same period, the percentage of workers in small employers (fewer than 25 workers) covered by employer-based insurance grew by a comparatively steep 14 percentage points.

What Explains the Gap in Employer-based Insurance Coverage between Smaller and Larger Firms?

To identify viable policy approaches to assist small firms and the workers of small firms to access health insurance coverage, it is necessary to understand some of the underlying factors driving trends in coverage.

Large employers have some natural advantages over small employers in the market for health insurance. Insurance markets typically function best for large, well-defined populations for which clear information regarding health care status and risk profiles are available. When insured groups are large (e.g., large employer groups) the risks of unanticipated and costly medical events can be distributed across large risk pools. Therefore, insurance premiums reflect a stable and actuarially "fair" assessment of groups' health care experience. Further, per capita administrative costs are relatively low because they are spread out over many premium-paying individuals. Even with these advantages, the high costs of health care have led many large employers to trim benefits or shift more health care costs to workers.

Many of the characteristics of health insurance for large employers are lacking in the small group market. Smaller groups are typically unable to establish large and stable risk pools over which to spread the risk of high health care costs. Small groups can be particularly vulnerable to insurers' underwriting and pricing practices designed to avoid the possibility of adverse selection. Moreover, small groups are less able to establish economies of scale in the administration of health benefits. Smaller employer groups are also disadvantaged, relative to larger groups, since many "lack the resources, the expertise, and the inclination to cope effectively with the complex task of buying health insurance."[6]

These and other factors have contributed to higher insurance premiums being offered to small employers relative to the premiums typically available to larger employers. In North Carolina, for example, the average annual health insurance premium for workers in the smallest firms (with fewer than 10 employees) was $3,998 in 2004, compared to $3,684 for firms with more than 100 employees.[7] Importantly, these figures only account for those employers who actually provided or subsidized coverage for their workers. In 2004, only 39% of North Carolina firms with less than 50 employees actually offered health insurance to their employees, compared to 93% of firms with more than 50 employees.[8] Thus, many employers choosing not to offer coverage would have faced even higher premiums. Indeed, surveys suggest that most small employers (about 80%) not offering health insurance do not do so because of the high costs of coverage.[9]

Despite all of the challenges that smaller firms face receiving comparable premium offers relative to larger employers, the underlying factor influencing firms' decisions about whether to offer insurance coverage to workers is the actual value of premiums themselves. Thus, simply reducing or eliminating the *differences* between the average premiums available to large and small employer groups may not fully address the gap in coverage between employers of different sizes. For myriad reasons, smaller employers are typically more price sensitive than larger employers. Thus, while employers of all sizes have had to cope with medical cost growth consistently exceeding the general rate of inflation, small employers are especially susceptible to the rising cost of care.

The challenges that small employers face in the market for health insurance are particularly problematic in North Carolina since small employers represent a relatively large proportion of the state's total workforce. About one in four workers in the state (25%) work for employers with fewer than ten employees. Over one in three workers (36%) work for employers with less than 25 employees. Over half (53%) of the state's working population is employed by a firm with less than 100 employees. Moreover, the small business workforce has increased its share of the total state workforce in recent years. The percentage of North Carolina workers employed by small employers (with less than 25 employees) grew from 33% in 2001 to 38% in 2006.

The lack of health insurance coverage among workers in small employers is an important and growing policy challenge in North Carolina. The next section highlights several state-level approaches that may assist small businesses in the provision of health insurance.

Policy Options to Expand Insurance Coverage in the Small Group Market

Tax Credits and Deductions

Employer-based health insurance has been closely connected to the nation's tax system since the federal government declared in 1954 that employer contributions would not be taxed as income. Since then, the tax implications of health care benefits have figured prominently in both the growth of employer-sponsored health insurance and in health reform efforts.

Tax credits and tax deductions are two tax-based incentives to expand employer-based health coverage by subsidizing the employer's cost of providing coverage. While tax credits are applied after employers' tax liabilities are determined, tax deductions allow eligible employers to deduct amounts paid toward employee premiums from taxable income before tax liabilities are determined. These tax incentives are intended to reduce employers' income taxes to the extent that employers incur qualifying health care expenditures or premiums. Thus, such approaches are designed to induce smaller employers to offer insurance coverage to their employees.

However, there are concerns about the relative efficiency of such proposals. Broadly available tax credits or deductions may simply reward those employers already offering health care coverage. Moreover, using the tax code to change employer behavior may not ultimately be effective if employers must finance expensive health care premiums before tax benefits are actually available. To be effective, tax-based approaches must ultimately lower the relative prices that employers or individuals face enough to make premiums affordable.

To address these concerns, policymakers can establish "targeted" tax benefits and make them available before premium payments are due for employers with lower-paid employees or those not currently offering coverage. This could more effectively yield the desired policy effects at a lower cost in public tax expenditures. Moreover, since the tax liabilities of employers can vary substantially, policymakers can also establish "refundable" tax credits that are available to employers regardless of their tax liability. This would mean that the effective value of tax incentives is not reduced for employers with lower tax liabilities. More importantly, however, a significant challenge is ensuring that the amount of tax credits or deductions made available is sufficient to bring insurance premiums in range of affordability from the perspective of small employers.

In 2006, the General Assembly passed legislation that would allow small employers (with 25 or fewer workers) providing health benefits for all employees to take a state tax credit for the employer's costs in providing the benefits.[10] To be eligible, the employer must pay at least 50% of the premiums for health coverage that meets or exceeds the minimum provisions of a basic health care plan of coverage recommended by the Small Employer Carrier Committee. The credit is equal to a maximum of $250 for each employee covered whose annual wage and salary payments do not exceed $40,000.

Premium Assistance

An alternative approach to encourage small employers to offer health care coverage for their workers is to use public funds to directly subsidize the cost of employer-based health insurance premiums. Premium assistance programs can be targeted to small employers or directly to individuals, usually previously uninsured individuals with relatively modest incomes. Either way, the goal is to create additional incentives for small employers or other hard-to-insure groups or individuals to offset the higher premiums they are offered by private insurers.

Under the Balanced Budget Act of 1997, Congress authorized states to establish premium assistance programs for low-income children and their families under the State Child Health Insurance Program (SCHIP). A major benefit to states was federal matching funds for such programs. As a result, several states are experimenting with employer-based premium assistance programs as part of their broader HIFA waiver requests.[11]

Previous studies examining the experience and impact of state premium assistance programs suggest several lessons for policymakers. First, such programs can be very difficult to administer for states. Second, experience shows that some populations, such as uninsured individuals with limited experience with health care insurance or the health care system, may be particularly difficult to attract to premium assistance programs.[12] Such programs may need to include extensive outreach efforts to educate eligible families about the importance of health insurance and how it works.

Additionally, the effectiveness of programs that are targeted to individuals – and not small employers directly – may depend on the degree to which employers actually offer health insurance coverage to workers, as many do not.[13] This is because even with the availability of premium assistance, individuals still need a source for coverage. If their employer does not offer coverage, individuals may have to seek health insurance through the individual market in order to use premium assistance benefits.

Reinsurance

Reinsurance compensates health plans that enroll high-cost individuals or groups by functioning as secondary insurance for insurance carriers. When insurance claims for a particular enrollee or group exceed a predetermined level, the responsibility for paying for a portion of those claims shifts from the insurer to the reinsurer. This arrangement affords insurers some protection against high cost claimants or groups and reduces the potential impact of adverse selection.

Advocates of reinsurance contend that such arrangements can reduce the barriers faced by those with poor health status. However, private reinsurance is currently available in the marketplace, which raises questions about the role for government in establishing or subsidizing reinsurance arrangements. That said, the benefits that health plans receive from reducing their exposure to high cost enrollees or groups can be largely offset by the cost of reinsurance. Thus, a possible rationale for government-sponsored or subsidized reinsurance is to maximize the extent to which health plans do receive the benefits from reinsurance so that those benefits can be passed on to small employers in the form of reduced premiums.

States can establish reinsurance arrangements in concert with other policy efforts, such as premium assistance or limited benefit plans. The Healthy New York program, for example, which has been operational since 2001, is perhaps the best-known state effort to use state subsidization of reinsurance as a key mechanism to provide coverage for workers in small employers. Program eligibility for "streamlined" benefit packages is limited to small employers (50 or fewer workers) employing workers with modest wages[a] who have not been offered employer-based health coverage in the previous twelve months.[14] Under the program, the state of New York acts as a reinsurer to reimburse private insurance carriers for 90% of the claims costs between $5,000 and $75,000 per individual. Below $5,000 and above $75,000, insurance carriers are fully responsible for medical costs. Despite limited initial enrollment, Healthy New York now covers more than 100,000 previously uninsured individuals.

In 2006, the North Carolina Institute of Medicine Task Force on Covering the Uninsured recommended that the state establish a publicly subsidized health insurance product that would be available for small employers with 25 or fewer employees, sole proprietors, or employees not offered health insurance through their jobs.[15] A key part of the proposal was for the state to act as a reinsurer to reduce the premium costs for small employers by at least 30% from what is available in the private market. Price sensitive small employers, it was argued, would take advantage of these discounts to provide health insurance coverage to their employees for the first time.

The recommendation of the Task Force to establish a Healthy North Carolina program was based on the Healthy New York model. Legislation to enact and finance the proposal was introduced in the General Assembly as Senate Bill 1512, which remains under consideration by the legislature.

---

[a] At least 30% of the employees must earn wages of $35,500 or less.

Purchasing Pools for Small Employers

Policymakers in several states have experimented with purchasing pools as a way to make health insurance more affordable for small employers and/or individuals purchasing health insurance. The basic premise underlying purchasing pools is that by aggregating large numbers of small employers into consolidated purchasing arrangements, smaller purchasers can achieve the same market advantages that large employers enjoy. Thus, advocates of purchasing pools argue that they can result in more favorable premiums for participating groups or individuals relative to what they could achieve outside of pooling arrangements.

Analysts have studied small group pooling arrangements and have found that, in general, they have not resulted in lower premiums for participating groups.[16] Moreover, pooling arrangements or purchasing alliances have not dramatically increased small employer health insurance offer rates.[17] Although purchasing pools are designed to mimic the purchasing clout of large employers and other major purchasers (and thereby achieve more affordable premiums), voluntary pools differ from large employers for at least two reasons.

First, since purchasing pools are typically voluntary, participating small employers can choose to enter and exit the pool. If and when more affordable options avail themselves on the open market, small employers are likely to decline participating in special purchasing pooling arrangements and instead obtain more affordable coverage outside of the pool. Small employers that are able to obtain more affordable options on the open market are more likely to be lower-risk groups. This has the effect of leaving small employer groups with higher-risk populations inside the purchasing pool, which in turn causes prices for remaining groups to escalate still further. A purchasing pool with higher-than-average health care risk is by definition more expensive to insure. Even very large purchasing pools cannot exert market influence to command better rates unless they can demonstrate and maintain stable participation by eligible groups, including relatively low-risk groups that can help to subsidize higher-risk participants.

A second and related challenge associated with small group purchasing pools has to do with the risk profile of employers participating in pooling arrangements. From the standpoint of health plans that have the option of offering coverage to small employers participating in purchasing pools, there is some risk inherent in the very existence of the purchasing pool. Since they are formed for the exclusive purpose of achieving more affordable coverage for participating individuals and groups, such pooling arrangements may in general attract participants with higher-than-average health care costs and needs. Risk pools need a strong base of low-risk groups who will contribute premiums without adding substantially to medical costs. Health plans will seek to avoid providing "favorable" coverage terms (i.e., lower premiums) for groups that have a disproportionate share of high risk groups or individuals. By contrast, health plans make comparatively better rates available to large firms because their workers have not joined together for reasons solely related to their expected health care costs.

The general challenges associated with purchasing pools played out in North Carolina over the last decade when the state became one of the first in the country to establish a small business purchasing pool in 1993 (called "Caroliance").[18] The General Assembly created a system of regional purchasing alliances designed to help small employer groups obtain better health

insurance rates than were otherwise available on the open market. Caroliance formally began operations in 1995 and existed until 2000.

Over the five-year history of Caroliance, total enrollment was modest, amounting to only about 1% of the total small group market in the state. Despite limited enrollment, Caroliance did offer some advantages for hard-to-insure small groups. Before the 1997 federal Health Insurance Portability and Accountability Act (HIPAA) was enacted, Caroliance offered higher-risk groups in North Carolina a more attractive package of benefits than was available on the open market. However, HIPAA required that insurers offer all plans on a guaranteed issue basis to small groups. As a result Caroliance was no longer the only mechanism through which high-risk small groups could gain access to comprehensive coverage. Thus, the implementation of HIPAA effectively deprived Caroliance of its central advantage for small high risk groups.

The key challenge for Caroliance, as for most purchasing pool arrangements, was that it was unsuccessful in encouraging healthy groups to participate. Rather, it became a magnet for small, high risk groups for which insurers typically prefer to avoid providing coverage. The program's marketing and design features themselves were also to blame for the program's inability to achieve a balanced risk population. Marketing and media coverage contributed to the perception that the program was designed for hard-to-insure populations. More importantly, Caroliance used a two-tier rating methodology to underwrite policies. By contrast, insurers typically use at least three or more rating tiers to establish premiums. The effect of making fewer risk distinctions in Caroliance was to effectively elevate the prices that healthy groups must pay to participate, reducing their incentive to participate.

Caroliance was also unsuccessful in encouraging a significant number of health plans to participate. Despite some early interest from several health plans, the number of plan options declined such that by 1999, Blue Cross Blue Shield of North Carolina was the only plan offering Caroliance products statewide. Health plans were reluctant to participate because of the perception, if not the reality, that Caroliance was predominantly designed for high-risk and unprofitable groups.

In its later years, Caroliance made some changes, including consolidating the regional alliances into one statewide alliance, introducing additional rating/risk tiers so that healthier groups could gain access to lower rates. However, these changes could not reverse the program's reputation or experience. Caroliance closed operations as of December 31, 2000.

Under certain conditions, purchasing pools are useful mechanisms that improve the affordability of health insurance for small employers. Pools require stable populations with balanced risk profiles to mimic the natural advantages of large groups. Government financing could help achieve this goal by enticing small employers with healthy workers into the pool. Purchasing pools could also be combined with other strategies, such as reinsurance and tax credits, discussed elsewhere in this brief. Policymakers exploring purchasing pool arrangements as opportunities to expand insurance coverage among small employers must heed the lessons from Caroliance and similar initiatives nationwide.

Regulation of the Small Employer Market

States have primary responsibility for the regulation of health insurance. In North Carolina, the Department of Insurance (DOI) issues licenses to organizations that provide health insurance coverage and monitors the financial viability and business practices of insurers. DOI reviews insurers to make certain that they guarantee the issue and renewability of insurance plans. Overseeing the regulation of health insurance premiums is another key function performed by DOI.

Given the state's role in regulating health insurance, policymakers can use regulatory approaches to address coverage issues in the small employer market. In the 1990s, the General Assembly enacted small group reform laws to stabilize the small group market. These reforms resulted in North Carolina's adoption of a rating methodology known as "adjusted community rating with rate bands", which serves as a methodology for setting premiums for small employer groups. This includes self-employed "groups of one" up to firms with 49 workers.[19] The "community rating" aspect of the state's rating methodology bases premiums on the expected per-capita annual claims cost for an insurer's entire book of small group business. This means that premiums for individual groups are not underwritten based solely on specific risk characteristics. Rather, premiums are based on an insurer's entire small group business statewide. Community rating regulation condenses the variation in premiums for groups with different risk profiles, creating subsidies from healthier, lower risk groups to less healthy, higher risk groups. Groups characterized by higher risks benefit from these effective subsidies because their (higher) costs are spread across lower-risk groups that are less costly to insure.

In North Carolina, small group premiums are also adjusted according to some individual group characteristics, including age, sex, family composition, and geographic location. These basic adjustments help to ensure that small firms with predominantly healthy workers do not face the higher premiums that would result from full community rated premiums. These adjustments are thus intended to prevent firms with lower risk characteristics from exiting the small group market altogether. In addition to these demographic-based adjustments, small group premiums can vary by up to 20% based on the estimated medical risk of specific groups. Thus, North Carolina's current small group regulatory environment seeks to strike a balance between full medical underwriting in which groups receive premium offers based solely on their own risk characteristics and full community rating in which premium variation is eliminated and premiums are set regardless of groups' risk characteristics.

The impact of regulatory approaches on small group coverage can be very difficult to predict. The net effects of regulatory reforms will depend on how individuals and groups with different risk profiles respond to changing prices and incentives. Among those currently insured, healthy individuals may drop coverage to the extent that insurance is not valued at its higher cost. However, relatively unhealthy "high-risk" firms or individuals, facing prohibitively high premiums before regulatory changes are enacted and thus lacking employer-based coverage, may now find that the cost of insurance has dropped sufficiently to induce them to purchase coverage.

In general, if regulatory changes attract more high risk groups and individuals to the small group market relative to the number of low risk groups and individuals that exit, overall premiums may increase. Thus, the effects of additional rating restrictions on insurance

coverage and premiums depend on the responses of healthy groups and individuals that drop coverage compared to the unhealthy groups and individuals gaining coverage. The more standardized premiums become (i.e., the more premium variation is condensed despite risk characteristics), the larger the potential subsidies from low to high-risk groups and the less attractive insurance will be to low-risk individuals. Policymakers should thus exercise caution in making significant changes in regulations affecting premiums as the effects can be very difficult to anticipate.

One of the recommendations of the NC Institute of Medicine Task Force on Covering the Uninsured was for the state DOI to review the state's small group reform laws to determine if there are potential modifications that could increase coverage among small employer groups. Accordingly, the DOI recommended several reforms with the goal of reducing premiums for lower-risk groups within the small group market. While this would decrease the subsidies that effectively lower the premiums of higher-risk groups, the intention of this proposed change is to encourage more low-risk groups to participate in the small group market, thus lowering the average overall claims costs in the small group market. The General Assembly continues to consider this recommendation.

Conclusions

This brief highlights several policy approaches that states have considered or experimented with in recent years to reduce the number of uninsured people working for small businesses. Some states have had much success with these approaches while other policy experiments have not yielded the outcomes that were desired. Therefore, policymakers and advocates considering new approaches for North Carolina should carefully examine the key lessons learned from past policy efforts in North Carolina as well as other states' experimentations with similar approaches.

The key theoretical assumption underlying the reform approaches described in this brief are that small employers will be more likely to offer insurance coverage to their workers when they perceive that costs of doing so are affordable. To the extent that these reforms can reduce the effective prices that employers and their employees face, many more workers in small firms may be offered private insurance options and thus may "take up" insurance. This is a desirable policy outcome, particularly if newly insured workers were previously uninsured.

However, policy efforts aimed at offsetting some of the inherent natural pricing disadvantages that small groups face, relative to larger employers, may not completely eliminate the gap in coverage between smaller and larger employers. First, even if small firms could receive the same premium offers as typical large employers, many small employers may still deem the absolute value of premiums to be prohibitively costly.

Second, there may be other reasons that workers in small firms lack insurance coverage. For example, some of the uninsured may not value insurance and thus may simply choose to go without coverage. Thus, policy approaches focusing solely on changing the relative prices that small groups and individuals working for small firms face may not completely address the myriad factors that may influence firm and individual decision-making. Policy efforts in Massachusetts and elsewhere to "mandate" individuals to purchase insurance are not based

solely on the notion that expensive premiums alone are the sole factors inhibiting insurance coverage among certain individuals. Such approaches seek to address affordability issues while simultaneously mandating coverage to induce participation in the health insurance market for those who may choose not to participate even if affordable coverage is available.

Beyond the policy options highlighted in this report, other options exist to expand insurance coverage, including expanding eligibility criteria and financing for public programs. These approaches, too, can be costly and can pose other challenges. However, the increasing number of Americans receiving health insurance coverage through public programs suggests the important role that state and federal governments play in ensuring health care coverage. Given the active state health policy reform environment of the last two decades, state policymakers have the opportunity to carefully consider the experiences of the many policy efforts that have been implemented across the country to expand both public and private insurance coverage.

References

[1] Health Insurance Coverage of the Total Population, states (2004-2005), U.S. (2005). State Health Facts. Kaiser Family Foundation. U RL: http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=compare&category=Health+Coverage+%26+Uninsured&subcategory=Health+Insurance+Status&topic=Total+Population&link_category=&link_subcategory=&link_topic=&viewas=&showregions=0&sortby=&printerfriendly=0&from=none&datatype=number

[2] Medical Expenditure Panel Survey, MEPSnet/IC Trend Query: Percent of private-sector establishments that offer health insurance, by firm size groups (2001 and 2005).

[3] Ibid.

[4] P. Silberman, C.H. Odom, T. Lambeth, G.M. Holmes, and K. Dubay. "North Carolina's Uninsured." *North Carolina Medical Journa*l. May/June 2006, Vo. 67, No. 3.

[5] Ibid.

[6] E.K. Wicks and M.A. Hall. "Purchasing Cooperatives for Small Employers: Performance and Prospects." *The Milbank Quarterly*. Vol. 78. No 4. 2000.

[7] Agency for Healthcare Research and Quality (AHRQ), 2004.Table I.C.1.

[8] Medical Expenditure Panel Survey-Insurance Component. Percent of private sector establishments that offer health insurance by firm size and state: United States: 2004. (Table II.A.2: 2004). Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. Available at: http://www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_2/2004/tiia2.htm.

[9] P. Fronstin, R. Helman, and M. Greenwald. "Small Employers and Health Benefits: Findings From the 2002 Small Employer Health Benefits Survey." Employee Benefit Research Institute, Issue Brief 253, January 2003. URL: http://www.ebri.org/pdfs/0103ib.pdf.

[10] Bills Affecting General Fund Revenues. 2006 Regular Session. Senate Bill 1741, Chapters 24 and 24A.

[11] National Conference of State Legislatures, Summary of Employer Premium Assistance Programs, July 2003. URL: http://www.ncsl.org/programs/health/buyin03.htm

[12] J.B. Mitchell, S.G. Haber, S. Hoover. "Premium Subsidy Programs: Who Enrolls, And How Do They Fare?" *Health Affairs*, 24, no. 5 (2005): 1344-1355.

[13] M.S. Marquis and K. Kapur, "Employment Transitions and Continuity of Health Insurance: Implications for Premium Assistance Programs," *Health Affairs* 22, no. 5 (2003): 198–209.

[14] Healthy New York website. URL: http://www.ins.state.ny.us/website2/hny/english/hnybp.htm

[15] See: North Carolina Institute of Medicine. Expanding Health Insurance Coverage to More North Carolinians. Durham, NC. April 2006. URL: http://www.nciom.org/projects/uninsured/uninsuredreport.html.

[16] S.H. Long and M.S. Marquis. "Pooled purchasing: who are the players?" *Health Affairs*. 1999;18:105-111.

[17] S.H. Long, M.S. Marquis. "Have small-group health insurance purchasing alliances increased coverage?" *Health Affairs*. 20:154-163

[18] Figures and analysis regarding the rise and fall of Caroliance is based largely on the following study: J.S. Lawlor and M.A. Hall. "North Carolina's Health Insurance Cooperative for Small Businesses Needs a Doctor." *North Carolina Medical Journal*. November/December 2000. Vol. 61. No. 6.

[19] B.M. Burke. "Public Policy Options for Small Employer Health Insurance." *North Carolina Medical Journal*. May/June 2006, Vo. 67, No. 3.

Task Force *for a* Healthier North Carolina

Recommendations on Small Employers and the Provision of Affordable Health Coverage in North Carolina

November 2007

Lieutenant Governor Beverly Perdue
Chair, Health and Wellness Trust Fund Commission

Task Force Co-Chairs:

Senator Bill Purcell
Representative Verla Insko
Carole Bruce, HWTF Commissioner

University of North Carolina at Chapel Hill

Dr. Daniel Gitterman, Associate Professor of Public Policy
Stephanie Coplin, Research Associate
Jessica Dorrance, Research Associate

The Task Force for a Healthier North Carolina is a partnership between the Health and Wellness Trust Fund and the University of North Carolina at Chapel Hill.

Co-Chairs

Bill Purcell, North Carolina Senator, 25th district

Verla Insko, North Carolina Representative, 56th district

Carole Bruce, HWTF Commissioner, Attorney, Smith Moore LLP

Members

Bill Farmer, Vice President of Corporate Development, Time Warner Cable

Dr. Olson Huff, HWTF Commissioner

Dr. Jim Jones, Medical Director, Black River Health Services

H. Kel Landis III, Principal, Plexus Capital

Valeria Lee, President, Golden LEAF Foundation

Vernon Malone, North Carolina Senator, 14th district

Daniel McComas, North Carolina Representative, 19th district

Dr. Karen McNeil-Miller, President, Kate B. Reynolds Charitable Trust

Norma Mills, Lecturer, University of North Carolina, School of Government

Dr. Daniel Gitterman, Director (Ex Officio), Associate Professor of Public Policy, UNC-CH

On November 16, 2006, Lieutenant Governor Beverly Perdue, Chair of the Health and Wellness Trust Fund Commission, announced the formation of the Task Force for a Healthier North Carolina. The Task Force was given the charge to hold public forums and make recommendations on strategies to improve access to health insurance in North Carolina, including: access to prescription drug coverage for seniors; access to public health insurance for children; and access to affordable health insurance coverage for small employers. The Task Force for a Healthier North Carolina was created by a grant from the NC Health and Wellness Trust Fund Commission (HWTF). The Lewin Group was commissioned to prepare background policy briefs and to provide analytical support.

The Task Force for a Healthier North Carolina held a public meeting to explore strategies to improve access to affordable health insurance coverage for workers in small businesses on June 8, 2007. The Task Force invited presentations from the following individuals or organizations:

Cindy Avrette, *Principal Legislative Analyst, NC General Assembly, Research Division*

John Friesen, *Vice-President, Chief Actuary, A&U, Blue Cross and Blue Shield of NC*

Mark A. Hall, *J.D., Professor of Law and Public Health, Wake Forest University*

Ken Lewis, *President, FirstCarolinaCare*

Steve Millard, *Executive Director, Council of Smaller Enterprises (COSE)*

Barbara Morales Burke, *Chief Deputy Commissioner, NC Department of Insurance*

Steve Neu, *Vice President, Key Account Sales and Account Management, United Healthcare of the Carolinas*

Jack Rodman, *President & CEO, North Carolina Business Group on Health*

Pam Silberman, *President and CEO, NC Institute of Medicine*

E. Norris Tolson, *Vice Chairman, Board of Directors, NC Biotechnology Center; Secretary, NC Department of Revenue*

The Task Force respectfully submits the following recommendations on strategies to improve access to affordable health insurance for small employers.

Background and Findings

The Uninsured and Small Employers in North Carolina

Small business is a vital sector of North Carolina's economy. One in four workers works for a small employer with fewer than 10 employees and only 23 percent of these workers have health insurance coverage. In 2006, 54 percent of North Carolinians employed by businesses with fewer than 100 employees, 40 percent of those working in businesses with fewer than 25 employees, and 23 percent of those working in businesses with fewer than 10 employees had employer-sponsored coverage.[1] Affordability is the number one reason cited by small employers for not offering coverage to employees and their families. In contrast, larger employers have some natural advantages in provision of health insurance coverage. Due to a larger, more stable population, they are able to distribute risk more evenly. In addition, per capita costs for benefit administration are lower because the cost can be spread across more employees.

For a full background report on small employers and health insurance coverage in North Carolina, see http://www.healthwellnc.com/LewinSmallBusinessCoveragereport.pdf.

Past and Present Initiatives for Improving Small Employer Provision of Health Insurance

North Carolina has attempted three major reforms to improve access to affordable health insurance coverage for small employers since the early 1990s: a voluntary purchasing pool, regulation of the small group market, and a small employer tax credit for provision of health insurance. There is also one excellent model of a community-based initiative.

Caroliance: A Voluntary Purchasing Pool

In 1995, North Carolina's small business purchasing pool, Caroliance, began enrolling members. Experts who presented at the June public meeting concluded that the state-run pool yielded to adverse selection for two primary reasons. First, insurers were reluctant to participate because of a real or perceived estimate that the pool would attract only high-risk, high-cost participants. Second, without an employer or individual mandate, higher-risk members drove out lower-risk members by raising the premium levels. This cyclical behavior, known as "the death spiral," has caused the failure of many state-sponsored health insurance purchasing pools.[2]

Small Group Market Reforms

North Carolina made regulatory changes to stabilize its small group market in the 1990s. The changes reflected a rating strategy known as "adjusted community rating with rate bands." Community rating can decrease the variance in premiums from one small group to another by pooling all of a carrier's small groups to determine pricing. The rates may then be "adjusted" depending upon a few characteristics of the specific group, such as age, sex, family composition, and geographic location. Adjusting for medical risk is limited to 25 percent of the average market rate.[3] The effects of changes made to small group regulations were incremental and difficult to predict. An expert at the meeting explained that North Carolina's regulatory changes

"serve only to redistribute market costs, but are not a vehicle for reducing the real costs of health insurance."[4] Therefore, regulatory changes to the small group market have the capacity to make current prices more equitable, but are not able to solve the problems of overall affordability and accessibility.

Small Business Health Insurance Tax Credit

The most recent state initiative involved a tax credit for small businesses to help defray the employers' premium costs. The credit, which was passed by the GA in 2005, was up to $250 per eligible employee whose total wages did not exceed $40,000 from a business with 25 or fewer workers. Anecdotal evidence suggests that the credit was too small to induce small employers to offer coverage.

Community-Based Initiatives

Community-based initiatives have been effective in connecting the uninsured with affordable health insurance.[5] For example, in North Carolina, FirstPlan is a model for providing quality, low-cost insurance products to small businesses in an eight-county region. It uses subsidies to keep low-wage workers and their dependents enrolled. FirstPlan was created by FirstHealth of the Carolinas, a not-for-profit health care system serving rural North Carolina, and is offered through its subsidiary, FirstCarolinaCare. FirstPlan is targeted to employers with 50 or fewer employees. It requires the health system, the insurance company, the providers, and the employers to collaborate in order to offer an affordable, comprehensive insurance product. Three key mechanisms were utilized to implement FirstPlan: care credits for employers (there is a 100 percent employee participation requirement); subsidized premiums for employees ($10/hour or less wage employees); and reduced provider reimbursement for low-wage employees.[6]

FirstCarolinaCare also partnered with the Moore County Chamber of Commerce to create a highly affordable plan for Chamber members. A separate initiative, called CoverMoore, involved offering further reduced premiums ($50/month) to workers making less than $10 per hour through the local Chambers. Despite aggressive outreach efforts, there was not enough interest to create a critical mass and implement the plan. According to the president of FirstCarolinaCare, Ken Lewis, the product was too complex, too exclusive, and had the appearance of uncertainty. Through their experience with the CoverMoore initiative, FirstCarolinaCare found that the young and healthy employees were not interested in health insurance even at a very low cost.[7] FirstCarolinaCare closed the initiative after identifying only 130 interested individuals. In the end, businesses that already offered coverage did not see how the initiative would eventually benefit them and reduce their premiums.[8]

The Perspective of Small Employers: Key Survey Findings

In order to better understand small business owners' views on health insurance coverage, the University of North Carolina at Chapel Hill and the NC Rural Center partnered to conduct a survey of 5,000 small employers.

Early findings include:

Small business owners lack awareness of the health insurance tax credit.

- 63 percent of survey respondents reported never having heard of the tax credit.
- Less than 2 percent of respondents indicated that they would take advantage of the health insurance tax credit.
- Small employers reported a tax credit would need to be worth approximately $1,000 in order to induce them to offer health insurance.

Small business owners are carrying much of the burden of employee premium costs as dependent coverage is suffering.

- 70 percent of employers who offer health coverage reported paying up to 75 percent of the cost of employee coverage.
- Nearly 80 percent of employers said that they did not pay any portion of dependent coverage.

Small business owners have strong preferences on health policy.

- 90 percent favored the government "providing financial incentives to encourage small employers to provide health insurance for their employees."
- 88 percent favored "allowing small businesses to join together for the purpose of purchasing health insurance."
- 50 percent favored "a state-funded, universal health care program."
- 47 percent opposed "reducing the required benefits that must be covered in insurance plans (such as coverage for immunizations, mammograms, chiropractic care, etc.) in return for lower premiums."

Health insurance is not a major factor in attracting or retaining qualified labor for many small business owners.

- Of those companies that did not offer health insurance, only half (54 percent) believed that it affected their ability "to attract or retain qualified workers."

A full report on the survey findings will be released by the UNC-CH Office of Economic and Business Development and the NC Rural Center.

Key Recommendations

The Task Force recommends creation of a new state-wide Office of Small Business Health Insurance Partnerships (OSBHIP) to serve the following major needs of small employers and employees: 1) provide a single source of information on and portal to purchase private health plans; and 2) direct technical and financial assistance for small employers who wish to offer flexible and portable health insurance coverage to their employees. The Department of Insurance Seniors Health Insurance Information Program (SHIIP), an important means for seniors to access health insurance, could serve as one model for creating a necessary link between small employers (and employees) and health insurance coverage.[9]

Recommendation 1: OSBHIP should improve access to information on and/or purchase of affordable and quality health insurance coverage through creation of an online information portal and/or exchange.

Health insurance is a complicated product to research and purchase, and the amount of effort small employers must invest, per worker, is relatively high in comparison to the same amount of effort by a large employer. In addition to the affordability issue, the time and knowledge requirement is often too high a barrier to purchasing health insurance for many small employers.[10]

There is a need in North Carolina for a comprehensive source of impartial and credible information and resources for small employers seeking to purchase health insurance. Currently, the DOI has information on a few "resources that are commonly utilized by businesses to understand their insurance needs" and a list of "insurers actively marketing small employer group health insurance coverage." For example, see http://www.ncdoi.com/Consumer/consumer_business.asp.

Small employers have an uneven variety of information when shopping for health insurance. For example, independent insurance agents, health insurance companies, trade associations, and advocacy groups all provide some information (much of it available online). However, there remain two significant barriers to small business owners' accessing that information and transforming it into useful knowledge. First, the resources are scattered across many different Web sites, sponsored by many different organizations. This requires a small business owner to perform extensive online research to get the "full picture." Second, the largest source of health insurance information comes from the insurance companies themselves. Despite the efforts of the private health insurance industry to bring information and online applications to small business purchasers, there is a perception that for-profit companies might provide either biased or unmanageable information. For example, even though Blue Cross and Blue Shield of North Carolina "offers more than 1,000 benefit combinations and can customize different plans based on the needs and budget of your group health insurance program," such a large financial investment and commitment often needs the assistance of a skilled and impartial intermediary.

The portal would be a central place for making all types of health insurance information accessible to small employers and their employees. It would:

- create online tools and resources to assist small employers, workers in small firms, the self-employed, start-up businesses, and those eligible for the high-risk pool with their health insurance coverage needs;
- consolidate the online resources for health insurance available to small firms;
- provide guidelines for purchasing health insurance; and,
- introduce a "plan finder" that matches small firms and the self-employed with private health plans.

There is also a larger opportunity to create a health insurance exchange—a mechanism that facilitates the buying, selling, and administration of private health insurance. The concept is comparable to a stock exchange or a farmer's market that brings buyers and sellers together. A legal structure would be created to act as a clearinghouse for approved health insurance products, to collect and consolidate insurance premiums from individuals and employers, and to forward the payments to the insurance companies. The entity would be established to comply with federal tax law (Section 125 Cafeteria Plan) to allow employees to pay health insurance premiums with pre-tax dollars.

There might also be a larger opportunity for the OSBHIP, in partnership with the State Health Plan and the Department of Health and Human Services (DHHS), to improve access to information about the quality of providers and hospitals in a private health plan's network. For example, the U.S. Department of Health and Human Services has launched an initiative to improve consumer access to information that will help Americans compare the quality and price of health care services.[11] The initiative involves pooling data on procedures, hospitals, and physicians' services. Regional health information alliances could then collect such data and make it more accessible to consumers. The OSBHIP would take the lead in compiling and communicating plan information on a regional basis. Assisting small employers and employees to be better consumers of health care would be an important long-term strategy toward making affordable and quality health care coverage more accessible.

Recommendation 2: OSBHIP should sponsor a pilot small business premium assistance program.

Affordability is the number one reason cited by small employers for not offering health insurance. A premium assistance program, based on the CoverTN shared-responsibility model, could be as an initial step toward making insurance more affordable and accessible in North Carolina.

Tennessee's CoverTN requires that employees, employers, and the state share equally in the cost of health insurance premiums. Tennessee's plan for workers in small firms is portable. The state contracts with Blue Cross Blue Shield–Tennessee to offer two products with an average total monthly premium of $150, including the employee's, employer's, and the state's share. Premiums vary around this amount based on age, tobacco use, and body mass index. The benefits package emphasizes primary and preventive services with no deductibles and modest

copays. Tennessee received a federal Health Resources and Services Administration (HRSA) grant to pilot this small business health insurance coverage initiative. According to CoverTN officials, enrollment had reached 9,672 employees by August 2007. This is an impressive enrollment number, since CoverTN only started enrollment in March 2007.

The program focuses on preventive services and primary care. BCBS–TN offers coverage for up to six physician visits per year, with a $20 copay per visit and no deductible.[12] Coverage also includes some annual hospital care, generic pharmacy coverage, outpatient services, lab services, and mental health services.[13] If an employee exceeds their number of doctor visits, they can still get care, but at a higher rate.[14] Employees with preexisting conditions are subject to a 12-month waiting period before receiving care for the condition.[15]

The Task Force urges the creation of a two-year "pilot" premium assistance plan with start-up funding from and in partnership with several health care foundations. For example, to be eligible for assistance, a limited number of small employers and employees would *each* pay 1/3 of an average premium cost of a basic health plan. The remaining 1/3 of the monthly premium would be provided by the pilot program from external grant funds. If the premium assistance program is successful beyond the two-year pilot period, more sustainable state funding should be identified.

Recommendation 3: OSBHIP should provide technical and financial assistance to small employers who currently offer health insurance to offer that coverage as a Section 125 premium-only plan (POP).

Section 125 Plans give employees additional benefits by allowing pre-tax deductions for expenses such as health care, child care, and dependent care. Employees can deduct the cost of these items regularly from their gross salary and avoid paying federal, state, or FICA taxes on the deducted income.[16] For more information on 125 premium-only plans, see http://www.hra4u.com/content/pop.htm.

As one example, Massachusetts employers with 11 or more full-time-equivalent employees must adopt and maintain a Section 125 Plan. The larger program is being administered by the Commonwealth Health Connector Authority, commonly referred to as the Connector.[17]

Recommendation 4: OSBHIP should provide technical and financial assistance to small employers who offer workplace wellness programs.

Unhealthy lifestyles have led to increasing medical and insurance costs for employers small and large.[18] Workplace wellness and disease management programs have become increasingly popular avenues for cost containment. Federal and state tax credits to employers to implement a qualified workplace wellness program have become more common.[19,20]

The overall success of wellness programs may be in part attributable to the prevalence of preventable health conditions.[21] For example, a review of 15 years of research literature found that companies with health-promotion programs showed an average of $3.50 savings in reduced absenteeism and health care costs for every dollar spent. Other factors, such as reductions in on-

the-job injuries and in work-related stress levels, were also cited as tangible benefits to workplace wellness programs.[22]

The Health and Wellness Trust Fund, Blue Cross Blue Shield of North Carolina, and OSBHIP could partner to promote wellness in the workplace and design a competitive grants program for small employers who need start-up finances for wellness programs. For example, the Health and Wellness Trust Fund program, Fit Together, provides advice on free and low-cost ways to improve employee health. In addition, under the Blue Cross Blue Shield of North Carolina program called Get Fit Blue, members can receive discounts on gym memberships, personal training, health-related magazines, and nutrition counseling.

Recommendation 5: OSBHIP should support community-based pilots and encourage replication of successful community-based models.

With grant support from a W. K. Kellogg Foundation initiative, "Community Voices: Health Care for the Underserved," FirstHealth of the Carolinas developed and launched FirstPlan, a group of health care coverage products tailored to small businesses and offered through a wholly owned subsidiary, FirstCarolinaCare. Organized as a taxable, nonprofit insurer, fully licensed and regulated by the North Carolina Department of Insurance, FirstCarolinaCare operates a provider network that works together with hospitals, physicians, and the business community.[23] FirstHealth offers subsidies to low-income workers and premium discounts if employers meet certain criteria. Launched in 2002, the plan had enrolled 1,375 workers in 132 businesses after two and a half years of operation.[24]

In FirstHealth's region, fewer than 50 percent of small business employees are covered. FirstPlan was specifically designed to enroll and mainstream the working uninsured, and toward that end, emphasizes disease management for high-risk enrollees and a strong educational component to teach them how to use the system effectively. With FirstHealth of the Carolinas acting as convener, this plan was forged around the principle of shared responsibility and participation, and would not have succeeded without strong partnerships in the community to develop one-on-one relationships with the small businesses whose employees it was meant to help.[25]

Leaders of FirstHealth of the Carolinas viewed the FirstPlan model as a way to spread the costs of covering the uninsured working for small employers across many participants:

- The health system accepts reduced reimbursement, utilizes grants, and subsidizes remaining funding requirements.
- The physician network agrees to reduce reimbursement for lower-paid insured and participates in a medical management model.
- The insurer provides the claims-processing and education components to implement the plan.
- The small business owner provides premium contributions of at least 50 percent and enjoys the best rates if all employees are covered, whether through FirstCarolinaCare or another carrier.

Many experts conclude that universal coverage in North Carolina may indeed require some form of mandate to ensure that the risks and costs are shared across a larger population.

Conclusion and Next Steps

An Office of Small Business Health Insurance Partnerships (SBHIP) that provides information and technical and financial assistance to small employers would be a small and incremental step in the right direction. However, many of the experts who presented at the Task Force's public meeting believed that an individual mandate would be required to ensure affordable health coverage. Without a mandate, they argued, the young and healthy will "opt out" and drive up premiums.

The key lesson learned from North Carolina's purchasing cooperative, Caroliance, is that voluntary participation in a health insurance purchasing pool will lead to "market failure." Without full participation, the insurance market becomes overwhelmed by the unhealthy, high-risk members who have higher medical costs.

Some health care leaders believe that an employer mandate might be necessary to address the uninsured.[26] Others experts conclude that "in addition to avoiding adverse selection problems, mandatory approaches reduce cost shifting, prevent employer crowd out, and avoid insurers cherry picking the best risks."[27]

Health insurance is based upon the principle of shared risk. If most people are basically healthy, then they can afford to pay into a pool of money that is sufficiently large to cover the big expenses incurred by the few who are really ill. The Task Force recognizes that an employer and/or individual mandate is controversial and complex, but it is an issue that must be addressed with broader public debate and discussion as North Carolina decides its own path toward affordable and quality health insurance coverage for all residents. In the meantime, an Office of Small Business Health Insurance Partnerships that offers innovative technical and financial assistance is an important first step.

[1] Aaron McKethan and Adam Wilk, "Options to Expand Health Insurance Coverage for Workers in Small Businesses in North Carolina," June 2007, The Lewin Group; http://www.healthwellnc.com/LewinSmallBusinessCoveragereport.pdf (accessed July 2007).
[2] Gary Claxton, "How Private Insurance Works: A Primer," Kaiser Family Foundation, April 2002, 4; www.kff.org/insurance/2255-index.cfm. Janice Lawlor and Mark Hall, "Caroliance: North Carolina's Health Insurance Cooperative Needs a Doctor," *North Carolina Medical Journal* 61, no. 6 (Nov./Dec. 2000); http://www.ncmedicaljournal.com/november00/ar091100.pdf (accessed July 2007).
[3] McKethan and Wilk, "Options to Expand Health Insurance Coverage for Workers in Small Businesses in North Carolina."
[4] Barbara Morales Burke, "Regulation of Small Group Health Insurance Market," The North Carolina Biotechnology Center, Research Triangle Park, NC, June 8, 2007.
[5] Sharon Silow-Carroll, Tanya Alteras, and Heather Sacks, "Community-Based Health Coverage Programs: Models and Lessons," February 2004, The Economic and Social Research Institute; http://www.wkkf.org/Pubs/Health/CommunityBasedCoverageFINAL_00250_03763.pdf (accessed July 2007).
[6] For more information see http://www.communityhealth.dhhs.state.nc.us/OunceOfPrevention/(Charles_Frock)_Prevention_Strategies.ppt; http://aspe.hhs.gov/medicaid/july06/RoxanneLeopper.pdf.
[7] Charles Frock, "Health Care: Who Pays?" May 11, 2007, The Pilot.com; http://www.thepilot.com/stories/20070511/opinion/columns/20070511Frock.html (accessed July 2007).
[8] Ibid.
[9] http://www.ncshiip.com/Consumer/SHIIP/SHIIP.asp.
[10] Len M. Nichols, "Challenges Facing Small Employers in Purchasing Health Insurance," April 20, 2005, New America Foundation; http://www.newamerica.net/files/archive/Doc_File_2330_1.pdf (accessed July 2007).
[11] "Value Driven Health Care Home," July 9, 2007, U.S. Department of Health and Human Services; http://www.hhs.gov/transparency/ (accessed July 2007).
[12] "Q&A with CoverTN director," *Knoxville News Sentinel*, August 10, 2007; http://www.knoxnews.com/news/2007/aug/10/Harrington-Q-A-with-covertn-director/.
[13] "Q&A with CoverTN director," *Knoxville News Sentinel*, August 10, 2007; http://www.knoxnews.com/news/2007/aug/10/Harrington-Q-A-with-covertn-director/ and Cover TN Program overview, Tennessee Department of Finance and Administration; http://www.covertn.gov/cover_tn.html.
[14] "Q&A with CoverTN director," *Knoxville News Sentinel*, August 10, 2007; http://www.knoxnews.com/news/2007/aug/10/Harrington-Q-A-with-covertn-director/.
[15] Ibid.
[16] John S. Bauer, "Attracting and Retaining Employees—Employer and Employee Benefits of a Cafeteria Plan," American Thoracic Society; http://www.thoracic.org/sections/career-development/practitioners-page/practice-tips/articles/tip12.html (accessed August 2007).
[17] "Health Care Access and Affordability Conference Committee Report," April 3, 2006, Massachusetts Homepage; http://www.mass.gov/legis/summary.pdf (accessed August 2007).
[18]Kenneth E. Thorpe, Curtis S. Florence, David H. Howard, and Peter Joski, "The Impact of Obesity on Rising Medical Spending," October 20, 2004, Health Tracking; http://content.healthaffairs.org/cgi/content/full/hlthaff.w4.480/DC1 (accessed July 2007).
[19] "Workplace Wellness Program Credit," 2007 Assembly Bill 235, Wisconsin State Assembly; http://www.legis.state.wi.us/2007/data/AB-235.pdf (accessed July 2007). "Daily Health Policy Report: Capitol Hill Watch: Legislation Would Provide Tax Credits to Businesses That Offer Workers Wellness Programs," July 10, 2007, Kaiser Family Foundation; http://www.kaisernetwork.org/daily_reports/rep_index.cfm?hint=3&DR_ID=46114 (accessed July 2007).

[20] The Wisconsin State Assembly is considering Assembly Bill 235, which would provide a state tax credit to employers to implement a qualified workplace wellness program. Wellness services, including smoking cessation, weight management, nutrition education, and fitness incentives, could also qualify. The credit would cost the state a maximum of $5 million in revenues annually. U.S. Senator Tom Harkin announced the introduction of legislation that would provide a tax credit to businesses that offer wellness programs to their employees. The credit would be worth 50 percent of the costs they incur up to $200 per employee for the first 200 employees and $100 per employee for the remainder of workers. The measure is expected to be considered in fall 2007.

[21] One study found that 2001 health care spending among obese individuals was 37 percent higher than costs for normal-weight individuals. For the near-elderly who fall within the obese category (35.0+ body mass index), health care costs were 60 percent higher than for their normal-weight counterparts. Along with medical advances associated with treating weight-related diseases, the rising prevalence of obesity has contributed to increasing costs. Between 1980 and 2004, the prevalence of obesity doubled to 30 percent of the adult population. The authors found that the growth in obesity accounted for 27 percent of the growth of per capita health care spending between 1987 and 2001. Thorpe et al., "The Impact of Obesity on Rising Medical Spending."

[22] Beth Baker, "Pass the Pasta, Please, and Hold the Stress," July 10, 2007, *The Washington Post*; http://www.washingtonpost.com/wp-dyn/content/article/2007/07/09/AR2007070901305.html.

[23] http://www.thepilot.com/stories/20070511/opinion/columns/20070511Frock.html.

[24] aspe.hhs.gov/medicaid/july06/RoxanneLeopperAttachment2.pdf; aspe.hhs.gov/medicaid/july06/RoxanneLeopper.pdf.

[25] Ibid.

[26] Anne Krishnan, "Greczyn Wants Coverage Required: Blue Cross Chief Suggests Mandate," May 3, 2007, *News and Observer Online*; http://www.newsobserver.com/126/story/570180.html.

[27] Rick Curis, "Promising Elements of the Massachusetts Approach: A Health Insurance Pool, Individual Mandates, and Federal Tax Subsidies," Wisconsin Family Impact Seminars; http://www.familyimpactseminars.org/s_wifis24c02.pdf (accessed August 2007).

Strategies to Improve the Delivery of Child Health Care in North Carolina

Lessons from the Transition of Children (0 to 5) from Health Choice into Community Care of North Carolina Medicaid

A Background Report prepared for
The Task Force *for a* Healthier North Carolina

FEBRUARY 2008 (Final draft to KBR/HWTF)

Dr. Julie C. Jacobson Vann, Clinical Assistant Professor, School of Nursing
Dr. Daniel P. Gitterman, Associate Professor of Public Policy
University of North Carolina at Chapel Hill

The authors gratefully acknowledge the generous grant support from The Kate B. Reynolds Charitable Trust and the NC Health and Wellness Trust Fund. The findings and recommendations are the authors alone and do not represent formal positions of the KBR, HWTF or the Task Force *for a* Healthier North Carolina. The authors also gratefully acknowledge the helpful comments and reactions of Dr. Allen Dobson, former Assistance Secretary of Health and Dr. Olson Huff, HWTF Commissioner and Member of the Task Force *for a* Healthier North Carolina.

THE UNIVERSITY of NORTH CAROLINA at CHAPEL HILL

Background

North Carolina, like an estimated 39 other states, operates a hybrid financing system for providing health insurance coverage for low-income children.[12] Most states use a separate non-Medicaid SCHIP program, either alone or in combination with a Medicaid program. The remaining states use the Medicaid expansion model for SCHIP.[12] Based on age and family income, children are covered by either Medicaid or a separate SCHIP. In North Carolina, this tiered system of coverage is structured in the following way:

- All children ages 0-18 years, with family income at or below 100 percent of the federal poverty level (FPL), are eligible for coverage through Medicaid. [20]
- As of January 2006, children ages 0-5 years with family income between 100 and 200 percent FPL, are also eligible for coverage through Medicaid (SCHIP Medicaid expansion).
- Children between the ages of 6 and 18 years with family income between 100 and 200 percent FPL are eligible for coverage through a separate SCHIP program (Health Choice).
- Beginning in March 2007, children ages 6-18 years enrolled in SCHIP were given access to the Medicaid managed care program (CCNC) that had already been providing services for children ages 0-5 years; however, the children receive the level of benefits in the Health Choice program.
- In addition to the current hybrid system, the recent state budget included funds for NC Kids Care which will extend access to coverage for up to 38,000 children living in families with incomes between 200 and 300 percent of the FPL. The new expansion is targeted to begin in July 2008. Families that qualify for coverage will share in the cost of care through deductibles, premiums, and co-payments for certain services. Costs will be on a sliding scale based on income. [26]

On January 1, 2006, low income children between the ages of 0 and 5 years in families between 100 and 200 percent of the federal poverty level were transferred from the North Carolina Health Choice program, a separate State Children's Health Insurance Program (SCHIP), to the Community Care of North Carolina (CCNC) Medicaid managed care program. This transition allowed North Carolina to spend the SCHIP money on children in the 6- to 18-year old age bracket and to insure a larger number of children. The State would continue to benefit from the enhanced Federal match rate to expand Medicaid as one SCHIP option. [27] In addition, the transferred children were expected to benefit from CCNC's enhanced primary care case management (E-PCCM) structure. Beginning March 1, 2007 an additional 110,000 low income children in Health Choice (SCHIP), ages 6- to 18-years, were targeted to receive the same access to CCNC's networks, while remaining in the traditional Health Choice program.

A major goal of the Community Care of North Carolina Medicaid program is to "improve access to primary care and provide a more cost efficient health care system for Medicaid recipients," in part through linking Medicaid recipients with primary care providers who deliver and coordinate care.[18] Community Care of North Carolina utilizes an enhanced primary care case management form of managed care. Primary care case management (PCCM) programs are typically designed to link each beneficiary with a primary care provider who is charged with providing the patient beneficiary with a "medical home," coordinating health care services, increasing use of primary care and preventive services, and decreasing use of emergency departments, inpatient services, and some specialty care services.[2,8] The CCNC networks are structured with these core primary care case

management components, yet are "enhanced" by the development of local support services such as case management, disease management, and other programs that are intended to improve quality of care for enrolled Medicaid recipients with specific health needs. These local networks are state (Medicaid) supported, not-for-profit, and based on local collaboration and integration among providers.

The CCNC Medicaid program and networks implemented asthma, diabetes, and other disease management programs. These disease management initiatives utilize evidence-based practice management guidelines to increase the use of appropriate medications and other therapies with the expectation that utilization of emergency department and inpatient services for these health problems will decrease.[1] Case management services target patients who have experienced a significant increase in medical costs, emergency department utilization, or inpatient hospital stays as well as those identified as requiring follow-up, outreach, and/or health education. Case management services are supported by network-developed internet case management information systems. Additional cost containment and quality improvement programs include: (1) a voluntary Prescription Advantage List to control rising pharmacy costs; (2) a dental varnishing program in which medical providers are trained to provide fluoride varnish treatments to high-risk children under 3 years of age; [28, 33] (3) ABCD (a developmental screening tool); and (4) the Improving Pediatric Access through Collaborative Care (IMPACC) program, which focuses on improving the coordination of care between primary care providers and pediatric subspecialists for children with special health care needs.

This report briefly reviews several operational domains of the transition of 0- to 5-year old children from Health Choice to CCNC Medicaid and offers recommendations for process or systems improvement. Data for this short-term evaluation were collected through review of program documents, performance of key informant interviews, requests for client enrollment, provider participation and primary care utilization reports (Health Plan Employer Data and Information Set [HEDIS®] measures), and literature reviews. [15, 19] This review of the process and outcomes of linking the 0- to 5-year old children with CCNC primary care providers is expected to inform future efforts to link these children in the SCHIP Medicaid Expansion program as well as the 6- to 18-year olds who will remain in Health Choice yet utilize CCNC services, with PCPs.

I. Outreach and Enrollment

Beginning January 1, 2006, children were enrolled into CCNC from Health Choice and then linked with a primary care provider. This was done primarily by employees of county Departments of Social Services. The enrollment process was supplemented through outreach efforts of Health Check Coordinators (HCCs) and by permitting and encouraging physicians to enroll patients at their office using a mail-in application form.

Finding 1: Transitioning Children (0- to 5-Year Olds) from Health Choice to CCNC Medicaid and Linking Them to a CCNC Primary Care Provider

Enrollment Frequencies—Enrolling and Linking Children with CCNC Primary Care Providers

As of July 2007, of the 1,217,262 Medicaid recipients in North Carolina, 1,122,637 were eligible to be enrolled in North Carolina Medicaid managed care programs. Of those, 77.4 percent were enrolled in managed care programs.[21] This proportion increased slightly from the previously reported level of 73.2 percent (July 2006) [Appendix A]. In July 2007, the highest percentage of enrollment in managed care programs was observed in Davidson County (88 percent), and the lowest in Swain County (45 percent). These data include all Medicaid recipients, as data were not reported separately for children enrolled in Medicaid.

During July 2007, 39,471 children, 0- to 5-years of age, were eligible for CCNC Medicaid through the SCHIP Medicaid Expansion Program.[22] During the Federal Fiscal Year (FFY) 2006, the unduplicated number of children enrolled at any time during the year in the SCHIP Medicaid Expansion was 53,180.[23] The specific proportion of children, age 0- to 5-years in the SCHIP Medicaid Expansion program who were linked with PCPs, were not available. Anecdotal reports indicate that there were difficulties in getting the 0 to 5 year old children linked with CCNC primary care providers, and the process was incomplete. As of June 2007, of the 115,866 children (6- to 18-years) enrolled in North Carolina Health Choice, only 23.3 percent were enrolled with a CCNC primary care provider [Appendix B]. Proportions of 6- to 18-year old Health Choice children linked with PCPs ranged from 3.5 percent in Hyde County to 39.9 percent in Craven County [Appendix B].

Process for Enrolling Children in CCNC Medicaid and Linking Enrollees with Primary Care Providers

The process for linking 0- to 5-year old children transferred from Health Choice to CCNC Medicaid with a primary care provider is fragmented, relatively uncoordinated, and lacks direct accountability. The primary responsibility for formally linking children younger than 6 years of age who have been transferred from Health Choice to CCNC Medicaid with a primary care provider resides with the county-based and -employed Department of Social Services (DSS) caseworkers. Yet, these Department of Social Services caseworkers generally do not have a direct reporting relationship with the CCNC administrative offices or CCNC networks [Appendix C]. Therefore, state-level goals of linking 0- to 5-year old children who were transferred from Health Choice to CCNC Medicaid with a primary care provider are being delegated to employees who are accountable for meeting the goals of their respective counties, not those of the state. Because the effort to link children with primary care providers had not been fully successful, other mechanisms were added to try to increase the proportion of eligible children who get appropriately linked with primary care providers. One supplemental approach to help link children with primary care providers was to use county-based Health Check Coordinators (HCCs). The Health Check Coordinators were provided with lists of children from the North Carolina Division of Medical Assistance (NCDMA) who were being transferred from Health Choice to Medicaid. They were then asked to assist with the linkage efforts [Appendix C]. This supplemental approach was a strategic decision given that Health Check Coordinators are employed by 88 North Carolina counties to assist families with obtaining medical benefits and other services needed by children, educate families about Medicaid and Health Choice, help enroll eligible children, and follow

Medicaid-enrolled children in their respective counties to assure that they are receiving well-child check-ups and recommended follow-up care. [17] Having Health Check Coordinators link children with CCNC primary care providers tied in closely to their existing job responsibilities. The third strategy for linking eligible children with CCNC primary care providers involves primary care physician practices. These physician practices were provided with brief forms and instructions to help formally link children who already come to their practice for care with primary care providers. Some Health Check Coordinators and community-based CCNC case managers then asked medical practice staff members to assist Medicaid clients with completing the brief enrollment forms and faxing completed forms to the Department of Social Services. The overall success of these three strategies has not yet been validated with quantitative evidence; however, anecdotal reports and completed key informant interviews indicate that number of eligible children linked with primary care providers has not met expectations. In addition, the interview data provide initial evidence that the processes to link patients with primary care providers vary from network to network and county to county, and that collaboration and communication among all involved entities have been inconsistent. Some CCNC networks and providers seem unaware of the respective roles of those responsible for the linkage process. However, one CCNC network directly supervises Health Check Coordinators in their geographic area; and at least one other CCNC network partners with the Health Check Coordinators for pediatric patient care issues.

Other Potential Barriers to Linking 0- to 5-Year Old Children Transferred from Health Choice to CCNC Medicaid with Primary Care Providers

Perceptions of Department of Social Services caseworkers and Health Check Coordinators about the potential advantages and disadvantages of linking children with CCNC Medicaid primary care providers is likely to influence the diligence with which the linkage process occurs. Comments made during key informant interviews suggest that there may be resistance to linking children with CCNC Medicaid primary care providers. Several persons interviewed indicated that they believe they are advocating for children by encouraging them to "exempt out" of linking with a CCNC primary care provider. Some caseworkers may believe that by linking children with CCNC primary care providers they are limiting care choices for patients. They may view the primary care provider as a "gatekeeper" who restricts service access rather than a provider who coordinates care. The "exempt out" process may also be viewed by some as less time-consuming than linking children with primary care providers. In addition, some caseworkers have expressed concern that it may be inefficient for them to link children with primary care providers because children may later show up at other provider practices and need to be re-linked. This concern about the additional workload discourages some caseworkers from diligently striving to link children with primary care providers.

The Health Check Coordinators' specific role in linking 6- to 18-year olds enrolled in Health Choice with a CCNC primary care provider is not clear. Responsibility for Health Choice clients is specified repeatedly in the Health Check Coordinator position description. [17] However, the documented expected roles and responsibilities for working with Health Choice clients are vague. And, according to key informant interviews, Health Check Coordinators may not be aware of their responsibility for Health Choice clients and do not work with them. This seems to contradict the written position description.

Information Management Systems Utilized Within North Carolina Medicaid and Health Choice

The use of multiple non-integrated information systems within North Carolina Medicaid and Health Choice poses a barrier to efficient and effective linkage of children with CCNC primary care providers. The North Carolina Medicaid and Health Choice programs, Department of Social Services caseworkers, Health Check Coordinators, CCNC networks and case managers, and CCNC participating providers utilize a number of databases to manage Medicaid and Health Choice enrollees [Appendix C]. Yet, the multiple agencies and people involved in the care of children enrolled in Medicaid and Health Choice do not access or use the same databases. These databases serve to document and manage Medicaid and Health Choice eligibility, enrollment, linkage with primary care providers, case management performed by CCNC case managers, case management performed by clinicians, disease management and registry functions, and efforts to facilitate compliance with well-child screenings, immunizations, and referrals for special health care problems. In general a distinct database exists for each primary information system activity instead of utilizing one integrated information system. For example, the State Eligibility Information System (SEIS) is used by Department of Social Services caseworkers to formally link enrollees with primary care providers during Medicaid eligibility determinations and re-determinations. Second, the Automated Information and Notification System (AINS) is used by Health Check Coordinators to track Medicaid-eligible children from birth through 20 years of age.[17] This system provides lists of those Medicaid-eligible children who are receiving regular well-child screenings and immunizations. Third, the Clinical Management Information System (CMIS) supports case management and disease management activities within the CCNC Medicaid networks. Fourth, some CCNC Medicaid networks utilize their own databases to manage similar client information [Appendix C].

Based on findings from key informant interviews, evidence suggests that the existing standard databases are not integrated to the degree necessary for tracking or managing the linkage of patients with primary care physicians, as well as identifying patients (ages 6- to 18-years in Health Choice) in need of case management services [Appendix C]. The Medicaid eligibility database, used by Department of Social Services caseworkers for linking patients with primary care providers is reported to lack real-time tracking, at the client level, of those patients/clients who have been linked with a primary care provider versus those who have not yet been linked. In addition, the efforts made by Department of Social Services caseworkers to contact clients to initiate the primary care provider linkage process are not electronically documented to facilitate monitoring of linkage activities and evaluate the relative success of the various strategies. Access to the Medicaid eligibility database for purposes of linking patients with primary care providers is reported to be restricted to the Department of Social Services caseworkers and is not available to Health Check Coordinators, CCNC networks, CCNC community-based case managers, or providers who may assist with the linkage efforts. Electronic sharing of information between all of the players who are involved with linking children with primary care providers generally does not exist. Key informant interviews revealed that there are no true "tracking systems" to monitor real-time linkage of clients with primary care providers [Appendix C]. Therefore, the 0- to 5-year old children who were transferred from North Carolina Health Choice to CCNC Medicaid may not be linked to primary care providers in an efficient manner or possibly not at all.

A second major information system limitation is related to the 6- to 18-year old Health Choice enrollees who need to be linked with a CCNC primary care provider. Because these patients are enrolled in Health Choice, their health care claims are processed by Blue Cross and Blue Shield

(BCBS) of North Carolina, which does not provide linkage with a PCP. The claims files are sent to the North Carolina Division of Medical Assistance on a weekly and monthly basis. However, findings from key informant interviews indicate that the claims data and related case management reports are not readily available to CCNC networks to facilitate rapid identification of children who are likely to benefit from case management and/or disease management programs.

Recommendation 1: Improve the Linkage of Children with Primary Care Providers

A more fully integrated and collaborative approach to the process of linking children with a primary care provider is likely to improve the overall success of the program. We offer the following recommendations to the Task Force to enhance the transition of children, aged 0 to 5 years, from SCHIP to Medicaid and link these children with a primary care provider.

Recommendation 1.1: Strengthen Collaborative Efforts Among CCNC Medicaid Networks, County Departments of Social Services, and Health Check Coordinators

Collaborative Strategic Planning:

Encourage the CCNC Medicaid networks, through future contractual requirements, to work collaboratively with Departments of Social Services and Health Check Coordinators in their geographic service areas to develop, implement, and evaluate annual strategic plans to link children with primary care providers and promote the CCNC systems and medical home concept. As a first step, this collaborative plan should address efforts to educate the Department of Social Service caseworkers and Health Check Coordinators about the advantages of the CCNC health care delivery system and the concept of the "medical home." If these front-line employees, who are charged with linking children with a primary care provider, are not convinced of the value of linking children with a CCNC primary care provider, then the linkage results are likely to be less than optimal. The CCNC Medicaid networks need to be promoted, not only as an approach to managing children with chronic illnesses, but also as an integrated health care delivery system that facilitates access to primary and preventive care. The CCNC networks should facilitate this, in part, through orienting and training Department of Social Services caseworkers and Health Check Coordinators about CCNC and the "medical home" concept. In the interim, until existing contracts are amended, the CCNC networks should be encouraged to work with other involved agencies to develop and implement plans that focus on linking patients with primary care providers and promoting the CCNC and medical home concepts. The voluntary efforts of several CCNC networks to orient Department of Social Services caseworkers and Health Check Coordinators to CCNC and the medical home concept in some counties has been reported to enhance the linkage of clients with PCPs [Appendix C]. These efforts should be expanded to other CCNC networks.

Create formal relationships and accountability

Develop a mechanism that creates a reporting relationship or accountability between county Department of Social Services caseworkers and CCNC. One proposed strategy would involve partial payment of Department of Social Services caseworker salaries by CCNC to compensate counties for linking children with primary care providers. An alternative strategy would involve compensating counties on a per case basis for linking children with primary care providers. Because per case reimbursement potentially provides incentives to link children with primary care

providers in an expedited way, perhaps without parental buy-in, accountability would need to be built into the system. Recommendations described below, concerning data systems, online documentation of linkage attempts, and monitoring systems, are proposed to facilitate accountability.

Restructure Health Check Coordinator Responsibilities:

Restructure the outreach strategies of Health Check Coordinators to proactively educate Medicaid and Health Choice families about the CCNC networks at the time of enrollment or re-enrollment. The first documented "primary purpose" in the Health Check Coordinator Job Description is to "Increase community and family awareness of the benefits of Carolina ACCESS/Community Care of North Carolina and Health Check and Health Choice program." [17] This primary purpose supports the process of encouraging and assisting parents to link children with CCNC primary care providers. Ideally, this educational process should occur when children are enrolled in Medicaid or Health Choice rather than after a problem is detected (e.g., lack of routine health visits or inappropriate use of emergency department services). The Health Check Coordinators' operational strategies should be restructured so that the Health Check Coordinators meet with Medicaid and Health Choice clients shortly after enrollment to discuss the medical home concept, advantages of the CCNC program, and the importance of well child checks, immunizations, and other preventive care, and to verify that children have been linked with primary care providers. If a primary care provider has not been selected by a client, the Health Check Coordinator should facilitate the link at this meeting. This proposed approach is expected to facilitate more appropriate use of services.

Clarify the Health Check Coordinator Role:

Clarify the role of the Health Check Coordinator in linking 6- to 18- year old children who are enrolled in Health Choice with a CCNC primary care provider. The existing Health Check Coordinator job description lists the following "Primary Purpose of Position": "Coordinate the activities of Health Check and Health Choice and serve as a link with existing child health programs, local physicians, Medicaid agencies and professional organizations." [17] The Health Check Coordinator's specific role in linking 6- to 18-year olds enrolled in Health Choice with a CCNC primary care provider is not clear, yet responsibility for Health Choice clients is specified repeatedly in the Health Check Coordinator position description. This responsibility should be delineated more clearly in the Health Check Coordinator job description, "Policies and Procedures," and in the "Suggested Local Orientation Guide for New Health Check Coordinators." In addition, the CCNC networks need to be informed of the Health Check Coordinators' responsibilities related to Health Choice enrollees.

Recommendation 1.2: Improve Collaboration and Communication by Exploring Options for New Technology to Enhance Existing Information Systems

Explore the use of new, integrated, or enhanced information systems utilized by Department of Social Services caseworkers, Health Check Coordinators, and others involved with linking children to CCNC primary care providers. Well designed information systems that facilitate sharing of information among the those who link children with primary care providers is likely to improve linkage success. The information systems need to support and facilitate the linkage process, provide mechanisms for documenting contacts with clients and linkage attempts, and

monitor the relative success of alternative linkage strategies. Creating a more fully integrated information system that can be used and viewed by all involved with the linkage process is likely to improve communication and collaboration. One proposed approach is to add a primary care provider linkage tracking component to the State Eligibility Information System (SEIS) used by Department of Social Services case workers. This proposed tracking system would include a simple data entry screen to document attempted contacts with families (to link patients with primary care providers), including the date, time, reason for the contact, person initiating the contact, and result of the contact. If this component of the system were made available on line to all persons involved in the linkage process, a more coordinated effort to link patients with primary care providers could be developed. This proposed tracking system would also include on line real-time tracking reports and reminders that list enrollees not yet linked with primary care providers. These on line reports would be automatically updated whenever an enrollee is linked with a primary care provider. The proposed system module and data would also be used to generate reports to monitor and evaluate progress and the respective success of each strategy used to link children with primary care providers, and support continuous quality improvement efforts.

Link the State Eligibility Information System and Automated Information and Notification System databases to improve the efficiency and availability of information available to Health Check Coordinators. The Health Check Coordinators utilize the Automated Information and Notification System to identify and follow Medicaid-eligible children in their respective counties to determine which are receiving regular Health Check screenings, immunizations, and referrals for special health care problems. A link between AINS and SEIS is likely to facilitate a more coordinated approach by Health Check Coordinators so that outreach efforts to encourage appropriate utilization of health care services can occur simultaneously with efforts to link enrollees with primary care providers, avoiding duplication of effort. The information systems used to monitor the linkage of children with CCNC primary care providers should also include the 6- to 18-year olds who are enrolled in Health Choice.

II. Utilization of Primary Care Providers for Routine Well-Child and Preventive Visits

Children between the ages of 0- and 5-years of age, who were enrolled in North Carolina Health Choice (SCHIP), were transferred to the Community Care of North Carolina (CCNC) Medicaid managed care program. It was expected that these children could benefit from CCNC's enhanced primary care case management structure and services. The objectives of the Community Care of North Carolina (CCNC) Medicaid managed care models are "cost effectiveness, appropriate use of health care services, and improved access to primary preventive care." [18] These objectives are expected to be accomplished, in part, through the process of linking children in the CCNC networks with primary care providers who are responsible for coordinating care and providing primary care and preventive services. The efforts of primary care providers in achieving health access and quality of care goals can be enhanced with systematic implementation of evidence-based administrative support systems.

Performance improvement initiatives rely on measurement and monitoring of the constructs of interest, in this case, access to primary and preventive health care services for children enrolled in CCNC Medicaid. In 2001 the Centers for Medicare and Medicaid Services (CMS) recommended that Medicaid and SCHIP programs use a set of seven core measures to assess performance. Four of these measures are pediatric-focused: (1) well child visits in the first fifteen months of life; (2)

well child visits in the third, fourth, fifth, and sixth years of life; (3) use of appropriate medications for children with asthma; and, (4) children's access to primary care practitioners. [19, 23] These measures are based on the data specifications outlined by the Health Plan Employer Data and Information Set (HEDIS®). However, states can modify the HEDIS® measures as necessary, depending upon availability of data.

The Health Plan Employer Data and Information Set (HEDIS®), sponsored by the National Committee for Quality Assurance (NCQA), is a standardized set of performance measures that allows comparisons between health plans of performance in several key areas, such as well-child checks and immunization delivery. [3,14] These measures are widely used by employer-based managed care organizations, state Medicaid programs, and SCHIP plans, and can be used to compare the performance of Health Choice and CCNC Medicaid on several preventive services measures to estimate whether 0- to 5-year old children may achieve expected health benefits by transferring from Health Choice to CCNC Medicaid.

In this report, the utilization of primary care providers for routine well-child visits and preventive care was briefly assessed by performing a limited review of HEDIS® measures, comparing CCNC Medicaid programs with Health Choice, North Carolina fee-for-service Medicaid, national averages, and 2006 Medicaid HEDIS ninetieth-percentile benchmarks, as available. Additionally, interview data and program documents were reviewed to ascertain some of the strategies used by the CCNC Medicaid program and provider networks to encourage and facilitate appropriate utilization of well-child and preventive care services.

Finding 2: Utilization of Primary Care and Preventive Services

HEDIS Performance Measures

Children's access to primary care providers is generally defined within HEDIS® as the percentages of persons 12 to 24 months, 25 months to 6 years, 7 to 11 years, and 12 to 19 years of age who had a visit with a primary care provider during the measurement year. [19] For the 12 to 24 month old children, CCNC Medicaid and North Carolina Health Choice performance were nearly identical for this measure. Yet, for the other three age groups, North Carolina Health Choice measures exceeded the CCNC Medicaid measures by 1.2 to 5.7 percentage points. The CCNC Medicaid programs and NC Health Choice exceeded the national averages on this measure for each of the four age groups in calendar years 2003, 2004, and 2005 by approximately 2 to 11 percentage points. [19] Yet, the CCNC 2005 rates were 1.3 to 8.2 percentage points lower than the 2006 Medicaid HEDIS benchmarks (90^{th} percentile). [21] During 2005, almost 97 percent of the CCNC sampled enrollees, age 12 to 24 months, had a visit with a primary care practitioner during that year. The 2005 proportions drop to 88.5 percent for 25 month- to 6- year olds, 84.7 percent for 7- to 11- year olds, and 82.0 percent for 12- to 19- year olds. The three measures for children at least 25 months of age fall short of the goals set by the Health Choice program for federal fiscal year (FFY) 2007: 91 percent, 91 percent, and 86 percent respectively. [21] Refer to Appendix D for additional HEDIS® comparisons.

Well child visits in the first fifteen months of life is defined within HEDIS® as "the percentage of persons who turned 15 months old during the measurement year and who had the following number of well-child visits with a primary care practitioner during the first 15 months of life: zero; one;

two; three; four; five; six or more." [19] Within the CCNC networks during calendar year 2005, 62.8 percent of children had six or more well-child visits with a primary care practitioner during the first 15 months of life. [19] This measure exceeds that of Health Choice (39.0 percent) and the HEDIS® national mean of 45.0 percent, yet is less than the 2006 Medicaid HEDIS® ninetieth-percentile benchmark of 68.6 percent.

Well child visits in the third, fourth, fifth, and sixth years of life is defined within HEDIS® as "the percentage of persons who were three, four, fix, or six years of age during the measurement year who received one or more well-child visits with a primary care practitioner during the measurement year." [19] CCNC Medicaid (63.3 percent, 2005) exceeded NC Health Choice (58.2 percent) on this measure by 5.1 percentage points and the national HEDIS® mean (62.0 percent) by 1.3 percentage points. CCNC fell short of the 2006 Medicaid HEDIS® ninetieth percentile benchmark of 77.6 percent by 14.2 percentage points.

Adolescent well care visits is defined within HEDIS® as "the percentage of persons who were 12 to 19 years of age who had a least one comprehensive well-care visit with a primary care practitioner or an OB/GYN during the measurement year." [19] CCNC Medicaid did not meet the HEDIS® national mean values in calendar years 2003, 2004, or 2005. Only 32.2 percent of adolescents enrolled in CCNC Medicaid were reported to have received a well-care visit (as defined above) during calendar year 2005. In 2005 CCNC fell short of the 2006 Medicaid HEDIS® ninethieth percentile benchmark by 23.7 percentage points. Data were not available for North Carolina Health Choice for this measure.

Childhood immunization rates are defined within HEDIS® as the percentage of enrolled children who turned 2 years of age during the measurement year and who received all appropriate immunizations by their second birthday. The standard for "appropriate" immunizations has changed over time. The first combination rate (in 2004) included: four DtaP/DT, three IPV, one MMR, two H influenza type B (three in 2006), and three hepatitis B vaccines by the child's second birthday. The second combination rate (in 2004) included all immunizations in combination 1, and added one varicella (chicken pox) vaccine (VZV). In 2006, the combination also included four pneumococcal conjugate vaccines by the second birthday." [19] Childhood immunization rates in CCNC Medicaid were slightly lower than the national HEDIS® average in calendar year 2004, for combined rates I and II. The 2004 CCNC Child Immunization Rate II was 26.1 percentage points lower than the 2006 Medicaid benchmark of 82.7 percent. No comparable data are available for North Carolina Health Choice; however, Health Choice has established 2007 to 2009 performance objectives to increase immunization rates to 100 percent for 2 year olds and for children entering school.

Adolescent immunization rates are defined within HEDIS® as the percentage of children who have received the appropriate immunizations by age 13 years.[19] In 2004, Rate 1 included one additional MMR and three Hepatitis B vaccines. Rate 2 included the Rate 1 vaccines with the addition of one Varicella (chicken pox) vaccine. In calendar year 2004, CCNC Medicaid reported an Adolescent Immunization Rate I of 21.3 percent, less than half of the HEDIS® national mean value of 51.9 percent. [19] The 2004 CCNC Medicaid Adolescent Immunization Combination II rate of 1.9 percent is 59.6 percentage points lower than the 2006 Medicaid HEDIS® benchmark rate. No data are available for NC Health Choice for these measures.

The state of North Carolina began to roll out its state immunization registry in June 2005. At this time only statewide data are available. "According to the 2006 Child Health Report Card published by the NC Institute of Medicine, the immunization rate of all two-year old children is 85.2%. The rate for all children at school entry is 99.2%." [23]

In summary, the reported HEDIS data suggest that NC Health Choice exceeded CCNC Medicaid on some standard performance measures of well-child and preventive services, CCNC Medicaid performed better than Health Choice on others, and data were missing for Health Choice for some measures. For non-immunization measures CCNC Medicaid generally met or exceeded the national average performance levels, but often fell short of the 90th percentile benchmark levels. For immunization measures, CCNC Medicaid did not meet the 2006 Medicaid 90th percentile benchmark or even the national mean values. Health Choice immunization performance data were not available.

Health Status and Health Behaviors of Children in North Carolina Medicaid

Child Health Assessment and Monitoring Program

The Child Health Assessment and Monitoring Program (CHAMP) survey was developed in the fall of 2004 and implemented by the North Carolina State Center for Health Statistics in January 2005. [29] CHAMP measures the health characteristics of children ages 0 to 17. Eligible children for the survey are drawn each month from the BRFSS (Behavioral Risk Factor Surveillance System) random telephone survey of North Carolina residents aged 18 and older in households with telephones. [30] All adult respondents to BRFSS with children living in their households are invited to participate in the CHAMP survey. One child is randomly selected from each household, and the adult most knowledgeable about the health of the selected child is interviewed in a follow-up survey.

The CHAMP survey collects data on a variety of health-related topics, including breast feeding, early childhood development, access to health care services, oral health, mental health, physical health, nutrition, physical activity, family involvement, and parent opinion on topics such as tobacco and childhood obesity. [29] The Division of Medical Assistance requested that a question concerning health insurance be added to CHAMP to allow sorting of responses by Medicaid, Health Choice, and other insurers. [29] The CHAMP measures are important for monitoring the health of children in North Carolina, measuring performance of health programs, and planning strategies to improve health of populations. And, these data can be used to compare health status of children enrolled in North Carolina Medicaid and Health Choice. However, Medicaid data are not reported separately for CCNC Medicaid and fee-for-service Medicaid (smaller enrollment).

A sample of 2006 CHAMP survey results is displayed in Appendix E. These results help to identify key areas for health improvement in North Carolina children in general, as well as for children enrolled in North Carolina Medicaid and Health Choice. For example, more than 30 percent of Medicaid and Health Choice children evaluated were "overweight" (body mass index [BMI] between eighty-fifth and ninety-fourth percentile) or "obese" (BMI at or above ninety-fifth percentile). [29] Health Choice exceeded NC Medicaid for overweight or obese children by 3 percentage points. Several key contributing factors for overweight include an increased prevalence of sedentary lifestyles, increased TV or other screen time, and consumption of sugar-sweetened drinks. [5, 6, 11] Despite the need for lifestyle changes, 28 percent of Medicaid and 37 percent of

Health Choice respondents reported that they are *not* trying to encourage their children to engage in more physical activity or limit screen time. The health status and economic implications of overweight are staggering. Overweight and obese individuals are at increased risk of developing significant health problems, a few of which include heart disease, type 2 diabetes, stroke, several types of cancer, and osteoarthritis. [4, 6] Approximately one-third of responding parents of children in NC Medicaid indicated that their children smoke cigarettes, exceeding the Health Choice rate by 15.1 percentage points. [29] More than half (53.8%) of responding NC Medicaid parents report that their children do *not* use sunscreen with a Sun Protective Factor (SPF) of 15 or more when outside on a sunny summer day for more than 15 minutes between the hours of 10 a.m. and 4 p.m, compared with 36.8% of Health Choice parents. [29] Injuries that prevented children from participating in usual activities for at least a day during the previous month were reported by six percent of Medicaid parents and 7.3 percent of Health Choice parents. [29] Approximately 14 percent of Medicaid children missed at least 2 weeks of school in the prior 12 months because of injury or illness, compared with 16.8 percent of Health Choice children. [29] And, about one-third of children in North Carolina Medicaid (of responding parents) did not have a usual dental care provider, compared with 16.5 percent of Health Choice children. [29]

In general, for the select list of health behaviors listed in Appendix E and measured by the CHAMP survey, it appears that NC Health Choice parents generally reported healthier behaviors for their children than NC Medicaid parents. Many factors could account for these differences, including those which are independent of health care service delivery.

Systems to Promote Use of Primary Care and Preventive Services

The CCNC Medicaid and SCHIP programs have implemented a Medical Home Campaign to emphasize to patients the importance of having a "medical home" that provides preventive and primary health care services. [18] In addition, the CCNC Medicaid program formalizes this important concept by linking each enrolled child with a primary care provider. The North Carolina Health Check/EPSDT Program, administered by the Division of Medical Assistance, also supports this goal through efforts of 105 Health Check Coordinators who are based in 88 of 100 counties in the state. [17] The Health Check Coordinator responsibilities include using the Automated Information and Notification System (AINS) reports "to follow Medicaid eligible children to encourage their participation in preventive health screenings" and other preventive services. [17] The Health Check Coordinators are expected to make telephone calls and send letters, as needed, to remind patients of the need for well-child checks and to reschedule missed appointments. [17, 23] Yet, several key informant interview respondents mentioned that CCNC focuses on chronic diseases and does not actively focus on preventive services [Appendix C] because of the emphasis on cost containment and quality improvement in those enrollees with known disease. The lack of systems within CCNC to promote well-child and preventive care services seems to contradict one goal of transferring children from NC Health Choice to CCNC Medicaid, to improve well-child and preventive care for these children.

Recommendation 2: Utilization of Primary Care and Preventive Services

The focus within CCNC Medicaid on cost containment and chronic disease seems to be currently overemphasized when compared to the emphasis on preventive services. **Primary prevention must become a priority of the NC Medicaid program. The CCNC Medicaid networks,**

structured as enhanced primary care case-management programs, are uniquely positioned to expand their population-based strategies for improving access to primary and preventive health care services and thus improving the health of enrolled children. The "population health" approach generally entails the following steps: (1) identify the population of interest; (2) establish health services goals; (3) monitor utilization of health services and health status; (4) identify patients/enrollees who fail to meet specified process or outcome goals, and prioritize those who are likely to benefit from interventions; (5) apply interventions and outreach, stratifying approaches based on level of need or compliance; and, (6) evaluate the process of care, intermediate outcomes, and/or health outcomes. [7, 9, 31, 32] These steps are part of a cyclical process in performance improvement and have been demonstrated to be effective. [31]

In a population-based approach, efforts are made to reach the entire population of interest, not just those who come to clinics for well-child checks or other care. [7] If the goal is to increase the number of enrolled children who have at least six well-child checks in the first fifteen months of life, then a system must be established to monitor the number and dates of well-child checks each patient receives. For those children who fall behind the expected visit schedule, a stratified outreach process would be implemented. For example, initially a letter, signed by the primary care physician, may be mailed to the parent to remind him or her of the need to schedule and bring the child in for a well-child visit. If the letter reminder is not successful the second level of intervention, such as a personalized telephone call from the clinic nurse, case manager, or HCC, would be initiated. If the child does not then come to the clinic for a well-child check, then further outreach, such as a home visit by a case manager or HCC, may be done.

CCNC Medicaid has implemented a population model in its disease management programs. We recommend that CCNC Medicaid expand the capacity to implement population-based strategies and apply this model to primary care and prevention-based services to meet the overall goals of its program to benefit all children in the CCNC program, including those transferred in from Health Choice. This recommendation builds on the recommendations described in Section I of this report.

Recommendation 2.1: Explore Options for New Information Management Systems to Improve Primary Care and Prevention through Population-Based Strategies

Develop Integrated Information Systems to Support Population-Based Strategies:

Explore the use of new, integrated, or enhanced information systems utilized by Health Check Coordinators, CCNC case managers, and primary care providers to identify children in need of primary care and/or preventive services, document interventions, outcomes, and plans, and monitor outcomes, including overall compliance with primary care and prevention-based services. In Section I of this report we recommended the creation of a more fully integrated information system to improve communication and collaboration related to linking children with primary care providers. This involves linking data in the State Eligibility Information System (SEIS) with the Automated Information and Notification System (AINS). To improve compliance with primary care and preventive care services, we recommend the expansion of this previously outlined information system integration to also include the Clinical Management Information Systems (CMIS), North Carolina Medicaid and Health Choice claims history, North Carolina's new Immunization Registry, [25] and North Carolina's Child Health Assessment and Monitoring Program (CHAMP), which identifies risk factors in the population of interest.

Monitor Health Behaviors of All Enrolled Children:

Expand the administration of the CHAMP survey, or a subset of CHAMP survey questions, to parents of all North Carolina Medicaid and Health Choice children. Currently, CHAMP is administered to only a sample of parents of children in North Carolina. [29] Because the survey is relatively lengthy, we recommend that a subset of CHAMP survey questions be selected, according to evidence-based associations with health status and program goals, to be administered annually (for each enrolled child). This abbreviated "mini-CHAMP" survey could potentially focus on documenting the child's height and weight to calculate BMI (≥ 2 years of age), nutrition behaviors, physical activity behaviors, tobacco use, safety behaviors, and use of sunscreen. A new survey administration plan would need to be developed for the "mini-CHAMP" to reach all targeted participants, including those without telephones. For example, the survey might be administered during well-child checks by clinic staff, by Health Check Coordinators when implementing other outreach activities, by case managers, or according to strategies designed by each CCNC network or by CCNC administration (through collaborative strategic planning).

Systematically Identify Health Promotion and Primary Prevention Needs of Children:

Develop strategies to synthesize data from the "mini-CHAMP," health care claims (HEDIS® measures, such as compliance with well-child checks), the immunization registry, and Clinical Management Information Systems to identify enrolled children who are in need of primary care and preventive health care services. This system should include online real-time reports of enrollees, stratified by needs. For example, one report may list children who are not up-to-date with immunizations. Another report may include those children in need of well-child visits. Other reports may include children with multiple needs, such as immunizations, well-child visits, and coaching on health behaviors to facilitate addressing all identified preventive health needs efficiently.

Recommendation 2.2: Implement Population-Based Strategies and Improve Collaboration Among Primary Care Providers, Case Managers, and Health Check Coordinators to Improve Utilization of Primary Care and Preventive Services and Improve Health Behaviors and Health of Enrolled Populations

Collaborative and Coordinated Primary and Preventive Care:

Encourage the CCNC networks, through future contractual requirements, to work collaboratively with primary care practices and providers, case managers, and Health Check Coordinators in their geographic service areas to develop annual strategic plans to implement population-based strategies to improve the delivery of primary and preventive health care services and the health status of enrollees. These collaborative plans should include: (1) strategies for administering the mini-CHAMP survey to all enrollees in their respective networks; (2) algorithms for determining the types and level of outreach needed for enrollees based on health services needs, deficits, and health behaviors; (3) collaboration plans, involving primary care practices, case managers, and Health Check Coordinators, and, (4) plans for implementing office systems to support primary care and prevention goals. These office systems may include provider prompts, patient reminder systems, and other evidence-based strategies. [10]

III. Emerging Hybrid System of Financing Care for Low-Income Children

Finding 3: Emerging Hybrid System of Financing Care for Low-Income Children

Some states have experienced problems of coordination and equity because of the differences between Medicaid and SCHIP in processes such as enrollment. [13] North Carolina has worked to create an enrollment process and form(s) that are the same for Medicaid and Health Choice programs to reduce coordination issues. However, respondents of key informant interviews mentioned several problems experienced because of the separate SCHIP and Medicaid programs in North Carolina [Appendix C]. Some blended families have children enrolled in Medicaid and Health Choice, and other children who are uninsured because the biological children of both parents in the blended family do not qualify for either program. Parents with children in both programs, for example, 0- to 5-year olds in CCNC Medicaid, and 6- to 18-year olds in Health Choice, often have a difficult time understanding the differences in coverage between Medicaid and Health Choice. Data which quantify the number of families with children enrolled in both NC Medicaid and Health Choice are not currently available.

Both providers and clients seem confused by the multiple program names, such as CCNC, Carolina ACCESS, SCHIP, Health Choice, and individual CCNC network names. And, Health Check Coordinators answer families' questions about Medicaid, yet must refer families to Blue Cross & Blue Shield to answer questions about Health Choice. The problems associated with a lack of integrated databases were outlined previously.

Recommendation 3: Emerging Hybrid System of Financing Care for Low-Income Children

Because families are likely to have children enrolled in both Medicaid and Health Choice, it is important to improve coordination between the two programs, first by enhancing the integration of databases, and second by increasing the responsibility of Health Check Coordinators for Health Choice beneficiaries. Families need a consistent source for answers to their questions about benefits and services. Expanding the Health Check Coordinator role to provide the same types of information and services for Health Choice enrollees as currently provided for Medicaid recipients may help to alleviate some of the challenges associated with a tiered system of care.

Conclusion

North Carolina has taken significant action to help ensure appropriate and affordable coverage for low-income children; Medicaid and the Health Choice program are critical components of this effort. Providing access to the services available through the CCNC managed care network offers another opportunity to make health coverage more comprehensive for these children and to focus on preventive care, which is beneficial for both the individual and the state. The process of linking eligible children to these services should continue to be improved through enhanced collaboration and more streamlined data management systems.

References:

1. AccessCare, Programs & Initiatives [accessed on July 17, 2007 at: http://www.ncaccesscare.org/].

2. Adams EK, Bronstein JM, Florence CS. The impact of Medicaid primary care case management on office-based physician supply in Alabama and Georgia. Inquiry. 2003; 40:269-282.

3. Bardenheier B, Kong Y, Shefer A, Zhou F, Shih S. Managed care organizations' performance in delivery of childhood immunizations. Am J Manag Care. 2007; 13(4):193-200.

4. CDC, National Center for Chronic Disease Prevention and Health Promotion. Healthy youth! Childhood overweight. 2006 [Accessed on May 15, 2006 at: http://www.cdc.gov/healthyyouth/obesity/].

5. Ebbeling CB, Feldman HA, Osganian SK, Chomitz VR, Ellenbogen SJ, Ludwig DS. Effects of decreasing sugar-sweetened beverage consumption on body weight in adolescents: a randomized, controlled pilot study. Pediatrics. 2006; 117(3):673 – 680.

6. Friedman N, Fanning EL. Overweight and obesity: an overview of prevalence, clinical impact, and economic impact. Disease Management. 2004; 7(S1):S1-S6.

7. Halpern R, Boulter P. Population-based health care: definitions and applications. Tufts Managed Care Institute, November 2000 [accessed on July 28, 2007 at: https://www.thci.org/downloads/topic11_00.PDF]

8. Hurley RE, Freund DA, Taylor DE. Emergency room use and primary care case management: evidence from four Medicaid demonstration programs. AJPH. 1989; 79(7):843-847.

9. Ibrahim MA, Savitz LA, Carey TS, Wagner EH. Population-based health principles in managed care. Report prepared for Group Health Cooperative of Puget Sound.

10. Jacobson Vann JC, Szilagyi P. Patient reminder and recall systems to improve immunization rates. *The Cochrane Library, Cochrane Database Syst Rev. 2005*; [www.cochrane.org/reviews/en/ab003941.html].

11. Johnson S. Overweight in toddlers: motivating parents and caregivers. Medscape continuing education. 2006; [accessed on January 21, 2006 at: https://mir.ncaccesscare.org/Session/216-tBBDhF3v6HfsyesfAPyW/MessagePart/INBOX...].

12. Kenney G, Yee J. SCHIP at a crossroads: experiences to date and challenges ahead. Health Affairs. 2007; 26(2):356-369.

13. Kenney G, Chang DI. The State Children's Health Insurance Program: successes, shortcomings, and challenges. Health Affairs. 2004; 23(5):51-62.

14. National Committee for Quality Assurance, The State of Health Care Quality 2006, [accessed on July 24, 2007 at: http://web.ncqa.org/Default.aspx?tabid=447].

15. National Committee for Quality Assurance. National Medicaid Results for Selected 2000 HEDIS® and HEDIS/CAHPS® Measures. [accessed on July 24, 2007 at: http://www.ncqa.org/Programs/HEDIS/medicaidchildhood00.htm].

16. National Committee for Quality Assurance. Medicaid HEDIS 2006 Means, Percentiles and Ratios, [accessed on July 27, 2007 at: http://web.ncqa.org/Portals/0/HEDISQM/Programs/CompAud/MPR/HEDIS_2006_Means_Percentiles_Medicaid.pdf].

17. North Carolina Division of Medical Assistance, Health Check/EPSDT Program Policies and Procedures, July 16, 2007 [accessed on July 27, 2007 at: http://www.dhhs.state.nc.us/dma/healthcheck/hcmanual.htm].

18. North Carolina Division of Medical Assistance, Carolina Access Overview, [accessed on July 17, 2007 at http://www.dhhs.state.nc.us/dma/ca/caoverview.pdf].

19. North Carolina Division of Medical Assistance, DMA HEDIS Data (Health Plan Employer Data and Information Set), HEDIS Reporting for CY2005, [accessed on July 20, 2007 at: http://www.dhhs.state.nc.us/dma/ca/hedisreport2006.pdf].

20. North Carolina Division of Medical Assistance, Medicaid Eligibility, (accessed on August 9, 2007 at: http://www.dhhs.state.nc.us/dma/basicmedelig.pdf).

21. North Carolina Division of Medical Assistance, North Carolina Medicaid, Carolina ACCESS Statewide Enrollment Reports, 2006 and 2007; [accessed on July 28, 2007 at: http://www.ncdhhs.gov/dma/ca/enroll/enroll.htm].

22. North Carolina Division of Medical Assistance, North Carolina Eligibility Information – Authorized Eligibles by County, reports by month and year; [accessed on July 28, 2007 at: http://www.ncdhhs.gov/dma/elig/elig.html].

23. North Carolina Division of Medical Assistance, Draft: Framework for the Annual Report of the State Children's Health Insurance Plans Under Title XXI of the Social Security Act. July 2007 (draft annual report).

24. North Carolina Division of Medical Assistance, "Quality, Evaluation, and Health Outcomes (QEHO) Initiatives," http://www.dhhs.state.nc.us/dma/ca/qehoinitiatives.html.

25. North Carolina Division of Public Health, Women & Child Health Section, Immunize North Carolina, North Carolina Immunization Registry, [accessed on July 23, 2007 at: http://www.immunizenc.com/NCIR.htm].

26. Action for Children North Carolina. Press Release, August 1, 2007, [assessed on December 10, 2007 at http://www.ncchild.org/content/view/683/149/].

27. North Carolina Institute of Medicine. NC Health Choice: 2003, [accessed on December 19 at: http://www.nciom.org/pubs/child.html].

28. North Carolina Oral Health Section, Department of Health and Human Services, Division of Public Health. Into the Mouth of Babes, NC Dental Screening & Varnish Project, [accessed on August 7, 2007 at: http://www.communityhealth.dhhs.state.nc.us/dental/Into_the_Mouths_of_Babes.htm].

29. North Carolina State Center for Health Statistics, Child Health Assessment and Monitoring Program, [accessed on July 23, 2007 at: http://www.schs.state.nc.us/SCHS/champ/index.html].

30. North Carolina State Center for Health Statistics, Behavioral Risk Factor Surveillance System (BRFSS), [accessed on July 25, 2007 at: http://www.schs.state.nc.us/SCHS/brfss/].

31. O'Connor PJ, Pronk NP. Integrating population health concepts, clinical guidelines, and ambulatory medical systems to improve diabetes care. J Ambulatory Care Manage, 1998; 21(1):67-73.

32. Rivo ML. It's time to start practicing population-based health care. Family Practice Management. 1998; 5(6); (accessed on July 31, 2007 at: http:www/aafp.org/fpm/980600fm/popbased.html.).

33. Roberts MW, Vann WF. Access to dental care for young children in North Carolina: history and current status of workforce issues. NC Med J. 2005; 66(6):452-455.

Acknowledgments: The authors would like to thank Carrie Hamby for performing key informant interviews, Jessica Dorrance for editorial assistance, and Charles Dewar (NC DMA), Cinnamon Narron (NC DMA), Donna Brown (UNC-Health Care System), Dr. William Lawrence (NC DMA), and Becky Brown (NC DMA) for their diligent efforts to provide us with reports and data that have been integral to the development of presented findings.

Appendix A
North Carolina Medicaid
Enrollment and Linkage with CCNC Primary Care Provider, July 2006 and July 2007

County Name	July 2006 Medicaid Eligibles	July 2006 Managed Care Eligibles	July 2006 Managed Care Enrollment	July 2006 MC Enrollment % of MC Eligibles	July 2007 Medicaid Eligibles	July 2007 Managed Care Eligibles	July 2007 Managed Care Enrollment	July 2007 MC Enrollment % of MC Eligibles
Alamance	17,991	16,321	11,396	69.82%	18,525	16,835	12,849	76.32%
Alexander	4,797	4,352	3,252	74.72%	4,798	4,346	3,388	77.96%
Alleghany	1,769	1,588	1,191	75.00%	1,802	1,631	1,357	83.20%
Anson	5,642	5,043	3,789	75.13%	5,219	4,631	3,630	78.38%
Ashe	4,152	3,733	2,576	69.01%	4,167	3,736	2,735	73.21%
Avery	2,443	2,222	1,576	70.93%	2,344	2,139	1,531	71.58%
Beaufort	8,911	8,184	6,029	73.67%	8,782	8,073	5,925	73.39%
Bertie	5,229	4,763	3,431	72.03%	5,075	4,613	3,409	73.90%
Bladen	7,963	7,277	5,687	78.15%	7,825	7,131	5,734	80.41%
Brunswick	12,785	11,934	7,611	63.78%	12,980	12,091	8,815	72.91%
Buncombe	30,332	27,663	19,528	70.59%	30,549	27,805	22,327	80.30%
Burke	13,495	12,184	8,911	73.14%	13,234	11,938	9,191	76.99%
Cabbarus	17,626	16,198	13,199	81.49%	18,053	16,573	14,454	87.21%
Caldwell	12,295	10,986	9,113	82.95%	12,488	11,146	9,664	86.70%
Camden	831	773	542	70.12%	831	771	558	72.37%
Carteret	7,156	6,547	5,609	85.67%	7,087	6,471	5,877	90.82%
Caswell	4,227	3,792	2,266	59.76%	4,111	3,667	2,011	54.84%
Catawba	20,039	18,326	13,293	72.54%	19,618	17,867	13,694	76.64%
Chatham	5,683	5,161	4,158	80.57%	5,818	5,260	4,479	85.15%
Cherokee	4,293	3,837	2,604	67.87%	4,273	3,807	2,764	72.60%
Chowan	2,879	2,651	2,101	79.25%	2,911	2,665	2,138	80.23%

Clay	1,440	1,271	942	74.11%	1,412	1,241	1,024	82.51%
Cleveland	18,604	16,711	12,888	77.12%	18,652	16,772	13,416	79.99%
Columbus	14,201	13,211	9,847	74.54%	14,075	13,104	10,566	80.63%
Craven	12,107	11,241	7,916	70.42%	12,055	11,189	8,387	74.96%
Cumberland	45,515	43,533	35,034	80.48%	46,031	43,954	35,282	80.27%
Currituck	1,897	1,768	1,241	70.19%	1,950	1,809	1,365	75.46%
Dare	2,492	2,330	1,706	73.22%	2,490	2,338	1,845	78.91%
Davidson	21,038	19,047	15,947	83.72%	22,057	20,026	17,575	87.76%
Davie	3,966	3,599	2,854	79.30%	3,850	3,455	2,801	81.07%
Duplin	9,960	9,183	7,297	79.46%	9,760	9,008	7,686	85.32%
Durham	30,160	28,345	20,279	71.54%	29,183	27,403	19,810	72.29%
Edgecombe	14,652	13,591	11,390	83.81%	14,415	13,382	11,265	84.18%
Forsyth	42,159	39,498	32,166	81.44%	42,724	39,938	34,312	85.91%
Franklin	8,546	7,825	5,693	72.75%	8,625	7,891	5,696	72.18%
Gaston	31,386	28,391	20,060	70.66%	31,937	28,869	21,097	73.08%
Gates	1,594	1,458	1,113	76.34%	1,536	1,403	1,122	79.97%
Graham	1,674	1,495	1,164	77.86%	1,700	1,494	1,244	83.27%
Granville	7,177	6,635	5,174	77.98%	7,286	6,715	5,404	80.48%
Greene	3,643	3,383	2,691	79.54%	3,704	3,452	2,839	82.24%
Guilford	58,288	53,979	34,125	63.22%	58,740	54,376	33,657	61.90%
Halifax	14,873	13,739	11,553	84.09%	14,510	13,356	11,153	83.51%
Harnett	15,384	14,300	11,021	77.07%	15,214	14,184	11,573	81.59%
Haywood	8,815	7,933	4,449	56.08%	8,377	7,502	5,345	71.25%
Henderson	11,103	9,903	7,279	73.50%	10,796	9,575	7,510	78.43%
Hertford	5,861	5,343	3,560	66.63%	5,789	5,275	3,543	67.17%
Hoke	7,036	6,691	5,410	80.85%	6,870	6,527	5,541	84.89%
Hyde	1,107	1004	407	40.54%	1,081	967	501	51.81%
Iredell	15,908	14,576	10,316	70.77%	16,139	14,755	11,424	77.42%

Jackson	4,370	3,987	2,315	58.06%	4,381	4,012	2,513	62.64%
Johnston	21,893	20,246	14,558	71.91%	22,684	21,034	15,849	75.35%
Jones	1,733	1,561	928	59.45%	1,713	1,528	998	65.31%
Lee	8,350	7,762	5,600	72.15%	8,577	7,994	6,266	78.38%
Lenoir	12,674	11,781	9,506	80.69%	12,360	11,451	9,711	84.80%
Lincoln	8,664	7,807	4,096	52.47%	8,738	7,862	5,257	66.87%
Macon	4,522	4,072	3,091	75.91%	4,366	3,927	3,220	82.00%
Madison	3,533	3,186	2,092	65.66%	3,483	3,140	2,198	70.00%
Martin	5,494	4,987	3,484	69.86%	5,417	4,919	3,451	70.16%
McDowell	6,965	6,224	4,531	72.80%	6,868	6,106	4,604	75.40%
Mecklenburg	89,518	84,739	57,292	67.61%	89,457	84,473	67,586	80.01%
Mitchell	2,624	2,331	1,194	51.22%	2,557	2,275	1,181	51.91%
Montgomery	5,399	4,939	3,288	66.57%	5,404	4,923	3,750	76.17%
Moore	9,595	8,708	6,228	71.52%	9,492	8,562	6,443	75.25%
Nash	14,875	13,763	9,410	68.37%	14,547	13,402	9,176	68.47%
New Hanover	20,991	19,427	13,325	68.59%	20,817	19,241	14,159	73.59%
Northhampton	5,326	4,813	3,121	64.85%	5,274	4,738	3,095	65.32%
Onslow	14,720	13,986	11,384	81.40%	14,677	13,908	11,742	84.43%
Orange	8,794	8,147	4,844	59.46%	8,690	8,008	5,090	63.56%
Pamlico	1,930	1,776	1,312	73.87%	1,885	1,716	1,276	74.36%
Pasquotank	6,556	6,014	4,707	78.27%	6,478	5,931	4,874	82.18%
Pender	6,520	5,977	4,507	75.41%	6,431	5,900	4,731	80.19%
Perquimans	2,079	1,900	1,281	67.42%	2,131	1,960	1,198	61.12%
Person	5,961	5,289	3,440	65.04%	5,989	5,303	3,590	67.70%
Pitt	21,399	20,213	16,298	80.63%	21,444	20,258	16,973	83.78%
Polk	2,080	1,811	1,348	74.43%	2,056	1,778	1,424	80.09%
Randolph	19,463	17,737	13,475	75.97%	19,926	18,195	14,337	78.80%
Richmond	10,598	9,742	6,857	70.39%	10,438	9,590	7,058	73.60%

Robeson	34,123	32,309	24,695	76.43%	34,169	32,291	24,495	75.86%
Rockingham	15,655	14,016	9,720	69.35%	15,796	14,132	10,118	71.60%
Rowan	18,568	16,750	11,618	69.36%	18,886	16,939	12,901	76.16%
Rutherford	11,232	10,144	7,651	75.42%	11,231	10,108	8,062	79.76%
Sampson	13,015	12,046	9,028	74.95%	13,225	12,275	9,773	79.62%
Scotland	9,830	9,170	6,983	76.15%	9,839	9,169	7,025	76.62%
Stanly	8,066	7,179	5,016	69.87%	8,268	7,369	5,612	76.16%
Stokes	6,017	5,456	3,754	68.80%	5,841	5,236	3,644	69.60%
Surry	12,010	10,735	8,323	77.53%	12,130	10,815	8,904	82.33%
Swain	2,530	2,315	965	41.68%	2,631	2,411	1,091	45.25%
Transylvania	4,088	3,665	2,751	75.06%	3,931	3,526	2,882	81.74%
Tyrell	758	691	554	80.17%	769	694	564	81.27%
Union	14,909	14,022	11,818	84.28%	15,311	14,403	12,564	87.23%
Vance	12,011	11,219	8,428	75.12%	11,885	11,106	8,457	76.15%
Wake	61,627	58,147	41,978	72.19%	61,145	57,616	45,617	79.17%
Warren	4,600	4,254	2,657	62.46%	4,603	4,222	2,574	60.97%
Washington	3,485	3,266	2,327	71.25%	3,470	3,245	2,438	75.13%
Watauga	3,171	2,835	2,021	71.29%	3,120	2,801	2,153	76.87%
Wayne	20,352	18,939	15,144	79.96%	20,213	18,750	15,403	82.15%
Wilkes	11,221	10,214	7,110	69.61%	11,240	10,207	7,658	75.03%
Wilson	14,706	13,669	10,438	76.36%	14,186	13,154	10,336	78.58%
Yadkin	4,718	4,235	2,921	68.97%	4,686	4,188	3,003	71.70%
Yancey	3,054	2,800	1,800	64.29%	2,959	2,690	1,846	68.62%
TOTAL	**1,217,496**	**1,124,519**	**822,596**	**73.15%**	**1,217,262**	**1,122,637**	**868,383**	**77.35%**

Source: [21] North Carolina Division of Medical Assistance, http://www.ncdhhs.gov/dma/ca/enroll/enroll.htm.

Appendix B
North Carolina Health Choice
June 2007 Enrollment with CCNC Primary Care Provider

County Name	NCHC Eligibles	CCNC Enroll	Percent CCNC Enrollment	County Name	NCHC Eligibles	CCNC Enroll	Percent CCNC Enroll
Alamance	1,820	609	33.46%	**Johnston**	2,536	604	23.82%
Alexander	605	108	17.85%	**Jones**	198	59	29.80%
Alleghany	203	44	21.67%	**Lee**	853	242	28.37%
Anson	402	99	24.63%	**Lenoir**	1,022	351	34.34%
Ashe	558	124	22.22%	**Lincoln**	913	211	23.11%
Avery	382	96	25.13%	**Macon**	617	187	30.31%
Beaufort	783	239	30.52%	**Madison**	381	74	19.42%
Bertie	350	103	29.43%	**Martin**	406	90	22.17%
Bladen	666	199	29.88%	**McDowell**	637	180	28.26%
Brunswick	1,511	363	24.02%	**Mecklenburg**	8,505	969	11.39%
Buncombe	3,477	814	23.41%	**Mitchell**	305	20	6.56%
Burke	1,367	293	21.43%	**Montgomery**	668	202	30.24%
Cabbarus	1,883	639	33.94%	**Moore**	1,141	286	25.07%
Caldwell	1,146	382	33.33%	**Nash**	1,347	376	27.91%
Camden	133	31	23.31%	**New Hanover**	1,896	416	21.94%
Carteret	855	197	23.04%	**Northhampton**	290	87	30.00%
Caswell	330	45	13.64%	**Onslow**	1,522	509	33.44%
Catawba	2,234	304	13.61%	**Orange**	918	209	22.77%
Chatham	659	130	19.73%	**Pamlico**	187	53	28.34%
Cherokee	523	148	28.30%	**Pasquotank**	642	175	27.26%
Chowan	197	58	29.44%	**Pender**	778	246	31.62%
Clay	195	46	23.59%	**Perquimans**	166	29	17.47%
Cleveland	1,189	305	25.65%	**Person**	532	95	17.86%
Columbus	1,080	325	30.09%	**Pitt**	1,687	596	35.33%
Craven	1,091	435	39.87%	**Polk**	267	51	19.10%
Cumberland	3,325	706	21.23%	**Randolph**	2,020	479	23.71%
Currituck	237	48	20.25%	**Richmond**	864	258	29.86%
Dare	392	64	16.33%	**Robeson**	2,454	547	22.29%
Davidson	2,266	678	29.92%	**Rockingham**	1,257	165	13.13%
Davie	524	144	27.48%	**Rowan**	1,680	506	30.12%
Duplin	1,071	348	32.49%	**Rutherford**	925	253	27.35%
Durham	2,884	373	12.93%	**Sampson**	1,221	354	28.99%
Edgecombe	875	212	24.23%	**Scotland**	636	179	28.14%
Forsyth	3,936	1,161	29.50%	**Stanly**	804	176	21.89%

Franklin	930	181	19.46%	**Stokes**	609	109	17.90%
Gaston	2,372	529	22.30%	**Surry**	1,384	475	34.32%
Gates	149	38	25.50%	**Swain**	276	33	11.96%
Graham	232	65	28.02%	**Transylvania**	466	141	30.26%
Granville	706	228	32.29%	**Tyrell**	75	23	30.67%
Greene	371	108	29.11%	**Union**	2,057	453	22.02%
Guilford	4,418	312	7.06%	**Vance**	952	230	24.16%
Halifax	767	265	34.55%	**Wake**	7,259	1,198	16.50%
Harnett	1,580	382	24.18%	**Warren**	425	101	23.76%
Haywood	870	245	28.16%	**Washington**	249	72	28.92%
Henderson	1,444	380	26.32%	**Watauga**	476	144	30.25%
Hertford	324	78	24.07%	**Wayne**	1,948	644	33.06%
Hoke	585	184	31.45%	**Wilkes**	1,129	340	30.12%
Hyde	114	4	3.51%	**Wilson**	1,294	378	29.21%
Iredell	1,508	213	14.12%	**Yadkin**	550	117	21.27%
Jackson	520	118	22.69%	**Yancey**	403	120	29.78%
				TOTAL	**115,866**	**27,012**	**23.31%**

Source: North Carolina Division of Medical Assistance, North Carolina Health Choice office, July 17, 2007.

Appendix C
Key Informant Interviews—Brief Summary of Responses

OUTREACH AND ENROLLMENT INTO CCNC AND LINKAGE WITH PRIMARY CARE PROVIDERS

Perceived outcomes of the linkage with primary care providers process

- An estimated 35,000 of the 110,000 6- to 18- year old Health Choice children may have enrolled with a CCNC network, just during March and April, 2007.

Strategies used to facilitate linkage of children with CCNC primary care providers

- The North Carolina Division of Medical Assistance sent each HCC a list of children who were being transferred from Health Choice to CCNC Medicaid. These lists were to be used by HCCs when following up with families who needed well-child checks or other services.
- The North Carolina Division of Medical Assistance created a process by which primary care providers (practices) could sign up children who were already their patients by completing and faxing in an enrollment (linkage) form.
- North Carolina Medicaid enrollees are informed about the PCP/medical home concept through brochures.
- HCCs in some counties made telephone calls to patients to inform them about and encourage them to enroll with a CCNC primary care provider. Some followed up with letters and/or home visits.
- At least one network collaborated with other involved agencies (social services, health departments, health care providers) to link clients with PCPs.
- Some networks worked to educate the DSS caseworkers about CCNC.
- One network covered part of the DSS caseworker salaries to pay for the time that the caseworkers spent educating clients about the CCNC network.
- Some people involved in the linkage process reminded the practices of the $2.50 per member per month (PMPM) management fee as an incentive to assist with the linkage process.
- Some case managers went to clinics to encourage them to assist with the linkage process.

Perceived barriers to linking children with CCNC primary care providers

General process:

- There may be some reluctance to link clients with primary care providers because if a patient shows up at a different practice it may be time-consuming to switch the PCP assignment.
- Because the linkage process is part of the routine process of re-enrollment for 6- to 18- year olds, it may take up to 12 to 18 months to get children linked with PCPs.

DMA:

- The mailing to clients from DMA regarding the transition included too much information.

CCNC networks:

- Some CCNC networks may not be informed about the process of linking children with PCPs. Some networks may not understand the role of HCCs.

Department of Social Services:

- The county Departments of Social Services (DSS) caseworkers do not directly report to the North Carolina Division of Medical Assistance (NCDMA) and/or CCNC networks. This reduces their responsibility and accountability for linking eligible children with PCPs. In addition, the CCNC networks and NCDMA do not have authority to determine the messages delivered to eligible recipients and their parents about the medical home concept.
- Concern was expressed by several interviewees that some DSS caseworkers may believe they are advocating for Medicaid and Health Choice eligibles if they encourage them to "exempt out" of the CCNC primary care provider linkage. Some DSS case workers may believe that the "medical home" concept limits choices for patients, and may view the PCP as more of a gatekeeper than a care coordinator. Also, "exempting" a client out of managed care may be quicker for the case worker.
- DSS caseworkers may be overworked.
- The process of linking clients with PCPs is viewed as time-consuming and extra work by some. So, it is believed that some DSS caseworkers just wait for eligibility to expire rather than link clients with PCPs.
- CCNC needs to get DSS supervisors to "buy into" the CCNC managed care concept. The supervisors need to understand the program, its benefit for patients, and the potential benefits for the budget. Then perhaps supervisors could build linkage goals into employee evaluations.
- There may be a lack of sufficient training of DSS caseworkers regarding CCNC and the process of linking clients with PCS. Some networks do this, yet this was considered a deficit.

Health Check Coordinators:

- The HCCs often do not have current contact information for clients and need to request this from the local CCNC network (from CMIS).
- The role of HCCs in the process of linking 6- to 18- year olds with PCPs is not clear. Some believe that HCCs are not responsible for working with Health Choice children. However, this seems to contradict the HCC job description, which mentions Health Choice in many sections. This issue needs to be clarified.
- HCCs have other roles and priorities.

Primary care practices:

- There may have been a lack of practice-level education about the 6- to 18- year old linkage with CCNC primary care providers.
- Physicians' offices are generally overwhelmed with paperwork; so, another form to complete to assist with the PCP linkage process may not be welcome. Some practices may not believe it is their responsibility to "enroll people in a health insurance program."

Medicaid and Health Choice recipients:

- Patients may not understand what a medical home is and what the benefits of having one are.
- Some parents/patients don't understand that it is important for a primary care physician to know what is going on medically with them (if care occurs with multiple providers).

Information systems:

- Information systems are problematic. Different people involved in the process of working with Medicaid clients see different information and systems. DSS has real-time data, yet others who work with clients are not able to access the same real-time data.

- Privacy issues may affect which information is available to which agencies involved with the clients.
- Information systems often don't talk with each other.
- The 6- to 18- year old Health Choice children are in a Title 21 program, so access to data is limited, making it difficult to target enrollment/linkage.

Recommendations:

- Establish a more direct reporting relationship between the county Departments of Social Services and CCNC so that the roles and responsibilities of DSS caseworkers in the linkage process are more targeted and deliberate.
- Separate the linkage process from eligibility determination and provide more opportunities to educate patients/parents. Provide patients/parents with the opportunity to make a more informed decision.
- Re-create the DSS managed care positions.
- Make the exemption process more onerous so that it is not easier to exempt a client than to link a child with a PCP.
- Automatically enroll clients with CCNC networks and require action to disenroll them from the managed care program. Now, disenrollment or exemption is the default for disabled children and foster children. This should be changed.
- The switch from Health Choice to Medicaid (CCNC) needs to occur at the state level rather than the county level, given that the state has the information about the clients.
- Work more closely with the school systems; they identify children at 200 percent FPL to enroll them in the free lunch program. Perhaps they could assist with Health Choice enrollment.

Tracking system at the state or county level to monitor who has and has not been linked with a primary care provider, and to facilitate the linkage process.

- There is not a tracking system to monitor the linkage of children with primary care providers; frequencies are computed.
- Different information systems have different information (e.g., contact information); so, employees need to work between several sources of data to obtain what is needed.
- CMIS: some HCCs want access to this database.
- AINS: does not have a good mechanism for documenting notes or comments, and runs a month behind SEIS (the DSS enrollment database). AINS may contain out-of-date phone numbers.
- Creating a link between AINS and SEIS was suggested.
- It is difficult to obtain information about the Health Choice children. Medicaid "pre-populates" CMIS with claims data, but they don't have this data for Health Choice children.

UTILIZATION OF PRIMARY CARE PROVIDERS FOR ROUTINE WELL-CHILD AND PREVENTIVE VISITS

Strategies used by the North Carolina CCNC Medicaid program to facilitate patient use of primary care, well-child services, and preventive services

- The focus of CCNC is on chronic disease, so preventing complications of chronic disease is a main focus. Others mentioned that the networks are "disease-based" and that they do disease management.
- Some working groups are looking at strategies to promote more patient education in the eligibility process.
- One HCC does queries of the AINS system and contacts patients who need follow-up by telephone or letter.
- One HCC also does follow-up for the CCNC emergency department (ED) utilization initiative, calling patients who have been seen in the ED to encourage follow-up with the PCP.
- One network indicated that they do not focus on preventive services.
- One network collaborates with the local health department.
- Some HCCs work with the networks to help get children in for well-child visits if they miss their appointments.
- The involvement of case managers in the CCNC networks is viewed as making the networks more humane and nurturing. This is felt to encourage patients to participate in the program.
- One HCC indicated that it is her role to educate the patients on how to navigate the system.
- One network offers some educational programs through local clinics.

Strategies to facilitate well-child and prevention efforts

- DSS caseworkers and HCCs should develop collaborative strategies.
- Coverage should be increased for a nutritionist's time.

ACCESS TO CARE AND PROVIDER REIMBURSEMENT

Provider (physician) participation in Medicaid

- There are perceived to be adequate numbers of providers for the pediatric population. It is believed that before Carolina ACCESS there were problems with provider participation, but now most providers are accepting Medicaid patients and have dropped limits on the number of Medicaid patients they care for. There may be a few geographic areas with little access.
- Low reimbursement levels are viewed to be a problem, yet some providers believe that if they care for pediatric patients they are likely to see Medicaid patients.

Provider (physician) participation in Health Choice

- There do not seem to be provider participation problems with Health Choice.
- At the same time that DMA changed the CCNC enrollment for 0- to 5- year olds (January 1, 2006), the provider reimbursement rates for Health Choice were decreased, initially to 115 percent of Medicaid, and 6 months later to the level of Medicaid rates. There has not been sufficient time to see if this has had a negative effect of provider participation.

Dental participation in Medicaid and Health Choice

- Access to dental providers is viewed as a major problem. One respondent indicated that the dental resources are poor to none in one county, and most dentists see none to a few Medicaid or Health Choice patients.
- Primary care physicians are allowed to perform dental varnishes in North Carolina because of the dental access issues.
- Advocacy for improved dental reimbursement is ongoing. Reimbursement levels are up to about 60 percent of usual and customary charges. It is generally agreed that 65 to 70 percent of usual and customary charges covers the dentists' costs.
- One respondent felt that at least $60 per hour is needed just to support the 4 full time equivalent support staff that are needed in a dentist's office. And, the only way general dentists earn a living is by doing procedures such as fillings.
- Reimbursement is the major driver of participation. There may also be misconceptions of Medicaid patients.
- In eastern North Carolina the Division of Public Health is piloting a program that creates a "dental home" for patients similar to a medical home.
- It is felt that there aren't enough dentists to participate.
- A dental school is trying to train pediatricians to screen patients to help alleviate access problems.
- There may be perceptions that the younger children have behavior management problems.
- There may be concerns that Medicaid families may have a lot of family members in the waiting rooms.
- One recommendation was to create Medicaid dental clinics where dentists periodically volunteer for a half day rather than try to incorporate Medicaid patients into existing practices.
- It was felt that dental students can complete dental training with minimal care for pediatric patients.
- There have been reports that dentists will no longer be willing to see Health Choice patients now that the reimbursement rates for them match Medicaid rates.

NORTH CAROLINA'S EMERGING HYBRID SYSTEM OF FINANCING CARE FOR LOW-INCOME CHILDREN

Implications for patients/enrollees and providers

- Example: a blended family had one child in Medicaid, one child enrolled in Health Choice, and a third child with no health insurance because the third child is a biological child of both parents in the blended family.
- Some patients prefer Health Choice because of the Medicaid stigma; in Health Choice the patients receive a regular insurance card instead of the bigger Medicaid card.
- Example: if one family member is enrolled in Medicaid and another family member is enrolled in Health Choice, the HCC answers questions pertaining to Medicaid but refers the family to the DSS caseworker to answer questions about Health Choice.
- Example of communication challenges: if an HCC has a patient with a question about Health Choice, the HCC has to call the same customer service line as others; and, the Blue Cross Blue Shield staff may not want to talk with the HCC, only with the client or parent.

- It is believed that physician choice is better in Health Choice, so families with children enrolled in both programs may see different health care providers.
- Some parents don't understand the difference between Health Choice and Medicaid. Some prefer Health Choice because of greater provider choices and the lack of limits on referrals. Some families may prefer Medicaid because of more extension coverage and no copayments.
- Families may have a hard time understanding why one child qualifies for some benefits and another child in the same family does not qualify for the same set of benefits.
- The multiplicity of program names makes it difficult for people to understand the programs (CCNC, individual network names, Carolina ACCESS, etc.). The confusion may also make it hard for DSS caseworkers to sell the program.

Appendix D
HEDIS Measures: North Carolina Medicaid, North Carolina Health Choice, and National Benchmarks

D-1. HEDIS Measures of Children's Access to Primary Care Providers: Comparisons Between North Carolina Medicaid, Health Choice, and National Benchmarks [% of children with visit to PCP during the measurement year]

HEDIS Indicator	Year	CA II	CA I	NC Medicaid HMO	NC Fee-for-service Medicaid	Total NC Medicaid	NC Health Choice	2006 Medicaid HEDIS 90th percentile	HEDIS Mean (national)
12 to 24 Months	CY 2005	96.9%	98.6%	96.3%	96.5%	96.9%	95.6%	98.2%	92.0%
	CY 2004	96.5%	98.2%	85.5%	95.2%	96.2%	96.4%		92.0%
	CY 2003	95.9%	97.6%	94.7%	95.0%	95.9%	95.8%		90.9%
25 Months to 6 Years	CY 2005	88.5%	92.0%	75.9%	86.4%	88.0%	90.1%	91.5%	81.6%
	CY 2004	87.5%	90.2%	64.9%	84.4%	86.8%	88.7%		81.5%
	CY 2003	87.4%	88.5%	73.3%	85.0%	86.6%	90.9%		79.9%
7–11 Years	CY 2005	84.7%	88.5%	62.6%	83.7%	84.4%	90.3%	92.0%	82.5%
	CY 2004	84.8%	85.4%	65.8%	83.0%	83.9%	90.5%		81.7%
	CY 2003	86.3%	82.8%	68.6%	80.2%	82.5%	89.9%		80.2%
12–19 Years	CY 2005	82.0%	85.3%	62.7%	81.9%	84.4%	85.7%	90.2%	79.1%
	CY 2004	82.4%	83.0%	65.5%	81.7%	83.9%	85.8%		Not available
	CY 2003						85.4%		

D-2. HEDIS Measures of Well Child Visits in the First 15 Months of Life: Comparisons Between North Carolina Medicaid, Health Choice, and National Benchmarks

HEDIS Indicator	Year	CA II	CA I	NC Medicaid HMO	NC Fee-for-service Medicaid	Total NC Medicaid	NC Health Choice	2006 Medicaid HEDIS 90th percentile	HEDIS Mean (national)
No Visits	CY 2005	2.2%	0.9%	3.7%	3.0%	2.5%	8.0%		6.2%
	CY 2004	2.1%	0.8%	9.0%	3.6%	2.7%	0.0%		6.4%
	CY 2003	3.6%	1.6%	4.1%	4.5%	3.6%	9.3%		6.9%
One Visit	CY 2005	1.9%	1.4%	6.8%	3.3%	2.5%	0.0%		4.2%
	CY 2004	2.0%	1.4%	10.9%	3.7%	2/8%	0.0%		4.0%
	CY 2003	1.4%	2.2%	10.3%	4.1%	3.0%	0.0%		5.0%
Two Visits	CY 2005	2.2%	1.7%	14.1%	4.8%	3.4%	4.0%		5.1%
	CY 2004	2.2%	2.5%	13.2%	5.0%	3.7%	0.0%		5.2%
	CY 2003	2.3%	3.5%	14.4%	5.5%	4.2%	3.1%		6.1%
Three Visits	CY 2005	4.1%	4.7%	12.0%	7.6%	5.8%	6.0%		7.9%
	CY 2004	3.9%	5.0%	22.6%	8.3%	6.4%	12.5%		8.1%
	CY 2003	4.4%	5.9%	24.6%	9.0%	7.1%	3.1%		8.3%
Four Visits	CY 2005	8.1%	9.1%	23.0%	12.7%	10.3%	18.0%		12.9%
	CY 2004	8.1%	9.8%	25.5%	12.9%	10.8%	20.8%		13.0%

	CY 2003	9.6%	11.5%	28.2%	14.7%	12.6%	25.0%		12.8%
Five Visits	CY 2005	18.7%	22.0%	17.8%	19.9%	19.5%	24.0%		18.7%
	CY 2004	18.9%	19.7%	12.7%	20.2%	19.6%	33.3%		18.8%
	CY 2003	22.5%	21.8%	13.9%	21.7%	21.9%	37.5%		18.6%
Six or More Visits	CY 2005	62.8%	60.3%	22.5%	48.6%	56.0%	39.0%	68.6%	45.0%
	CY 2004	62.8%	60.8%	6.3%	46.3%	54.0%	33.3%		44.5%
	CY 2003	56.2%	53.5%	4.6%	40.5%	47.7%	21.9%		42.3%

Sources: [24] North Carolina Division of Medical Assistance, "Quality, Evaluation, and Health Outcomes (QEHO) Initiatives," http://www.dhhs.state.nc.us/dma/ca/qehoinitiatives.html.

[23] Draft 2006 North Carolina Health Choice Annual Report, Framework for the Annual Report of the State Children's Health Insurance Plans Under Title XXI of the Social Security Act (NCDMA)," July 17, 2007.

[16] National Committee for Quality Assurance, "Medicaid HEDIS 2006 Means, Percentiles and Ratios," http://web.ncqa.org/Portals/0/HEDISQM/Programs/CompAud/MPR/HEDIS_2006_Means_Percentiles_Medicaid.pdf (accessed July 27, 2007).

D-3. HEDIS Measures of Well Child Visits in Early Childhood and Adolescence: Comparisons Between North Carolina Medicaid, Health Choice, and National Benchmarks

HEDIS Indicator	Year	CA II	CA I	NC Medicaid HMO	NC Fee-for-service Medicaid	Total NC Medicaid	NC Health Choice	2006 Medicaid HEDIS 90th percentile	HEDIS Mean (national)
Well-Child Visits in the 3rd–6th Year of Life	CY 2005	63.3%	61.3%	51.8%	58.2%	61.4%	58.2%	77.5%	62.0%
	CY 2004	61.7%	62.3%	37.3%	56.5%	60.0%	56.7%		59.9%
	CY 2003	61.2%	59.1%	44.9%	55.5%	58.3%	54.8%		58.1%
Adolescent Well-Care Visits Ages 12–19 Years	CY 2005	32.2%	30.8%	24.8%	30.3%	31.3%		54.5%	39.3%
	CY 2004	31.9%	30.2%	19.1%	30.2%	30.9%			37.9%
	CY 2003	30.0%	26.2%	24.0%	26.2%	27.3%			36.7%

Sources: [24] North Carolina Division of Medical Assistance, "Quality, Evaluation, and Health Outcomes (QEHO) Initiatives," http://www.dhhs.state.nc.us/dma/ca/qehoinitiatives.html.
[23] "Draft 2006 North Carolina Health Choice Annual Report, Framework for the Annual Report of the State Children's Health Insurance Plans Under Title XXI of the Social Security Act (NCDMA)," July 17, 2007.
[16] National Committee for Quality Assurance, "Medicaid HEDIS 2006 Means, Percentiles and Ratios," http://web.ncqa.org/Portals/0/HEDISQM/Programs/CompAud/MPR/HEDIS_2006_Means_Percentiles_Medicaid.pdf (accessed July 27, 2007).

D-4. Comparisons of HEDIS Immunization Measures Between North Carolina Medicaid, Health Choice, and National Benchmarks

HEDIS Indicator	Year	CA II	CA I	NC Medicaid HMO	NC Fee-for-service Medicaid	Total NC Medicaid	NC Health Choice	2006 Medicaid HEDIS 90th percentile	HEDIS Mean (national)
Child Immunization Rate I	CY 2004	58.3%	64.3%	35.7%	55.0%	57.9%			61.2%
	CY 2003	61.9%	65.5%	45.6%	55.2%	60.2%			57.2%
Child Immunization Rate II	CY 2004	56.6%	61.6%	33.8%	52.9%	55.9%		82.7%	57.8%
	CY 2003	58.5%	59.8%	42.5%	50.9%	55.8%			52.7%
Adolescent Immunization Combination I	CY 2004	21.3%	25.1%	8.9%	19.6%	21.3%			51.9%
	CY 2003	22.6%	26.3%	8.3%	19.4%	22.6%			42.4%
Adolescent Immunization Combination II	CY 2004	1.9%	2.0%	1.0%	1.5%	1.7%		69.8%	33.9%
	CY 2003	1.3%	1.3%	1.3%	1.2%	1.3%			24.4%

Sources: [24] North Carolina Division of Medical Assistance, "Quality, Evaluation, and Health Outcomes (QEHO) Initiatives," http://www.dhhs.state.nc.us/dma/ca/qehoinitiatives.html.
[23] "Draft 2006 North Carolina Health Choice Annual Report, Framework for the Annual Report of the State Children's Health Insurance Plans Under Title XXI of the Social Security Act (NCDMA)," July 17, 2007.
[16] National Committee for Quality Assurance, "Medicaid HEDIS 2006 Means, Percentiles and Ratios," http://web.ncqa.org/Portals/0/HEDISQM/Programs/CompAud/MPR/HEDIS_2006_Means_Percentiles_Medicaid.pdf (accessed July 27, 2007).

Appendix E

2006 North Carolina Selected Child Health Assessment and Monitoring Program (CHAMP) Survey Results for Children

Health Status, Health Behavior, or Access to Care Measure	North Carolina %	NC Medicaid %	Health Choice %
Weight Status: Percent of children who are at risk for overweight (85th–94th percentile) or overweight (95th percentile or greater)		30.7%	33.7%
< 5 years of age	22.1%		
5–10 years of age	29.2%		
11–13 years of age	31.7%		
14–17 years of age	27.2%		
Parent Reaction to Child Weight: Are you trying to encourage more physical activity time or limit TV/video/computer game time? (Response options: Yes (both); Yes, more physical activity; Yes, limit TV or video time; Neither)		Neither: 28.0%	Neither: 37.0%
<5 years of age (response = neither)	44.4%		
5 through 10 years of age (response = neither)	29.8%		
11 through 13 years of age (response = neither)	32.4%		
14 through 17 years of age (response = neither)	39.8%		
Tobacco: "To your knowledge, does (child) currently smoke cigarettes?"		32.7%	17.6%*
5 through10 years of age	7.4%		
11 through 13 years of age	16.2%		
14 through 17 years of age	30.4%		
Sun Safety: On a sunny summer day, when (child) is outside for more than 15 minutes between 10 am and 4 pm, how often does he/she use sunscreen with a Sun Protective Factor or SPF of 15 or more? (Response options: Always; Nearly always; Sometimes; Seldom; Never)		Seldom or Never: 53.8%	Seldom or Never: 36.8%
5 through 10 years (response = seldom or never)	26.1%		
11 through 13 years (response = seldom or never)	37.1%		
14 through 17 years (response = seldom or never)	43.7%		
Child Safety and Injury: How many times in the past month was (child) injured so that he/she could not participate in his/her usual activities for at least one day? (5–10 years of age)		(all ages)	(all ages)

Not in the past month 1–5 times 6–20 times More than 20 times	93.8% 6.0% 0.2% 0.0%	94.0% 5.7% 0.3% 0.1%	92.6% 5.3% 0.0% 2.0%
Child Safety and Injury: How many times in the past month was (child) injured so that he/she could not participate in his/her usual activities for at least one day? (11–13 years of age) Not in the past month 1–5 times 6–20 times More than 20 times	 87.9% 11.2% 0.3% 0.5%	See above	See above
Child Safety and Injury: How many times in the past month was (child) injured so that he/she could not participate in his/her usual activities for at least one day? (11–13 years of age) Not in the past month 1–5 times 6–20 times More than 20 times	 90.3% 8.9% 0.2% 0.6%	See above	See above
School Performance (Absenteeism): During the past 12 months, about how many days did (child) miss school because of illness or injury? (response options: No days; Less than 1 week; 1 to 2 weeks; 2 to 3 weeks; 3 or more weeks) 5 through 10 years of age (2 to 3 weeks, or 3 or more weeks) 11 through 13 years of age (2 to 3 weeks, or 3 or more weeks) 14 through 17 years of age (2 to 3 weeks, or 3 or more weeks)	 10.8% 12.5% 11.8%	2 weeks or more: 13.7%	2 weeks or more: 16.8%
Oral Health: Does (child) have a dentist or dental clinic where he/she goes toregularly? No, < 5 years of age No, 5 through 11 years of age No, 11 through 13 years of age No, 14 through 17 years of age	 56.3% 15.1% 13.7% 9.8%	No: 32.1%	No: 16.5%

*small number of respondents.

Source: [29] North Carolina State Center for Health Statistics, "Child Health Assessment and Monitoring Program," http://www.schs.state.nc.us/SCHS/champ/index.html (accessed July 23, 2007).