

Program Evaluation Proposal

for

Division of Tobacco Prevention and Control

North Dakota Department of Health

by

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**North Dakota Department of Health: Tobacco Prevention and Control
Program Evaluation**

Step 1: Description of the Program to be Evaluated

Purpose of Program

The mission of the Division of Tobacco Prevention and Control within the North Dakota Department of Health is to improve and protect the health of North Dakotans by reducing the negative health and economic consequences of tobacco use. Tobacco use is the state's number-one cause of preventable disease and death (Tobacco Prevention and Control in North Dakota, 2004). The goals of the division are to reduce disease, disability and death related to tobacco use by addressing the following goal areas:

- Goal Area 1: Prevent initiation and promote quitting among youth
- Goal Area 2: Eliminate exposure to secondhand smoke
- Goal Area 3: Promote quitting among adults
- Goal Area 4: Identifying and eliminating tobacco-related disparities
- Goal Area 5: Infrastructure and capacity building

The division is taking a comprehensive approach to preventing and reducing tobacco use in North Dakota by following an integrated approach (where each component reinforces the other) as set forth by a U.S. Centers for Disease Control (CDC) model. To this end, six major programmatic initiatives have been integrated into the areas of focus. These programs are:

Tobacco Prevention and Control Program

This program provides grants, training and technical assistance to 28 local public health units (LPH's), four American Indian tribes and one Indian service area to support infrastructure and build capacity for tobacco prevention and control efforts in communities and schools. The training focuses on the TNT curriculum, Life Skills Training, Know Your Body, and others. There are two staff persons in the Division dedicated to these training activities.

Community Health Grant Program

This program provides grants to all LPH's for community and school programs to prevent and reduce tobacco use and provide tobacco cessation services.

School Grant Programs

Include Information Here

Three Tobacco Cessation Programs

1. The City-County Employee Cessation Program which provides grants to cities and counties for tobacco cessation programs.
2. The State Employee Cessation Program supports a comprehensive cessation program for state employees.

3. The North Dakota Tobacco Quitline is a free tobacco telephone cessation service that provides assistance/counseling to any tobacco user in North Dakota who wants to quit.

Clients

The clients of these programs span the age range, from young people age birth through 25, to adult tobacco users who want to quit. The Tobacco Prevention and Control Programs also place a special emphasis on reaching Native American populations. A distant third group of clients could be considered non-smokers, as those impacted by second hand smoke are indirectly the clients (or beneficiaries) of the prevention campaigns.

Basic Operation

The Division works to assist Local Public Health (LPH) units implement four broad strategy areas that address tobacco use. These strategies are: assessment, community intervention, policy, and strategic use of media. All funded LPH agencies' work must fall within one of these strategy areas.

Financial support for the Division is provided by three funding sources: The Centers for Disease Control and Prevention (CDC)/Office of Smoking and Health Cooperative Agreement, the state-funded Community Health Grant Program (CHG), and the American Legacy Grant (School Grant). Total funding for the Division for 2006 was (xxxx,xxxx,xxx)

The Community Health Grant Program utilizes an advisory committee which reviews and approves each unit's plan and allocates 50 percent of the biennial appropriation for the first fiscal year. This grant was developed in 2001 after the Master Settlement Agreement (MSA) between the State of North Dakota and the tobacco industry was negotiated. Only a portion of the original MSA dollars (10%) is currently allocated to tobacco prevention and control in North Dakota. The funds are dispersed to the LPH units according to a formula. This formula uses a base dollar amount plus an added dollar amount based on per capita and population of children grades 4-12. The total amount of dollars allocated for the 2006-2007 biennium was \$3,760,000. Of that amount, \$1,763,386 (or 46.9 percent) was expended in fiscal year 2006. The remaining funds will be allocated in the second fiscal year of the biennium. The highest, lowest and average amount received per LPH (xxx,xxx,xxxx) with the average amount being (xx,xxx) and the highest going to () at (xx,xxx) and the lowest going to () at (xx,xxx).

CDC funds, which are discretionary in nature, are distributed by the office. These funds have been distributed to the largest communities in North Dakota and to the tribes. The CDC money is flexible/ discretionary in contrast to the CHG formula dollars. The total amount The total amount of dollars dispersed for the 2006-2007 biennium for this grant was xxx,xxx,xxx. The highest, lowest and average amount received per LPH (xxx,xxx,xxxx) with the average amount being (xx,xxx) and the highest going to () at (xx,xxx) and the lowest going to () at (xx,xxx).

Step 2: Focus of the Evaluation

Purpose of the Evaluation

This evaluation has a dual purpose: the first is a descriptive procedure that will produce a management model describing the types of LPH units and their relationship to outcomes. The second portion of the evaluation is confirmatory in nature. It will examine why the outcomes were or were not achieved and explore the descriptive validity of the model.

The primary purpose of this evaluation is to develop a management model that describes the factors that appear to enhance or detract from the completion of stated goals and objectives. In other words, the model will be an examination of the input factors and what then in turn resulted. This model will possess a firm data underpinning, incorporating the used of rubrics with specific criteria which will help to objectively categorize differing LPH activities. Selected goals and objectives will be examined for all LPH units statewide. The achievement of these goals and objectives will focus on the activities of the Tobacco Prevention and Control Program, the Community Health Grant Program and the School Grant Program as reported on the biannual reporting form. Table 1 is presented below to clarify the areas of focus of this evaluation because of the complex mix of program activities, goals, and funding. These areas of focus can be expanded in future years to encompass a larger number of goal areas and program efforts. These areas of study for inclusion in the evaluation may be subject to change due to the complexity of this process. For example, the need may arise to include further portions of the biannual report form in year one for data reliability purposes. All changes to the evaluation plan will be subject to direction and support from the Division director and appropriate program staff.

Table 1.Goal Areas by Program

Goal Areas	Programs					
	CHP -Community Health Grant	CDC Coop. Agree- ment	School Grant Funds	City/County Cessation Program	State Employee Cessation	ND Tobacco Quitline
Goal Area 1: Prevent initiation and promote quitting among youth	yes	yes	yes	no	no	no
Goal Area 2: Eliminate exposure to second hand smoke	no	no	no	no	no	no
Goal Area 3: Promote quitting among adults	no	no	no	no	no	no
Goal Area 4: Identifying and eliminating tobacco-related disparities	yes	yes	yes	no	no	no
Goal Area 5: Infrastructure and capacity building	yes	yes	yes	no	no	no

The descriptive portion of the evaluation will be used both internally and externally by the Division to answer management questions and to assist LPH units improve their program activities. This process will herein be referred to as Procedure 1.

The second purpose of this evaluation is to confirm which of the descriptive factors are most based in the day-to-day functioning of the LPH's and how those factors then can be used at the state level to make appropriate management decisions. In other words, this second purpose will be an examination of the validity of the model used to describe input processes and the products produced. This purpose will herein be referred to as Procedure 2. Procedure 2 will be considered the expanded portion of this evaluation proposal.

Assumptions

A major assumption of this evaluation model is that the data submitted by the LPH's are an accurate reflection of their expenditures, staff time and efforts. Also, in-kind services will impact goal attainment.

Audiences

The clients for this evaluation are the Director of the North Dakota Division of Tobacco Prevention and Control, state program office staff, and LPH unit directors and staff. Other audiences and interested stakeholders include: local policy makers, state legislative decision makers, tribal leaders, program participants, and families of those impacted by tobacco use.

Major Contextual Factors

1. The evaluation must be completed by June 30, 2006, as there have been CDC dollars made available to fund this activity.
2. The former director, Kathy Mangskau, has only recently discontinued her employment as director. A new director, Karalee Harper, has been hired effective October 1, 2006.

Step 3: Evaluation questions and sub-questions

The questions and sub-questions for this evaluation are included in the Table 2 which follows. The audiences interested in each question and its associated sub-questions are also identified in the table as is the importance of each set of questions.

Table 2. Step 3: Evaluation Questions for Procedure 1
Descriptive component (the what)

<u>Evaluation Questions</u>	<u>Sub-questions</u>	<u>Audience</u>	<u>Importance</u>
<p>1. Are the LPH units accomplishing the goals they have established for the Tobacco Prevention and Control Program, the Community Health Grant Program, and the School Grant Program?</p>	<p>1) What are the goals and objectives?</p> <p>a. Are the goals/objectives too easily obtained or more challenging (potentially develop a rubric here as mentioned previously)</p> <p>b. What are the areas of focus for the goals/objectives</p> <p>c. What is the average number of goals/objectives being worked on?</p> <p>d. To what degree are the LPH's achieving their goals/objectives?</p> <p>e. What is the average number of goals/objectives achieved?</p>	<p>1. Division director 2. State level program staff 3. LPH unit directors 4. Legislators</p>	<p>It is necessary to develop a base model that aggregates the factors collected on the bi-annual reporting form and uses them to make management decisions based on the outcomes of the program. Thoroughly understanding and capturing the range of goals/objectives being worked on gives the model a firm data underpinning.</p>
<p>2. What is the extent of program activities for each LPH? (potentially develop a rubric here as mentioned previously)</p>	<p>2) How many staff are hired for each program?</p> <p>3) How much money does each LPH get to implement each program?</p> <p>4) Where do the treatments/interventions occur?</p> <p>5) How often is programming implemented?</p> <p>6) How many people received program?</p> <p>7) When do they receive the programming?</p> <p>8) Other factors as needed taken from bi-annual quarterly report</p>		<p>Thoroughly understanding and capturing the range of activities being implemented gives the model a firm data underpinning.</p> <p>Developing rubrics with specific criteria will help to objectively categorize differing grantee activities.</p>

<p>3. Are there differences between the LPH's in the achievement of goals and objectives on the three programs?</p>	<p>9) Are the achievement of goals/objectives different influenced by geographic location (rural/urban)?</p> <p>10) Which LPH's achieved all of their goals/objectives?</p> <p>11) Which LPH's did not achieve any of their goals/objectives?</p> <p>12) What factors seem to contribute to the achievement of stated goals and objectives for the implementation of these three tobacco programs by the LPH units?</p>	<p>1. Division director 2. State level program staff 3. LPH unit directors</p>	<p>Examining differences between the LPH's as they relate to the goals and objectives may reveal factors important to the management model.</p>
<p>4. If there are differences, is it because there are LPH's implementing programs different from the majority?</p>	<p>13) What are programs doing differently from one another? Or do they all look similar?</p> <p>14) Are there specific "typologies" of LPH's? based on location, programming, etc?</p> <p>a. If so, what do those different types implement for programming?</p> <p>15) Are programs that are doing things differently more or less successful than other LPH's in achieving their goals/objectives?</p>	<p>1. Division director 2. State level program staff 3. LPH unit directors</p>	<p>Examining differences between the programs being implemented by the LPH's and how that potentially impacts outcomes, will further help enlighten factors important to the management model.</p>

Process component (the why)

<u>Evaluation Questions</u>	<u>Sub-questions</u>	<u>Audience</u>	<u>Importance</u>
<p>5. Why are some LPH units accomplishing their goals while others are not? (assuming the management model demonstrates that differences exist)</p>	<p>16) All LPH's work on the same four goals and strategies, but they use different approaches/ activities. Why are some of these strategies more effective than others? 17) In what situations are alternative strategies more or less effective and why? 18) Are there some specific circumstances preventing LPH's from achieving their goals and objectives? 19) How does the state office influence the achievement of stated goals and objectives by the LPH's? 20) What are the strengths and weaknesses of the Division in helping the LPH's accomplish their goals and objectives? 21) Once the descriptive model analysis is complete, why do those difference factors exist? (according to state staff, director, and LPH staffs)</p>	<p>1. Division director 2. State level program staff 3. LPH unit directors 4. Legislators</p>	<p>Using the descriptive processes model described in Procedure 1 will guide the questioning process for Procedure 2. There may be specific components of the model that will reveal avenues of further questioning and help to answer the sub-questions put forth here. The answers to the 'why' questions will be used to inform, modify, or expand Procedure 1 in future iterations.</p> <p>Further, the Division will have expanded information about further actions/roles it can take to help LPH's accomplish their goals/objectives</p>

Table 3. Step 4: Question-Procedure Plan

<p><u>Information Collection Procedure</u></p>	<p>Question 1. Are LPH's accomplishing goals/ objectives ? <i>Subquestions: 1a,1b, 1c, 1d,1e,</i></p>	<p>Question 2. Are there differences in the achievement of goals and objectives? <i>Sub-questions: 2, 3, 4, 5, 6, 7, 8</i></p>	<p>Question 3. Which programs are doing different program processes? <i>Subquestions: 9, 10, 11, 12</i></p>	<p>Question 4. Why are the LPH units so different in their outcomes? <i>Sub-questions: 13, 14, 14a, 15</i></p>	<p>Question 5. Why are some LPH units accomplishing their goals while others are not? <i>Sub-questions: 16, 17, 18, 19, 20, 21</i></p>
<p>Review of Grant applications from local public health units submitted to Division</p>	<p><i>1a,1b, 1c, 1d,1e,</i></p>	<p><i>2, 3, 4, 5, 6, 7, 8</i></p>	<p><i>9,10,11,12</i></p>	<p><i>13, 14, 14a, 15</i></p>	
<p>Review Bi-annual quarterly report forms from LPH's submitted to Division</p>	<p><i>1a,1b, 1c, 1d,1e,</i></p>	<p><i>2, 3, 4, 5, 6, 7, 8</i></p>	<p><i>9,10,11,12</i></p>	<p><i>13, 14, 14a, 15</i></p>	
<p>Focus groups</p>					<p><i>16,17,18, 19, 20, 21</i></p>
<p>Structured interviews (if not focus groups)</p>					<p><i>16,17,18, 19, 20, 21</i></p>
<p>Review of archival data (YRBS/YTS /BRFSS, other)</p>	<p><i>1a, 1d</i></p>		<p><i>10,11</i></p>		
<p>Review, develop and use other information collection tools not yet specified</p>					

Table 4. Step 5: Procedural Plan

<u>Procedure</u>	<u>Evaluation Questions Addressed</u>	<u>Schedule for Collections</u>	<u>Respondents</u>	<u>Sample</u>
Records Analysis/Database Review of LPH's Grant Applications	<i>1a,1b, 1c, 1d,1e, 2, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 14a, 15</i>	February 1 -March 31	<ul style="list-style-type: none"> • Documents of LPH staffs 	All grant applications from 2005 and 2006 will be reviewed
Records Analysis/Database Review of LPH's biannual reports	<i>1a,1b, 1c, 1d,1e, 2, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 14a, 15</i>	February 1 - March 31	<ul style="list-style-type: none"> • Documents of LPH staffs • Appropriate Division staff and Director 	All Bi-annual reports from the last three quarters (July01, 2005-Dec,2005 Jan01,2006-June30, 2006 July01, 2006-Dec 2006
Records Analysis/Database Review of local and county outcome data indicators	<i>1a, 1d</i>	February 1 - March 31	<ul style="list-style-type: none"> • Clint Boots • Data Committee • Division Director • Other appropriate Division staff 	Clint Boots and Data committee charged with aggregating local, county and statewide outcome indicators. Indicators used by LPH's will be reviewed with this group.
Structured Interviews or Focus Groups with LPH staffs	<i>16,17,18, 19,20,21</i>	April 1 -May 31	<ul style="list-style-type: none"> • LPH staffs 	All LPH staffs will have an opportunity to provide feedback on descriptive model results and to Division.

Table 5. Step 6: Reporting Plan

The evaluation of the Division of Tobacco Prevention and Control as set forth in this proposal covers eight months, from February 1, 2007 to June 30, 2007. The June deadline is set to meet the timeline guidelines set forth by the Division. For Division staff and LPH staff, many opportunities for informal reporting exist and will frequently be utilized in the normal performance of the evaluator's duties and actions. Formal reports will be completed on a set schedule, and those deadlines are also indicated.

<u>Event</u>	<u>Date/Frequency</u>	<u>Format</u>	<u>Nature of Content</u>	<u>Audience</u>
Informal meeting with Division Director and Data Analyst. Other staff as appropriate or necessary	February -March	Two meetings at state offices in Bismarck	Discuss evaluation plan, review grant applications, review completed bi-annual reports.	Division Director and other staff as deemed appropriate or necessary by Director or evaluator
Progress updates	Monthly update phone conference and as needed.	Oral synopses	Progress, preliminary findings, next steps	Division Director and other staff as deemed appropriate by her
Focus Group/or Key Informant Interviews	April-May, 2007	Either Focus Groups at statewide meeting, or telephone interviews	Solicit feedback on descriptive model, answer appropriate evaluation questions	LPH staff
Draft Report	June 1, 2007	Written draft report	Discuss needs, format, uses of final report. Solicit edits, changes needed	Division Director and other staff as deemed appropriate by her
Final Report	June 30, 2007	Written report with all appendices and instruments	Phone conference/IVN (video-conference) review of report, present data, conclusions, interpretations, recommendations, implications	Division Director, data committee members, Division staffs, LPH staffs, and other staff as deemed appropriate by director
Final Report: Executive Summary	June 30, 2007	Written summary	Overview of study, present conclusions, interpretations, recommendations, implications	Division Director, data committee members, Division staffs, LPH staffs, legislators, and other staff as deemed appropriate by director

Table 6. Step 7: Evaluation Budget

Procedure 1 and 2 (Focus Groups)

ND Dept. of Health-Procedure 1 AND 2	
Tobacco Control & Prevention Evaluation	
Nov. 1, 2006 - June 30, 2007	
With Focus Groups	
	Year 1
<u>PERSONNEL</u>	<u>BUDGET</u>
<u>Salary</u>	
Garth Kruger (Evaluator)	\$15,698
Sue Offutt (focus group facilitator)	\$5,962
Administrative Assistant	\$3,004
Student Assistant	\$3,472
TOTAL SALARY	\$28,136
Fringe Benefits (10%)	\$1,590
Regular Staff (32%)	\$2,869
TOTAL FRINGE BENEFITS	\$4,459
TOTAL PERSONNEL AND FRINGE BENEFITS	\$32,595
<u>OPERATING</u>	
<u>Travel</u>	
2 Trips to Bismarck, 2 Nights Hotel, 3 days Per Diem, 2 people	\$525
State Vehicle (550 miles RT)	\$370
Three Focus Groups	
Room Rental x3 \$100 per room	\$300
Travel 3 trips across state. Ave Round trip 350 miles	\$353
Meals (13 meal per site x 3 sites) \$10 plate	\$400
Tape recording equipment, misc supplies	\$100
3 Trips to Locations, 3 Nights Hotel, 3 days Per Diem, 3 people	\$1,600

Communications	
Telephone	\$100
Mailing	\$100
Supplies	
Duplicating	
Binding, est. 40 copies, \$20 each	\$800
TOTAL OPERATING	\$4,648
TOTAL DIRECT COSTS	\$37,162
Indirect Cost	\$3,345
TOTAL PROJECT	\$40,588

References

Identification and Elimination of Tobacco-Related Disparities in North Dakota: Strategic Plan (2006). <http://www.ndhealth.gov/tobacco/Reports/Tobacco%20Related%20Disparities%20Report.pdf>

North Dakotas Local Tobacco Control Programs.
<http://www.ndhealth.gov/tobacco/TobaccoPrograms.htm>

Tobacco Prevention and Control in North Dakota (2004): A status report of leading indicators
<http://www.ndhealth.gov/tobacco/Reports/TobaccoAnnualReport.pdf>

Division of Tobacco Prevention and Control
North Dakota Department of Health
600 E. Boulevard Ave., Dept 301
Bismarck, ND 58505-0200
Phone 701-328-3138
www.ndhealth.gov/tobacco

Appendix A: LPH Unit Programs

**North Dakota's Local
Tobacco Prevention and Control Programs**

Click [here](#) to view a map of North Dakota's Local Tobacco Prevention and Control Programs.

Bismarck-Burleigh Public Health

500 E. Front Avenue
Bismarck, N.D. 58504
Phone: 701.222.7516
Fax: 701.221.6883
Website: www.bismarcktobaccofree.com
(Serves Burleigh County)

Pat McGeary
Tobacco Prevention and Control Coordinator
E-mail: pmcgeary@nd.gov
Phone: 701.222.7516

Sue Kahler
School Coordinator
E-mail: skahler@nd.gov
Phone: 701.222.7516

Cavalier County Health District

901 Third Street, Suite 11
Langdon, N.D. 58249
Phone: 701.256.2402
Fax: 701.256.5765
(Serves Cavalier County)

Barb Thomas
Tobacco Prevention Coordinator
E-mail: bthomas@nd.gov
Phone: 701.256.2402

Central Valley Health District

122 Second Street NW
P.O. Box 880
Jamestown, N.D. 58402-0880
Phone: 701.252.8130
Fax: 701.252.8137
Website: www.centralvalleyhealth.org
(Serves Logan and Stutsman Counties)

Nancy Thoen
Tobacco Prevention Coordinator
E-mail: nthoen@nd.gov
Phone: 701.252.8130

City-County Health Department

230 Fourth Street NW, Room 102
Valley City, N.D. 58072-2947
Phone: 701.845.8518
Fax: 701.845.8542
(Serves Barnes County and Valley City)

Vicki Voldal-Rosenau
Tobacco Prevention Coordinator
E-Mail: bctprev@daktel.com
Phone: 701.845.8595

Gloria Pesek
Cessation Specialist
E-mail: gpesekpass@hotmail.com
Phone: 701.845.8595

Custer Health

210 Second Avenue N.W.
Mandan, N.D. 58554
Phone: 701.667.3370
Fax: 701.667.3371
Website: www.mandantobaccofree.com
(Serves Grant, Mercer, Morton, Oliver and Sioux Counties)

Brady Weaver
Tobacco Prevention Coordinator
E-mail: bweaver@nd.gov
Phone: 701.667.3370

Mary Hillerud
Tobacco Prevention Outreach Coordinator for
Mercer and Oliver Counties
E-mail: Mary.Hillerud@sendit.nodak.edu
Phone: 701.748.3655

Dickey County District Health Unit
P.O. Box 238
Ellendale, N.D. 58436
Phone: 701.349.4348
Fax: 701.349.3277
(Serves Dickey County)

Stephanie Voightman
Tobacco Prevention Coordinator
E-mail: svoightm@nd.gov
Phone: 701.349.4348

Emmons County Public Health
P.O. Box 636
Linton, N.D. 58552
Phone: 701.254.4027
Fax: 701.254.4027
(Serves Emmons County)

Vanessa Graham
Tobacco Prevention Coordinator
E-mail: vgraham@nd.gov
Phone: 701.254.4027 or 701.254.4082

Fargo Cass Public Health
401 Third Avenue N.
Fargo, N.D. 58102-4839
Phone: 701.241.1360
Fax: 701.241.8559
(Serves Cass County and Fargo)

Rich Fenno
Tobacco Control Coordinator
E-mail: RFenno@cityoffargo.com
Phone: 701.476.4148

Holly Scott
School Coordinator
E-mail: HScott@cityoffargo.com
Phone: 701.241.8576

Chelsey Plummer
Cessation Coordinator
E-mail: cplummer@ci.fargo.nd.us
Phone: 701.241.1367

First District Health Unit
P.O. Box 1268
Minot, N.D. 58702-1268
Phone: 701.852.1376
Fax: 701.852.5043
Website: www.fdh.u.org
(Serves Bottineau, Burke, McHenry, McLean, Renville, Sheridan and Ward Counties)

Lori Brierley
Director of Tobacco Prevention
E-mail: lbrierley@nd.gov
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Renae Byre
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Foster County Health Department
1000 Fifth Street N.
P.O. Box 80
Carrington, N.D. 58421
Phone: 701.654.3087
Fax: 701.652.3087
(Serves Foster County)

Jackie Schroeder
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E-Mail: jschroeder@nd.gov
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School Coordinator
E-mail: lweninger@nd.gov
Phone: 701.652.3037

Grand Forks Public Health Department

151 S. Fourth Street, Suite N301
Grand Forks, N.D. 58201-4735
Phone: 701.787.8100
Fax: 701.787.8145
Website: www.tobaccobytes.com
(Serves Grand Forks County and Grand Forks)

Carrie Kaltenberg
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E-mail: ckaltenb@grandforksgov.com
Phone: 701.787.8142

Rachel Salwei
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E-mail: rsalwei@grandforksgov.com
Phone: 701.787.8135

Theresa Knox
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Kidder County District Health Unit

422 Second Avenue NW
Steele, N.D. 58482
Phone: 701.475.2582
Fax: 701.475.2652
(Serves Kidder County)

Antoinette Heier
Tobacco Prevention Coordinator
E-mail: aaheier@bektel.com
Phone: 701.475.2582

Lake Region District Health Unit

524 4th Avenue NE Unit 9
Devils Lake, N.D. 58301-2490
Phone: 701.662.7035
Fax: 701.662.7097
Website: www.lakeregiontobaccofree.com
(Serves Benson, Eddy, Pierce and Ramsey Counties)

Amy Berg
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E-mail: aberg@nd.gov
Phone: 701.662.7035

William Goad
Tobacco Prevention Coordinator
E-mail: wgoad@nd.gov
Phone: 701.662.7035

LaMoure County Public Health Department

P.O. Box 692
LaMoure, N.D. 58458
Phone: 701.883.5356
Fax: 701.883.5711
(Serves LaMoure County)

Leslie Hanson
Tobacco Prevention Coordinator
E-mail: ljhanson@nd.gov
Phone: 701.883.5356

McIntosh District Health Unit

Box 25
Ashley, N.D. 58413
Phone: 701.288.3695
Fax: 701.288.3671
(Serves McIntosh County)

Donna Moos
Tobacco Prevention Coordinator
E-mail: dmoos@bektel.com
Phone: 701.288.3957

Nelson/Griggs District Health Unit

P.O. Box 365
McVie, N.D. 58254
Phone: 701.322.5624
Fax: 701.322.5111

Julie Ferry
Tobacco Prevention Coordinator
E-mail: jferry@nd.gov
Phone: 701.322.5624

(Serves Griggs and Nelson Counties)

Pembina County Health Department

301 Dakota Street W. #2
Cavalier, N.D. 58220-4100
Phone: 701.265.4248
Fax: 701.265.5193

(Serves Pembina County)

Tina Lorenzen
Tobacco Prevention Coordinator
E-Mail: tlorenzen@nd.gov
Phone: 701.265.4248

Ransom County Public Health Department

P.O. Box 89
Lisbon, N.D. 58054
Phone: 701.683.5823 ext 140
Fax: 701.683.0034

(Serves Ransom County)

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Appendix C: Menu of Objectives and Strategies

Goal: Prevent Initiation Among Youth

Objectives	
	<ol style="list-style-type: none"> 1. By June 2007, increase to 250 the number of school plants that implement evidence-based tobacco prevention curricula (From 228 in 2005). 2. By June 2007, increase to 1,200 the number of students that participate in tobacco prevention activities (From 214 in 2005). 3. By June 2007, increase to 15 the number of communities that conduct local compliance surveys (From 7 communities in 2004). 4. By June 2007, decrease to 36 the percent of students in grades 9-12 who would wear or use something with a tobacco company name on it (From 38 percent in 2003). 5. By June 2007, increase to 85 the percent of schools that have policies against tobacco advertising in specific locations – in school buildings, on school property, at school functions and in all school publications (From 82 percent in 2004). 6. By June 2007, increase to 130 the number of schools with tobacco-free grounds policy (From 53 in 2002).
Strategies	
<p style="text-align: center;">Assessment</p>	<ol style="list-style-type: none"> 1. Assess/update current tobacco policies in all school districts. 2. Assess the number of schools with tobacco-free grounds policies. 3. Assess the number of schools with evidence-based tobacco prevention curricula. 4. Assess the number of students receiving evidence-based tobacco prevention education. 5. Monitor the implementation of evidence-based tobacco prevention curricula. 6. Assess the number of teachers trained in evidence-based tobacco prevention curricula. 7. Assess public support for tobacco-free school policies. 8. Assess the number/percentage of businesses selling tobacco products to minors. 9. Assess the number of students involved in tobacco prevention activities. 10. Assess tribal youth access policies. 11. Conduct a retailer survey to assess knowledge and enforcement of tribal youth access laws/policies. 12. Conduct a survey to assess where tribal youth get their tobacco products. 13. Assess tobacco policies at BIA and tribal school districts.

<p>Community Interventions</p>	<ol style="list-style-type: none"> 1. Support youth tobacco coalitions, youth coalitions or groups working on tobacco related projects. 2. Partner with local schools to implement evidence-based tobacco prevention curricula. 3. Educate school leaders, business and community members about youth tobacco use. 4. Implement/support youth activities that encourage youth to remain tobacco-free (GASO, WNTD, KBD, SADD conference, Youth summit, etc.) 5. Conduct retailer education. 6. Educate law enforcement about current state (& local) youth access laws. 7. Educate local policy-makers and the community about youth access issues. 8. Conduct education to school administrators/school board and community members about the benefits of comprehensive tobacco-free school policy. 9. Purchase evidence-based tobacco prevention curricula. 10. Provide teacher training on evidence-based tobacco prevention curricula. 11. Educate tribal leaders about reducing youth access to tobacco products. 12. Promote the implementation of the CDC Guidelines for School Health Programs to Prevent Tobacco Use and Addiction. 13. Educate parents, youth and the tribal community about youth tobacco issues, including traditional cultural use. 14. Conduct compliance surveys.
<p>Strategic Use of Media</p>	<ol style="list-style-type: none"> 1. Conduct paid/earned media to educate the public and policy makers on youth tobacco use. 2. Publicize activities of youth coalitions/groups working on tobacco prevention. 3. Publish a listing of schools with tobacco-free grounds policies. 4. Publicize new research/information on youth tobacco use. (YRBS, YTS, etc.) 5. Communicate school tobacco policy through student handbook, newsletter, signs, local media, etc. 6. Meet with local media to highlight the prevalence of youth access in the community and advocate for change. 7. Publicize the results of local/state compliance surveys.
<p>Policy</p>	<ol style="list-style-type: none"> 1. Provide consultation to school districts in developing and implementing tobacco-free school policy. 2. Work with local policy makers to develop/implement youth access ordinances. 3. Work with retailers and law enforcement agencies to ensure laws regarding youth access are being enforced. 4. Work with tribal policy makers to develop/implement resolutions to decrease youth access to tobacco products.

Goal: Promote Quitting Among Adults and Young People

Objectives	
	<ol style="list-style-type: none"> 1. By June 2007, increase to 61 the percent of North Dakota adult smokers who received smoking-cessation counseling by healthcare providers (From 59 percent in 2004). 2. By June 2007, increase to 67 the percent of North Dakotans who support increasing the excise tax on cigarettes by one dollar (From 62 percent in 2003). 3. By June 2007, increase to 51 the percent of North Dakota pregnant smokers who report being advised to quit smoking by a health care provider (From 48 percent in 2002). 4. By June 2007, increase to 58 the percent of students in grades 9-12 who want to quit smoking (From 55.5 percent in 2003). 5. By June 2007, increase to 230 the monthly average number of calls to the ND Tobacco Quitline (From 71 in 2004). 6. By June 2007, increase to 17 the percent of monthly average callers to the ND Tobacco Quitline that are from disparate population groups such as Native American, pregnant women (From 15 percent in 2005).
Strategies	
Assessment	<ol style="list-style-type: none"> 1. Assess the number of healthcare providers trained in effective cessation services. 2. Assess available cessation programs and/or resources for both youth and adults. 3. Assess the availability of effective and affordable tobacco cessation programs and resources for specific populations (Native Americans, pregnant women, etc.). 4. Assess local public and private health service and prevention agencies to determine if they provide information on the hazards of smoking during pregnancy. 5. Assess local public and private health service and prevention agencies to determine if they provide information on cessation programs and/or resources. 6. Assess availability of cessation programs and/or resources for adults and youth at tribal health clinics. 7. Identify sources of information for women of childbearing age on the dangers of tobacco use during pregnancy. 8. Assess the availability of cessation programs targeted to pregnant women. 9. Assess support for increasing the excise tax on tobacco products.
Community Interventions	<ol style="list-style-type: none"> 1. Promote the development of worksite-supported cessation and/or support groups. 2. Promote the development of community-supported cessation and/or support groups. 3. Conduct, coordinate or facilitate community cessation and/or support groups. 4. Conduct, coordinate or facilitate youth cessation classes. 5. Train healthcare providers in effective cessation services. 6. Provide technical assistance and consultation on the development and implementation of effective cessation programs. 7. Educate businesses about the benefits of providing cessation services to

	<p>employees and inform them about local cessation programs and/or resources.</p> <ol style="list-style-type: none"> 8. Distribute Quitline materials to local health and human service providers. 9. Meet with local public and private health and prevention agencies to ensure that information on the hazards of tobacco use during pregnancy is made available to clients. 10. Meet with local public and private health agencies to ensure that information about cessation resources is made available to clients who may be pregnant. 11. Meet with schools to educate them on available youth cessation programs and/or resources. 12. Promote the use of the ND Tobacco Quitline to healthcare professionals, local organizations, businesses, insurance companies and the general public. 13. Educate tribal leaders about the importance of including cessation services in the tribal health care system. 14. Provide updates to the state cessation directory. 15. Promote the development of tobacco cessation programs and/or support groups for specific populations (Native Americans, pregnant women, etc.). 16. Educate the tribal community about the importance of not using tobacco products during pregnancy. 17. Provide technical assistance/consultation for appropriate cessation programs for specific population groups (Native Americans, pregnant women, etc.). 18. Develop/acquire low-literacy cessation materials. 19. Develop partnerships to address tobacco use among low SES populations. 20. Collaborate with military officials to address cessation. 21. Educate tribal leaders and community members about the benefits of taxing tobacco products on ND reservations. 22. Educate local/state policy makers and the community about the need for/benefits of increasing the excise tax on tobacco products.
<p>Strategic Use of Media</p>	<ol style="list-style-type: none"> 1. Promote available cessation programs and the ND tobacco Quitline through paid and earned media. 2. Publish a listing of available cessation programs and/or resources. 3. Publicize/promote cessation success stories. 4. Use paid and earned media to educate about smoking during pregnancy. 5. Publicize healthcare providers that are trained in appropriate cessation interventions. 6. Promote tobacco cessation programs/resources through tribal wellness programs. 7. Publicize public support for increasing the excise tax on tobacco products.

Policy	<ol style="list-style-type: none"> 1. Work with businesses to include cessation services in their health benefits plan. 2. Work with third party payers to include cessation as a covered benefit. 3. Work with local hospitals/clinics to institutionalize the use of the PHS Guidelines. 4. Work with schools to include resources/services for students and staff as part of a comprehensive tobacco-free school policy. 5. Work with tribal leaders to advocate for tobacco cessation as part of the current tribal health care system. 6. Work with tribal leaders to develop compacts with the state to tax tobacco products on the reservations. 7. Work towards passage of legislation to increase the excise tax on tobacco products.
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Goal: Eliminate Exposure to Secondhand Smoke

Objectives	<ol style="list-style-type: none"> 1. By June 2007, increase to 38 the percent of ND adults who believe exposure to secondhand smoke has a very harmful impact on the health of a non-smoker (From 32 percent in 2002). 2. By June 2007, increase to 63 the percent of North Dakota adults, ages 18-54, who believe smoking should not be allowed in private businesses and other non-governmental places (From 54 percent in 2002). 3. By June 2007, increase to three the number of communities with local ordinances stronger than the state smoke-free law (From 2 in 2005). 4. By June 2007, increase to two the number of communities that conduct local compliance surveys for the smoke-free law (From 0 in 2005). 5. By June 2007, increase to two the number of tribal areas with resolutions for smoke-free workplaces and/or public places. (From one in 2005).
Strategies	
Assessment	<ol style="list-style-type: none"> 1. Assess tobacco policies for bars. 2. Assess compliance with state/local smoke-free laws. 3. Conduct satisfaction survey of state/local smoke-free laws. 4. Track local economic impact of state/local smoke-free laws. 5. Assess tobacco policies on college/university campuses. 6. Assess tobacco-free worksite policies. 7. Assess tobacco-free policies for tribal workplaces and public places. 8. Assess tobacco policies for tribal childcare facilities.
Community Interventions	<ol style="list-style-type: none"> 1. Deliver presentations to business and community leaders about the impact of secondhand smoke on worker health. 2. Train healthcare providers to counsel expectant women, adults and youth about the dangers of secondhand smoke.

	<ol style="list-style-type: none"> 3. Ask bars to be smoke-free for the Great American Smokeout. 4. Use existing public awareness events (health fairs, GASO, etc.) to educate about the dangers of secondhand smoke. 5. Support activities to increase smoke-free venues, etc. 6. Educate College/University administration and students about the benefits of tobacco use restrictions on campus.
	<ol style="list-style-type: none"> 7. Educate law enforcement about the smoke-free law and their role in enforcement. 8. Educate businesses and community members about the smoke-free law. 9. Provide consultation and/or information to employers to help implement tobacco-free policies using the worksite tool kit. 10. Educate tribal businesses and leaders about secondhand smoke. 11. Conduct parent/care giver education on ways to reduce exposure of children to secondhand smoke. 12. Continue to educate identified priority populations (i.e. Native Americans, pregnant women) on the dangers of secondhand smoke. 13. Educate local coalitions and policy makers on the economic and health benefits of smoke-free policies. 14. Educate pregnant women and their families about the dangers of tobacco use during pregnancy and secondhand smoke.
<p>Strategic Use of Media</p>	<ol style="list-style-type: none"> 1. Support the statewide public education campaign on secondhand smoke. 2. Conduct free media using editorials, letters to the editor, news releases, etc. to promote smoke-free environments. 3. Publicize public support for smoke-free environments. 4. Publicize public satisfaction with the smoke-free law. 5. Publicize support for smoke-free environments on college/university campuses. 6. Publicize the results of the secondhand smoke survey. 7. Conduct a paid/earned media campaign on the dangers of secondhand smoke.
<p>Policy</p>	<ol style="list-style-type: none"> 1. Work with college administration to adopt tobacco-free policies campus wide – including grounds, events and residence halls or dorms, and off-campus, college-affiliated housing. 2. Expand current smoke-free protections through voluntary policies or local ordinances. 3. Provide training and technical assistance on policy and ordinance development and implementation. 4. Work with tribal businesses to develop and implement SF policies. 5. Work with tribal leaders to develop and implement smoke-free policies for public places (housing authority policies). 8. Promote “smoke-free home” and “smoke-free car” policies, especially related to reducing exposure of children and other family members to secondhand smoke. 9. Work with tribal policy makers to pass resolutions to prohibit smoking in workplaces and public places. 10. Work with military officials to establish smoke-free policies.

Goal: Identify and Eliminate Disparities Related to Tobacco Use

Objectives	
	<ol style="list-style-type: none"> 1. By June 2007, publish and disseminate a plan to address tobacco-related disparities to all public health units, partner agencies and identified priority populations. 2. By June 2007, institutionalize the identification of tobacco-related disparities into the local planning process.
Strategies	
Assessment	<ol style="list-style-type: none"> 1. Identify tobacco related disparate populations and who can represent their point of view. 2. Identify and assess state and local data sources to identify tobacco related disparities. 3. Identify policy opportunities related to tobacco disparities. 4. Identify data gaps and assess opportunities for data collection at the local level.
Community Interventions	<ol style="list-style-type: none"> 1. Share the tobacco-related disparities strategic plan with local coalitions, community members and identified priority populations. 2. Establish partnerships to address tobacco-related disparities. 3. Educate local decision makers about tobacco-related disparities. 4. Include disparately affected populations in the development of community strategies. 5. Develop and implement programs to address tobacco-related health disparities. 6. Collaborate with disparate groups to understand cultural issues related to tobacco use.
Strategic Use of Media	<ol style="list-style-type: none"> 1. Assist the state tobacco program in publicizing the tobacco-related disparities plan. 2. Publicize information on tobacco-related disparities.
Policy	<ol style="list-style-type: none"> 1. Advocate for policies to safeguard disparately affected populations.

Goal: Building Infrastructure

Objectives	
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	<ol style="list-style-type: none"> 1. During fiscal year 2006-2007 maintain/enhance tobacco prevention and control programs in all local public health units and tribal areas. 2. During fiscal year 2006-2007 develop/enhance local coalitions in all local public health units and tribal areas to prevent and reduce tobacco use.
Strategies	
Assessment	<ol style="list-style-type: none"> 1. Assess coalition, partnerships and collaborations to determine if they are inclusive and representative of the community. 2. Assess coalition's composition: <ul style="list-style-type: none"> • Types of organizations represented • Extent of members' ability to be liaisons for their organizations • Members' capacity for outreach to multi-cultural groups within their communities 3. Assess available tobacco control resources in the community. 4. Assess the participation of coalition members in tobacco prevention activities. 5. Conduct annual evaluation of program progress.
Community Interventions	<ol style="list-style-type: none"> 1. Recruit new coalition members to fill identified gaps in coalition composition. 2. Hold informational meetings regarding the coalition's mission. 3. Recruit volunteers, grassroots and other community members who are available and willing to participate in tobacco activities. 4. Hold regular meetings with coalition members and grassroots. 5. Create a database of grassroots members. 6. Conduct or provide trainings (leadership skill development, media literacy) for coalition members. 7. Attend quarterly tobacco update meetings and other appropriate trainings. 8. Develop and distribute coalition membership application. 9. Maintain/enhance statewide/local partnerships. 10. Provide/attend media advocacy training or other appropriate training.
Strategic Use of Media	<ol style="list-style-type: none"> 1. Produce a community/coalition newsletter. 2. Update coalition website. 3. Provide coalition updates through media. 4. Enhance communication with state/local partners by sharing appropriate reports, newsletters, etc. 5. Use swiss-cheese news releases as appropriate. 6. Develop local fact sheets, reports, news releases, etc. as appropriate.
Policy	<ol style="list-style-type: none"> 1. Develop coalition structure, by-laws and/or operating guidelines. 2. Assure program accountability. (Reports submitted by deadlines, meeting performance measures, etc.)