health & wellness

Trust Fund Commission

Annual Report to the Joint Legislative Commission on Governmental Operations and the Joint Legislative Health Care Oversight Committee 2003

Annual Report to the Joint Legislative Commission on Governmental Operations and the Joint Legislative Health Care Oversight Committee
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November 1, 2003

To: Joint Legislative Commission on Governmental Operations
Senator Marc Basnight, Co-Chair
Speaker Jim Black, Co-Chair
Speaker Richard Morgan, Co-Chair

Joint Legislative Health Care Oversight Committee

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

Subject: Annual Report

Section I. Implementation of the Enabling Statute

The Commission now funds four initiatives that address the vision expressed by the General Assembly in creating a Commission to improve the health and wellness of North Carolinians. The Senior Care prescription drug program was launched one year ago today. Since that time, three prevention initiatives have been implemented statewide at the grassroots level to promote:

- Safe and effective use of medications among seniors,
- Tobacco use prevention and cessation among youth
- Obesity reduction and prevention among youth and children

With technical assistance from expert agencies and organizations, local grantees across the state are establishing service capacity and building community support for specific public health and related policy goals. This process takes time, especially in those communities where collateral resources are scarce and capacity is being built from the ground up. Nonetheless, significant progress is being made and measured, as summarized below.

Statutory Requirement:: **Address the health needs of the vulnerable and underserved populations of NC.**

HWTFC Initiative: Senior Care provides prescription drug access for the state's most vulnerable and underserved seniors.

Program Design

- $ 91 million allocated over three years
- Covers the three diseases that affect 70% of NC's seniors
  - cardiovascular disease
  - diabetes mellitus
  - chronic obstructive pulmonary disease (COPD).
- Pays up to $600 for covered drugs per year, with the senior contributing a 40% co-pay plus a $6 dispensing fee
- Commercial Pharmacy Benefit Manager administering program
- Coverage began November 1, 2002.

Enrollment

- Current enrollment approximately 23,000
- Website: www.ncseniorcare.com and toll free line (866) 226-1388
- Enhancing minority enrollment through grants to the General Baptist State Convention

Medicaid Waiver May Expand Program

- DHHS has applied to the federal government for a Section 1115 Medicaid waiver that would match the Commission's investment on a 2-to-1 basis
- Would represent a new source of federal funds for NC
- If the waiver is approved, Senior Care would be expanded as follows:
  - Medications for all disease states would be covered
  - The annual benefit would increase to $1,000 annually
  - The co-pay would be reduced to $5 for generics and $15 for brand name drugs

Statutory Requirement: **Fund research, education and prevention programs that increase community capacity.**

HWTFC Initiative: ***Medication Assistance Programs*** educate seniors on the safe and effective use of medications, thus preventing adverse reactions from drug interactions and duplicative therapy. Research is being conducted on the health outcomes of providing this service, such as reduction in emergency room visits and hospitalizations. Grant programs also increase community capacity to assist low income individuals of all ages to gain access to prescription drugs from pharmaceutical companies for free or at sharply discounted prices.

Program Design

- $15 million over 3 years; 23 local grants awarded in October 2002
- 3 additional grants awarded in October 2003
- Approval of Medicaid waiver would provide matching funds on a 3-to-1 basis

Medication Management for Seniors

- 63 counties served locally
- Remaining 37 counties served by UNC School of Pharmacy hotline
- Specialized training for pharmacists provided by the Area Health Education Centers (AHEC)
- All grantees accept referrals of high-risk seniors from the *Senior Care* program
- No cost for Senior Care clients

Prescription Assistance for low-income individuals of all ages

- Grantees use a software-driven search engine to identify the best source for needed drugs and complete application forms for clients
- Eligibility requirements are defined by pharmaceutical companies that sponsor such programs
- Commission is currently preparing for expansion statewide

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

HWTFC Initiative*: *Teen Tobacco Use Prevention and Control programs include grants to local school and community organizations, statewide organizations capable of addressing the needs of priority populations, paid media and enforcement of the state law restricting the sale of tobacco to minors. All of these programs are part of a community-based plan aimed at reducing and remedying to health effects of tobacco use among North Carolina's youth.

Program Design

- $18.6 million allocated over three years for a pilot program based on CDC recommendations
- local grants were awarded to 26 community-based organizations and schools serving 62 counties
- four statewide grants were awarded to focus on communications with minority teens:
  - El Pueblo
  - NC Commission of Indian Affairs
  - Old North State Medical Society
  - General Baptist State Convention

Program Elements

- Other elements of the Commission's initiative that support the local and statewide grantees are as follows:
  - A paid media campaign entitled, *"Tobacco.Reality.Unfiltered"* was launched in year one, and budgeted at $1.5 million per year.
  - A non-punitive cessation program for teens, called N-O-T (Not On Tobacco), sponsored by The American Lung Association, and budgeted at $200,000 per year.
  - Enforcement of the ban on tobacco sales to minors by the Division of Alcohol Law Enforcement, budgeted at $500,000 per year
  - Counseling for pregnant teen on the dangers of tobacco use, provided by the Women's and Children's Health Section of DHHS, budgeted at $100,000 per year
  - A statewide effort to promote local adoption of tobacco use restrictions on school property and at school functions, provided by the Tobacco Prevention and Control Branch of DHHS, budgeted at $345,000
  - A statewide leadership forum for youth, organized by the Tobacco Prevention and Control Branch of DHHS, budgeted at $100,000
  - Sponsorship of three regional youth empowerment programs, called "Question Y", budgeted at $250,000 per year

Statutory Requirement: **Fund initiatives that treat health problems in North Carolina and increase community capacity**

HWTFC Initiative*: *Children, Youth and Community Obesity Reduction / Prevention grants were awarded on October 24, 2003, to create and increase community capacity to address the epidemic of childhood obesity. Grantees will provide intervention programs for overweight children including after school exercise programs and nutritional counseling. Grantees will also focus efforts on public education and adoption of local policies that address the underlying issues.

Program Design

- 3 year initiative funded at $3 million per year
- Initiative design based on recommendations developed by DHHS under the North Carolina Healthy Weight Initiative
- 12 grants were awarded to local organizations that will serve schools and communities in 19 counties initially, then expanding to 35 counties.
- 4 grants were awarded to statewide/regional organizations that will provide service on a much broader basis
- Department of Community and Family Medicine at Duke will provide technical assistance to grantees
- Grant implementation will begin in January 2004

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**:**

- Senior Care -- UNC School of Public Health/School of Pharmacy and NC A&T School of Nursing
- Medication Management -- UNC School of Public Health/School of Pharmacy
- Teen Tobacco Use Prevention and Cessation -- UNC School of Family Medicine
- Obesity – To be determined

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 Commissioners spent 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.

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

Youth are particularly susceptible to tobacco use, overweight and obesity. Therefore, the Commission designed two community-based initiatives to address these pressing issues.

According to the Centers for Disease Control (CDC), over 90 percent of first-time tobacco use occurs prior to age 20, with the average age of initiation being 13. The health effects of prolonged tobacco use among the general population are well documented, and studies by the CDC show that African Americans suffer disproportionately high rates of heart disease, stroke and lung cancer. The Commission has followed the 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. The Commission awarded $6.7 million in grants to 27 local coalitions that are principally comprised of school districts, county health departments and community-based organizations. The funds will be used for organizational development, promotional activities and local cessation programs. Another $2.2 million in grants was awarded to four organizations that will focus their efforts on reaching out to African American, Hispanic and American Indian teens statewide, through culturally appropriate messages.

Overweight/Obesity is the first chronic disease that is spreading at epidemic rates. At its current rate, it will soon become the costliest disease, surpassing cardiovascular diseases. The percentage of children who are overweight in the United States 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 sixteen grants statewide to address this problem. Grant funds will be used to provide intervention programs for overweight children including after school exercise programs and nutritional counseling. Grantees will also focus efforts on public education and adoption of local policies that address the underlying issues. A social marketing campaign will be developed to communicate effectively with minority communities, where the problem is especially acute. UNC-TV will participate by creating and airing messages on its statewide network to reach both at-risk youth and their caregivers.

The Commission is embarking on an effort to examine childhood obesity related policy options by creating a study panel comprised of experts from the fields of medicine, public health, education, business and child advocacy. The purpose of the study panel would be to evaluate the status of obesity among the State's children; recommend policy initiatives to the Commission, which may include suggested recommendations for the NC Department of Health and Human Services, the Department of Public Instruction and other interested bodies. The study panel may also develop legislative proposals that could be presented to the General Assembly. The study panel will be co-chaired by Dr. Olson Huff, Sen. Bill Purcell and Rep. Verla Insko. The Commission has allocated a budget of $300,000 for staff support and other operational expenses.

The Senior Care program was implemented one year ago; Medication Assistance Centers and Teen Tobacco Prevention and Cessation programs have been in place for six to eight months. The grantees for Children, Youth and Community Obesity Reduction / Prevention have recently been selected, and the Commission is still in the process of finalizing the awards. Thus, it is too early to have outcomes that are measurable. However, the Commission has contracted with evaluation experts from local universities to track progress and report outcomes as they become available. Interim grantee progress reports are included elsewhere in this document, which point out both progress that has been made to-date and plans for work yet to be accomplished. In selecting grantees, the Commission has been mindful of its statutory obligation to build community capacity. Therefore, a number of the grantees are inexperienced in the particular area for which their grant was awarded. The Commission is providing technical support to all grantees through memoranda of understandings with expert agencies and university departments. The reality is that even with such assistance, the development of capacity in many underserved areas will take additional time than has yet been devoted to this endeavor.

Purpose of Disbursement	OrgName	Category of Recipient	3 Year Commitment	FY 02-03 Disbursements (Start Up Costs)
SENIOR CARE PROGRAM				
Drug Benefit and Program Administration	DHHS Office of Rural Health	State Agency	88,730,386	10,863,914
PDAP Transition Drug Benefit	DHHS Office of Rural Health	State Agency	1,832,265	1,032,064
Senior Care Program Evaluation	UNC School Public Health	State University	396,000	44,267
Senior Care Program Evaluation	NC A&T University	State University	165,418	-
	Program Total		91,124,069	**11,940,245**

MEDICATION ASSISTANCE PROGRAM				
Local Program Implementation	Alamance Regional Medical Center	Grantee	287,500	54,922
Local Program Implementation	Bladen HealthWatch	Grantee	280,768	58,080
Local Program Implementation	Caldwell Senior Center	Grantee	176,500	36,065
Local Program Implementation	Cape Fear Council of Gov. Area Agency on Aging	Grantee	398,000	69,348
Local Program Implementation	Carolina Family Health Centers (Wilson Community)	Grantee	389,000	67,780
Local Program Implementation	Cherokee Cnty Health Dept	Grantee	442,696	65,018
Local Program Implementation	Cumberland Cnty Hospital System	Grantee	450,000	78,409
Local Program Implementation	Eastern Carolina Council Area Agency on Aging	Grantee	802,110	144,926
Local Program Implementation	Gaston Family Health Services	Grantee	232,750	46,176
Local Program Implementation	Guilford Cnty Dept of Public Health	Grantee	449,968	78,227
Local Program Implementation	Isothermal Planning Commission Area Agency on Aging	Grantee	514,521	107,507
Local Program Implementation	Lumber River Council of Governments/AAA	Grantee	416,000	73,705
Local Program Implementation	Martin-Tyrrell-Washington District Health Dept.	Grantee	408,999	80,560
Local Program Implementation	MedAssist of Mecklenburg	Grantee	268,000	50,366
Local Program Implementation	Mid-East Commission Area Agency on Aging	Grantee	456,960	92,536
Local Program Implementation	Mission St. Joseph's Healthcare Foundation	Grantee	392,986	70,004
Local Program Implementation	Piedmont Triad Council of Government AAA	Grantee	145,000	26,561
Local Program Implementation	Resources for Seniors	Grantee	465,199	91,788
Local Program Implementation	Rural Health Group	Grantee	412,200	72,659
Local Program Implementation	Senior PHARMAssist	Grantee	207,999	36,242
Local Program Implementation	The Hunger Coalition	Grantee	336,000	71,106
Local Program Implementation	UNC School of Pharmacy	Grantee	256,846	38,179
Local Program Implementation	Winston-Salem Urban league	Grantee	262,000	41,901

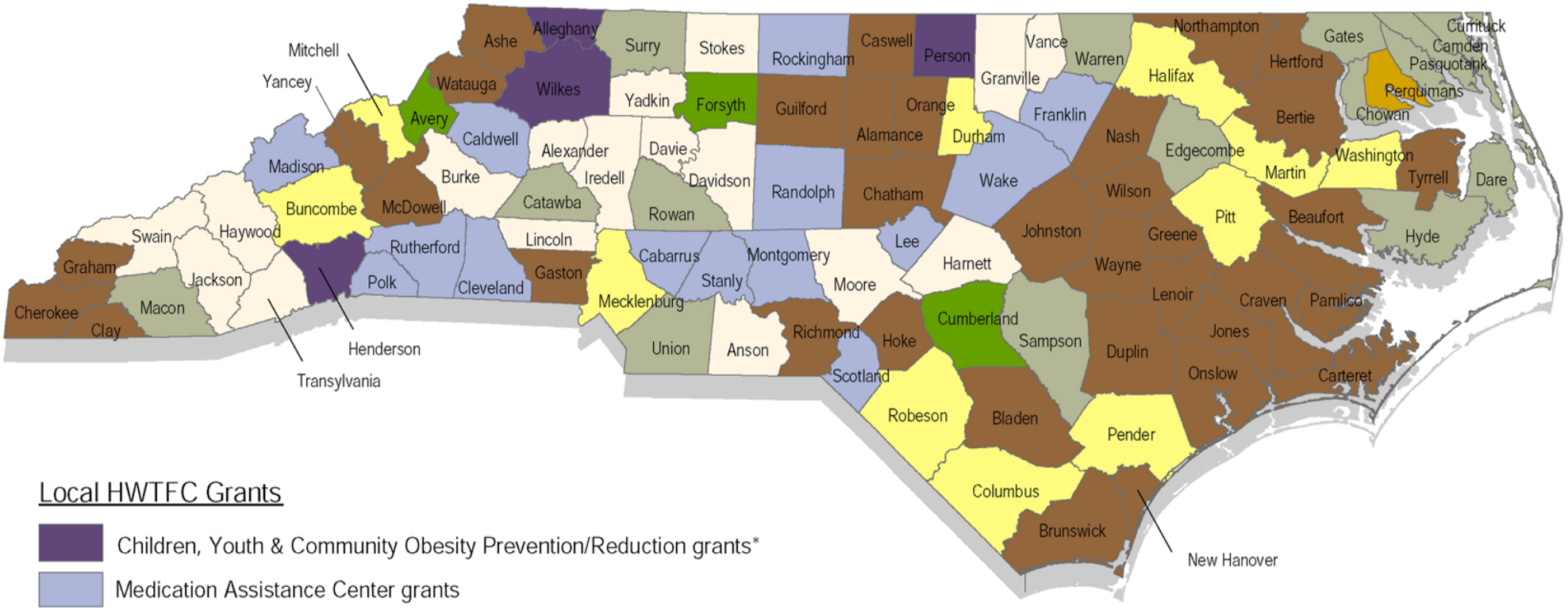
Purpose of Disbursement	OrgName	Category of Recipient	3 Year Commitment	FY 02-03 Disbursements (Start Up Costs)
MEDICATION ASSISTANCE PROGRAM (continued)				
Technical Assistance Provider	DHHS Office of Rural Health	State Agency	645,000	-
Pharmacist Training	Area Health Education Centers	State University	62,344	62,200
	Program Total		**,159,346**	**,614,266**

TEEN SMOKING PREVENTION AND CESSATION PROGRAM				
Local Program Implementation	Alamance-Caswell Area MH/DD/SA Authority	Grantee	200,000.00	31,543
Local Program Implementation	Ashe Cnty Schools	Grantee	199,640.98	31,675
Local Program Implementation	Buncombe Cnty Schools/Safe and Drug Free Schools	Grantee	299,727.00	45,347
Local Program Implementation	Cancer Services of Gaston Cnty	Grantee	170,000.00	22,216
Local Program Implementation	Catawba Cnty Public Health Dept	Grantee	300,000.00	52,273
Local Program Implementation	Chatham Cnty Health Dept	Grantee	264,596.00	39,799
Local Program Implementation	Chowan Regional Health Care Foundation	Grantee	300,000.00	45,455
Local Program Implementation	Durham Cnty Health Dept	Grantee	287,156.00	53,749
Local Program Implementation	El Pueblo	Grantee	465,000	72,412
Local Program Implementation	FirstHealth of the Carolinas	Grantee	280,613.00	39,888
Local Program Implementation	General Baptist State Convention of NC	Grantee	475,000	58,122
Local Program Implementation	Guilford Cnty Project ASSIST	Grantee	210,000.00	36,591
Local Program Implementation	Halifax County Schools	Grantee	292,080.00	50,161
Local Program Implementation	Hertford-Gates District Health Dept	Grantee	198,307.00	20,150
Local Program Implementation	Macon Cnty Public Health Center	Grantee	135,366.00	25,045
Local Program Implementation	McDowell Cnty Schools	Grantee	285,000.00	49,659
Local Program Implementation	Mecklenburg Cnty Health Dept	Grantee	300,000.00	39,091
Local Program Implementation	Mitchell Cnty Schools	Grantee	278,750.00	51,358
Local Program Implementation	N.C. Amateur Sports/State Games of North Carolina	Grantee	285,000.00	43,148
Local Program Implementation	NC Commission of Indian Affairs	Grantee	475,000	-
Local Program Implementation	Old North State Medical Society	Grantee	787,500	101,420
Local Program Implementation	Orange Cnty Health Dept	Grantee	232,848.00	36,978
Local Program Implementation	Public Schools of Robeson Cnty	Grantee	283,500.00	48,875
Local Program Implementation	Rowan Cnty Health Dept	Grantee	228,000.00	41,867
Local Program Implementation	SAVE of NC GASP	Grantee	210,000.00	36,591
Local Program Implementation	Surry Cnty Health and Nutrition Center	Grantee	272,346	44,827
Local Program Implementation	Tri-Cnty 2000 Community Health Project.	Grantee	150,000	22,727

Purpose of Disbursement	OrgName	Category of Recipient	3 Year Commitment	FY 02-03 Disbursements (Start Up Costs)
TEEN SMOKING PREVENTION AND CESSATION PROGRAM				
Local Program Implementation	Union Cnty Public Schools	Grantee	283,968	49,809
Local Program Implementation	Watauga Cnty Schools	Grantee	300,000	52,273
Local Program Implementation	Wilmington Health Access for Teens (WHAT)	Grantee	418,154	41,862
Not On Tobacco Program Implementation	American Lung Association	Grantee	600,000	-
Technical Assistance Provider	NC Prevention Partners	Contractor	52,000	-
Technical Assistance Provider	DHHS Tobacco Prevent/Control	State Agency	65,000	17,347
Technical Assistance Provider	DHHS Minority Health	State Agency	45,000	-
Tobacco Sales Law Enforcement	DHHS Substance Abuse Section	State Agency	,500,000	61,827
Pregnant Teen Cessation	DHHS Women/Children Health	State Agency	00,000	113,240
Program Evaluation	UNC School of Family Medicine	State University	50,000	-
Media Campaign	Goddin Media	Contractor	,522,450	,148,121
	Program Total		**18,102,002**	**,625,444**

ADMINISTRATIVE COSTS				
Commission operating costs				**36,236**
	TOTAL DISBURSEMENTS FY 02-03			**6,716,191**

HWTFC Grants Awarded in 2002/2003

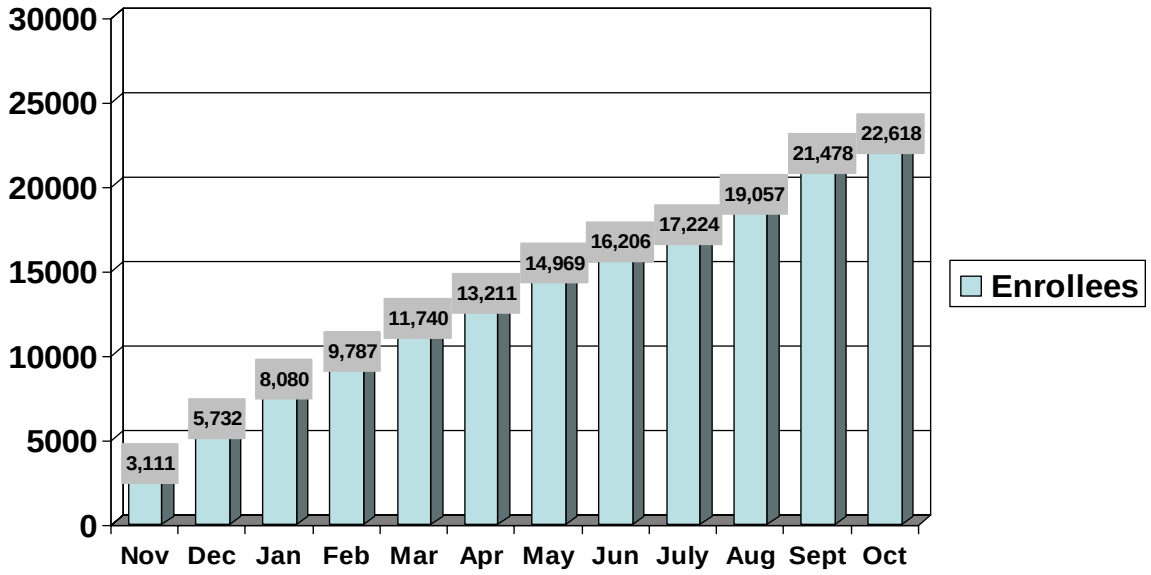


Local HWTFC Grants

- Children, Youth & Community Obesity Prevention/Reduction grants*
- Medication Assistance Center grants
- Teen Tobacco Use Prevention and Cessation grants
- Children, Youth & Community Obesity Prevention/Reduction grants; Medication Assistance Center grants
- Children, Youth & Community Obesity Prevention/Reduction grants; Teen Tobacco Use Prevention and Cessation grants
- Medication Assistance Center grants; Teen Tobacco Use Prevention and Cessation grants
- Children, Youth & Community Prevention/Reduction grants; Medication Assistance Center grants; Teen Tobacco Use Prevention and Cessation grants
- Teen Tobacco Use Prevention and Cessation Programs (statewide); Access to Medication Management Hotline

*Coverage expands from 19 counties in Year 1 to 35 counties in Year Two (not shown).

Senior Care Enrollment
November 2002 – October 2003



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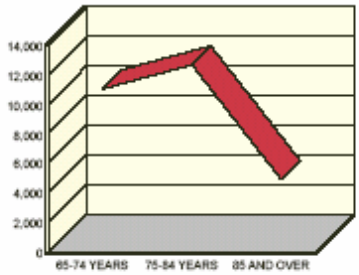
Number of Utilizers by Age Group

Run Date: 10/15/2003

From Month Ending 07/31/2003 To 08/31/2003

Client ID: NCSENR

Age Group	Count of Utilizers
65-74 YEARS	10,385
75-84 YEARS	12,008
85 AND OVER	4,266



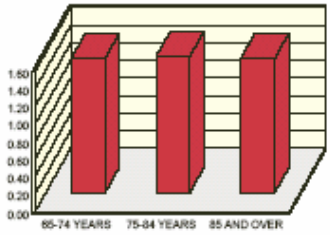
Rate of Utilization by Age

Run Date: 10/15/2003

From Month Ending 07/31/2003 To 08/31/2003

Client ID: NCSENR

Age Group	RX Count per Utilizing Member
65-74 YEARS	1.53
75-84 YEARS	1.55
85 AND OVER	1.53



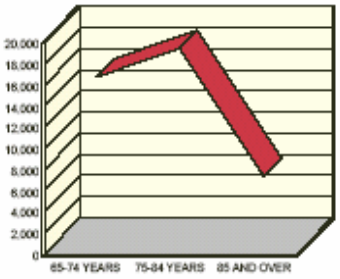
Number of Prescriptions by Age Group

Run Date: 10/15/2003

From Month Ending 07/31/2003 To 08/31/2003

Client ID: NCSENR

Age Group	Rx Count
65-74 YEARS	15,896
75-84 YEARS	18,641
85 AND OVER	6,533



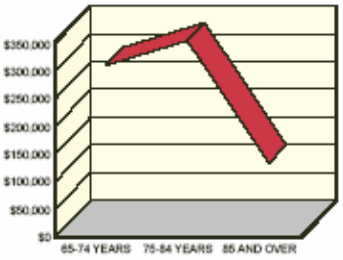
Total Cost by Age Group

Run Date: 10/15/2003

From Month Ending 07/31/2003 To 08/31/2003

Client ID: NCSENR

Age Group	Amount Paid
65-74 YEARS	$292,347
75-84 YEARS	$337,003
85 AND OVER	$115,615



Generic Utilization Summary by Amount Paid

Run Date: 10/15/2003

From Month Ending 07/31/2003 To 08/31/2003

Client ID: NCSENR

Generic Utilization	Amount Paid	Percentage
Brand	$583,044.83	78.26 %
Brand with Generic Available	$32,105.29	4.31 %
Generic	$129,815.17	17.43 %

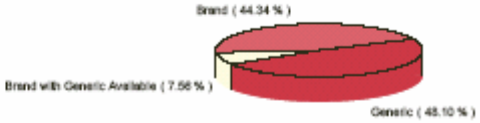
Generic Utilization Summary by Number of Prescriptions

Run Date: 10/15/2003

From Month Ending 07/31/2003 To 08/31/2003

Client ID: NCSENR

Generic Utilization	Rx Count	Percentage
Brand	18,210	44.34 %
Brand with Generic Available	3,104	7.56 %
Generic	19,756	48.10 %



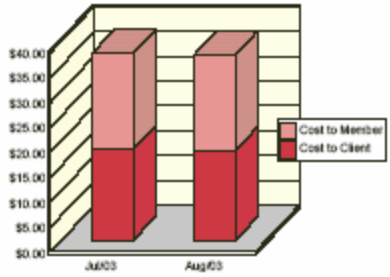
Total Prescription Costs

Run Date: 10/15/2003

From Month Ending 07/31/2003 To 08/31/2003

Client ID: NCSENR

Service Month	Cost to Client	Cost to Member
Jul/03	$18.22	$19.35
Aug/03	$18.06	$19.24



NORTH CAROLINA SENIOR CARE ENROLLMENT
November 2002 - September 2003

State Total approved: 22,440

COUNTY	TOTAL RECIPIENTS	RACE
ALAMANCE	1	A
ALAMANCE	59	AA
ALAMANCE	14	NA
ALAMANCE	2	O
ALAMANCE	238	W
ALAMANCE	61	
	375	
ALEXANDER	13	AA
ALEXANDER	2	NA
ALEXANDER	111	W
ALEXANDER	17	
	143	
ALLEGHANY	2	AA
ALLEGHANY	2	NA
ALLEGHANY	59	W
ALLEGHANY	12	
	75	
ANSON	48	AA
ANSON	1	H
ANSON	1	NA
ANSON	50	W
ANSON	16	
	116	
ASHE	2	AA
ASHE	6	NA
ASHE	151	W
ASHE	39	
	198	
AVERY	1	NA
AVERY	62	W
AVERY	10	
	73	
BEAUFORT	1	A
BEAUFORT	59	AA
BEAUFORT	1	NA
BEAUFORT	83	W
BEAUFORT	27	
	171	
BERTIE	1	A
BERTIE	25	AA
BERTIE	1	NA
BERTIE	31	W
BERTIE	14	
	72	
BLADEN	56	AA
BLADEN	4	NA
BLADEN	2	O
BLADEN	104	W
BLADEN	31	
	197	
BRUNSWICK	47	AA
BRUNSWICK	7	NA
BRUNSWICK	1	O
BRUNSWICK	181	W
BRUNSWICK	38	
	274	
BUNCOMBE	14	AA
BUNCOMBE	11	NA
BUNCOMBE	3	O
BUNCOMBE	339	W
BUNCOMBE	53	
	420	
BURKE	14	AA
BURKE	4	NA
BURKE	2	O
BURKE	312	W
BURKE	44	
	376	
CABARRUS	36	AA
CABARRUS	1	H
CABARRUS	10	NA
CABARRUS	2	O
CABARRUS	348	W
CABARRUS	52	
	449	
CALDWELL	1	A
CALDWELL	18	AA
CALDWELL	1	H
CALDWELL	5	NA
CALDWELL	311	W
CALDWELL	50	
	386	
CAMDEN	4	AA
CAMDEN	7	W
CAMDEN	1	
	12	

NORTH CAROLINA SENIOR CARE ENROLLMENT

COUNTY	TOTAL RECIPIENTS	RACE
CARTERET	2	A
CARTERET	10	AA
CARTERET	1	H
CARTERET	69	W
CARTERET	15	
	97	
CASWELL	17	AA
CASWELL	1	NA
CASWELL	43	W
CASWELL	9	
	70	
CATAWBA	28	AA
CATAWBA	12	NA
CATAWBA	2	O
CATAWBA	437	W
CATAWBA	71	
	550	
CHATHAM	23	AA
CHATHAM	1	H
CHATHAM	2	NA
CHATHAM	141	W
CHATHAM	21	
	188	
CHEROKEE	2	AA
CHEROKEE	1	H
CHEROKEE	1	NA
CHEROKEE	95	W
CHEROKEE	18	
	117	
CHOWAN	22	AA
CHOWAN	1	O
CHOWAN	39	W
CHOWAN	13	
	75	
CLAY	1	AA
CLAY	1	NA
CLAY	67	W
CLAY	10	
	79	
CLEVELAND	40	AA
CLEVELAND	2	H
CLEVELAND	4	NA
CLEVELAND	292	W
CLEVELAND	51	
	389	
COLUMBUS	72	AA
COLUMBUS	9	NA
COLUMBUS	1	O
COLUMBUS	182	W
COLUMBUS	44	
	308	
CRAVEN	48	AA
CRAVEN	4	H
CRAVEN	10	NA
CRAVEN	2	O
CRAVEN	133	W
CRAVEN	32	
	229	
CUMBERLAND	2	A
CUMBERLAND	116	AA
CUMBERLAND	4	H
CUMBERLAND	15	NA
CUMBERLAND	2	O
CUMBERLAND	191	W
CUMBERLAND	50	
	380	
CURRITUCK	7	AA
CURRITUCK	1	NA
CURRITUCK	35	W
CURRITUCK	4	
	47	
DARE	1	NA
DARE	22	W
DARE	5	
	28	
DAVIDSON	39	AA
DAVIDSON	9	NA
DAVIDSON	2	O
DAVIDSON	488	W
DAVIDSON	70	
	608	
DAVIE	6	AA
DAVIE	63	W
DAVIE	9	
	78	
DUPLIN	74	AA
DUPLIN	5	NA
DUPLIN	172	W
DUPLIN	37	
	288	
DURHAM	2	A

NORTH CAROLINA SENIOR CARE ENROLLMENT

COUNTY	TOTAL RECIPIENTS	RACE
DURHAM	52	AA
DURHAM	3	H
DURHAM	5	NA
DURHAM	111	W
DURHAM	25	
	198	
EDGECOMBE	88	AA
EDGECOMBE	9	NA
EDGECOMBE	104	W
EDGECOMBE	39	
	240	
FORSYTH	2	A
FORSYTH	83	AA
FORSYTH	2	H
FORSYTH	5	NA
FORSYTH	5	O
FORSYTH	290	W
FORSYTH	53	
	440	
FRANKLIN	48	AA
FRANKLIN	1	NA
FRANKLIN	71	W
FRANKLIN	23	
	143	
GASTON	1	A
GASTON	56	AA
GASTON	4	H
GASTON	13	NA
GASTON	2	O
GASTON	616	W
GASTON	103	
	795	
GATES	9	AA
GATES	12	W
GATES	4	
	25	
GRAHAM	1	NA
GRAHAM	29	W
GRAHAM	5	
	35	
GRANVILLE	91	AA
GRANVILLE	2	NA
GRANVILLE	62	W
GRANVILLE	12	
	167	
GREENE	12	AA
GREENE	1	NA
GREENE	44	W
GREENE	9	
	66	
GUILFORD	1	A
GUILFORD	175	AA
GUILFORD	3	H
GUILFORD	12	NA
GUILFORD	3	O
GUILFORD	580	W
GUILFORD	99	
	873	
HALIFAX	65	AA
HALIFAX	9	NA
HALIFAX	123	W
HALIFAX	34	
	231	
HARNETT	1	A
HARNETT	32	AA
HARNETT	1	H
HARNETT	7	NA
HARNETT	208	W
HARNETT	36	
HAYWOOD	1	AA
HAYWOOD	1	NA
HAYWOOD	111	W
HAYWOOD	17	
	130	
HENDERSON	2	AA
HENDERSON	2	H
HENDERSON	1	NA
HENDERSON	2	O
HENDERSON	105	W
HENDERSON	17	
	129	
HERTFORD	32	AA
HERTFORD	1	H
HERTFORD	1	NA
HERTFORD	19	W
HERTFORD	11	
	64	
HOKE	50	AA
HOKE	1	H
HOKE	19	NA
HOKE	40	W

NORTH CAROLINA SENIOR CARE ENROLLMENT

COUNTY	TOTAL RECIPIENTS	RACE
HOKE	20	
	130	
HYDE	17	AA
HYDE	1	NA
HYDE	14	W
HYDE	4	
	36	
IREDELL	1	A
IREDELL	29	AA
IREDELL	1	H
IREDELL	8	NA
IREDELL	2	O
IREDELL	247	W
IREDELL	46	
	334	
JACKSON	1	AA
JACKSON	1	NA
JACKSON	40	W
JACKSON	6	
	48	
JOHNSTON	57	AA
JOHNSTON	5	NA
JOHNSTON	2	O
JOHNSTON	295	W
JOHNSTON	43	
	402	
JONES	10	AA
JONES	30	W
JONES	3	
	43	
LEE	13	AA
LEE	1	H
LEE	2	NA
LEE	100	W
LEE	15	
	131	
LENOIR	73	AA
LENOIR	2	NA
LENOIR	139	W
LENOIR	34	
	248	
LINCOLN	8	AA
LINCOLN	13	NA
LINCOLN	211	W
LINCOLN	37	
	269	
MACON	3	NA
MACON	82	W
MACON	12	
	97	
MADISON	1	NA
MADISON	30	W
MADISON	4	
	35	
MARTIN	1	A
MARTIN	50	AA
MARTIN	1	NA
MARTIN	67	W
MARTIN	17	
	136	
MCDOWELL	5	AA
MCDOWELL	3	NA
MCDOWELL	127	W
MCDOWELL	15	
	150	
MECKLENBURG	6	A
MECKLENBURG	106	AA
MECKLENBURG	4	H
MECKLENBURG	10	NA
MECKLENBURG	1	O
MECKLENBURG	409	W
MECKLENBURG	100	
	636	
MITCHELL	7	NA
MITCHELL	86	W
MITCHELL	17	
	110	
MONTGOMERY	14	AA
MONTGOMERY	1	NA
MONTGOMERY	85	W
MONTGOMERY	22	
	122	
MOORE	1	A
MOORE	50	AA
MOORE	6	NA
MOORE	1	O
MOORE	187	W
MOORE	45	
	290	
NASH	75	AA

NORTH CAROLINA SENIOR CARE ENROLLMENT

COUNTY	TOTAL RECIPIENTS	RACE
NASH	2	H
NASH	2	NA
NASH	1	O
NASH	221	W
NASH	50	
	351	
NEW HANOVER	74	AA
NEW HANOVER	6	NA
NEW HANOVER	292	W
NEW HANOVER	52	
	424	
NORTHAMPTON	43	AA
NORTHAMPTON	40	W
NORTHAMPTON	20	
	103	
ONSLOW	17	AA
ONSLOW	1	H
ONSLOW	4	NA
ONSLOW	2	O
ONSLOW	137	W
ONSLOW	28	
	189	
ORANGE	17	AA
ORANGE	3	NA
ORANGE	69	W
ORANGE	13	
	102	
OTHER	2	W
PAMLICO	15	AA
PAMLICO	1	NA
PAMLICO	38	W
PAMLICO	15	
	69	
PASQUOTANK	15	AA
PASQUOTANK	1	NA
PASQUOTANK	37	W
PASQUOTANK	14	
	67	
PENDER	48	AA
PENDER	5	NA
PENDER	112	W
PENDER	19	
	184	

COUNTY	TOTAL RECIPIENTS	RACE
PERQUIMANS	12	AA
PERQUIMANS	17	W
PERQUIMANS	5	
	34	
PERSON	19	AA
PERSON	117	W
PERSON	16	
	152	
PITT	100	AA
PITT	2	NA
PITT	1	O
PITT	130	W
PITT	40	
	273	
POLK	2	AA
POLK	48	W
POLK	6	
	56	
RANDOLPH	1	A
RANDOLPH	25	AA
RANDOLPH	3	H
RANDOLPH	11	NA
RANDOLPH	1	O
RANDOLPH	474	W
RANDOLPH	80	
	595	
RICHMOND	15	AA
RICHMOND	3	NA
RICHMOND	66	W
RICHMOND	17	
	101	
ROBESON	83	AA
ROBESON	119	NA
ROBESON	4	O
ROBESON	185	W
ROBESON	49	
	440	
ROCKINGHAM	58	AA
ROCKINGHAM	9	NA
ROCKINGHAM	353	W
ROCKINGHAM	70	
	490	
ROWAN	58	AA
ROWAN	9	NA
ROWAN	1	O
ROWAN	409	W

NORTH CAROLINA SENIOR CARE ENROLLMENT

COUNTY	TOTAL RECIPIENTS	RACE
ROWAN	85	
RUTHERFORD	16	AA
RUTHERFORD	1	H
RUTHERFORD	2	NA
RUTHERFORD	157	W
RUTHERFORD	31	
SAMPSON	81	AA
SAMPSON	1	H
SAMPSON	10	NA
SAMPSON	1	O
SAMPSON	233	W
SAMPSON	78	
	404	
SCOTLAND	23	AA
SCOTLAND	13	NA
SCOTLAND	1	O
SCOTLAND	79	W
SCOTLAND	19	
	135	
STANLY	20	AA
STANLY	4	NA
STANLY	204	W
STANLY	37	
	265	
STOKES	9	AA
STOKES	6	NA
STOKES	130	W
STOKES	25	
	170	
SURRY	14	AA
SURRY	2	H
SURRY	14	NA
SURRY	1	O
SURRY	357	W
SURRY	58	
	446	
SWAIN	1	NA
SWAIN	31	W
SWAIN	5	
	37	
TRANSYLVANIA	1	A
TRANSYLVANIA	3	AA
TRANSYLVANIA	3	NA
TRANSYLVANIA	40	W
TRANSYLVANIA	11	
	58	
TYRRELL	13	AA
TYRRELL	13	W
TYRRELL	1	
	27	
UNION	1	A
UNION	22	AA
UNION	5	NA
UNION	203	W
UNION	38	
	269	
VANCE	53	AA
VANCE	1	NA
VANCE	84	W
VANCE	27	
	165	
WAKE	10	A
WAKE	167	AA
WAKE	11	H
WAKE	15	NA
WAKE	3	O
WAKE	429	W
WAKE	82	
	717	
WARREN	38	AA
WARREN	3	NA
WARREN	38	W
WARREN	22	
	101	
WASHINGTON	19	AA
WASHINGTON	1	NA
WASHINGTON	26	W
WASHINGTON	2	
	48	
WATAUGA	1	AA
WATAUGA	3	NA
WATAUGA	75	W
WATAUGA	14	
	93	
WAYNE	102	AA
WAYNE	1	H
WAYNE	5	NA
WAYNE	1	O
WAYNE	207	W

NORTH CAROLINA SENIOR CARE ENROLLMENT

COUNTY	TOTAL RECIPIENTS	RACE
WAYNE	51	
	367	
WILKES	17	AA
WILKES	9	NA
WILKES	2	O
WILKES	276	W
WILKES	39	
	343	
WILSON	1	A
WILSON	67	AA
WILSON	2	H
WILSON	2	NA
WILSON	115	W
WILSON	33	
YADKIN	3	AA
YADKIN	3	NA
YADKIN	176	W
YADKIN	27	
	209	
YANCEY	2	NA
YANCEY	49	W
YANCEY	8	
	59	

Evaluation of the Senior Prescription Drug Assistance Program ("Senior Care")
Annual Report
Principal Investigator: Morris Weinberger, PhD, University of North Carolina

Given their increased risk of chronic disease, elders are prescribed multiple medications. Impediments to receiving prescription medications can negatively affect the health of these elders. The Health and Wellness Trust Fund Commission has contracted with the North Carolina Department of Health and Human Services (DHHS) to administer Senior Care; ACS will administer the Program for the Health and Wellness Trust. Senior Care offers eligible North Carolina elders increased *access to prescription medications* and insulin and, for those at high risk for medication problems, referral to a *medication management program* (for patients with a program funded by the Commission in their community).

Our evaluation plan proposes to assess the effect of Senior Care on patients' access to medications and health outcomes. Specifically, we propose to evaluate the effect of Senior Care and the prescription assistance program on: (1) *Patients' access to medications and related services:* penetration of the program (i.e., the proportion of eligible patients enrolled), barriers to prescription drug use, prescription drugs received, medication management referral, and changes in prescription drug coverage; (2) *Medication compliance;* (3) *Satisfaction with Senior Care;* (4) *Self-reported health status;* and (5) *Health services utilization.* There are two major components of the evaluation:

1. The first component involves *primary data collection.* Specifically, UNC personnel will conduct telephone surveys with a random sample of 1,000 enrollees. Follow-up telephone surveys will be conducted every 4 months for one year.

2. The second component requires administrative data provided to UNC by the Health and Wellness Trust. Specifically, for this component of the evaluation, the Health and Wellness Trust have agreed to provide us with:

- *Critical data on **all** patients enrolled in Senior Care:* This includes data obtained at enrollment, annual re-enrollment, and administrative data collected during the first year after enrollment.
- *Data from Prescription Assistance Centers:* These Centers will complete a standardized form for each contact with patients referred for medication management. These data will allow us to describe some effects of the program on all enrollees. These data will be provided to the UNC evaluation team.

Progress to date:

- We obtained IRB approval to enroll patients by telephone and conduct telephone interviews.
- We hired and trained telephone interviewers.
- All baseline telephone interviews have been completed. From a random sample of 1,761 Senior Care enrollees, we completed interviews with 1,000 persons (56.8%); 481 enrollees (27.3%) could not be reached after multiple attempts; 260 enrollees (14.8%) declined to participate; and 20 (1.1%) died prior to our attempt to contact them.
- Follow-up telephone calls are currently being conducted. We anticipate completing all follow-up telephone interviews surveys by September 2004. This time frame is consistent with our proposal.
- With the completion of enrollment, we are beginning to analyze baseline data on our sample..
- We are continuing to work with the Health and Wellness Trust to obtain administrative data necessary for our evaluation. Currently, Health and Wellness Trust is working with the Prescription Assistance Centers to develop HIPAA-compliant protocols that allow us access to these data. The Health and Wellness Trust Fund is also working with ACS to develop the mechanisms by which we can obtain administrative data from all enrollees. Assuming we can secure administrative data from the Health and Wellness Trust Fund, we can complete this portion of the evaluation.

HBCU Health Promotion Alliance
North Carolina A&T State University
1020 East Wendover Ave., Suite 206
Greensboro, NC 27405
Phone: 336.334.4541
Fax: 336.334.4503

Senior Care Evaluation Progress Report

Project work to date.

From April to the end of July ACS worked to place the data set in the correct format for use by the HBCU Alliance. July to September 15, 2003 we worked with Office of Rural Health to explore issues related to dual eligibility. The information being prepared by the Office of Rural Health was not ready by the dead line so the first phone calls were made on September 26, 2003. To date 45 surveys have been completed. Four individuals as of October 23, 2003 have been trained to make calls and it is estimated that 250- 300 surveys will be completed by the end of November.

Analysis Plan.

Data collected from the survey can be used to test five hypotheses:

$H1_0$: Proportion of participants in Senior Care who have access to medication equals proportion of patients within the general population who have access to medication.

$H1_A$: Proportion of participants in Senior Care who have access to medication is greater than proportion of patients within the general population who have access to medication.

Proposed analysis: Bootstrapping of a proportion. This technique randomly samples, with replacement, the proportion from the observed dataset, and calculates the probability that this proportion of participants in Senior Care with access to medication equals that of the general population.

$H2_0$: The proportion of participants enrolled in Senior Care who are satisfied with the program equals the proportion of participants enrolled in Senior Care who are DISSATISFIED.

$H2_A$: The proportion of participants enrolled in Senior Care who are satisfied with the program is greater than the proportion of participants enrolled in Senior Care who are DISSATISFIED.

Proposed analysis: Bootstrapping of a proportion. This technique assumes the probability that a participant will say he is satisfied equals 0.5. By randomly selecting (with replacement) *n* responses (½ are "satisfied" and ½ are "dissatisfied"), this technique will test whether the proportion of participants in Senior Care who are satisfied equals the proportion of participants in Senior Care who are DISSATIFIED.

$H3_0$: The proportion of participants enrolled in Senior Care complying with prescribed medication regimens equals proportion of patients within the general population complying with prescribed medication regimens.

$H3_A$: The proportion of participants enrolled in Senior Care complying with prescribed medication regimens is greater than the proportion of patients within the general population complying with prescribed medication regimens.

Proposed analysis: Bootstrapping of a proportion. This technique randomly samples, with replacement, the proportion from the observed dataset, and calculates the probability that the proportion of participants in Senior Care complying with prescribed medication regimens equals that of the general population.

$H4_0$: The proportion of participants enrolled in Senior Care utilizing available health services equals proportion of patients within the general population utilizing available health services.

$H4_A$: The proportion of participants enrolled in Senior Care utilizing available health services is greater than proportion of patients within the general population utilizing available health services.

Proposed analysis: Bootstrapping of a proportion. This technique randomly samples, with replacement, the proportion from the observed dataset, and calculates the probability that the proportion of participants in Senior Care utilizing health services equals that of the general population.

$H5_0$: The proportion of participants enrolled in Senior Care who utilize available health services equals the proportion of participants enrolled in Senior Care who DO NOT utilize available health services.

$H5_A$: The proportion of participants enrolled in Senior Care who utilize available health services is greater than the proportion of participants enrolled in Senior Care who DO NOT utilize available health services.

Proposed analysis: Bootstrapping of a proportion. This technique assumes the probability that a participant will say he utilizes available health services equals 0.5. By randomly selecting (with replacement) n responses (½ are "satisfied" and ½ are "dissatisfied"), this technique will test whether the proportion of participants in Senior Care who utilize available health services equals the proportion of participants in Senior Care who DO NOT utilize available health services.

Bootstrapping, Efron (1982), expands an empirical dataset into a hypothetical population, and is based on the assumption that values within a dataset represent all data points within a population. Thus, taking repeated samples with replacement for a given size *n* from the empirical data generates a sampling distribution of a theoretical population. From this sampling distribution, one can estimate almost any kind of population parameter such as means, standard deviations, and confidence intervals. One can also estimate the probability of an event occurring, given only sampling variability.

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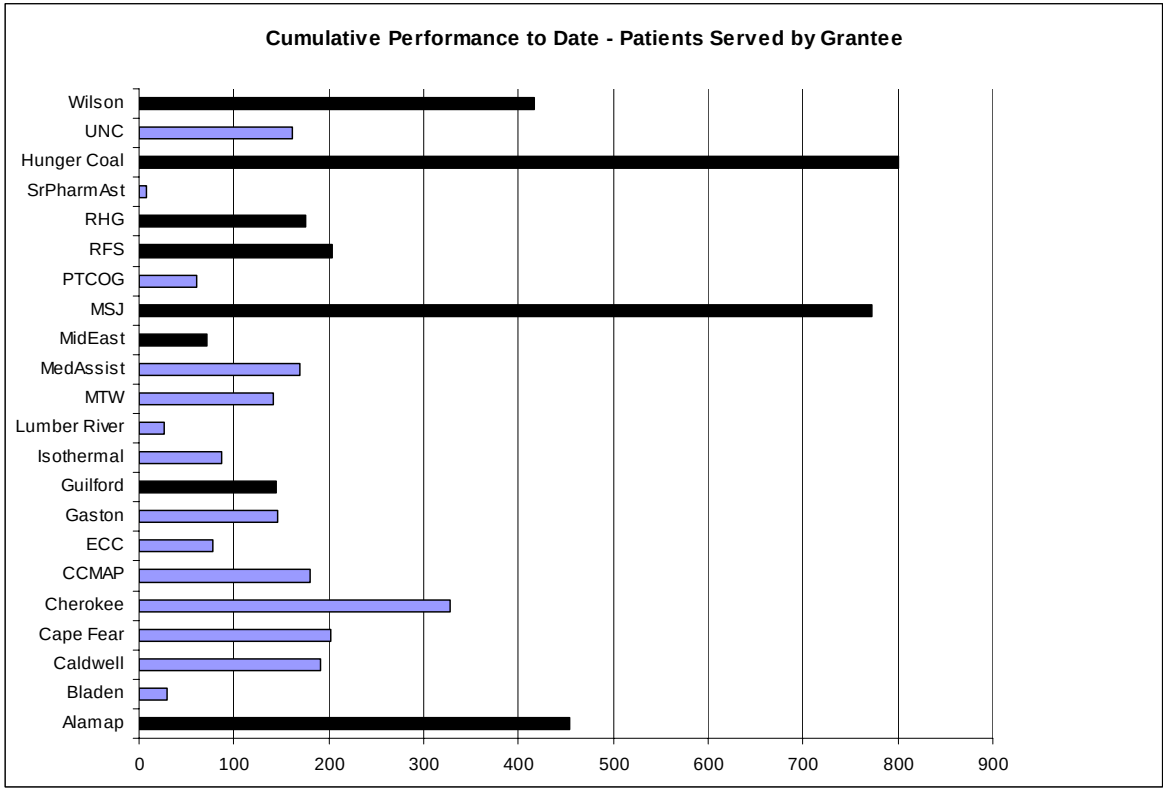
Shao, J., and Tu, D. (1995). The Jackknife and Bootstrap. New York: Springer-Verlag.

Medication Assistance Program (MAP)



Health and Wellness Trust Fund Commission
Medication Assistance Program

Grantees 6 Month Report
March 2003 through August 2003

I. Executive Summary

The 23 grantees reported that they are providing Medication Management and Prescription Assistance services through Pharmacists and Prescription Assistance Coordinators ("PACs"). Grantees which had existing programs have enhanced patient volumes for prescription assistance with HWTFC funds. Grantees that started new programs are still servicing primarily high risk referrals from Senior Care, but should begin outreach to generate referrals from local providers and service agencies in the next few months. Several of the grantees which were Area Agencies on Aging or senior focused programs have not expanded prescription assistance efforts beyond seniors. Many are challenged to serve the Hispanic population in their areas and are seeking part-time translators, often relying on volunteers.

All of the grantees have stated that relationship building with the local medical community is the key to the success of this program. This is not just to generate referrals, but to have providers directly involved in processing pharmaceutical company assistance program forms. The providers may also dispense medication and, most importantly, work with Pharmacists to resolve conflicts and approve medication regimen changes. All of the grantees report active efforts to create these relationships in their community, including presentations at local healthcare, senior and social service and home health agencies.

Common barriers to success reported by grantees included difficulties in hiring/contracting with pharmacists, scheduling patients to come in for visits, and establishing reliable ordering and dispensing processes. Grantees that did not have prior dispensing permits struggled with creating a reliable method to order, receive, and dispense the free drugs obtained through the pharmaceutical company programs. This includes working with local community pharmacies, having the prescribing physician's office dispense drugs, or using part-time physicians at the clinic.

All of the grantees reported that the MARP custom software provided by the Office of Rural Health under their contract with the Commission to deliver services had valuable features but that the implementation/rollout process was not well coordinated. A universal comment was that the gap of several months between formal MARP training sessions and on-site installation created confusion and mandated considerable re-training. Some grantees experienced technical difficulties with new servers, printers, or broadband communications. Grantees that did not have competent local technical support experienced substantial delays in implementation. The grantees have identified numerous MARP improvements to be incorporated in future releases. A MARP User Group has been established to coordinate user feedback and support development of future enhancements. The full scope of immediate MARP support requirements has been reviewed and is now sufficiently resourced.

Monthly activity reporting from the Grantees to HWTFC has been initiated, with a wide range of performance in evidence. The scope and content of this reporting will be refined during the next 6 months,

with added emphasis on data accuracy. Additional reporting on Grantee effectiveness is under development.

II. Narratives

Grantees were asked to write stories describing outcomes from their providing medication management and prescription assistance. A selected number of these stories are presented below organized according to the service provided.

Medication Management

Story # 1- Mrs. A. is 79-year-old widow. She visited the Medication Management Program because she has several medications that she cannot take because she cannot afford to purchase them. Her only income is a $750 per month social security check. Mrs. A. is supposed to take anti-depressant and anti-anxiety medication and medication for osteoporosis. She mentioned to the Pharmacist that she used to have high blood pressure and previously took medication for that. Currently, she was not taking any of these medications. Mrs. A. is very anxious and avoids going to the doctor. The Pharmacist realized that she had been taking two of the same type of anti-depressants. He also took her blood pressure and it was very high. The Pharmacist got permission to consult with the client's physician and will determine if the anti-depressant can be changed to one less expensive medication. He will also discuss medication for blood pressure and osteoporosis. When the physician decides on the appropriate medications after the pharmacy intervention, the PAC will assist Mrs. A will applying for these medications through the discount drug programs. Mrs. A. has a follow-up visit with the Pharmacist in two weeks to discuss the results of the contact that the Pharmacist made with her physician.

Story # 2 – One of our ACS high-risk referrals came in for medication management and access. He had been having financial difficulties in obtaining his medications, so his provider had been supplying him with as many samples as possible. As wonderful as this was on the provider's part, none of the bottles were labeled. The patient was taking excessive medication, Lescol XL® 80mg BID, setting him up for severe adverse events. In addition, the patient had several therapeutic duplications he was taking concurrently (e.g. Hyzaar® and Cozaar® as well as 2 ACE-Inhibitors). After correspondence with the patient's physician, his Lescol® was changed to the intended maximum dose (XL 80mg QD) and patient was instructed which angiotensin-receptor blocker and ACE-Inhibitor to take.
"

Prescription Assistance

Story # 3 – One client, Annie O., was having to spend over $600 a month on medicine, out of an income of $895. With the help of our program, her medication cost has been reduced to about $75. Annie is 75 years old and began subsidizing her income by working as a telemarketer at our local newspaper, at minimum wage, so she could afford her medicine. She says she feels like "she has been let out of prison" and "can now sleep at night without worrying about how she is going to pay for her medicine."

Story # 4 – Catherine met with a patient and her spouse. The patient's medication list included Novolin, Zocor, Zoloft, Glucovance, Flovent, Prednisone, Lasix, Prevacid, Celebrex, Rhinocort, Plavix, Avalide, Percocet, and Advair. The spouse's medication list included Atrovent, Amaryl, Actos, K-Tab, Theophylline, Sular, Lasix, Zoloft, Diovan, Lipitor, Prevacid, Prednisone, and Aspirin. The couple's combined monthly income is $1241.00. The couple's monthly prescription bill for 1-month supply of each medication totaled $1527.00. (As you can see they were not compliant on all medications due to cost).

After completing all available drug manufacturers' applications that they qualified for, their drug bill dropped to $85.00 per month. The patients only have to purchase Lasix, Prednisone, Percocet, and Aspirin. If they use their NC Senior Care cards as they were instructed to do, they will lower their drug bill even further.

Story # 5. We have been delivering medications now to at least 100 people through our medication program. The clients have unlimited access to our pharmacist and are encouraged to use this service. The use of a pharmacist and a PAC is one of the best outcomes for the program. We encountered one client who was seeing more than on doctor (e.g. specialist and family doctor) and this client had been taking the same medication daily from all the doctors. One med. was generic and one was the brand name med but both the same. This situation was potentially dangerous for the client. Our PAC instructed the client to go see their family doctor upon leaving the office, explained the medications were duplicates and the dangers of taking those duplicated meds. The client followed through with her doctor and the problem was corrected.

Story # 6 Marie Maynor heard about MedAssist through a friend at her senior center. Mrs. Maynor is seventy -five years old and has just retired from her part time job because of a recent stroke. Without this part time, job she cannot afford to pay for her medications. Mrs. Maynor was skeptical about being eligible for the MedAssist program because she does own her car. Having been turned down for Medicaid and other community resources, she felt lost between the cracks. However, she has been prescribed more medications and is taking eight in total. She cannot afford the cost of all of her medications. About $400 of her $1000 social security check was being spent on medications. The rest of her check does not cover her mortgage or other bills that she needs to pay each month. Mrs. Maynor said that she has to make a choice between which medications to get filled and buying groceries. She has also started skipping days so that the medications would last longer. Having to make a choice regarding which medications to take, she has decided to only take her high blood pressure medications. She is behind on her mortgage payments and decided to call our agency to see if she could receive any assistance. Mrs. Maynor will be able to receive seven of her eight medications free through the different patient assistance programs. Mrs. Maynor is delighted because now she can start to pay some of her outstanding bills with the money that she no longer will need to spend on medications.

Medication Assistance Program
Office of Rural Health, DHHS

Summary Report for End of First Program Year

I. Introduction

The Office of Research, Demonstrations and Rural Health Development (ORDRHD) serves as technical consultant to the Medication Assistance Program project under a Memorandum of Understanding (MOU) with the Health & Wellness Trust Fund Commission. Under the terms of the MOU, ORDRHD has fulfilled a range of functions for the Commission and the MAP project over the first year of the program.

Prior to the approval of the initial round of grantees in October 2002, ORDRHD provided consultation and support in developing the Request for Proposal, and in screening and selection of 24 grantees from among 61 applicants located across the state. Of those approved for funding, the 24 grantees represented 61 actual delivery sites for prescription assistance and medication management services.
Prescription Assistance involves helping citizens in applying for and obtaining free and low cost prescription drugs. Medication management encompasses the services of a pharmacist in evaluating patients' drug regimens.

This group of MAP service sites includes a crossection of public and private not-for-profit organizations possessing a broad range of experience and skills in serving the health, and social service support needs of North Carolina's seniors and low income citizens. This diversity of organization types and experience presented an implementation challenge that ORDRHD has spent a significant amount of time in addressing. After assisting in the development of the grant agreements, ORDRHD held three major day to day and a half long orientations and operations trainings for all grantees. These trainings covered a full range of operational readiness activities. Standard forms and procedures were distributed and advice given on setting up the MAPs to meet the service requirements of the target populations.

ORDRHD developed the Medication Access and Review Program (MARP) software using funding provided by the Duke Foundation to the North Carolina Foundation for Advanced Health Programs. This software was developed and distributed free of charge to all 61 sites funded under Commission grants. It automates the eligibility determination and application completion process for nearly 100 manufacturers' free drug programs. MARP also allows pharmacists to efficiently and effectively conduct "brown bag" reviews that involve a careful review of the medications, risk factors, and medical history of patients. MARP allows the pharmacist to automatically check for adverse drug reactions as well as to price the drugs that are provided at free or reduced rates through the program.

In addition, ORDRHD has provided software training to all but one site at this point through day and a half intensive hands-on sessions. A total of 26 training sessions have been done for 208 Prescription Assistance Coordinators and Pharmacists. A comprehensive user manual was also prepared and distributed to assist sites in using MARP. Users also receive technical support from ORDRHD by telephone from project staff. This includes assistance with downloading MARP, connectivity, and troubleshooting actual usage of the software. An updated version of the software is expected to be out by the end of 2003.

As a follow up to software training and as part of operational implementation, ORDRHD has conducted site visits throughout the state. Site visits involve on-sight troubleshooting, training and

technical assistance with local MAPs that last up to half a day. They have proven invaluable in providing hands-on assistance to the sites in using the software, and implementing their operations. Thus far ORDRHD has done over 60 site visits.

Monthly conference calls are held with all grantees. They are divided into four groups of 5-6 each for the purpose of these calls which allow them to update one another on their progress, get questions and concerns answered, discuss issues of common concern and hear about the statewide activities of the project.

ORDRHD working with its Senior Care enrollment contractor, ACS, Inc., has set up a process for identifying Senior Care enrollees who might benefit most from accessing the services of the Medication Assistance Programs. As part of the Senior Care enrollment process, applicants complete a "Medication and Health Questionnaire" on which they self report on risk factors that may predispose them for having medication related problems. Problems identified include adverse drug interactions, use of risky medications, and polypharmacy. Through this process over 4200 individuals have been identified and referred to the MAPs for follow up and evaluation of whom approximately 1500 have been seen on-site.

MAPs report monthly on total patients seen and services provided as a result of these efforts. In addition to the 1500 high risk referrals, they have reported serving over 3,000 other patients for some combination of prescription assistance in applying for the free and low cost drug programs, and medication management.

Health and Wellness Trust Fund Commission
Teen Tobacco Prevention Initiative

Grantees 6 Month Report
October 17, 2003

UNC Department of Family Medicine
Outcomes Evaluation Project

I. Executive Summary

In the monthly Progress Tracking System (PTS) reports, Health and Wellness Trust Fund Commission (HWTFC) grantees document their activities and accomplishments in relation to their objectives. In their Six Month Reports grantees provide a self-assessment of their individual programs and the linkage and support they are getting from other grantee agencies (NOT, SAVE etc.). They also write a story describing one of their accomplishments and make suggestions for improving the Teen Tobacco Prevention Initiative. These individual Six Month Reports are combined in this report to give a statewide view of the grantees' perspectives on how their tobacco prevention initiatives are progressing.

All of the Community/Schools grantees (26) and the Priority Population grantees (4) submitted this first Six Month Report in October 2003, and the results from these two groups are reported separately below. The individual reports from each of the grantees are also included in the appendix.

On the basis of the first ten program assessment questions in the 6 Month Report, grantees assess their own program progress as follows:

- About 80% (20 of 26) of the Community Schools grantees and all of the Priority Population grantees report that they have achieved most of their formative objectives during this initial 6 month period.
- Almost all (25 of 26) of the Community Schools grantees and 75% (3 of 4) of the Priority Population grantees report that to a large extent they feel well-prepared to achieve their program objectives for the next 6 month period.
- About 40% (11 of 26) of the Community Schools grantees and 25% (1 of 4) of the Priority Population grantees report that they have encountered significant barriers relatively frequently.
- About 75% of both the Community Schools grantees (19 of 26) and the Priority Population grantees (3 of 4) report that youth are actively involved in their program planning.
- About 90% (23 of 26) of the Community Schools grantees and all of the Priority Population grantees report that both new and existing community partnerships have assisted them in meeting their program objectives.
- About 70% (18 of 26) of the Community Schools grantees and 75% (3 of 4) of the Priority Population grantees report that the perceived health risks of tobacco use are only moderate or higher in their communities.
- About 45% (12 of 26) of the Community Schools grantees and 75% (3 of 4) of the Priority Population grantees report a low to moderate utilization level of media advocacy to promote their program objectives.

Community/School grantees' mean scores on the 10 program progress questions ranged from 5 to 7.9 on a 10 point scale, with a mean of 6.5 or more on 6 of the questions. Priority Population grantees' mean scores ranged from about 5 to 8.5, with a mean of 6.5 or more on 7 of the questions. (The higher the number, the more positive the assessment except in the case of question #2, barriers, where a lower number is more positive) These measures reflect healthy program status for this early period. See Charts 1-4 for a graphical representation of the responses to several of these questions.

In terms of the 9 questions inquiring about linkages and support from statewide initiatives and other resources:

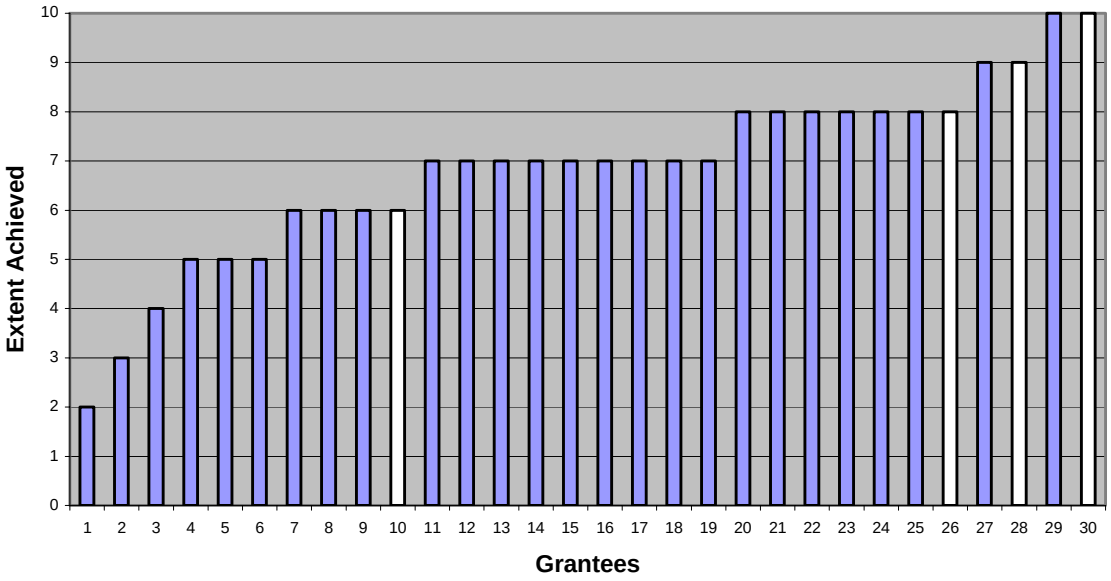
- About 95% (25 of 26) of the Community Schools grantees and all of the Priority Population grantees report that they are getting very good technical assistance and training support.
- About 55% (14 of 26) of the Community Schools grantees and 25% (1 of 4) of the Priority Population grantees reported that they have found PTS useful in tracking their program activities.
- About 85% (22 of 26) of the Community Schools grantees and all of the Priority Population grantees reported making good use of the Tobacco Reality Unfiltered (TRU) print media, but only 75% of Community Schools grantees and 50% of Priority Populations grantees reported moderate or greater exposure to the radio messages.
- Community Schools grantees reported the lowest level of partnering with the Priority Population grantees (20%:5 of 26), the next higher level with the SAVE program (35%: 9 of 26) and the highest level with the NOT program (45%:12 of 26). Priority Population grantees reported their highest level of partnering with each other (100%: 4 of 4), the next highest level with the NOT program (75%: 3 of 4), and the lowest level (25%: 1 of 4) with the SAVE program.

The mean scores on these 9 program linkage questions ranged from 3.2 to 8.2 for Community/School grantees, and from 1.5 to 8.3 for Priority Population grantees, a greater spread than that for the program progress questions. See Charts 5 and 6 for a graphical representation of responses to two of these questions.

All of the grantees also wrote stories describing one of their accomplishments. This report highlights one or two stories related to each of the four HWTFC program goals. From these narratives we learn more detail about the progress being made toward reaching the desired outcomes. They also reflect the energy and commitment of grantees for meeting the challenge of reducing the morbidity and mortality associated with tobacco use in their communities.

Addressing the desire for making better connections with the statewide initiatives, grantees offered a number of suggestions. These dealt with media themes, exposure, and utilization training; increased awareness of programs and resources available from the various initiatives; and overall communication of what is happening project-wide. These suggestions, summarized in this report, will be shared with the appropriate persons or groups so that all programs and initiatives can benefit.

Chart 1
FIRST 6 MONTHS' PROGRAM OBJECTIVES ACHIEVED



Dark bars	Community/ Schools	**Light bars**	Priority Populations

Chart 2
ON TARGET TO ACHIEVE NEXT 6 MONTHS' PROGRAM OBJECTIVES

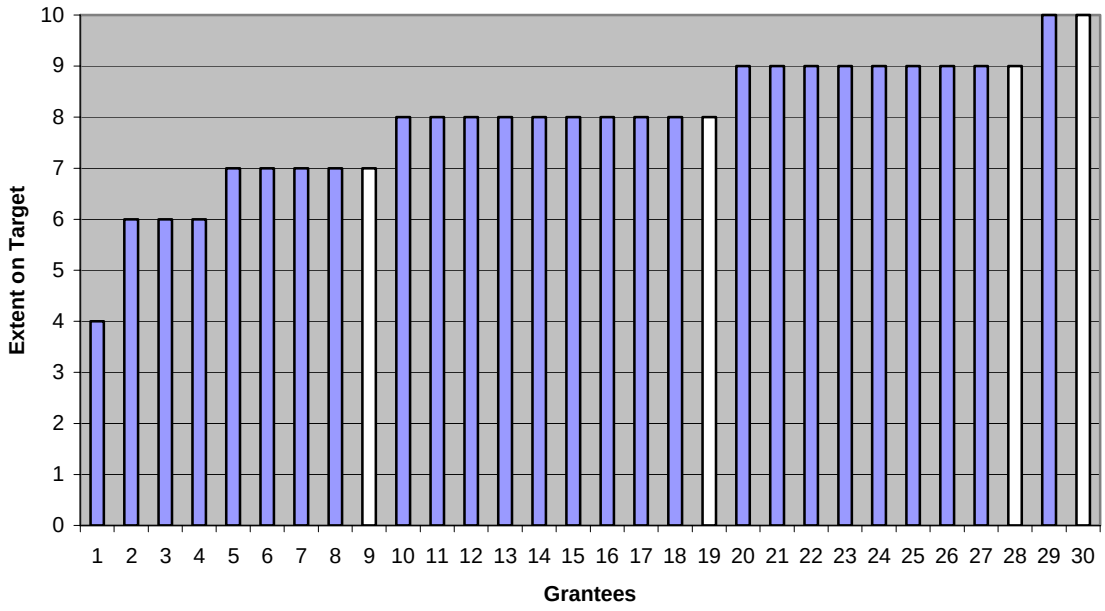
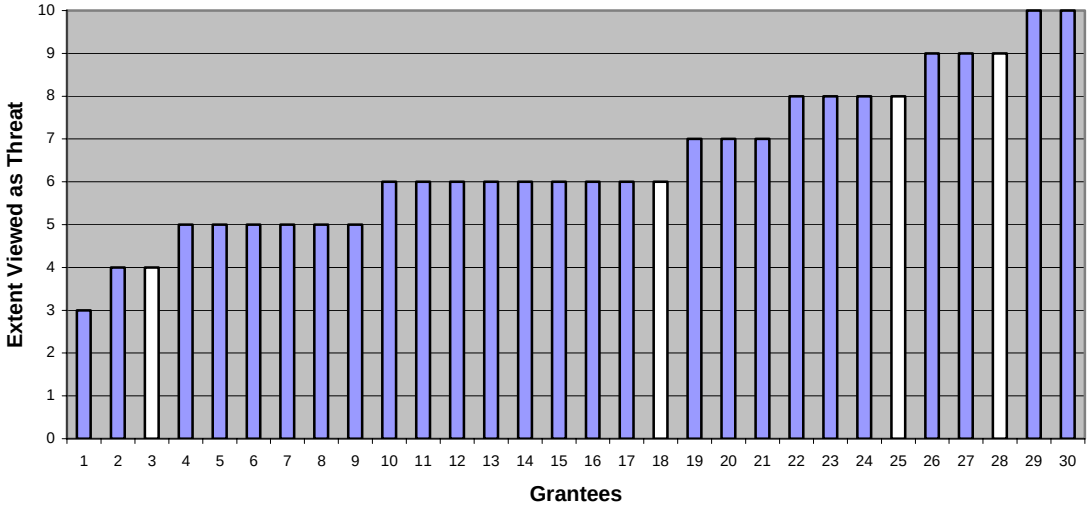


Chart 3
TOBACCO USE BY YOUTH VIEWED AS SERIOUS HEALTH THREAT BY COMMUNITY



Dark bars	Community/ Schools	**Light bars**	Priority Populations

Chart 4
ACTIVE INVOLVEMENT OF 4 OR MORE YOUTH IN PLANNING AND EXECUTION OF PROGRAM ACTIVITIES

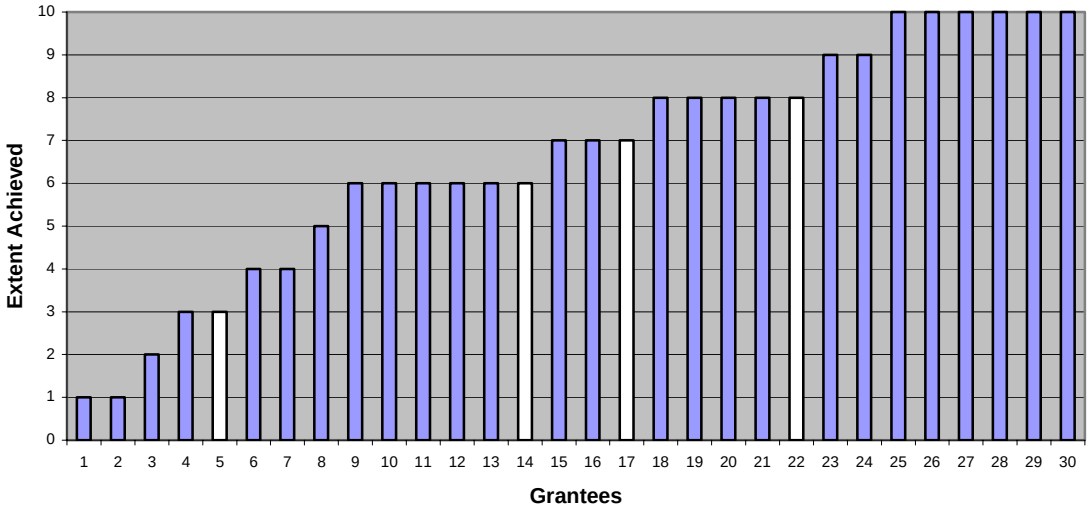
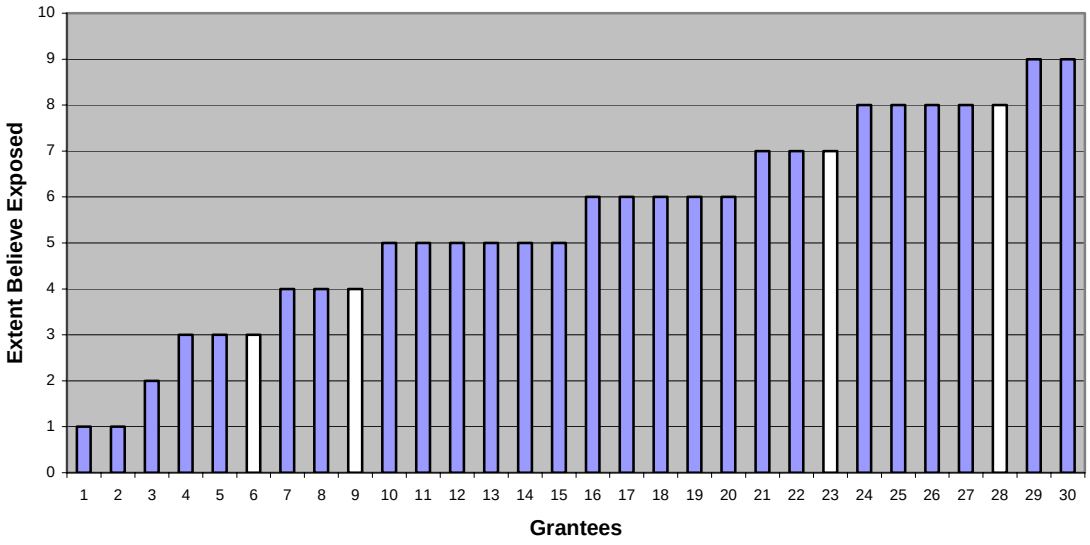
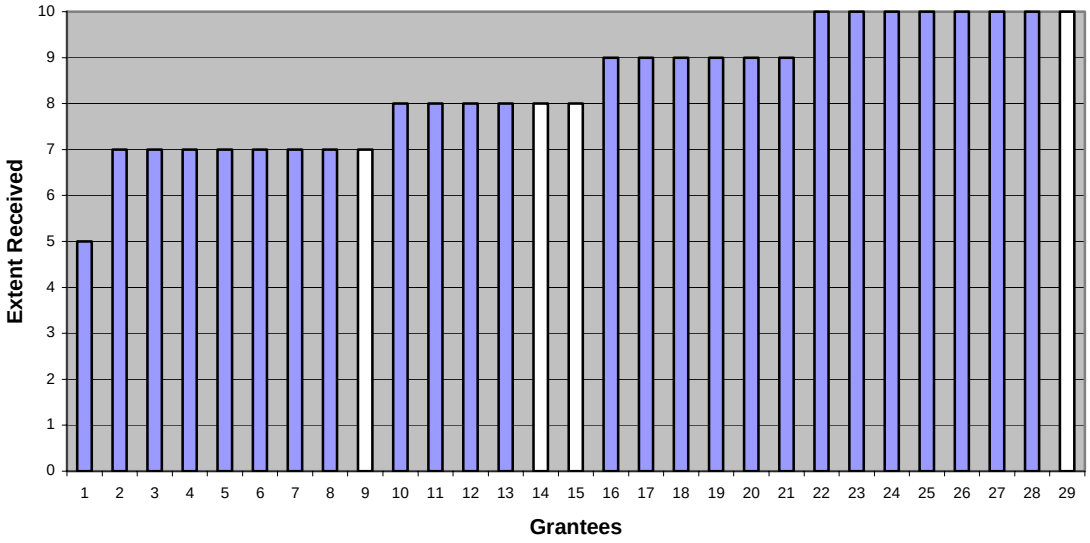


Chart 5
TEEN EXPOSURE TO "TOBACCO.REALITY.UNFILTERED."



Dark bars	Community/ Schools	**Light bars**	Priority Populations

Chart 6
TRAINING SUPPORT RECEIVED



II. Narratives

Grantees were asked to write stories describing some aspect of their progress toward meeting the goals of the HWTFC Teen Tobacco Prevention Initiative. A selected number of these stories are presented below organized according to their respective goals.

Goal 1: Prevent Youth Initiation of Tobacco Use

Story # 1- Community Schools grantee

As I explained my role as the project manager of the Youth Tobacco Use Prevention project to a co-worker, he became emotional and shared the following: "You don't know how happy I am to have you here working on this project. It means so much to me for so many reasons. You see, both my parents died of emphysema when I was younger. My kids didn't even meet their grandparents. I think it's so important to get to young people and let them know the dangers of smoking. Although my kids don't know it, if they wanted to do one thing that would absolutely crush me, it would be to start smoking." This co-worker's appreciation for my work, and his hope that through it youth, like his children, will be able to lead healthy, tobacco-free lives, has strengthened my passion for this cause and will push me to meet the project's ultimate objectives.

Story # 2 – Community Schools grantee

"We want to get our message out!" "We want to make a difference at our school!" Excitement ripples through the Butler High School DREAM meeting as students brainstorm ideas. "Football is a big deal at our school;, we should do something around the football game." The students let their creative juices flow and decided on "Project Pre-Game." To encourage great crowd participation, the first 200 students to show up at the game received a free wristband with "Refuse to Use", the DREAM team's current slogan. From signs and banners flanking the stadium to Public Service Announcements throughout the game, the DREAM team definitely made its presence felt that night! "Project Pre-Game's" great success gave added motivation to the DREAM team's tobacco prevention efforts. The youth came away from the experience with a true feeling of accomplishment and with the belief that they have the power to make a real difference in the lives of people around them.

Goal 2: Significantly Reduce Youth Exposure to Environmental "Secondhand" Smoke

Story # 3 – Community Schools grantee

Last school year, I introduced myself to the principal of our largest high school, describing the programs I hoped to initiate within our schools. The principal responded, "Hope you don't need my help, cause there is no way I'm going to get involved with any tobacco issue." He did agree to allow me to hang out at the school, talk to kids, and hand out Not On Tobacco pamphlets to interested kids. This school year the same principal called me into his office, saying, "Guess you're going to stay around here." I replied that I was. "How about this year we go smokeless in the bleachers," he suggested. After recovering from my shock, I told him that would be a great start. He put up signs and had PSAs on the radio about No Smoking in the bleachers. Our deal involves my attending all home sporting events to hand out information on quitting tobacco while the principal polices the bleachers for offenders! I have a TRU table with gobs of info and lots of freebies for kids. Because of doing TNT in the middle school, my TRU table is the new hang-out for kids. These kids are becoming peer activists. I can only see good coming from this. I am a happy health educator.

Goal 3: Provide Treatment Options for Youth Who Want to Quit

Story # 4 – Community Schools grantee

Ann is a 16 year-old student who began smoking at age 12. She contacted the school social worker seeking help for her addiction and, in return, the social worker referred her to my program. Before implementing a cessation program, I asked Ann why she wanted to quit smoking. She promptly replied, "I dunno. I just don't want to smoke anymore." After a couple of sessions in N-O-T, I asked Ann again why she wanted to quit smoking. She slowly said, "I want to prove to myself and everybody else that I can." I reminded Ann of her first answer and inquired why her reason changed. Ann responded, "Well, if I can quit smoking I can do anything, and then maybe my dad will quit too." Ann's answer captures our goals here in Ashe County. We want our students to know that they have the ability to achieve any goal they set for

themselves, especially if that goal is breaking an addiction such as smoking. We want them to realize that they can be role models for others—even for their parents. Ann began the N-O-T program smoking a pack of cigarettes a day. Currently, she smokes one a day and is determined to quit altogether. Most teenage smokers want to quit and it is our job to help them. An empowered teenager can achieve anything!

Goal 4: Reduce Health Disparities among Minority Youth Attributable to Tobacco Use

Story # 5 – Priority Populations grantee

The pride and dignity of being Coharie shone through elders' stories of the tribe's history. We asked them to talk about tobacco and its impact on the tribe. Some came from tobacco growing families. Farming and land are a valued part of the culture providing for basic economic needs, from food and shelter to a college education. As we steered our questions toward the impact of tobacco use on their health, powerful and moving stories poured forth. These "tobacco stories", as well as later ones about tobacco from a faith perspective, have become a "bank" of testimonies. We plan to edit and include these in our materials and resources, using them in outreach and education. As one of the "tobacco story tellers" poignantly observed, "I spent 40 years as a second hand smoker--my husband smokes. And now I have the worst things you can get-- cancer and heart conditions. I don't think nobody should be exposed to that."

III. Program Progress and Utility of Other Resources

The 6 Month Report form included a series of questions asking grantees to rank, on a scale of 1 to 10 (1= not at all and 10= to a large extent), the progress of their programs and the utility of specific outside resources. The first 10 questions probed program progress in the last 6 months, barriers, utilization of community partnerships and involvement of youth. These questions and their mean scores can be seen in Table 1 for both the Community Schools and Priority Populations grantees separately. Overall, grantees feel that they are on target to achieve their program objectives (all but one scoring 6 and higher). Three coalitions have had some major barriers in infrastructure, (no computers; staff only recently hired). With few exceptions, existing community partnerships were utilized and new partnerships developed. Youth were involved to a large extent in 13 coalitions (including two Priority Population groups), to a moderate extent in 9 coalitions (including 1 Priority Population), and to a small extent in 5 (including 1 Priority Population group). Eight coalitions (including two Priority Population groups) were able to use media advocacy techniques to a large extent (scoring 7 or above) in promoting their objectives. Community attitudes toward tobacco use scored mostly in the mid range with youth recognition of the health risks of tobacco ranking higher than that of adult recognition.

The next 9 questions, on the same scale of 1 to 10 (1= not at all and 10= to a large extent), probed the linkage and utility of other statewide resources for the Community/Schools and Priority Population coalition programs (see Table 2). Training and technical assistance support ranked highest among all questions, with 24 and 23 coalitions respectively scoring these 7 and above. Three of four Priority Population grantees ranked technical assistance and all ranked training support at 7 or above. Three questions on the "Tobacco Reality Unfiltered" campaign showed use of print materials ranked high, with the linkage to the grantee's program initiatives fairly evenly spread across the scale and perception of youth awareness of the campaign clustering around the middle of the scale. Eight Community/Schools coalitions have partnered with SAVE to a large extent and 12 grantees (including three Priority Population grantees) with N-O-T. Four Community/School grantees reported partnering to a large extent with Priority Populations, while all Priority Population grantees reported partnering to a large extent with one another. Fifteen coalitions (including three Priority Populations) indicated 'not at all' with regard to partnering with SAVE and 12 with Priority Populations. PTS was utilized to a large extent by thirteen grantees (including one Priority Population grantee), eight in the mid range, and six (including three Priority Population grantees) to a small extent.

Table 1: Program Progress Questions

QUESTIONS October 2003	Community/Schools		Priority Populations	
	MEAN	RANGE	MEAN	RANGE
1. During the past 6 months, to what extent have you achieved your program objectives?	6.6	(2-10)	8.3	(6-10)
2. During the past 6 months, to what extent have you encountered significant barriers to your program objectives?	5.2	(2-10)	4.5	(2-7)
3. During the past 6 months, to what extent have you been able to use *existing* community partnerships to assist you in meeting your program objectives?	7.7	(3-10)	8.3	(7-10)
4. During the past 6 months, to what extent were you able to develop *new* community partnerships to assist you in meeting your program objectives?	7.2	(2-10)	7	(5-9)
5. During the past 6 months, to what extent did you utilize media advocacy techniques (e.g. letter writing, press release, interviews, psa, etc.) to promote your program objectives?	5	(1-10)	6.5	(3-9)
6. During the past 6 months, to what extent do you believe your community views tobacco use by youth as a serious health problem?	6.5	(3-10)	6.8	(4-9)
7. During the past 6 months, to what extent do you believe your community views tobacco use by adults as a serious health problem?	5.6	(2-10)	6.5	(4-9)
8. During the past 6 months, to what extent do you believe your community views secondhand smoke as a serious health problem?	5.3	(3-9)	5.8	(4-7)
9. During the past 6 months, to what extent are at least 4 or more youth actively involved with planning or execution of your project activities?	7.8	(1-10)	6	(3-8)
10. For the *upcoming* 6 months, to what extent do you believe you are on target to achieve your program objectives?	7.9	(4-10)	8.5	(7-10)

Table 2: Questions on Linkage with Statewide Initiatives

QUESTIONS October 2003	*Community/Schools*		*Priority Populations*	
	MEAN	*RANGE*	*MEAN*	*RANGE*
1. During the last 6 months, to what extent do you believe that teens in your community have been exposed to the Health and Wellness Trust Fund's media campaign "Tobacco Reality Unfiltered"?	5.5	(1-9)	5.5	(3-8)
2. During the last 6 months, to what extent has the Health and Wellness Trust Fund's media campaign "Tobacco Reality Unfiltered" linked with your program initiatives?	5.7	(1-10)	6.3	(4-9)
3. During the last 6 months, to what extent has your program utilized print materials developed by the Health and Wellness Trust Fund's media campaign "Tobacco Reality Unfiltered"?	7	(1-10)	7.8	(6-10)
4. During the last 6 months, to what extent has your program received any technical assistance it needed?	8	(4-10)	7.5	(5-10)
5. During the last 6 months, to what extent has your program received any training support it needed?	8.2	(4-10)	8.3	(7-10)
6. During the last 6 months, to what extent have any of your program initiatives partnered with the SAVE (Survivors and Victims of Tobacco Empowerment) program?	4.4	(1-10)	1.5	(1-3)
7. During the last 6 months, to what extent has any of your program initiatives partnered with the N-O-T (Not on Tobacco) program?	4.9	(1-10)	5.8	(1-8)
8. During the last 6 months, to what extent has any of your program initiatives partnered with any of the priority population grantees (American Indian, African American, Hispanic, General Baptist)?	3.2	(1-9)	8.3	(7-10)
9. During the past 6 months, to what extent have you been able to use PTS to assist you in documenting your progress in meeting program objectives?	6.4	(1-10)	3.5	(2-7)

IV. Suggestions

Grantees were asked to suggest one way that the Health and Wellness Trust Fund's statewide funded campaigns (Media, N-O-T, SAVE, Priority Populations) could more effectively be linked with their programmatic initiatives. Their suggestions are listed below. Priority population grantees' suggestions are listed in italics.

MEDIA

- Media should include TV and newspapers, and run on radio stations that have a greater number of youth listeners

- Additional themes for media: Second Hand Smoke, Social Norms (i.e. 3 out of 4 teens don't smoke); less on negative consequences of tobacco use; short video clips with statements by tobacco survivors, link with 100% Tobacco Free Schools campaign
- Promotional materials, although "hip", had safety and quality issues
- More media training and technical assistance to better utilize resources available
- *Radio component of media campaign should also be produced in Spanish. Messages could be placed as Public Service Announcements on the many Spanish language radio stations in the Triangle, as well as used at Latino community events.*
- *Radio campaign should be expanded to include more stations that African American teens listen to*

PRIORITY POPULATIONS

- Get the word out on what technical assistance and/or partnering capacity is available to grantees from priority population groups.
- Workshop or training by priority population groups to build skills for grantees working with special populations in their schools and communities.

N-O-T

- Marketing tools for the N-O-T program (traditional and new on-line versions).
- A quarterly Health Action Council Newsletter to highlight best practice or successful examples of how N-O-T works in schools.

OTHER

- HWTFC Coordinator meetings for exchange of ideas, motivation, and support
- Bi-monthly newsletter to announce upcoming events, news, and resources, especially related to the statewide initiatives.

Division of Mental Health, Developmental Disabilities, and Substance Abuse Services

Substance Abuse Services Section

Contractor Progress Report: SFY 02-03

Instructions: Submit original and one copy of Contractor Progress Report by specified due date to Jo Yarbrough, SAS Section, 3007 Mail Service Center, Raleigh, NC 27699-3007. Address any questions about reporting requirements to Jo Yarbrough at (919) 733-4670 or to your assigned SAS Contract Administrator.

1. Report Type and Due Date *(Check (✓) One)*:

Quarterly:	☒ 1st Qtr.(Due 1/15)	☐ 2nd Qtr.(Due 4/15)	☐ 3rd Qtr.(Due 7/15)	☐ 4th Qtr.(Due 10/15)
Semi-Annual:	☐ 1st Six Months of Year (Due 4/15))	☐ 2nd Six Months of Year (Due 10/15)		
Annual:	☐ Entire Year (Due 10/15)			

2. Report Period Covered by This Report: 10/1/02 through 9/30/03

3. Contractor Name: **Alcohol Law Enforcement Division**	**4. Contract No.:** **1693**	**5. SAS Contract Administrator** **Margaret Brake**
6. Name and Title of Person Submitting Report: **John Simmons, Director of Operations**		**7. Date Report Submitted:** **April 30, 2003**

8. Progress Towards Contract Goals and Objectives

Describe below (or attach separate documentation) of progress in this Report Period towards achievement of goals and objectives established in the Contract. *Check (✓) this box* ☒ *if separate documentation is attached.*

Goal or Objective No.	Brief Description of Goal or Objective	Progress in this Report Period Towards Achievement of Contract Goal or Objective
1	Goal: Enhance current database and implement an enforcement model to include targeted enforcement in areas where noncompliance is high through the following activities: ❑ Conduct at least 600 tobacco compliance checks per month, for a total of 7,200 checks annually during SFY 2002-2003 ❑ Inform retailers who are issued a citation for violation of the State's Youth Access Law of the availability of the BARS (Be A	**1)** Contract became effective on October 28, 2002 (last date of signature). Contract activities began on November 1, 2003. **2)** Developed job description and personnel requirements to hire a Tobacco Coordinator to manage the education and enforcement program. **3)** Conducted compliance checks: November – 681 outlets checks; 156 sold to a minor; 23% noncompliance December – 673 outlets checks; 143 sold to a minor; 21% noncompliance **See Attachments**

Goal or Objective No.	Brief Description of Goal or Objective	Progress in this Report Period Towards Achievement of Contract Goal or Objective
	Responsible Seller) alcohol and tobacco education program ❑ Distribute signs and brochures regarding the state youth access law and responsibilities of the retail merchant	**4)** Conducted BARS Program: November - 38 Presentations; 353 Participants December - 17 Presentations; 138 Participants
2	Goal: Continue to build and enhance collaborative relationships with local law enforcement, merchants, Area Mental Health/Public Health Programs, local coalitions, youth organizations and community groups through the following activities: ❑ Conduct six regional trainings to engage ALE supervisors, agents, substance abuse services staff, merchants and key community agencies in discussions of local efforts everyone can partner on to reduce youth access to tobacco products ❑ Promote collaboration between the 38 Area Mental Health Programs, local organizations and district ALE agents to recruit and train youth ages 16-17 to participate in enforcement activities; distribute merchant education materials, develop local media stories and articles on youth access issues; and promote the availability of the BARS Education Program to local retail merchants	**1)** ALE district supervisors and agents participated in four regional meetings (hosted by Substance Abuse Services) with Tobacco Liaisons from the Area Mental Health Programs. Other participants included regional staff of the Tobacco Prevention and Control Branch, Project ASSIST Coalition Coordinators and Question Why Youth Empowerment Center Coordinators to discuss strategies and partnerships to reduce youth access to tobacco products. Topics for discussion included the ALE/SAS' grant from the HWTFC, particularly the regional trainings, and the Teen Tobacco Prevention and Cessation Initiative. The meetings were held in the following locations: Western Region – Friday, November 1, 2002 Foothills Area Program, Morganton NC North Central Region – Monday, November 4, 2002 Alamance-Caswell Area Program, Burlington NC Eastern Region – Thursday, November 7, 2002 Pitt County Area Program, Greenville NC South Central Region – Tuesday, November 12, 2002 Cumberland County Area Program, Fayetteville NC **2)** SAS and ALE held an initial meeting February 11, 2003 to discuss possible goals and outcomes for the six regional trainings and to identify a small planning group.
3	Goal: Increase activities to raise public awareness of the youth access law, its penalties and enforcement operations through the following activities: ❑ Get earned or free media attention for community education, recognition events and enforcement operations ❑ Conduct a campaign (mailings, community forums, participation	No activities to report during this quarter.

Goal or Objective No.	Brief Description of Goal or Objective	Progress in this Report Period Towards Achievement of Contract Goal or Objective
	in conferences) to raise awareness among judges, district attorneys and assistant district attorneys on the youth access law, impact of enforcement efforts on the federal law and to garner their support when these cases come to court.	
4	Goal: Reduce youth access to tobacco products in NC to 20% or lower to comply with the federal Synar Amendment through the following activity: ❑ Assess the impact of state and local activities (i.e. education, enforcement, media, community mobilization activities) in reducing youth access to tobacco products through results from the Annual Synar Survey conducted by the Division of MH/DD/SA	No activity to report during this quarter. Results of the Synar Survey will be released in August 2003.

9. Deliverables

Please note any deliverables that were met during this contract period.

- ❑ Conducted 1,354 tobacco compliance checks
- ❑ Conducted 55 BARS programs reaching 491 retailers

********** *FOR STATE OFFICE USE BELOW LINE* **********

10. SAS Contract Administrator Review: **Margaret Brake**

Date Reviewed: 5/16/03

Notes: Satisfactory progress towards achieving goals objectives.

Division of Mental Health, Developmental Disabilities, and Substance Abuse Services

Substance Abuse Services Section

Contractor Progress Report: SFY 02-03

Instructions: Submit original and one copy of Contractor Progress Report by specified due date to Jo Yarbrough, SAS Section, 3007 Mail Service Center, Raleigh, NC 27699-3007. Address any questions about reporting requirements to Jo Yarbrough at (919) 733-4670 or to your assigned SAS Contract Administrator.

1. Report Type and Due Date *(Check (✓) One)*:

Quarterly:	☐ 1st Qtr.(Due 1/15)	☒ 2nd Qtr.(Due 4/15)	☐ 3rd Qtr.(Due 7/15)	☐ 4th Qtr.(Due 10/15)
Semi-Annual:	☐ 1st Six Months of Year (Due 4/15))		☐ 2nd Six Months of Year (Due 10/15)	
Annual:	☐ Entire Year (Due 10/15)			

2. Report Period Covered by This Report: 10/1/02 through 9/30/03

3. Contractor Name: **Alcohol Law Enforcement Division**	**4. Contract No.:** **1693**	**5. SAS Contract Administrator** **Margaret Brake**
6. Name and Title of Person Submitting Report: **John Simmons, Director of Operations**		**7. Date Report Submitted:** **May 5, 2003**

8. Progress Towards Contract Goals and Objectives

Describe below (or attach separate documentation) of progress in this Report Period towards achievement of goals and objectives established in the Contract. Check (✓) this box ☒ if separate documentation is attached.

Goal or Objective No.	Brief Description of Goal or Objective	Progress in this Report Period Towards Achievement of Contract Goal or Objective
1	Goal: Enhance current database and implement an enforcement model to include targeted enforcement in areas where noncompliance is high through the following activities: ❑ Conduct at least 600 tobacco compliance checks per month, for a total of 7,200 checks annually during SFY 2002-2003 ❑ Inform retailers who are issued a citation for violation of the State's Youth Access Law of the availability of the BARS (Be A Responsible Seller) alcohol	**5)** Posted job description and interviewed applicants for the Tobacco Coordinator position. Tobacco Coordinator will start on April 1, 2003 and will manage the education and enforcement program. **6)** Conducted compliance checks: January – 93 outlets checks; 17 sold to a minor; 18% noncompliance *Note - ALE Division began reorganization in January. February – 582 outlets checks; 153 sold to a minor; 26% noncompliance March – 685 outlets checked; 194 sold to a minor; 28% noncompliance **See Attachments**

Goal or Objective No.	Brief Description of Goal or Objective	Progress in this Report Period Towards Achievement of Contract Goal or Objective
	and tobacco education program ❑ Distribute signs and brochures regarding the state youth access law and responsibilities of the retail merchant	**7)** Conducted BARS Program: January – 30 Presentations; 305 Participants February – 51 Presentations; 505 Participants March – 50 Presentations; 849 Participants
2	Goal: Continue to build and enhance collaborative relationships with local law enforcement, merchants, Area Mental Health/Public Health Programs, local coalitions, youth organizations and community groups through the following activities: ❑ Conduct six regional trainings to engage ALE supervisors, agents, substance abuse services staff, merchants and key community agencies in discussions of local efforts everyone can partner on to reduce youth access to tobacco products ❑ Promote collaboration between the 38 Area Mental Health Programs, local organizations and district ALE agents to recruit and train youth ages 16-17 to participate in enforcement activities; distribute merchant education materials, develop local media stories and articles on youth access issues; and promote the availability of the BARS Education Program to local retail merchants	1) Held 5 meetings to plan regional trainings which ALE and SAS named "Regional Forums on Reducing Tobacco Sales to Minors". It was decided to hold 7 forums instead of six in order to make the forums more accessible to everyone. A planning group included ALE, SAS staff, State Advisor on Preventing Teen Tobacco Use, local Substance Abuse Prevention staff and a consultant working with retailers in NC was convened to formulate the goals of the forums and to generate ideas regarding the target audience and the agenda. The sites selected for the forums are Elizabeth City, Lumberton, Durham, Wilson, Winston Salem, Charlotte and Asheville. **See Attachments**
3	Goal: Increase activities to raise public awareness of the youth access law, its penalties and enforcement operations through the following activities: ❑ Get earned or free media attention for community education, recognition events and enforcement operations ❑ Conduct a campaign (mailings, community forums, participation in conferences) to raise	**1)** Held a meeting on March 25, 2003 with ALE Agents from each district who have been designated as Tobacco Coordinators within their region. These agents will be responsible for compiling compliance checks data, making contacts with the media regarding enforcement operations, coordinating activities with local agencies and groups and submitting data to ALE Headquarters in Raleigh.

Goal or Objective No.	Brief Description of Goal or Objective	Progress in this Report Period Towards Achievement of Contract Goal or Objective
	awareness among judges, district attorneys and assistant district attorneys on the youth access law, impact of enforcement efforts on the federal law and to garner their support when these cases come to court.	
4	Goal: Reduce youth access to tobacco products in NC to 20% or lower to comply with the federal Synar Amendment through the following activity: ❑ Assess the impact of state and local activities (i.e. education, enforcement, media, community mobilization activities) in reducing youth access to tobacco products through results from the Annual Synar Survey conducted by the Division of MH/DD/SA	No activity to report during this quarter. Results of the Synar Survey will be released in August 2003.

11. Deliverables

Please note any deliverables that were met during this contract period.

- ❑ Conducted 1,360 tobacco compliance checks
- ❑ Conducted 131 BARS programs reaching 1,659 retailers

********** *FOR STATE OFFICE USE BELOW LINE* **********

12. SAS Contract Administrator Review: **Margaret Brake**

Date Reviewed: 5/27/03

Notes: Satisfactory progress towards achieving goals/objectives

Division of Mental Health, Developmental Disabilities, and Substance Abuse Services

Substance Abuse Services Section

Contractor Progress Report: SFY 02-03

Instructions: Submit original and one copy of Contractor Progress Report by specified due date to Jo Yarbrough, SAS Section, 3007 Mail Service Center, Raleigh, NC 27699-3007. Address any questions about reporting requirements to Jo Yarbrough at (919) 733-4670 or to your assigned SAS Contract Administrator.

1. Report Type and Due Date *(Check (✓) One)*:

Quarterly:	☐ 1st Qtr.(Due 1/15)	☐ 2nd Qtr.(Due 4/15)	☒ 3rd Qtr.(Due 7/15)	☐ 4th Qtr.(Due 10/15)
Semi-Annual:	☐ 1st Six Months of Year (Due 4/15))		☐ 2nd Six Months of Year (Due 10/15)	
Annual:	☐ Entire Year (Due 10/15)			

2. Report Period Covered by This Report: 10/1/02 through 9/30/03

3. Contractor Name: **Alcohol Law Enforcement Division**	**4. Contract No.:** **1693**	**5. SAS Contract Administrator** **Margaret Brake**
6. Name and Title of Person Submitting Report: **John Simmons, Director of Operations**		**7. Date Report Submitted:** **8/1/03**

8. Progress Towards Contract Goals and Objectives

Describe below (or attach separate documentation) of progress in this Report Period towards achievement of goals and objectives established in the Contract. Check (✓) this box ☒ if separate documentation is attached.

Goal or Objective No.	Brief Description of Goal or Objective	Progress in this Report Period Towards Achievement of Contract Goal or Objective
1	Goal: Enhance current database and implement an enforcement model to include targeted enforcement in areas where noncompliance is high through the following activities: ❑ Conduct at least 600 tobacco compliance checks per month, for a total of 7,200 checks annually during SFY 2002-2003 ❑ Inform retailers who are issued a citation for violation of the State's Youth Access Law of the availability of the BARS (Be	1) Conducted compliance checks: April – 1158 checks; 237 sold to a minor; 20% noncompliance May – 849 checks; 211 sold to a minor; 25% noncompliance June – 1433 checks; 359 sold to a minor; 25% noncompliance **2) Conducted BARS Program:** April – 55 Presentations; 976 Participants May – 57 Presentations; 602 Participants ***June – 44 Presentations; 420 Participants***

Goal or Objective No.	Brief Description of Goal or Objective	Progress in this Report Period Towards Achievement of Contract Goal or Objective
	A Responsible Seller) alcohol and tobacco education program ❑ Distribute signs and brochures regarding the state youth access law and responsibilities of the retail merchant	**(See Attachments)**
2	Goal: Continue to build and enhance collaborative relationships with local law enforcement, merchants, Area Mental Health/Public Health Programs, local coalitions, youth organizations and community groups through the following activities: ❑ Conduct six regional trainings to engage ALE supervisors, agents, substance abuse services staff, merchants and key community agencies in discussions of local efforts everyone can partner on to reduce youth access to tobacco products ❑ Promote collaboration between the 38 Area Mental Health Programs, local organizations and district ALE agents to recruit and train youth ages 16-17 to participate in enforcement activities; distribute merchant education materials, develop local media stories and articles on youth access issues; and promote the availability of the BARS Education Program to local retail merchants	1) ALE had an exhibit at the Vision 2010 Tobacco Use Prevention Conference on April 9, 2003. Information on ALE's tobacco program and the regional forums were distributed along with posters and pens. ALE also participated in two breakout sessions during the conference on April 10, 2003 with SAS staff during a presentation regarding the state's education and enforcement program to reduce youth access to tobacco products. 2) Regional Forums on Reducing Tobacco Sales to Minors were held across the state. Participants included, ALE District Supervisors and Agents, local law enforcement, retailers, public health/substance abuse prevention staff representing Mental Health Centers, Health Departments, community based organizations and youth programs, local school staff, Tobacco Prevention and Control Branch field staff and local ASSIST Coordinators, Question Why Youth Empowerment Center Coordinators, and HWTFC school/community grantees. The forums were held in Elizabeth City, Lumberton, Durham, Wilson, Winston-Salem, Charlotte and Asheville. A total of 146 participants were engaged in discussions regarding the impact of tobacco use in their communities, barriers and strategies to reduce tobacco sales to minors, and resources that would help them to be successful. Feedback from all of the forums regarding each of these dimensions will be provided to all participants. ALE plans to make this information along with compliance check data available to participants on its website. Participants also received information packets and incentive items – t-shirts, water bottles and pens. Media coverage of these events was very positive as well as the evaluations from the participants.
3	Goal: Increase activities to raise public awareness of the youth access law, its penalties and enforcement operations through the following activities:	1) Earned Media April 24, 2003 Article in the Fayetteville Observer May 6, 2003 Article in Mount Airy News May 13, 2003 Coverage for the Durham Forum: WPTF Radio, WRAL, WTVD May 29, 2003 Coverage for the Winston Salem Forum-

Goal or Objective No.	Brief Description of Goal or Objective	Progress in this Report Period Towards Achievement of Contract Goal or Objective
	❑ Get earned or free media attention for community education, recognition events and enforcement operations ❑ Conduct a campaign (mailings, community forums, participation in conferences) to raise awareness among judges, district attorneys and assistant district attorneys on the youth access law, impact of enforcement efforts on the federal law and to garner their support when these cases come to court.	Fox 8 news June 12, 2003 Coverage for the Asheville Forum – ABC Affliate, Channel 13 news June 2003 Article in the Dare County newspaper June 2003 Article in ALE's newsletter, Ten-Fourteen Online **(See Attachments)**
4	Goal: Reduce youth access to tobacco products in NC to 20% or lower to comply with the federal Synar Amendment through the following activity: ❑ Assess the impact of state and local activities (i.e. education, enforcement, media, community mobilization activities) in reducing youth access to tobacco products through results from the Annual Synar Survey conducted by the Division of MH/DD/SA	No activity to report during this quarter. Results of the Synar Survey will be released in August 2003.

13. Deliverables

Please note any deliverables that were met during this contract period.

- ❑ Conducted 6,154 tobacco compliance checks
- ❑ Conducted 342 BARS programs reaching 771 retailers with 4,148 participants
- ❑ Conducted seven regional forums across the state on Reducing Tobacco Sales to Minors

********** *FOR STATE OFFICE USE BELOW LINE* **********

14. SAS Contract Administrator Review: **Margaret Brake**

Date Reviewed: 8/11/03

Notes: Contractor has made outstanding progress in achieving goals/objectives.

Division of Mental Health, Developmental Disabilities, and Substance Abuse Services

Substance Abuse Services Section

Contractor Progress Report: SFY 02-03

Instructions: Submit original and one copy of Contractor Progress Report by specified due date to Jo Yarbrough, SAS Section, 3007 Mail Service Center, Raleigh, NC 27699-3007. Address any questions about reporting requirements to Jo Yarbrough at (919) 733-4670 or to your assigned SAS Contract Administrator.

1. Report Type and Due Date *(Check (✓) One)*:

Quarterly:	☐ 1st Qtr.(Due 1/15)	☐ 2nd Qtr.(Due 4/15)	☐ 3rd Qtr.(Due 7/15)	☒ 4th Qtr.(Due 10/15)
Semi-Annual:	☐ 1st Six Months of Year (Due 4/15))		☐ 2nd Six Months of Year (Due 10/15)	
Annual:	☐ Entire Year (Due 10/15)			

2. Report Period Covered by This Report: 10/1/02 through 9/30/03

3. Contractor Name: **Alcohol Law Enforcement Division**	**4. Contract No.:** **1693**	**5. SAS Contract Administrator** **Margaret Brake**
6. Name and Title of Person Submitting Report: **John Simmons, Director of Operations**		**7. Date Report Submitted:** **10/31/03**

8. Progress Towards Contract Goals and Objectives

Describe below (or attach separate documentation) of progress in this Report Period towards achievement of goals and objectives established in the Contract. Check (✓) this box ☒ if separate documentation is attached.

Goal or Objective No.	Brief Description of Goal or Objective	Progress in this Report Period Towards Achievement of Contract Goal or Objective
1	**Goal: Enhance current database and implement an enforcement model to include targeted enforcement in areas where noncompliance is high through the following activities:** ❑ Conduct at least 600 tobacco compliance checks per month, for a total of 7,200 checks annually during SFY 2002-2003 ❑ Inform retailers who are issued a	1) Conducted compliance checks: July – 1451 checks; 268 sold to a minor; 18% noncompliance August – 570 checks; 90 sold to a minor; 17% noncompliance September – 414 checks; 74 sold to a minor; 18% noncompliance **2) Conducted BARS Program:** July – 56 Presentations; 406 Participants August – 57 Presentations; 554 Participants

Goal or Objective No.	Brief Description of Goal or Objective	Progress in this Report Period Towards Achievement of Contract Goal or Objective
	citation for violation of the State's Youth Access Law of the availability of the BARS (Be A Responsible Seller) alcohol and tobacco education program ❑ Distribute signs and brochures regarding the state youth access law and responsibilities of the retail merchant	***September – 42 Presentations; 406 Participants*** 3) ALE has developed a certificate program for the purpose of recognizing retail clerks who refused to sell tobacco products to underage persons during compliance checks. The certificate of commendation will be delivered to the retail outlet's management for presentation to the individual clerk. **(See Attachments)**
2	Goal: Continue to build and enhance collaborative relationships with local law enforcement, merchants, Area Mental Health/Public Health Programs, local coalitions, youth organizations and community groups through the following activities: ❑ Conduct six regional trainings to engage ALE supervisors, agents, substance abuse services staff, merchants and key community agencies in discussions of local efforts everyone can partner on to reduce youth access to tobacco products ❑ Promote collaboration between the 38 Area Mental Health Programs, local organizations and district ALE agents to recruit and train youth ages 16-17 to participate in enforcement activities; distribute merchant education materials, develop local media stories and articles on youth access issues; and promote the availability of the BARS Education Program to local retail merchants	Follow-up Activities from the Regional Forums: 1) ALE is in the process of developing a link within its division website specifically designed for those who attended the Regional Forums on Reducing Tobacco Sales to Minors in the 3rd quarter. Once complete, the site will make available a directory of those in attendance at each of the seven forums, a comprehensive report of the outcomes of the forums, including evaluation results, as well as ALE tobacco compliance check statistics by county. As the website develops it will be a place where an open exchange of information may be shared. 2) A final report on the Regional Forums was developed and includes an executive summary, methodology, outcomes, conclusions and recommendations. The report will be made available to forum participants and will be used to design the next round of forums to be held in 2004. **(See Attachment)**
3	Goal: Increase activities to raise public awareness of the youth access law, its penalties and enforcement operations through the following activities: ❑ Get earned or free media attention for community	1) Earned Media August 18, 2003 *The Associated Press* Article on Tobacco Enforcement Activities in western NC; News Story on WRAL-TV. **(See Attachment)** 2) ALE did not conduct a mailing to District Attorneys and

Goal or Objective No.	Brief Description of Goal or Objective	Progress in this Report Period Towards Achievement of Contract Goal or Objective
	education, recognition events and enforcement operations ❑ Conduct a campaign (mailings, community forums, participation in conferences) to raise awareness among judges, district attorneys and assistant district attorneys on the youth access law, impact of enforcement efforts on the federal law and to garner their support when these cases come to court.	Assistant District Attorneys. This campaign will be continued over the next year to identify District Attorneys and Judges who are supportive of this issue and can help to educate their peers on the impact of enforcement activities on state as well as federal law and to get their support on youth access efforts.
4	Goal: Reduce youth access to tobacco products in NC to 20% or lower to comply with the federal Synar Amendment through the following activity: ❑ Assess the impact of state and local activities (i.e. education, enforcement, media, community mobilization activities) in reducing youth access to tobacco products through results from the Annual Synar Survey conducted by the Division of MH/DD/SA	Results of the Annual Synar Survey to test retailer compliance with the State's Youth Access Law was completed during this quarter. Results of the survey show a reduction in the overall rate of illegal youth tobacco sales from 18% in 2002 down to 14.8% in 2003, which puts the State ahead of this year's goal of reducing tobacco sales to 20% or less.

9. Deliverables

Please note any deliverables that were met during this contract period.

- ❑ Conducted 8,618 tobacco compliance checks
- ❑ Conducted 497 BARS programs reaching 971 retailers with 5,693 participants
- ❑ Conducted seven regional forums across the state on Reducing Tobacco Sales to Minors

********** *FOR STATE OFFICE USE BELOW LINE* **********

9. SAS Contract Administrator Review: **Margaret Brake**

Date Reviewed: 10/31/03

Notes: Contractor has made great progress in achieving goals/objectives.

Health and Wellness Trust Fund Commission
Smoking Cessation for Pregnant Teens Project
Quarterly Programmatic Report
Reporting Period: February 1, 2003 - April 30, 2003

I. Summary of executed activities during the reporting period:

The Women's Health Branch (Branch) conducted several conference calls and an initial site visit with the participating Smoking Cessation for Pregnant Teens Project sites. The project sites are: Durham County Health Department (located in Durham), Gaston County Health Department (located in Gastonia), and Robeson Health Care Corporation (which has three prenatal care sites located in Pembroke, Fairmont, and Maxton). All three project sites provide prenatal care services to patients enrolled in Medicaid (ACCESS sites).

During the initial site visits with the Durham and Gaston project sites, the Branch requested that each project site develop and submit a draft proposal that would describe the design and procedures for the Smoking Cessation for Pregnant Teens Project at their site. Draft proposals were received in February 2003 and conference calls were held with the Local Project Coordinator and program staff at each project site in March and April 2003 to review and discuss the proposals. Both project sites submitted revised proposals based upon the Branch's recommendations.

The Branch conducted an initial site visit with the Robeson Health Care Corporation (RHCC) on March 5, 2003. During this meeting, the WHB met with the Local Project Coordinator and the Director of Perinatal Services to discuss the steps involved for implementing this project at the RHCC. The roles and responsibilities for both the Branch and the RHCC program staff were discussed and outlined in detail. The Local Project Coordinator and the Branch developed a timeline of activities for program implementation.

The Branch and the three Local Project Coordinators participated in the Health and Wellness Trust Fund of NC (HWTFC) Kickoff Event on April 8th and the Vision 2010: Exploring Best Practices in Tobacco Use Prevention and Control Conference on April 9th and 10th held in Durham. At the HWTFC Kickoff Event, the WHB Program Manager and the Local Project Coordinators had the opportunity to learn about all of the Teen Tobacco Use Prevention and Cessation Initiatives. Contacts were made with representatives from the organizations funded under the Priority Populations and the Community Schools grants.

The Branch developed a core set of data elements that each project site will be required to collect on each patient that participates in the project. During the HWTFC Kickoff Event, a meeting was held with all three Local Project Coordinators to review and finalize the list of required data elements. The Branch distributed the final list of required data elements to the project sites in April 2003. Based upon the list of required data elements, the Branch will develop a database in Microsoft Access software that each Local Project Coordinator will use for data entry and to submit quarterly data reports.

The Durham and Gaston project sites have begun to develop a smoking cessation counseling recording form that they will use to document patient information and counseling activities. Each project site has been given the responsibility to create a form that will collect all of the required data elements.

The contract paperwork between RHCC and the WHB was submitted to the Division of Public Health's Contracts Office for processing in February 2003. The contract was not finalized during this reporting period. However, the Local Project Coordinator at RHCC has been involved in several program planning activities and participated in the HWTFC Kickoff Event on April 8th and the Vision 2010 Conference on April 9th and 10th.

The contract with the North Carolina Healthy Start Foundation (Foundation) was finalized in March 2003. Under this contract, the Foundation will develop, print and distribute age-appropriate smoking cessation and secondhand smoke educational materials for pregnant teenage women. During this reporting period, the Foundation has conducted one focus group and has scheduled two others. Their first focus group was conducted on March 25, 2003 at the Coats United Methodist Church in Coats. Participants included: eighteen pregnant and/or parenting females and two teenage dads. Four mothers of the teens were also in attendance. The participants ranged from 15 to 19 years of age. Among the teenage females, three were Latino, three were Caucasian, and twelve were African American. Among the teenage dads, one was African American and one was Caucasian. During this focus group, information was collected on what content teens would like to see in smoking cessation and secondhand smoke materials, what formats would appeal to teens, and discussion of possible titles for the new print materials. The Foundation also solicited votes for the titles of the new print materials at the Vision 2010 conference on April 9th. The Foundation scheduled two additional focus groups, to be held in May, for testing content, format and design.

II. Barriers and challenges experienced, if any, during the implementation of proposed activities during the reporting period:

None to report during this reporting period.

III. Copies of project materials (brochures, handouts, flyers, training materials) will be included when developed:

No project materials were developed during this reporting period.

Contractor Quarterly Progress Report

1. Report Type and Due Date *(Check (✓) One)*:

Quarterly: ☒1st Qtr) (Due 7/15) ☐2nd Qtr.(Due 10/15) ☐3rd Qtr.(Due 1/15) ☐4th Qtr.(Due 4/15)

2. Report Period Covered by This Report: __04/01/03__ through ___06/30/03__

3. Contractor Name:	**4. Person Submitting Report:**	**Date Submitted:**
American Lung Association of NC	**Sarah E. Cox, MPH**	**8/8/03**

8. Progress Towards Contract Goals and Objectives

Describe below (or attach separate documentation) of progress in this Report Period towards achievement of goals and objectives established in the Contract. Check (✓) this box ☐ if separate documentation is attached.

Goal or Objective No.	Brief Description of Goal or Objective	Progress in this Report Period Towards Achievement of Contract Goal or Objective
1	**Provide up to 20 adult facilitator trainings in the N-O-T® program for HWTFC grantees and other local and state tobacco control coalitions.**	Conducted one (1) N-O-T® adult facilitator trainings. May 13, 2003 in Fayetteville, NC. Two more trainings are scheduled for the summer: July 28, 2003 in Burlington, NC; and August 1, 2003 in Monroe, NC.
2	**Provide mini-grant funds to HWTFC grantees and other local and state tobacco control coalitions to implement the N-O-T® program.**	Funded $14,667 worth of N-O-T® implementation mini-grants to the following locations (* = HWTFC grantee): Robeson County*, Henderson County, Wake County, Chowan County*, Perquimans County*, Tyrrell County*, Bertie County*, Washington County*, Cumberland County, Mitchell County*, Greene County, Guilford County*, McDowell County*
3	**Distribute N-O-T®-in-a-box packages to mini-grant recipients and other N-O-T® facilitators**	Participants in trainings as well as mini-grant recipients have been offered certificates that they may redeem for this package when packages are ready. Should be available for distribution by 9/2/03.
4	**Distribute Monthly Newsletters to facilitators.**	Newsletter distributed in May and June, 2003. Please find attached.
5	**Support local and/or regional smoke-free youth summits/conferences.**	ALANC participated as a planner and presenter at the HWTFC kick-off conference.
6	**Develop online cessation support center for teens.**	ALANC is in the process of designing this web site which will also be available in Spanish.

Goal or Objective No.	Brief Description of Goal or Objective	Progress in this Report Period Towards Achievement of Contract Goal or Objective
7	**Offer facilitator stipends to HWTFC Communities and Schools grantees.**	HWTFC recipients have been offered stipends through the newsletter mailings. Grantees will be able to apply for stipends online.
8	**Conduct up to six (6) "Booster" trainings.**	One Booster training scheduled for 7/28/03 in Burlington, NC
9	**Conduct a scientifically sound process and outcomes evaluation of the N-O-T® project**	Met with UNC evaluators. Evaluation system in place.
10	***Provide quarterly progress reports to the NC Health and Wellness Trust Fund Commission***	Submitted 8/8/03
Trainings	Brief Description of Trainings	**Number of Participants and Community/Schools Grantees Represented**
	N-O-T in Fayetteville, NC – 5/13/03	17 participants. Included Alamance Caswell MH/DD/SAS, Halifax Co. Schools, Macon County Schools, SAVE, FirstHealth of the Carolinas and Robeson County Public Schools.

15. Deliverables

Please note any deliverables that were met during this contract period.

- One N-O-T® adult facilitator training conducted.
- Funded $14,667 worth of local mini-grants
- Distributed two (2) newsletters to facilitators
- Submitted first quarterly report.

NC Tobacco Prevention and Control Branch

Progress Report
Submitted to the Health and Wellness Trust Fund Commission

October 2003

The North Carolina Tobacco Prevention and Control Branch (TPCB) entered an agreement with the Health and Wellness Trust Commission (HWTFC) to plan and implement an evidence-based training and technical assistance plan for the 26 Community/School Grants funded as part of the Teen Tobacco Use Prevention and Cessation Initiative. The Branch's plan is based on supporting community/school grants to implement evidenced-based policies and programs in schools and community settings.

The Branch's training and technical assistance infrastructure, priorities and process are described below.

Training and Technical Assistance Infrastructure. The 26 HWTFC School and Community grants have provided a powerful infusion of excitement, funding and human resources into the youth tobacco-use prevention movement in North Carolina. TPCB is using established infrastructure to ensure that each grant is provided tailored, high quality training, support and assistance as grant personnel develop community coalitions and youth groups and implement activities. The established support infrastructure includes: 1) an assigned expert to serve as a Primary Contact person for each grant, 2) access to local ASSIST Coalition Coordinators to provide practical advice and serve as peer counselors, 3) the Question Why Youth Centers to provide specific training centered around working with youth and adults, and 4) specialized program staff to provide expertise and training in specific program areas (such as Tobacco Free Schools). To ensure consistency and communication among all of these consultants working with the grants, TPCB developed Training and Technical Assistance Guidelines.

Training and Technical Assistance Priorities. During the first months of the School and Community grants, TPCB worked with them to provide program orientation as well as problem solve regarding hiring staff and setting up office operations. Then TPCB training and technical assistance focused on educating and training the grants to get the community infrastructure and plans in place to implement the priorities established by HWTFC/Vision 2010. Training on infrastructure focused on identifying and recruiting appropriate and diverse school and community partners and champions. TPCB also worked with the grantees on strategic planning: to help them understand what they wanted to achieve; how to operate effectively in school and community settings; and how to plan effective strategies with realistic deadlines and outcomes.

Since all grants are focusing on Tobacco Free Schools, training and technical assistance focused on activities to support the adoption of tobacco-free schools policies or enforcement of existing policies. TPCB trained grantees in developing school survey tools, implementing youth groups needs assessments, forming Teens Against Tobacco Use (TATU) and Students Working Against Tobacco (SWAT) clubs or groups, establishing Alternative to Suspension programs, coordinating Not On Tobacco youth cessation training, and developing strategies regarding approaching and working with School Boards. In addition TPCB helped provide trainers for Project TNT and Lifeskills school curricula workshops. Since promoting tobacco-free policies in public places where youth spend leisure time or work is another priority, some grants focused on youth working with restaurants to persuade them to go smoke-free. Utilizing the Working SmokeFree website and special secondhand smoke educational materials, TPCB trained adults and youth regarding reducing youth exposure to secondhand smoke and effective advocacy techniques. Youth learned to develop and implement surveys with restaurant patrons and to deliver factual and persuasive messages regarding strengthening policy to restaurant owners and managers.

Dynamic Training Process. After the Health and Wellness Trust Fund Kickoff event (described below), training occurred primarily through site visits and one on one training opportunities. Now that grants are fully operational and have developed some infrastructure, training can focus on skill building for grant staff and volunteers and information sharing among grants through regional workshops. Upcoming regional training workshops will focus on building stronger and more diverse coalitions; youth leadership skills; and effectively managing youth and adult groups to implement multiple priority activities. Grantees will also be trained to develop, write and implement more sophisticated, effective action plans that involve priority populations and successfully influence tobacco policies that impact youth on the local level. Providing training for School and Community grants has been a dynamic and fluid process and the future training opportunities must reflect that process.

The Branch's **key accomplishments** on this year's training and technical assistance interventions are as follows.

Health and Wellness Trust Fund Statewide Kick-Off Event for Teen Tobacco Prevention and Cessation Initiative

This event, attended by 135 participants served as the Health and Wellness Trust Fund Commission's program launch and orientation for the 32 newly funded Community/School Grantees and the 4 Priority Population Initiatives in North Carolina. Local initiatives sent 1-4 representatives for training on: Youth tobacco prevention in NC, reporting requirements to the Health Trust, program evaluation overview, and an orientation to youth resources in NC. This event led into an evening session and a subsequent 2-Day statewide tobacco prevention conference on April 9th and 10th. The evening banquet highlighted Lieutenant Governor Beverly E. Perdue who pledged support to the teen tobacco use prevention and cessation initiative and unveiled the new developed youth radio campaign ads--entitled *Tobacco. Reality. Unfiltered*. Also featured was Dr. Tom Houston, Director of Smokeless States Project at the American Medical Association who provided a broad teen tobacco use prevention perspective, which set the stage for the 2-Day "best practices" conference that followed. Over 280 tobacco prevention educators attended this event and over 300 participated in the 2-Day Vision 2010 Conference.

Video Capture and Internet-based Archive of Conference Events

The Health and Wellness Trust Fund Kick-Off Event and the Vision 2010 Conference provided an excellent showcase and baseline for all tobacco prevention and control advocates and educators. The need for redistribution of the valuable information was anticipated due to the ongoing issue of public health educator turnover and the hiring of new staff for the new Health and Wellness Trust Fund grants program. With assistance from our state Agency for Public Telecommunication we captured video and audio of all the general sessions and breakouts. Six out of eight "key issue" sessions were also captured. The video was converted to Real Player format and hosted on the Information Technology Services' (another state agency) Real Player Server. A simple word document with embedded links to the server was used for distribution of the web-cast sessions - along with e-mailed instructions for successful use. The sessions will be available on-line through January, 2004 at significant savings over private sector costs - since state agencies were used as the production vendors.

Regional Training for Grantees

The Branch partnered with Question Why (?Y) Youth Empowerment Center to host a one-day workshop for adult leaders in the central region on Youth Empowerment and Advocacy. There were 60 adult participants, 23 individuals that are from HWTFC funded agencies (either school and community or priority population). There were 3 national speakers and 3 statewide HWTFC speakers (NC SAVE, NC Amateur Sports, Health Action Council) Topics covered included: Understanding Youth, ?Y Youth Empowerment Model, Local Activity Development (lessons from the field), Resource Development and Usage and a Youth Panel on effective adult leadership.

The TPCB partnered with Question Why (?Y)Youth Empowerment Center to conduct adult leader training "Successfully Running Youth Tobacco Use Prevention Groups" on Friday, October 17, 2003. Twenty-eight adult leaders attended from 16 different counties representing the western region. The training agenda included a session by Paul Turner of NC STEP on spit tobacco and youth, an adult leader panel on tips and hints for creating successful youth groups, and ?Y adult and youth leader-led sessions on the ?Y model of youth empowerment, youth cessation, and assessment techniques. The training received high evaluation marks--with highlights of the training including the spit tobacco information, the networking, the ideas and resources shared, and the wisdom from the adult leader panel.

Web-based Technical Assistance

TPCB staff and Web Design Subcontractor has continued to update the Branch's teen tobacco prevention website: www.StepUpNC.com. Two recent additions are a downloadable teen cessation booklet provided by the CDC Office on Smoking and Health and an updated list of school systems that have developed 100% tobacco-free policies. The Web Design subcontractor has developed two test sites (still under development) for additional sites to serve as resources for those doing teen tobacco prevention and cessation programs in North Carolina. The first will be a website for the Question Why Youth Empowerment program, which will contain a training calendar, links to teen tobacco prevention groups around the state, and how-to program descriptions for many youth activities, including a smoke-free teen hangout initiative. The second site will be a comprehensive site on school tobacco policies in North Carolina, filled with how-to descriptions on developing and enforcing 100% tobacco-free school policies.

Program Evaluation and Tracking System Technical Assistance and Training

The Branch's Surveillance and Evaluation staff provided technical writing on the HWTFC's Request for Application (RFA) for the contractor to conduct the overall Outcomes Evaluation for the Teen Tobacco Use Prevention and Cessation Initiative. Branch staff also participated in the review process to select an agency to conduct the overall Outcomes/Evaluation.

The Branch's Surveillance and Evaluation staff worked with a Computer Programming Specialists as a sub-contractor to develop a plan to incorporate TPCB Program Tracking System (PTS) into variable options for HWTFC grantees to report their progress on achieving goals. In March 2003 staff worked with newly awarded HWTFC Outcome Evaluation Contractor at UNC School of Medicine to quickly bring them up to speed regarding aspects of the HWTFC Teen Tobacco Initiative. Staff collaborated on strategic planning sessions to assess status of program goals and objectives. In April 2003, Branch staff presented and UNC staff provided an overview of Program Tracking System during the HWTFC Kickoff Meeting to grantees.

In early spring Branch staff worked with HWTFC and UNC Evaluation Team to modify and adapt PTS for use with HWTFC grantees and work with sub-contractor to implement changes, test the new system and write a PTS users manual. In July and August 2003, the Branch provided hands-on training to more than 60 grantees responsible for program tracking and monitoring at 3 regional training workshops in Greenville, Asheboro and Flat Rock. Following in August and September 2003, the Branch provided follow-up on installation of PTS system within each grantee's office. This included on-site assistance with Office of Minority Health/Health Disparities coordinator and worked with UNC and grantees to correctly enter several months' worth of activities and events. This month the Branch worked with HWTFC Evaluation Team to organize, clean up and generate PTS reports back to grantees. Also, work to develop a meaningful format for the 6-month self-assessment report.

Branch's Surveillance and Evaluation staff will continue to provide consultation as needed with both individual grantees and HWTFC Evaluation Team. Staff will regularly attend and provide suggestions in both small core and large team meetings sponsored by the UNC and HWTFC Evaluation Team.

Youth Summits and Training Events. Since April of 2003 the Branch, in collaboration with the three Question Why Youth Empowerment Centers, have assisted in training and providing resources and technical assistance to more than 20 local HWTFC grantee youth training events/summits on teen tobacco use prevention.

Four recent examples include:

- On October 8, 2003, Question Why provided resource center materials to General Baptist State Convention for an upcoming training they were hosting for youth. Resources included ?Y Manuals and 4 videos from the ?Y Video Library.
- On October 10, 2003, Question Why staff and TPCB Central Region Field Coordinator were asked to present at Public Schools of Robeson County 2-day Teen Empowerment Summit. ?Y Adult led two 1 ½ hours Tobacco 101 trainings. Approximately 100 youth (middle and high school) were served.
- On October 13, 2003 Question Why Adult Director and Youth along with TPCB Field Coordinator met with First Health of the Carolinas grant contact to provide technical assistance and planning for First Health 2-day Youth Retreat scheduled for Nov. 14-15, 2003 for the counties of Moore, Montgomery Richmond and Hoke.
- On October 18, 2003 Question Why and Branch staff provided assistance for the one-day Union County Public School teen tobacco prevention kickoff and training event. The Head of the TPCB provided the keynote address for the event.

Collaboration on Media Campaign. The Branch's Director of Public Education and Communication has devoted a tremendous number of in-kind hours in planning meetings, consultation and the detailed selection process for the media contractor. This Branch staff position works closely with HWTFC staff to play a significant role in the development process and implementation for the HWTFC statewide teen-oriented media campaign--*Tobacco.Reality.Unfiltered.* This position also provides direct training and technical assistance for all of the 26 community/school grantees related to media communications and public education.

In conclusion, the 6-month PTS Grantee Report generated by the UNC Outcome Evaluation Contractor reported from all Community/School grantees and four Priority Population grantees contained one item focused on their satisfaction with the technical assistance and training support that they received. Twenty-five out the twenty-six grantees (96.2%) report "...they are getting very good technical assistance and training support." (Grantee 6 Month Report,UNC Outcome Evaluation Team, October 2003, p3)

A MID-COURSE REPORT

FROM

THE NORTH CAROLINA OFFICE OF MINORITY HEALTH & HEALTH DISPARITIES

TO

THE NORTH CAROLINA HEALTH & WELLNESS TRUST FUND COMMISSION

ON

THE PRIORITY POPULATIONS INITIATIVE ON TEEN TOBACCO USE PREVENTION AND CESSATION

OCTOBER 15, 2003

Brief Description of the Priority Populations Initiative on Teen Tobacco Use Prevention and Cessation:

The North Carolina Health and Wellness Trust Fund Commissions Priority Populations Initiative ("PP Initiative") is part of the Commission's Teen Tobacco Use Prevention and Cessation Initiative. Under this initiative, the Commission will issued grants to four entities ("PPI Grantees") to address disparities in the use of tobacco by minority youth in North Carolina. The Grantees are

1. The General Baptist State Convention's Center for Health and Wellbeing, representing a faith-based community outreach to the African-American and other youth.
2. El Pueblo Inc. which is targeting the Hispanic/Latino community.
3. The North Carolina Indian Commission, which has a focus on Native American youth.
4. The Old North State Medical Society, whose focus is on Africa American youth.

Pursuant to this Agreement, the North Carolina Office of Minority Health and Health Disparities (OMHHD) was charged with answering questions and providing technical assistance to entities who were interested in applying for grants from the Commission. In addition, OMHHD had the broader mission of providing training and technical assistance to the eventual Grantees, with the goal of helping the Grantees identify and address tobacco use prevention and control issues for their target minority youth, gain insights into those issues and carry out the PPI Initiative grant-supported activities in a manner that increases the likelihood of successful tobacco use prevention and cessation outcomes for those targeted youth. As part of this broader mission, OMHHD was to assist the Grantees in capacity building and enhancement of core skills and capabilities to ensure success in carrying out their respective programs. OMHHD is to also provide support and guidance for "Youth Fellows" selected by each Grantee. The chosen "Fellow" is to work with the Grantee on teen tobacco use prevention as a way to develop leadership skills and build a commitment to community service.

Since the activation of this agreement, both the spirit and intent of these responsibilities given to the OMHHD have either been met or are being met accordingly. Despite organizational and infrastructure challenges by many Grantees, they have made significant progress as a whole in the past six months in

building capacity, core skills and capability to carry out their respective missions, since receipt of their initial funding.

Attached to this report are summary reports from all the Grantees covering their activities in the past six months since receipt of their initial funding from the Commission. Three of the four (Commission on Indian Affairs financial summary not included) also have a year-to-date financial report.

A. The General Baptist State Convention "Picture Me Tobacco Free" Program.
This program may end up having the largest impact and have the broadest participation of youth in the State. Although their progress initially may have appeared slow, much time has gone into the development of a strategy and outline of a detailed infrastructure that would be needed to eventually make this program truly a statewide effort. Besides working with a UNC-Greensboro team whose leader has had experience with the "Photo Voice " concept in Baltimore, this organization has also invested in a project coordinator with a Masters level public health degree and community health experience to help increase its core skills and capabilities to assist in the capacity building efforts needed in it's target communities.
The program will first be piloted in this first year in the "Rowan Association" district (see map), then replicated through other association affiliates across the State.
The dedication and commitment will to make this program a success is very palpable, and there are no apparent obstacles to progress at this time.

B. The El Pueblo "No Fumo" Youth Leadership Project.
The major goals of the El Pueblo project is to develop a curriculum in Spanish specific for North Carolina Latinos, build capacity of community-based youth groups and develop leadership among the Latino youth, and lastly to reach community service providers with the "No Fumo" message. El Pueblo has made significant progress in acquiring, developing and translating appropriate resources for use in North Carolina. Some youth groups have been identified for their pilot and initial training activities. They have been encouraged to explore further collaborations with other Hispanic/Latino organizations across the State, given the wide distribution of Hispanics/Latinos in North Carolina.
El Pueblo is also looking at various forms of media outlets to promote their message, especially since a significant percentage of their target population may not be able to read or have access to written material. Given their initial seed money prior to the HWTF grant, El Pueblo was the most exposed to the tobacco campaign compared to the other grantees, and they continue to play a constructive role in working with the other grantees in their progress.

C. Commission on Indian Affairs: "Many Voices, One Message: Stop Tobacco Addiction" Campaign.
The UNC consulting team led by Tim McGloin has done an excellent job in moving this project along, despite their late start as compared to the others. A tool kit has been developed for training, twelve mini-grants have been distributed and a significant number of Indian community institutions and churches have been recruited to participate. They have already made successful outreach efforts to all 8 Indian tribes in North Carolina and are now at the early stages of training youth leaders. This enthusiastic team is making great strides despite the constraints of the parent organization with it's limited staff. It is expected that this program can become a model for many States with significant Indian populations.

D. Old North State Medical Society "Physicians United for Teen Health".
This organization has had the most difficulty in getting of the ground with it's project. The first project coordinator eventually resigned, and there was significant assistance provided to establish a reasonable working relationship between the ONS and it's experienced consultant, the Paragon Foundation. In spite of that, ONS formed a physician advisory committee and has recently made great strides in establishing and beginning to implement it's project. ONS is beginning to work more closely with it's

collaborators and consultant, and has scheduled it's first formal physician training workshop. OMHHD is closely working and monitoring their progress to provide timely technical assistance and training.

Specific OMHHD Responsibilities, Accomplishments and Current Status:

A. Training and Technical Assistance to Individual Grantees

1. *Assign a staff member to the grantee as Liaison between OMHHD and the Grantee:*
   OMHHD assigned an experienced staff member (a public health physician) to serve as the principal liaison between the office and the Grantees. In addition, other staff support has been provided as needed, to each Grantee according to individual needs e.g. OMHHD's coordinator on Native American Health continues to provide additional support to the Commission on Indian Affairs, since this health initiative is a relatively new focus by the Commission.

2. *Conduct a "capacity building needs assessment" for each PPI Grantee, and identify grantee-defined needs, identify resources required to address the identified needs and outline a plan and timeline for the delivery of technical support and training to fulfill those needs:*
   An assessment was conducted for each PPI Grantee soon after each received it's initial funds. The meetings with the Grantees to conduct these assessments included their consultants where appropriate, to ensure adequate understanding and coordination of their individual projects. The needs of the Grantees varied widely, and sometimes depended on their relationship and/or capability of their consultants. Technical and resource support provided by OMHHD included assisting the Old North State Medical Society and the General Baptist State Convention on staffing needs and selection, to helping the grantees in general to re-focus and refine their program objectives, given their target population and available resources e.g. El Pueblo was encouraged to look not only about their diverse target youth population, but also the Spanish stores that serve many of them. Many of the immigrant Spanish store owners may need to be educated about the laws about tobacco sales, and be oriented to the culture here about the acceptance of youth tobacco use. Significant technical support and facilitation was required to create a successful healthier working relationship between Old North State Medical Society, their staff and their consultant, Paragon Foundation. The needs assessment will continue to be an ongoing exercise between the OMHHD and the Grantees, as the programs evolve and mature.

3. *Define the core skills needed for capacity building for each PPI Grantee and develop a menu of opportunities and activities to provide training and technical assistance to PPI Grantees. This is to bring each PPI Grantee to the same high level of skills shared by other PPI Grantees.*
   As expected, the Grantees were at different levels of capacity mostly as a result of past experience if any, of conducting either a targeted youth program, health related program or a program with a statewide focus. In addition, some limitations existed due to the nature of the organization e.g. The Commission of Indian Affairs being a State agency and therefore has certain proscribed protocols for program development. In this latter case, their consulting team from UNC-Chapel Hill's Office of Prevention has been instrumental in providing the ongoing core skills and capabilities needed to meet its program development needs.

   In contrast, the El Pueblo organization had received a grant for a tobacco project at least a year before winning the HWTFC grant and, therefore, had the opportunity to develop some core skills and capability which has aided in their current efforts.

   However, the differences in skill among the Grantees has narrowed in the last two months after much consultation and technical support. OMHHD continues to provide opportunities and activities in response to the needs of the Grantees. In addition, monthly meetings with all the grantees has

encouraged sharing of experiences and strengths, including peer appreciation of expected standards of program development.

4. *Develop Customized Capacity building plans for each Grantee where appropriate, and serve as an intermediary to facilitate the Grantees access to local, state and national technical consultants, trainers and other resources which are needed to meet the customized needs.*

   OMHHD continues to facilitate the Grantees access to local, state and national technical consultants and other resources. OMHHD staff have attended State and National conferences on Tobacco, including those offered by CDC/Federal Government, in order to increase its resources and referral capacity on behalf of the Grantees. Such activities included attending, with representatives from El Pueblo, the LCAT (Latino Council on Alcohol and Tobacco) conference in Washington DC, and also joining the NC Tobacco and Control Branch to attend the CDC sponsored Tobacco training conference in Arizona. They all yielded additional resources and contacts that has been helpful in customizing capacity building activities for the Grantees.

5. *Assist each Grantee in developing baseline small program implementation and management evaluation methodologies that can help each Grantee strengthen its organization and achieve its grant goals.*
   OMHHD recently began this effort in cooperation with the UNC evaluation team. Together with an evaluation team representative, OMHHD met with each Grantee for an extensive discussion and planning of program implementation and management evaluation methodologies. The Grantees were provided a guide book and will continue to receive technical assistance in this area. Their plans will be reviewed in November, and as part of the exercise, each Grantee has been asked to present their plan to the rest of the group at our year-end meeting in late November.

6. *Provide financial and administrative support for up to 400 hours of experience-based service learning in the twelve month term of this Agreement to one Youth Fellow from each Grantee.*
   Each Grantee requested and has been granted a "Youth Fellow". This program has been very successful in providing not only additional resources to the Grantees, but has attracted quality Fellows who are contributing and also gaining skills from the experience. It is an area worth re-examining for possible expansion.

7. *Provide up to 100 hours of customized consulting time per twelve month term of this Agreement to each Grantee.*
   This requirement has been met and exceeded. Consulting has not been limited to one-on-one formal meetings, but has included OMHHD staff attending events, programs and other activities of the Grantees in order to gain a first hand view and appreciation to enrich the consultation process and also promote a feeling of team work in this endeavor.

B. Assistance to PPI Grantees as a Group.

a. *Conduct a one day workshop on capacity building for Teen Tobacco Use Prevention and Control for Grantees and their staffs within eight weeks of the Commissions announcement of its choice of PPI Grantees.*
   The workshop on capacity building for Teen Tobacco Use was held in cooperation with the NC Tobacco and Control Branch and was attended by representatives of all Grantees. However, since some Grantee program coordinators were hired after the fact, and also to refresh and promote further skills enhancement, a nationally known youth tobacco use consultant was invited to provide another review on the issues Youth Tobacco and also program planning. OMHHD will be meeting

with representatives of the Tobacco Branch this month (mid-course) to assess needs for additional workshops/training, given experiences so far and also results of the PTS etc.

b. *Conduct three PPI Grantee Information Exchange Training Events during the twelve month term of this Agreement. Each event will last one and one-half days. Each Grantee will host one of the Events for the other Grantees.*
In the past six months alone, OMHHD has sponsored five information exchange events, with the last three hosted by a Grantee. The frequency was to help the Grantees as a group in their development and promote the benefits of peer review. The Grantees have reported that it has been most useful and helpful, especially since they have been able to share information and ideas, spurred collaboration among them and often inspired others who were relatively new. For example, El Pueblo representatives were invited and they attended the Ujima Youth Retreat, which, by report helped El Pueblo to further refine they youth retreat program. These information Exchange events will not be as frequent in coming months but may last longer per meeting.
All the Grantees were represented at an OPEN/Net television forum sponsored by OMHHD in September. El Pueblo is planning a follow-up forum in Spanish for early 2004.

c. *Assistance to Entities Interested in Applying for a PP Initiative Grant.*
Provide four toll-free, publicly noticed conference calls for persons and entities interested in applying for PP Initiative Grants from the Commission. During these calls OMHHD will provide information and assistance in filling out the Commission grant application for the PP Initiative.
This objective was successfully met. OMHDD assisted several grant applicants, including Old North State Medical Society and the General Baptist State Convention.

Reports.

A. *OMHHD agrees to work cooperatively with the Tobacco Prevention and Control Branch ("TBCB") to use the Program Tracking system ('PTS") designed and maintained by TPCB to collect program activity data from all the PPI grantees. OMHHD further agrees to submit a six month and annual progress report for each of the PPI grantees to the Commission using the data collected through the PTS system.*
OMHHD is working cooperatively with the Tobacco Prevention and Control Branch, and the UNC Evaluation Team to use PTS for data collection and reporting to the Commission. October was the first implementation of the PTS for the PPI Grantees. Most of the technical difficulties have been resolved and therefore it is expected that subsequent reports will be more timely.

B. *OMHHD agrees to submit a monthly invoice for payment from the Commission, and also submit quarterly progress reports to the Commission in a mutually agreed upon format.*
OMHHD has worked with the Division of Public Health Budget Office and the Department of Health and Human Services Office of the Controller, to develop and implement a monthly invoice for payment process. Currently, the DHHS Office of the Controller submits a monthly request for reimbursement to the NC Health and Wellness Trust Fund Commission Grants manager. Expenditure data for the request is derived from the Division of Public Health Budget system form DAPG 2605. Payments are made to the Division of Public Health.

Health and Wellness Trust Fund Commission
Teen Tobacco Prevention Initiative

UNC Outcomes Evaluation Project

Six Month Report
April - October 2003

The Outcomes Evaluation Team has conducted a number of activities during its formative, data gathering, and training phases. Listed below are the Team's activities for the first six months by category, as well a description of factors that either facilitated or presented challenges to the group's work.

Administrative Activities

- Developed administrative infrastructure for the Project including hiring of two research staff, building of a research team, creation of a new office space, and establishment of regular meetings both as a team and with collaborating partners such as the HWTFC and Tobacco Prevention and Control Branch (TPCB) staff
- Initiated and developed collaborative working relationship with member and partner groups, including the HWTFC, TPCB, the Office of Minority Health, and the Community/Schools and Priority Population grantees
- Presented evaluation plans at Kick-Off Conference in April

Technology

- Prepared for use of the Progress Tracking System (PTS) with HWTFC grantees. This included learning the system, adapting it to fit HWTFC objectives, and developing a Six Month Report for grantees.
- Began creation of a template for website to be used in communication with grantees and to disseminate information about evaluation findings

Community/School Grantees

- Reviewed and prepared summaries of 26 grantees' proposals, highlighting their strategies and objectives, in preparation for utilization of the PTS system, logic model development, and creation of evaluation plans
- Incorporated individual grantee activities into work on development of logic models for four major HWTFC goals
- Collaborated with TPCB in planning and conducting three regional PTS trainings attended by 52 Community/School grantees
- Provided ongoing technical assistance to grantees for purposes of answering questions about PTS, developing logic models, and discussing evaluation plans. Technical assistance in form of phone calls or emails to all 26 Community/School grantees; more extensive assistance provided to 18 grantees, including two site visits and one individual PTS training
- Collected grantees' PTS Monthly Report Summaries beginning in September. Twenty-five of 26 grantee reports received in September and 24 in October. Cleaned and edited report data; worked individually with grantees to refine and improve use of the PTS system; compiled individual reports into a summary report for the HWTFC
- Collected grantees' PTS Six Month Reports in October. All 26 received and compiled for report to HWTFC

Priority Population Grantees

- Incorporated individual grantee activities into work on development of logic models for four major HWTFC goals
- Collaborated with TPCB in planning and conducting three regional PTS trainings attended by eight Priority Population grantees

- Attended three Project Director meetings for Priority Population grantees
- Conducted site visits with all four grantees for purposes of answering questions about PTS, developing logic models, and discussing evaluation plans. Provided ongoing technical assistance in form of phone calls or emails to answer follow-up questions
- Offered technical assistance to Office of Minority Health in initial cleaning and editing of Priority Population grantee PTS Monthly Report Summaries
- Collected grantees' PTS Six Month Reports in October. All four received and compiled for report to HWTFC

Media Evaluation

- Presented proposal to the HWTFC for evaluating the 2003 media campaign and have begun to gather those data
- Added questions to North Carolina Youth Tobacco Survey 2003 and the Six Month PTS Report to better assess exposure to NC statewide media campaign.
- Began preparation for development of a best practices model for the 2004 media vendor
- Presented preliminary proposal to HWTFC for evaluation of the 2004 statewide media campaign

Not-On-Tobacco and Pregnant Teen Tobacco Use Cessation Programs

- Reviewed and prepared summaries of grantees' proposals, highlighting their strategies and objectives, in preparation for logic model development and creation of evaluation plans
- Incorporated individual grantee activities into work on development of logic models for four major HWTFC goals
- Provided technical assistance through site visit to Pregnant Teen Tobacco Use Cessation Program on development of evaluation plans

Factors Influencing the Work of the Evaluation Team

A number of factors have aided the Evaluation Team in its work. The productive working relationship with HWTFC and TPCB staff fostered by monthly meetings and open communication has facilitated evaluation planning and work with grantees. Both the Kick-Off Conference and PTS trainings have been informative, well-organized, and useful, based on the feedback received. In addition, grantees have shown enthusiasm about their projects and willingness to work with the Evaluation Team.

Some challenging factors have presented themselves as well. The Evaluation Team started later than the media contractor and many of the grantees, making it more difficult to prepare for their evaluation. The wide range of grantee experience with logic models, evaluation, and PTS has required substantial technical assistance time. This time has been used to clarify grantees' strategies and anticipated outcomes in order to produce effective evaluation practices. Though the need for training has delayed final development of the logic models and evaluation plans, grantees will be better equipped to plan project activities to meet their objectives as they prepare for year two of their programs.

North Carolina Health and Wellness Trust Fund Commission

Children, Youth and Community Obesity Prevention/Reduction Initiative

Request for Proposals

CONTENTS:

Health and Wellness Trust Fund Commission

Mail Service Center 7090
Raleigh, NC 27699-7090
Phone: (919) 733-4011 Fax: (919) 733-1240
E-mail HWTFC@ncmail.net
Website www.hwtfc.org

North Carolina Health and Wellness Trust Fund Commission

Children, Youth and Community Obesity Prevention/Reduction Initiative

Request for Proposals

PURPOSE

The Health and Wellness Trust Fund Commission ("Commission") announces the availability of grant funding during calendar years 2004-2006 to expand and enhance the statewide effort to prevent and reduce obesity. Funds will be provided to local community agencies, schools, state agencies, local government or other political subdivisions of the state, and nonprofit organizations for initiatives that seek to build local collaborations to:

- Raise awareness about the prevalence of obesity in their community,
- Engage decision makers to encourage adoption of state and local policies to promote community-based strategies that support healthy eating and increased physical activity,
- Emphasize school policies and environments that ensure access to healthful food choices and opportunities for physical activity,
- Promote healthy eating and physical activity in children and their families through culturally relevant social marketing interventions that are designed to affect behavioral change.

These goals are linked to a Plan entitled: *Moving Our Children Toward a Healthy Weight: Finding the Will and the Way.* This document is available on the web at http://www.nchealthyweight.com. The North Carolina Healthy Weight Initiative was established in October 2000 with obesity prevention/reduction grant funding from the Centers for Disease Control and Prevention (CDC). Partners, both internal and external to the NC Division of Public Health, collaborated on the original response to CDC's request for proposal and in the development of the Plan.

The Plan uses a multi-level approach, focusing not only on behavioral and interpersonal change, but also on the organizational, community, and societal change necessary to support healthy eating and increased physical activity by children, youth, and their families. The recommendations target increasing physical activity, improving eating patterns, and reducing disparities in the prevalence of childhood overweight.

BACKGROUND

Overweight/Obesity is the first chronic disease that is spreading at epidemic rates. At its current rate, it will soon become the costliest disease, surpassing cardiovascular diseases. The percentage of children who are overweight in the United States doubled during the past two decades and the percentage of overweight adolescents tripled.

North Carolina data from children seen in public health settings show an even greater increase. The most striking increase is in the 5 to 11 year age group, where there was a 40 percent increase in the prevalence of overweight between 1995 and 2000. One in eight (12.0 percent) children 2 to 4 years of age, more than one

in five (20.6 percent) children 5 to 11 years, and more than one in four (26.0 percent) youth 12 to 18, are overweight. 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.

Racial, ethnic, and socioeconomic disparities in the prevalence of overweight and obesity exist among adults in the U.S., and may occur in children and adolescents. For all racial and ethnic groups combined, women of lower socioeconomic status are approximately 50 percent more likely to be obese than those of higher socioeconomic status. Among children, the relationship is weaker. Girls from lower income families have not consistently been found to be overweight compared to girls from higher income families. The data is not yet robust enough to provide reliable answers to all questions regarding racial, ethnic, and socioeconomic disparities in the prevalence of childhood overweight. Data from *Healthy People 2010* are clear, however, that there are marked disparities in the impact of poor diet, physical inactivity and obesity on various groups of people, particularly by race/ethnicity and by education level. The health consequence of overweight and obesity is among the most burdensome public health issue faced by the nation. Type 2 diabetes, formerly called adult-onset diabetes, is increasingly being diagnosed in overweight children and young adults. Many overweight children and adolescents have impaired glucose tolerance, a condition that often appears before the development of type 2 diabetes. High blood lipids and hypertension, as well as early maturation, orthopedic problems, and sleep apnea also occur with increased frequency in overweight youth. In addition to being an increasing health problem during childhood, overweight perpetuates the upward spiral of adult overweight and obesity and earlier onset of associated chronic disease such as heart disease, stroke, diabetes and cancer, four of the leading causes of death in North Carolina. Overweight adolescents have a 70 percent chance of becoming overweight or obese adults. This chance increases to 80 percent if one or more parent is overweight or obese.

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. In 2000 the total economic cost was estimated to be $117 billion ($61 billion direct and $56 billion indirect). Social and emotional costs for those affected and for their friends and families, are immeasurable.

From Moving Our Children Toward a Healthy Weight: Finding the Will and the Way, NC Dept. of Health and Human Services, 2002, The Surgeon General's Call to Action to Prevent and Decrease Overweight and Obesity, U.S. Department of Health and Human Services, and the chapter on *Promoting Healthy Eating and Physical Activity for a Healthier Nation* in *Promising Practices in Chronic Disease Prevention and Control: A Public Health Framework for Action*, Centers for Disease Control and Prevention.

GENERAL GUIDELINES

Grant applicants are encouraged to consider incorporating strategies from existing program models, where feasible. Applicants are also encouraged to consider incorporating strategies from the North Carolina Department of Health and Human Services' *Moving Our Children Toward a Healthy Weight*, which can be found at http://www.nchealthyweight.com, and the *North Carolina Blueprints for Changing Policies and Environments in Support of Healthy Eating and Increased Physical Activity*, which can be found at http://www.eatsmartmovemorenc.com. Applicants should also consider addressing the Healthy People 2010 risk reduction objectives with regard to physical activity, overweight, and obesity. (http://www.healthypeople.gov/default.htm) and recommendations for community-based interventions in the chapter on *Promoting Healthy Eating and Physical Activity for a Healthier Nation* in *Promising Practices in Chronic Disease Prevention and Control: A Public Health Framework for Action*, available at http://www.cdc.gov/nccdphp/promising_practices/index.htm.
A list of related websites is provided below as a resource for reviewing pertinent information. Both the Healthy Weight and the Eat Smart Move More web sites provide additional resource lists.

National:

- www.cdc.gov/nccdphp/dnpa/physicalactivity.htm
- www.cdc.gov/nccdphp/dnpa/kidswalk/index.htm
- www.cdc.gov/nccdphp/dnpa/5aday
- www.cdc.gov/nccdphp/dash/shi/
- www.bam.gov
- www.cdc.gov/powerfulbones/
- www.ced.gov/cdcnergy/
- http://www.eatright.org
- http://www.asfsa.org
- http://ctb.lsi.ukans.edu
- http://www.cde.ca.gov/nsd/nets/rfaleaf02.pdf
- http://www.cancer.org

North Carolina:

- www.nchealthyweight.com
- www.eatsmartmovemorenc.com
- www.nutritionnc.com
- www.nchealthyschools.org
- www.startwithyourheart.com
- www.ncdiabetes.org
- www.healthycarolinians.org
- http://www.ncaahperd.org

THE PROGRAM

Who May Apply

Under the NC General Statutes, an organization is eligible to receive a grant from the Commission if it is:

- A state agency,
- A local government or other political subdivision of the state or a combination of such entities (includes local education agency and/or public charter schools), or
- A nonprofit organization.

Other entities interested in reducing/preventing obesity may apply in partnership with an eligible organization which is functioning as the lead applicant for the grant. This lead applicant bears responsibility for fiscal and overall management.

An Overview of the Children, Youth and Community Obesity Prevention/Reduction Initiative

The Children, Youth and Community Obesity Prevention/Reduction Initiative will consider grants from applicants to:

- **Initiate new community/school partnerships and collaborations.** It is anticipated that grants will be awarded to applicants that are structured as follows:

- Lead Applicant Organization: Typically, a public local education agency, public charter school, childcare facility, health organization, or healthcare organization, this entity bears the responsibility for overall program and fiscal management.
- Partners: This is a formal agreement among community-based organizations, including the lead applicant, to implement the proposed program. These organizations are listed as co-applicants, and could include public health organizations, medical practices, hospitals, local education agencies, public charter schools, childcare facilities, youth organizations, voluntary agencies, non-profits, and faith communities, among others. Other community-based, non-traditional organizations, such as police and fire departments, can play an important role in organizing and managing sports and similar events for children.
- Collaborating Organizations/Individuals: The Commission encourages the broadest possible coalition-building among diverse organizations, dedicated to achieving the goals of this Initiative. Collaborating entities may include, but are not limited to, community organizations and individuals such as health care providers, concerned volunteers, and parents who are committed participants in the proposed program. These entities are not listed as co-applicants. However, their description and roles should be included in the body of the proposal.

Although it is anticipated that most of the applicants will be from collaborations/ organizations that will focus their efforts on their local community, applications will also be considered from collaborations/organizations that seek to implement one or more of the goals of this initiative statewide.

- **Build on existing efforts.** Funds will also be available to organizations currently conducting obesity reduction/prevention activities for enhancement of those activities. It is anticipated that most of these enhancement grants will be awarded to applicants that are structured as described above. Preference will be given to applicants that encourage participation from community partners as well as collaborating organizations and individuals.

- **Stimulate innovation in reduction/prevention**. The Commission will also consider applications from eligible organizations proposing innovative new approaches to prevent and reduce obesity.

How Funds Can Be Used

Each Youth and Community Reduction/Prevention Initiative recipient must use the funds to carry out activities that support the following goals and objectives. The examples listed below each goal/objective are examples provided as guidance to grant applicants. Applications should be based on locally-identified needs.

GOAL I: REDUCE BARRIERS IN CHILDREN'S HOMES/COMMUNITIES TO HEALTHY EATING AND PHYSICAL ACTIVITY.

OBJECTIVES:

1. Increase the number of people who have access to opportunities for healthy eating and increased physical activity, to learn skills for healthy lifestyles, and to receive support for healthy behaviors.

   Examples:

a. **Provide educational opportunities and practical skills that will improve caregivers' abilities to meet recommendations for healthy eating and physical activity.**
b. **Ensure safe and accessible places for physical activity for all children and youth.**
c. **Increase access to a variety of affordable healthy foods in grocery stores and restaurants in all neighborhoods.**

2. **Increase the proportion of children and adolescents who view television no more than 1 to 2 hours a day.**

Examples:

a. **Provide educational opportunities to raise awareness of the positive association between the number of hours children watch television and their risk of being overweight.**
b. **Help caregivers develop skills to encourage active play as an alternative to TV watching and video games.**
c. **Test one of the school-based programs that have shown promise in helping to reduce children's TV viewing by providing means for parents and children to monitor and budget the time children spend watching TV.**

GOAL II: SIGNIFICANTLY INCREASE THE NUMBER OF SCHOOL AND CHILD CARE SETTINGS THAT PROMOTE HEALTHY EATING AND PHYSICAL ACTIVITY.

OBJECTIVES:

1. Increase the number of children and youth who participate in daily physical activity at school.

Examples:

a. **Increase the availability of quality daily physical education in schools for all children.**
b. **Provide extracurricular physical activity programs, targeted to all ability levels, especially intramural programs and physical activity clubs.**
c. **Incorporate physical activity into core subjects at school.**
d. **Ensure universal access to physical education and physical activity opportunities for children and youth with disabilities and special health care needs.**
e. **Partner with communities to make school facilities available for physical activity beyond school hours and promote their use by families.**
f. **Establish or participate in safe walk/bicycle-to-school promotions.**

2. Increase the number of schools and child care facilities that adopt and implement policies to limit consumption of sugar-sweetened beverages.

Examples:

a. **Set standards for nutritional content, portion size, and hours of service of beverages sold in vending machines, snack bars, and as school cafeteria a la carte menu items.**
b. **Ensure that water, small sizes of 100 percent juice, and low-fat milk are available in vending machines.**
c. **Provide education and skill practice about how to resist advertising pressures to buy foods and beverages high in calories and low in nutrients.**

3. Increase the number of schools and child care facilities that provide appropriate portion sizes of foods and beverages.

   Examples:

   a. Set standards for maximum portion sizes of foods and beverages sold in vending machines, snack bars, and as school cafeteria a la carte menu items.
   b. Follow age-group recommendations for portion sizes of foods and beverages served in the National School Lunch, School Breakfast, and Child and Adult Care Food Programs.
   c. Provide education and skill practice to students, as well as school and child care staff, about calorie need, portion size, and satiety/appetite awareness.

4. Increase the number of schools that adopt and implement a plan to create an environment that establishes and promotes healthy eating and active lifestyles as the norm rather than the exception.

   Examples:

   a. **Provide healthy lifestyle skills education as well as practice that includes nutrition, food purchasing and preparation, physical activity, and media literacy.**
   b. **Participate in community-wide social marketing interventions that promote healthy eating and physical activity, such as "5 a Day" or "1% or Less" milk.**
   c. **Promote safe routes to walk or bike to school and provide bike racks.**
   d. **Ensure that National School Lunch and School Breakfast Program meals meet or exceed national standards.**
   e. **Prohibit access to vending machines, snack bars, and other venues in which snacks compete with healthy meals in child care and elementary schools, and limit access in middle and high schools.**
   f. **Make healthy eating and physical activity initiatives part of the coordinated school health program to ensure collaboration among all school health professionals.**
   g. **Involve parent-teacher organizations in designing interventions, developing incentives, and promoting commitment.**

GOAL III: INCREASE THE NUMBER OF NEIGHBORHOODS THAT ARE DESIGNED TO SUPPORT SAFE PLAY AND HEALTHY EATING.

OBJECTIVES:

1. Increase the number of children and youth who have the opportunity to participate in at least 60 minutes of physical activity every day.

   Examples:

   a. **Partner with schools to make facilities for physical activity available to the community beyond school hours.**
   b. **Encourage the promotion of physical activity in faith communities and the expanded use of their physical activity facilities.**
   c. **Engage organizations for children and youth in promoting physical activity among their members.**
   d. **Review transportation policies and traffic patterns and revise to facilitate safe walking and biking.**

2. Increase the number of community settings that adopt practices that limit consumption of sugar-sweetened beverages.

   Examples:

   a. Promote availability of water, low-fat milk, and small sizes of 100 percent juice in vending machines in parks, recreation facilities, hospitals, and other public buildings.
   b. Engage organizations for children and youth in increasing water consumption and reducing consumption of sugar-sweetened beverages among their members.
   c. Work with industry on availability, pricing, and marketing of water, 100 percent juice, low-fat milk, and small sizes of 100 percent juice and sugar-sweetened beverages.
   d. Engage faith communities in making available and promoting alternatives to sugar-sweetened beverages at all functions where beverages are served.

3. Increase the number of community settings that provide appropriate portion sizes of foods and beverages.

   Examples:

   a. Promote appropriate portion sizes of foods and beverages in community operated facilities.

4. Increase the number of community-based opportunities for leisure-time/recreational physical activity for all children and youth.

   Examples:

   a. Expand offerings of affordable physical activity such as league sports, gymnastics, dance, swimming, and martial arts classes.
   b. Ensure universal accessibility for physical activity resources and opportunities.
   c. Include youth representation in planning and promoting physical activity opportunities.

5. Increase the number of community partners that adopt practices that help create an environment that establishes and promotes healthy eating and active lifestyles as the norm rather than the exception.

   Examples:

   a. Engage community leaders to work with restaurants and other food outlets to promote availability of affordable options that support healthy eating.
   b. Support events, such as Special Olympics, that focus on physical activity among children and youth of all ability levels.
   c. Adopt local policy that sets standards for green space and sidewalks in new developments.
   d. Establish workplace programs and policies that promote breastfeeding.
   e. Promote the establishment of workplace programs and policies that support healthy eating and physical activity.

6. Increase equitable access to prevention and treatment services for children who are overweight or at-risk for overweight in order to reduce health disparities.

   Examples:

a. **Provide support for a network of accessible, family-based and culturally relevant interdisciplinary weight management services for children and youth who are overweight or at-risk for overweight.**
b. **Increase awareness of prevention and treatment programs among children and youth, parents/caregivers, school personnel, primary care providers, and community leaders.**

GOAL IV: 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.

OBJECTIVES

1. Increase equitable access to prevention and treatment services to reduce health disparities.

   Examples:

   a. **Engage local practices in routinely discussing obesity prevention/reduction with children and parents, including availability of local resources.**
   b. **Establish and support a network of accessible, family-based and culturally relevant interdisciplinary weight management services for overweight children and youth.**
   c. **Maintain a list of health care professionals who are trained to provide treatment to overweight children, youth, and their families.**

2. Increase number of children and youth screened during routine physical assessment for overweight and related chronic disease risk factors using nationally established guidelines for screening and referral.

   Examples:

   a. **Provide training to health care professionals on current pediatric screening recommendations and anthropometric measurement protocols.**
   b. **Develop brief overweight assessment tools for pediatric health care professionals.**

GRANT TERMS

The Commission will award grants to new local programs or to enhance existing local programs. The awards will range from $75,000- $150,000 annually. Project funding will be commensurate with the size and scope of the proposed activities. **Subject to availability of funds, and further subject to annual satisfactory program evaluation and continuation plans, the awards will be for three calendar years, 2004 - 2006.**

Grants will be disbursed as follows: up to 3 months startup funding at the beginning of the funding cycle, followed by an equal monthly advance of the remainder of the annual grant, beginning in the second month. These monthly advances will be triggered by submission of monthly financial reports detailing expenditures incurred in the previous month.

The Commission expects to receive more funding requests than can be awarded. Therefore, submission of a grant application does not guarantee receipt of an award. Additionally, grants that are funded may not be funded at their requested amount. The grant size may vary by circumstances, need, and program model. The Commission reserves the right to conduct pre-award interviews or onsite assessments.

As a condition of receiving a program grant award, the Commission requires that each grantee participate in project evaluation as well as a monthly program activity tracking system. Applicants should budget for 4-5 hours/month of staff time for the program activity tracking system and 7-8 hours/month of staff time for the state-level outcomes study. Duke University Medical Center's Department of Community and Family Medicine will provide training and technical assistance in the proper use of the computer-based activity tracking system and in submitting the information for central data processing. As part of the evaluation system, specific reports or information, as well as site visits and telephone interviews, will be required as needed to document program implementation and operation.

Applicants are also required to submit both an interim (6-month) and an annual progress and financial report to the Commission (user-friendly forms will be available on the Commission's website). A final cumulative progress report and financial report will be due 30 days after the end of the grant period.

Use of Grant Funds

Funds may be used for planning, staff salaries, project-related travel, supplies, a limited amount of equipment, and other direct expenses essential to the project. The Commission anticipates that one Full-Time Employee (FTE) of dedicated staff will be needed for most funded programs and should be accounted for either in the proposed budget or as an in-kind contribution.

The Commission discourages the use of grant funds to pay indirect costs. Any allocated funds that are used to pay indirect costs must be clearly identified along with justification for the expense. Indirect costs include operating and maintaining buildings, grounds, equipment, depreciation, administrative salaries, general telephone expenses, general agency travel expenses and general office supplies. Also, Commission funds may **not** be used for capital expenditures or equipment expenses over $2,000 per unit. Computers, including laptops, are an acceptable expenditure with justification. Commission funds may not support any efforts to engage in any political activities or lobbying including, but not limited to, support of or opposition to candidates, ballot initiatives, referenda, or other similar activities. These funds may not be used for research studies, unless this research is directly linked to evaluation purposes, or to substitute for funds currently supporting similar services. Applicants may subcontract for proposed services after notice to the Commission.

Auditing and Reporting Requirements

State law requires that all grant recipients that are nongovernmental entities and receive at least $15,000 but less than $300,000 in combined state funds annually, must file with each of the funding entities, a sworn accounting of receipts and expenditures of these funds. Grant recipients that are nongovernmental entities and receive $300,000 or more in combined state funds annually must file both with the State Auditor and the funding entities an audited financial statement as prescribed by the State Auditor.

A single audit is required if a unit of government or public authority expends $300,000 or more of combined state awards in either a federal program (such as a state match) or a state program. Nongovernmental entities are not required to perform a single audit, based only on state awards expenditures.

APPLICATION PROCESS

The Commission has established a two-step process for awarding funds under the Children, Youth and Community Obesity Prevention/Reduction Initiative, consisting of a Letter of Intent and a full Application Package. Both can be submitted either by using the Commission's online process or in writing. A letter of intent is strongly recommended, but not required. A full Application Package is required of each applicant. The detailed description of a Letter of Intent and Application Package follows. The Duke Management Team will provide direction and technical assistance to all applicants in preparing the application package through conference calls and will provide technical assistance to all grantees in the evaluation of the funded programs. Applicants can refer specific questions either in advance or during the conference calls. Advanced questions can be relayed via email to hwtfc@ncmail.net.

Stage I: Letter of Intent

The Commission requests that potential applicants submit a letter indicating the applicant's intention to submit a complete application. Please complete the Letter of Intent online at www.hwtfc.org. If you do not have web access, you may contact the Commission for the Letter of Intent form. Two pre-bidders' conference calls will be held on **May 28 and 29, 2003** to provide technical assistance for potential applicants. The Commission requests receipt of a Letter of Intent by **Friday, June 13, 2003** (see Timetable).

The letter of intent should clearly describe:

- A brief review of the lead applicant's history, mission, services offered and recent accomplishments, and if relevant, of partnering organizations that will be listed as co-applicants,
- Whether this is an application to create a new program or enhance an existing effort,
- The geographic area to be served,
- A brief summary of proposed program including the target population, goals, objectives, intervention strategies, and
- Estimate of budget amount to be requested and intended use of funds.

Applicants are strongly encouraged to use the Commission's website for submission of letters of intent, however, written letters will be accepted through the mail as well. Mailed applications should contain three sets - an original plus two copies to be sent to the Commission. Faxed copies will not be accepted. The

name and address of the institution and the name, address and telephone number of the contact person must be included. No additional materials will be accepted.

Stage II: Full Proposals

All applicants must submit full proposals in order to be considered. Technical Assistance conference calls will be held on **June 30 and July 1, 2003** to answer any questions that applicants have in developing their proposals. (See Timetable below for dates).

Applicants are strongly encouraged to use the online capabilities found at www.hwtfc.org for full proposals; however, written full proposals will be accepted through the mail as well. Please contact the Commission to receive an application form by mail if you are unable to access the Internet. Applications submitted by mail must strictly adhere to the character count listed in the printed application form. This same character count is coded into the online application. Mailed applications should contain three sets - an original plus two copies to be mailed to the Commission. Faxed copies will not be accepted. All mailed proposals must be typed or printed in ink in 12-point type on 8 1/2" by 11" white or light colored paper. To the extent possible, applicants sending their applications by mail should also provide an electronic copy in a format such as a formatted diskette or via e-mail using Microsoft Word.

The proposal should include:

1. **Cover page.** Include the name, mailing address, telephone number, facsimile number, email, and federal identification number for the lead applicant organization, and the name and contact information of the key contact person at that organization. Identify the partnering entities, including local education agencies or public charter schools (if other than lead applicant) and include the name of the key contact person in each organization. **The Certification Page found at the end of the application must be signed by the chair of the Board of Directors or the head of the lead applicant organization in order for the application to be considered complete.**

2. **Executive summary.** The executive summary should include an overview of the lead applicant organization, total amount of grant request for three years, a concise description of the need for the program and the target population benefiting from services; objectives and measurable outcomes for the program for which funding is requested; how the proposed program demonstrates innovation at the community, county or regional level; and information on the integration of the program with existing services, partnering organizations (co-applicants), and evidence of community support and participation in planning and implementation.

3. **Program Description.** The narrative of the description should include:
    - **Background of the lead organization and its partners.** Provide an overview of the lead applicant organization, including its mission statement, current programs, accomplishments and experience working on obesity reduction/prevention policy and programmatic activities. Provide brief overviews of all partners (co-applicants) and their proposed roles and responsibilities. Include information on the capacity of the lead organization to administer the program. Provide information about the various assets of the partnership that apply to the proposed project.
    - **Need for establishing a new program or need for enhancement of existing program**. Describe the community's need for the program or program expansion. Include current demographic information about obesity. Provide information on current obesity prevention/reduction activities and infrastructure in the community. Describe the geographic area and population the program will serve and an explanation of how these people will benefit from the program. Explain how the program will build or enhance the community's capacity to prevent/reduce overweight and obesity. (*More information* is *available from the Health*

Promotion Branch at www.community health.dhhs.state.nc.us *or at the Centers for Disease Control and Prevention (CDC) at www.cdc.gov*).

- **Program goals, objectives, and strategies for achievement**. Include a description of the proposed program plan that covers the years for which funding is requested. The program plan must include specific goals, objectives, and intervention strategies for year one. Program objectives must be specific, measurable, time-phased, and realistic. Anticipated goals and objectives for years 2 and 3 may be briefly summarized in paragraph form. Proposed intervention strategies should be evidence-based and demonstrate a commitment to involve target audiences in program development. Applicants are also encouraged to propose innovative strategies.
- **Outcomes/Evaluation Plan.** Using the goals and strategies on pages 4-6, provide a list of expected outcomes from the program including what the applicant expects the program to accomplish in the first year. How will the quality and quantity of obesity reduction and prevention activities be measured? Give examples. Describe how this evaluation will be used to make the program more effective and efficient, and how results of the evaluation will be disseminated. In order to maximize impact of the program, identify any school and/or community policies, and program services that will have to be monitored during the length of the program.
- **Program outcomes for existing programs**. All existing programs applying for enhancement grants must describe program outcomes for all the years that the intervention program has been in existence.
- **Program management.** Describe the roles and responsibilities of program staff in the proposed project. The description should include their titles, qualifications, and experience, as well as the percentage of time and number of hours each will devote to the program, and the portions of their salary that will be paid from the grant award.
- **Integration of services and collaborations with local organizations.** Describe all collaborations with community organizations and describe their roles in supporting the program, including the extent of the collaboration with the local education agency (if it is not a lead applicant or partner). Outline how the proposed program will complement or build upon existing programs and services that address obesity prevention/reduction.
- **Participation in program activity tracking system.** All applicants must demonstrate a willingness and ability to participate in a program activity tracking system and specifically dedicate staff time in their proposal.
- **Sustainability.** Identify how the organization will sustain its efforts after the grant period. Discuss strategies for long-term funding and viability.

4. **Budget and Fiscal Information.** Applicants must include the following:
    - A detailed budget of the projected annual funding requests for the proposed program in the form provided in the online application, including any indirect costs, if requested. A narrative budget justification that describes how the categorical costs are derived must also be completed. Applicants should also list any in-kind resources that they will contribute to the project.
    - The current year budget of the lead applicant organization.
    - A complete list of sub-recipients under the grant and a specific description of how the applicant will account for funds disbursed to sub-recipients (sub-recipient includes partners, collaborators and other contractors). The applicant shall have an on-going duty to identify sub-recipients annually under the grant.
    - A description of the bank accounts and internal accounting ledgers or books that will be set up and used and an assurance that all accounts, books, and ledgers can be audited by the Commission or the State auditor.
    - A list and history of lead applicant's programs funded by grants or awards in the last five years,

as well as the names of all granting entities involved in those grants or awards.

- For existing programs applying for enhancement grants, a list and history of all grants and awards, as well as names of all granting entities involved in those grants or awards.

Budget Note: *Program grantees are required to include Training and Development expenses in the Annual Budget Section of the proposal. Grantees are required to attend all regional and Statewide Annual Meetings. A minimum of $1,500 per individual (up to three) attending these events should be included to support these expenses.*

5. Additional Materials. Applicants must include:

- Letters of agreement from application partners outlining roles/responsibilities of the partner for the entire grant period.
- Letters of support from Collaborating Organizations/Individuals.
- Statement agreeing to provide computer with minimal capabilities to provide data, facilitate communication, and support the Management Team. See attached description.
- Evidence of non-profit status, if applicable.

REVIEW PROCESS AND CRITERIA

All applications will be evaluated through a multi-stage process. The Commission staff will initially screen all applications to determine if they are complete. Incomplete applications will not be considered. No grant may be awarded for a program that is unlawful. Applications that are complete will be forwarded to an independent, objective Grant Review Committee, consisting of Commissioners and expert advisors appointed by the Commission. The Grant Review Committee will focus its review and evaluation of the applications on the required program narrative elements listed above. During the review and evaluation of proposals, the Grant Review Committee may request that Commission staff or a designee make site visits to applicant agencies and report to the Grant Review Committee. At the conclusion of their review and evaluation, the Grant Review Committees will make recommendations to the Commission as to which applications should be funded.

The Commission will receive the recommendations of the Grant Review Committees and will evaluate proposals based on the beneficial impact of the funding request on the health and wellness of the people of North Carolina. In making this evaluation, the Commission may consider: who/how many will be served by the grant, the cost of administering the grant, community capacity building, sustainability of the grant application, and whether the program has measurable outcomes. Scoring and ranking of proposals will be determined by using a consistent rating methodology.

The proposal will be evaluated on the criteria listed below, thus it is recommended that applicants account for each item in their proposal:

1. Statement of need and program rationalization: **10%**
    - Well-documented community need and program justification.

2. Soundness of proposed plan and strategy: **35%**
    - Based on an assessment of objective data about obesity and the communities to be served, (*More information* is *available from Health Promotion Branch at* www.communityhealth.dhhs.state.nc.us *or at the Centers for Disease Control and Prevention (CDC) at www.cdc.gov/nccdphp/dnpa/nutrition.htm* and www.cdc.gov/nccdphp/dash/shi *See also General Guidelines*).
    - Based on an analysis of risk factors, protective factors, assets, or other variables identified through scientifically based research.
    - Grounded in scientifically-based research that provides evidence on strategies to reach the proposal's goals and objectives. (Please refer to goals, objectives and strategies section of this Request for Proposals and also *refer to websites in General Guidelines Section*).
    - Evidence of an innovative and sound strategy and program design for reducing obesity in children and their caregivers.
    - Based on input from community leaders representing a range of local organizations, diverse community members, and youth.
    - For all existing programs applying for enhancement grants, the presence of significant program outcomes for all years of existence.

3. Organizational capacity: **35%**
    - Demonstrated ability to provide sound programmatic and fiscal oversight.
    - Dedication of at least one full time equivalent (FTE) staff to prevention efforts where funding level warrants.
    - Evidence of organizational experience in reduction/prevention programs and youth involvement.
    - Likelihood to sustain effort after grant period.
    - Creation of partnerships between public health agencies, nutritionists, physicians, local education agencies, or other community-based organizations that are listed as co-applicants for the grant.
    - Collaborating entities that are committed supporters of the program goals, but are not listed as co-applicants.
    - Support from local media outlets, and in case of existing programs, evidence of media support in prior efforts.
    - Commitment to actively involve youth in program development, implementation, and in all other aspects, over the life of the grant.

4. Outcomes/Evaluation plan: **10%**

    (More information on outcomes/evaluation planning for obesity prevention/reduction programs is available at http://www.cdc.gov/nccdphp/dnpa/obesity/index.htm).
        - Demonstrates strong strategic planning skills and an understanding of the importance of program monitoring and evaluation. Includes providing information to monitor progress on implementation of both planned and opportunistic events and analyze impact of proposed activities.
    - Monitoring system in place to periodically review, refine, improve and strengthen the program.
    - Clarifies lead agency's ability and willingness to participate in ongoing progress tracking and outcomes study.

5. Proposed budget: **10%**
    - Cost-effectiveness of proposed budget in relation to the scope and nature of the program.

In order to facilitate the development of additional statewide community and school partnerships to reduce obesity, Commission will provide individual critiques of proposals.

IMPORTANT DATES

Monday, May 5, 2003	Grant RFP announcement
Wednesday, May 28, 2003 **Thursday, May 29, 2003**	Pre-bidders conference call regarding the RFP from 3:30 pm to 5:00 pm E-mail advance questions to HWTFC@ncmail.net. Pre-registration required: contact Giselle Roman at 919-681-3023
Friday, June 13, 2003	Letters of Intent due
Monday, June 30, 2003 **Tuesday, July 1, 2003**	Pre-application technical assistance conference call 3:30 pm to 5:00 pm. E-mail advance questions to HWTFC@ncmail.net. Pre-registration required: contact Giselle Roman at 919-681-3023
Tuesday, August 5, 2003	Applications due
Mid-November 2003	Notifications of awards by the Health and Wellness Trust Fund Commission
January 2004	Projects begin

Special thanks to the North Carolina Department of Health and Human Services, authors of Moving Our Children Toward a Healthy Weight: Finding the Will and the Way, 2002, and NC Blueprints for Changing Policies and Environments in Support of Healthy Eating and Increased Physical Activity on which much of this document is based.

Technology Requirements for the

North Carolina Health and Wellness Trust Fund Commission

Children, Youth and Community Obesity Prevention/Reduction Initiative

Participation in Children, Youth and Community Obesity Prevention/Reduction Initiative activities will require Internet access and other computer capabilities. Table 1 indicates minimum and recommended hardware specifications for compatibility with the Children, Youth and Community Obesity Prevention/Reduction Initiative.

Table 1 – Hardware

Category	Minimum	Recommended	Required
Processor	Pentium 166	Pentium III	
Memory	32 megabytes	128 megabytes	
Disk Space	2 Gigabytes	6 Gigabytes or larger	1 Gigabyte free space

Minimum system components are necessary to run the required software effectively. Recommended components reflect current technology and should be considered if a new system is purchased. Grantees should select a vendor that can provide service under warranty and meet the needs of your project. Grantees are not obligated to purchase the systems listed in Table 2. Information has been provided for reference only.

Table 2- Vendor Information

Manufacturer	Model/Series
Dell	Optiplex GX110
Compaq	DeskPro EX

These systems come with a CD-ROM, Ethernet card, sound card, keyboard, mouse, monitor, 1.44 floppy drive, and speakers. They can be customized to include a modem, and other options such as a CDRW or a Zip Drive. One important reason for buying these machines is the warranty. For example, Dell's standard warranty on the GX110 is 3 years, next business day, on-site service. We expect that the technology included in these systems to be stable, which means you should not have to worry about recalls and

standard applications not working correctly. Though these systems are not a requirement, they are likely to meet your needs for the duration of the project.

The Youth and Community Obesity Reduction/Prevention Initiative will require the Microsoft Windows operating system (Windows 95/98/ME or Windows NT/2000) with Office 97 Professional and current service packs loaded to ensure Y2K compatibility. Office 97 Professional's basic components include Access, Word, Excel, and PowerPoint.

All grantees must demonstrate their capability for Internet access. Electronic transfer of information for the duration of the Program will be essential to overall project management. The computer designated for project use needs the capability for uninterrupted access to the Internet. This connection should be as fast as possible to make the transfer of data as efficient as possible. Any of the methods listed below are possible:

- Dial up modem to and Internet service provider (such as Earthlink, AT&T Globalnet, AOL, etc)
  ** requires a modem to be installed in the PC and a dedicated analog telephone line

- ADSL (local phone company) or cable modem (i.e. Time Warner's Road Runner)
  ** requires Ethernet card to be installed in the PC, ADSL/cable modem service, and TCP/IP software configured (TCP/IP configuration will be performed during the installation of the cable modem or ADSL)

- Local Area Network with access to Internet
  ** requires Ethernet card to be installed in the PC and TCP/IP software configured (TCP/IP configuration is performed by the network's administrator)

The dial up method is the slowest of the three but may be the only available system. An ADSL/cable modem will provide good performance at a reasonable price. A Local Area Network will more than likely provide the best performance of the three depending on setup, but may not be available.

OBESITY APPLICATIONS – GRANTS AWARDED

ORGANIZATION	SERVICE AREA	BUDGET AMOUNT	COMMENTS
Be Active North Carolina, Inc.	Statewide	$ 330,796	
Children First of Buncombe County	Buncombe	$ 434,283	
Cumberland County Schools	Cumberland	$ 445,096	
Durham Public Schools (DPS)	Durham	$ 441,945	
Halifax County Health Department	Halifax	$ 236,362	
Mecklenburg County Health Department	Mecklenburg	$ 450,000	
Mitchell County Schools	Mitchell, Avery	$ 450,000	
NC Academy of Family Physicians Foundation	Statewide	$ 417,678	
New Life Women's Leadership Project	Martin, Washington	$ 337,082	Includes recommended additional funding ($90K)
North Carolina Division of Public Health	Statewide	$ 371,032	Does not include external evaluation in year three ($47.8K)
-Directed grants to minority lead organizations		$ 147,800	$47.8K transfers from DPH grant request + $100K
Partnership for Health, Inc.	Henderson	$ 442,245	
Person County Schools	Person	$ 450,000	
Pitt County Schools	Pitt	$ 449,028	
Southeastern Regional Medical Center	Robeson	$ 450,000	
UNC-TV	Statewide	$ 449,970	
Wake Forest University School of Medicine	Forsyth	$ 450,000	
SUBTOTAL RECOMMENDED GRANTS		**$ 6,753,317**	
Duke Management Contract (Planning Phase)		$ 75,000	
Duke Management Contract 2004-06 (Implementation Phase)		$ 600,000	
Obesity Study Commission (Proposed)		$ 300,000	
Outcomes Study (Pending)		$ 325,000	
SUBTOTAL MANAGEMENT		**$1,300,000**	
GRAND TOTAL		**$8,053,317**	
TOTAL AMOUNT AUTHORIZED FOR INITIATIVE	**$ 9,000,000.00**		
GRAND TOTAL RECOMMENDED and MANAGEMENT	**$ 8,053,317.00**		
AVAILABLE BALANCE	**$ 946,683.00**		Recommend allocation in year two