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May 2012



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## EXECUTIVE SUMMARY

- Tobacco use in North Dakota has been falling, but tobacco remains a major problem that costs North Dakota nearly half a billion dollars annually.
- As of 2010, overall smoking had declined to the national average and youth smoking and smokeless use remained well above the national average; adult smoking rates were high among American Indian/Alaskan Native and Hispanic populations.
- North Dakota lobbyists are not required to report how much they were paid by their clients, which makes it impossible to track changes in the tobacco industry's expenditures on lobbying over time.
- From 2000 to 2010 the tobacco industry made campaign contributions primarily to North Dakota political party organizations, mostly Republican (72 percent), but rarely contributed directly to individual legislative candidates.
- The largest increase in tobacco industry campaign contributions took place in the 2009-2010 election cycle when Republican political party organizations accepted \$38,850, an increase of nearly 430 percent from the 2007-2008 election cycle. The legislature was considering Measure 3-approved tobacco control program funding in 2009.
- From 1985, when Tobacco Free North Dakota formed, to 2012, tobacco control advocates usually had a statewide tobacco control coalition, though the coalition's level of organization depended on whether funding and leadership were available.
- North Dakota created the Department of Health (DOH) Tobacco Prevention and Control Program in 1989 but did not fund it at a level that could have an impact until the 2001-2003 biennium, when the Legislature created the Community Health Grant Program.
- Though still below CDC *Best Practices* funding levels, from 2001 to 2008 the Community Health Grant Program substantially funded local communities to work on tobacco control for the first time. Local Public Health Units built policy-focused coalitions in cities throughout North Dakota and passed two local clean indoor air laws which were stronger than the statewide law and two comprehensive local smokefree air laws.
- The Legislature refused to fund a statewide media campaign, so, in 2002, Local Public Health Units formed the Public Education Task Force on Tobacco and pooled their money to create a statewide media campaign. The Task Force's campaigns increased public understanding of the dangers of secondhand smoke and contributed to passage of the 2005 statewide clean indoor air law and local smokefree ordinances.
- In 2005, the Healthy North Dakota Tobacco Policy Subcommittee was successful in getting the Legislature to pass a statewide clean indoor air law that prohibited smoking in public places and workplaces but that exempted bars and enclosed bars within restaurants, hotels and bowling alleys.
- In 2007, a smokefree air bill that would have closed the loopholes in the 2005 law did not have support in the Legislature and went nowhere.
- In 2008, a group of tobacco control program leaders formed the Support Tobacco Prevention Committee and launched a successful campaign to pass Measure 3, an initiative that secured new MSA payments for a fully funded comprehensive tobacco control plan and created a new tobacco control agency, separate from the DOH, to implement the plan which complemented existing DOH programs.

- Senate Republicans attempted to amend Measure 3 to give the money to the DOH in 2009. Support Tobacco Prevention, Tobacco Free North Dakota, and the TPC Executive Committee mobilized the local advocates who got Measure 3 passed and successfully generated public pressure for the Legislature to make the appropriation.
- In addition to fighting with the Legislature to appropriate its funding, the TPC Advisory Committee spent the first half of 2009 working with the DOH, CDC and national tobacco control program consultants to create a comprehensive plan and an annual work plan based on CDC *Best Practices*. The work plan divided program responsibilities among the state partners.
- The Legislative Assembly divided the state's \$9.3 million (which included federal grants from CDC) funding for tobacco control activities between the DOH and the Center.
- The Center was required by Measure 3 to follow CDC *Best Practices*, and the DOH was required to follow *Best Practices* by the CDC grant that it managed; the DOH did not feel that it was required to spend its MSA funding on tobacco control programs sanctioned by *Best Practices*.
- From 2009 to 2011, the TPC Advisory and Executive Committees and the Center exceeded many of the goals established in the five-year state plan, including the implementation of local legislative and voluntary smokefree policies and increased usage of the state Quitline ahead of schedule.
- From 2009 to 2011, five cities passed comprehensive smokefree ordinances, increasing the fraction of the North Dakota population covered by a comprehensive law to 37 percent.
- States with limited program funding should consider running initiatives if legislators refuse to appropriate adequate funding for tobacco control.
- Measure 3 did not provide for a clear division of roles for the new agency and the DOH. Despite early difficulties, the TPC Executive Committee and the DOH are generally working together well but should increase their level of communication, especially as DOH expands its programs, to ensure that their activities complement each other and are mutually supportive.
- The TPC Executive Committee and Tobacco Free North Dakota, by mounting aggressive and visible campaigns to mobilize support, defended the program against legislative efforts to gut Measure 3 in 2009 and 2011.
- While there is much work left to be done, the fact that many of the TPC Advisory Committee's goals were met ahead of schedule and tobacco use rates among youth and adults declined in recent surveys is an indication that this tobacco control program is maturing and having a positive effect on public health.
- Opponents of Measure 3 will likely return in future legislative sessions and tobacco control advocates should not assume that North Dakota's programmatic successes will prevent future attacks.
- Public health advocates and the Department of Health must be willing to take a publicly active role to protect both the Center and DOH tobacco control programs; attacks on one weaken both.
- Tobacco control advocates have the support of the public in their favor, which passed Measure 3 and supported numerous smokefree laws, and should continue to use that support to their advantage with legislators to protect and expand their efforts.

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## **NORTH DAKOTA ORGANIZATIONS, PROGRAMS, AND COALITIONS**

American Cancer Society (ACS)

American Cancer Society Cancer Action Network (ACS CAN)

American Heart Association (AHA)

American Lung Association (ALA)

Americans for Nonsmokers' Rights (ANR)

Bismarck Tobacco Free Coalition (BTFC)

Campaign for Tobacco Free Kids (CTFK)

Centers for Disease Control and Prevention (CDC)

Center for Tobacco Prevention and Control Policy (the Center)

Community Health Grant Program

Grand Forks Tobacco Free Coalition (GFTF)

Healthy North Dakota Tobacco Policy Subcommittee

House Bill (HB)

Lake Region Tobacco Free Coalition (LRTF)

Local Public Health Unit (LPHU)

North Dakota Coin and Tavern Association

North Dakota Department of Health (DOH) Tobacco Prevention and Control Program/Division

North Dakota Hospitality Association

Public Education Task Force on Tobacco (PETF)

Senate Bill (SB)

Smoke-Free Air For Everyone Coalition (SAFE)

Tobacco Free North Dakota (TFND)

Tobacco Prevention and Control (TPC) Advisory Committee

Tobacco Prevention and Control (TPC) Executive Committee

## CHAPTER 1: BACKGROUND

- Tobacco use in North Dakota has been falling, but tobacco remains a major problem that costs North Dakota nearly half a billion dollars annually.
- As of 2010, overall smoking had declined to the national average and youth smoking and smokeless use remained well above the national average; adult smoking was increasingly concentrated among American Indian/Alaskan Natives and Hispanics.
- From 2004 to 2008, tobacco control advocates won passage of a statewide clean indoor air law that exempted bars, two local clean indoor air laws which were stronger than the statewide law and two comprehensive local smokefree air laws.
- In 2008, tobacco control advocates won voter approval of Measure 3, which created and funded a new agency solely devoted to tobacco control to go beyond the tobacco control programs in the North Dakota Department of Health. As of 2012, North Dakota was in a good position to reduce its overall tobacco use, and to reduce disease and economic costs due to tobacco use.

In 2004, Welle, Ibrahim and Glantz published *Tobacco Control Policy Making in North Dakota: A Tradition of Activism*, a history of tobacco control advocacy, tobacco control programming and tobacco industry involvement in North Dakota since the late Nineteenth Century.<sup>14</sup> The report documented North Dakota's role as a leader in tobacco control policy in the 1980s, including the 1985 formation of Tobacco Free North Dakota (TFND), a 501c(3) nonprofit organization, which was a tobacco control coalition spearheaded by state Department of Health (DOH) employees and public health groups, with which the American Lung Association was especially active. In its first two years, TFND succeeded in getting the North Dakota Legislative Assembly to pass a clean indoor air law that required designated smoking and nonsmoking areas in places of public assembly and a 9¢/pack cigarette tax increase. Welle, et al. used previously secret, internal tobacco industry documents in the Legacy Tobacco Documents Library (<http://legacy.library.ucsf.edu>) which revealed that, as tobacco control advocates became organized, the tobacco industry began recruiting third party ally groups, that included the Tobacco Wholesalers Association, North Dakota Grocers Association, North Dakota Petroleum Marketers Association, North Dakota Retail Association, and the Greater North Dakota Association, to interfere with tobacco control advocates' attempts to pass stronger tobacco control laws. None of these groups openly opposed tobacco control policy proposals between 2004 and 2012, which is the focus of this report update.

In 1998, North Dakota was one of 46 states that signed the Master Settlement Agreement which settled the state's lawsuit brought against the tobacco industry. The MSA provided a substantial amount of money every year for North Dakota (including \$336 million from 2000 to 2011) which tobacco control advocates wanted to secure for tobacco control programming. However, in 1999, TFND was disorganized and unsuccessful in securing funding for a program based on the US Centers for Disease Control and Prevention (CDC) *Best Practices for Comprehensive Tobacco Control Programs*<sup>15</sup> recommendations.

In 2001, TFND was successful in getting the state to create the Community Health Grant Program and appropriate \$5.1 million for tobacco control programs for the 2001-2003 biennium, with \$4.7 million going to local tobacco control programs (\$940,000 of this was not required to

be spent on tobacco control). Some tobacco control leaders, many of whom were current or former state and local tobacco control program leaders, were unsatisfied with the level of funding appropriated for the Community Health Grant Program because they wanted a *Best Practices* program funded at \$8.2 million annually. (Beginning in 2007, CDC's updated *Best Practices* recommended that North Dakota spend \$9.3 million on tobacco control programs.<sup>15</sup>) These tobacco control leaders blamed members of TFND, particularly the American Heart Association, who, they argued, agreed to the legislation proposed by Governor John Hoeven (R, 2000-2010) without consulting the rest of the coalition. The American Heart Association responded that all members of TFND had the opportunity to participate but that TFND was disorganized and the decision regarding the legislation was left to the most active individuals and organizations at the time who did the best they could.<sup>16, 17</sup> This disagreement, along with a continual lack of coalition leadership and funding, caused TFND to fall dormant after the 2001 Legislative Session. The 2001 disagreement was exacerbated between 2004 and 2012, influenced the level of involvement of AHA in later years and interfered with the strength of the state level tobacco control coalition.

In 2001, the American Cancer Society, American Heart Association, American Lung Association, North Dakota Medical Association, North Dakota Nurses Association, North Dakota Public Health Association, and Blue Cross/Blue Shield of North Dakota formed a new coalition, the North Dakota Tobacco Policy Initiative (NDTPI), funded by the Robert Wood Johnson Foundation (RWJF), to work on tobacco control policy advocacy. Led by the North Dakota Medical Association, it received approximately \$200,000 from RWJF from 2001 to 2003.<sup>18, 19</sup> The coalition eventually stopped using the name NDTPI in 2004 after RWJF funding ended. Welle et al.<sup>14</sup> observed that, in 2004, tobacco control advocates were working to rebuild their coalition to pass stronger statewide tobacco control policies and recommended that advocates develop a cohesive plan, including a close cooperation among coalition partners.

In 2002, the DOH had created the Tobacco Policy Subcommittee as part of DOH's broad statewide health initiative, Healthy North Dakota. In 2004, the Subcommittee, which had a membership comprised of the American Cancer Society, American Heart Association, American Lung Association, other statewide health groups and local tobacco control coordinators, became the primary statewide tobacco control coalition. The DOH contributed a staff member, which often played a leading role in the Subcommittee. In 2005, the state branch of the American Lung Association had taken over leadership when the Tobacco Policy Subcommittee convinced the Legislature to pass a clean indoor air law prohibiting smoking in public places and places of employment, except for bars, enclosed bars within restaurants and in certain other locations. The DOH disbanded the Healthy North Dakota Tobacco Policy Subcommittee in 2008 because both DOH and other tobacco control leaders (at both the state and local level) wanted efforts to pass tobacco control policy to be separated from the DOH. To replace the Subcommittee, the DOH and a group of tobacco control leaders decided to reactivate TFND as the state-level tobacco control coalition. Since 2008, the DOH educated legislators when tobacco control policies came under consideration, but did not take a leadership role on policy issues.

**To replace the Subcommittee, the DOH and a group of tobacco control leaders decided to reactivate TFND as the state-level tobacco control coalition.**

North Dakota tobacco control program leaders and other state advocates utilized creative methods to implement effective tobacco control programs. In 2002, in response to the Legislative Assembly's refusal to appropriate funding for a statewide media campaign, local public health units pooled funding, formed the Public Education Task Force on Tobacco, and launched a statewide media campaign. In the summer of 2007, while state and local program leaders were meeting to reorganize and revive the TFND coalition, former state Attorney General Heidi Heitkamp presented an idea to use a voter-initiated measure (which would become Measure 3) to secure newly-available MSA funds, called the Strategic Contribution Funds (scheduled to be paid from 2008-2017 in addition to normal MSA payments), to create a new tobacco control program independent of the DOH.

In November 2008, voters enacted Measure 3 which created the Tobacco Prevention and Control Advisory and Executive Committees, and mandated that the new tobacco control committees create and implement a comprehensive tobacco control plan for which the Legislature would appropriate funding. North Dakota became the only state in the U.S., other than Alaska, funded at CDC's recommended levels. While this was an important accomplishment, Measure 3 also left North Dakota with two tobacco control agencies; one within the DOH and one that was an independent agency. Funding and responsibilities were divided between the two agencies, a situation that led to a series of challenges.

**Measure 3 also left North Dakota with two tobacco control agencies; one within the DOH and one that was an independent agency.**

This report updates tobacco control activities in North Dakota since 2004 and provides an assessment of the new state tobacco control program, divided between two agencies, nearly three years after the July 2009 launch.

## **Status of Tobacco Control Policies and Tobacco Use in North Dakota as of 2012**

### ***Clean Indoor Air***

As of 2012, North Dakota's statewide clean indoor air law (passed in 2005) prohibited smoking in enclosed public places and most workplaces but allowed smoking in bars and in separately enclosed bars within restaurants, bowling alleys and hotels. The law also exempted retail tobacco stores, truck stops and several other locations. Enclosed areas within hospitals and other health care facilities were smokefree but patients could smoke inside of hospitals and on hospital grounds and at nursing homes in cases of "medical necessity" with physician authorization. The 2005 statewide law covered enclosed areas of schools, as well as all other public and private educational facilities (including universities), but did not address outdoor areas of school/university grounds.

Americans for Nonsmokers' Rights reported that as of January 2012, 23 states, along with Puerto Rico, the U.S. Virgin Islands, and Washington D.C., had smokefree air laws that required non-hospitality workplaces, restaurants and bars to be 100 percent smokefree.<sup>20</sup>

By January 2012, local tobacco control advocates had passed seven smokefree city ordinances that included all restaurants and bars, and 37 percent of North Dakota’s population was protected by a comprehensive smokefree ordinance, an increase from 19 percent in 2009.<sup>21</sup> The seven cities were Bismarck, Devils Lake, Fargo, Grand Forks, Napoleon, Pembina and West Fargo (Figure 1). Five of the seven local ordinances passed were enacted between 2009 and 2011, following the 2008 passage of Measure 3, the voter-initiated measure that created and allocated funding for a new, independent tobacco control agency which, in turn, increased funding for local coalition-building throughout the state. This new local funding played a crucial role in the increase in successful local ordinance activity.

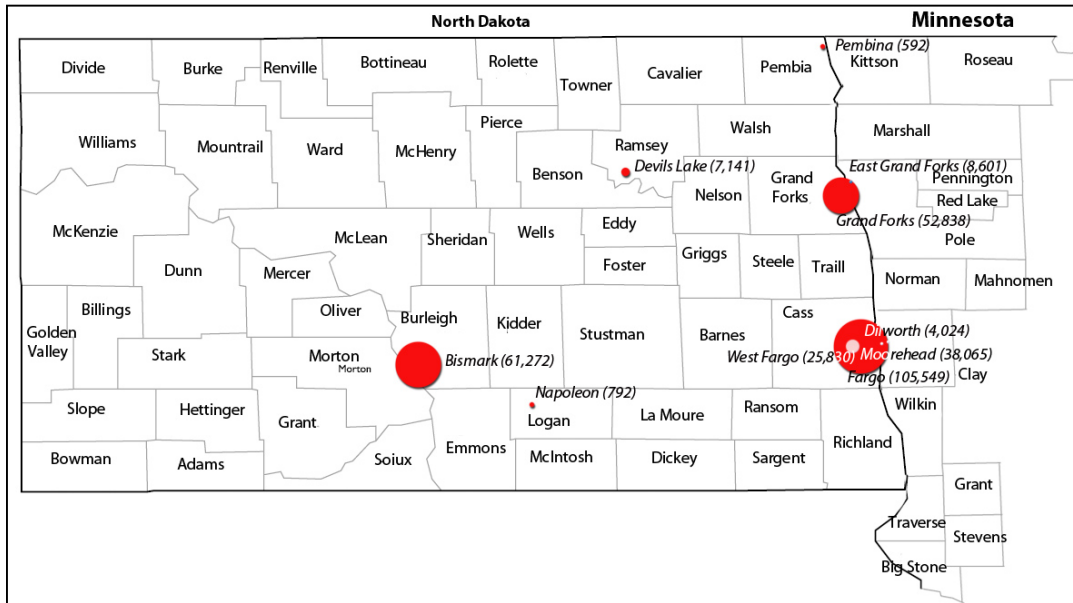


Figure 1: Map of North Dakota Counties and Selected Cities<sup>9</sup>

### *Cigarette Taxes*

Increasing the cost of tobacco products through tax increases is effective in reducing tobacco use.<sup>22</sup> North Dakota’s cigarette tax was 44 ¢/pack in 2012, the fifth lowest in the U.S. and far below the \$1.46 national average.<sup>23</sup> This situation led the American Lung Association (ALA) to give North Dakota an “F” rating for its cigarette tax rate on its 2011 tobacco control report card.<sup>24</sup> The tax has been 44¢/pack since 1993, when it was increased from 29¢/pack. Tobacco control advocates were not involved in the 1993 cigarette tax increase; the Legislative Assembly added the tax increase at the end of the 1993 Legislative Session to balance the budget.<sup>12, 14</sup> As of 2012, North Dakota also charged a 28 percent wholesale cigar and pipe tobacco tax, on par with many other states with such taxes, and 60¢/ounce on snuff and 16¢/ounce on chewing tobacco, lower than most other states with taxes on the same products. These taxes on other tobacco products were last increased in 2001.<sup>25, 26</sup>

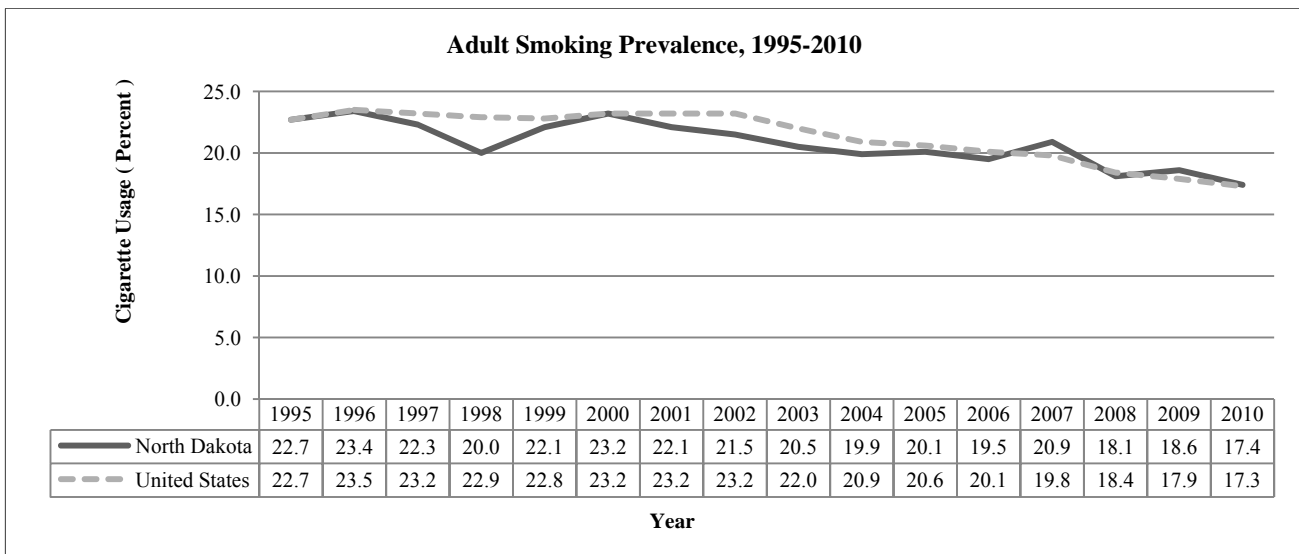
## Funding

As of January 2012, North Dakota was one of only two states to have tobacco control programs funded at levels recommended by the Centers for Disease Control and Prevention’s (CDC) 2007 *Best Practices for Comprehensive Tobacco Control Programs* (\$9.3 million annually; the other was Alaska).<sup>27, 28</sup> Programs funded consistently at high levels have been shown to be effective at reducing tobacco use and tobacco-related diseases; programs that experienced funding reductions became less effective.<sup>29-34</sup> For the 2011-2013 biennium, North Dakota appropriated \$8.15 million to tobacco control programs from funds that it received from the MSA. The remaining \$1.15 million needed to meet CDC’s \$9.3 million recommendation was anticipated to come from CDC’s Office on Smoking and Health annual tobacco control grant.

**Programs funded consistently at high levels have been shown to be effective at reducing tobacco use and tobacco-related diseases; programs that experienced funding reductions became less effective.**

## Tobacco Use

As of 2012, tobacco use in North Dakota was still a major problem for both adults and youth. Smoking cost North Dakota nearly half a billion dollars annually in unnecessary healthcare costs and productivity losses. North Dakota spent \$247 million annually on health care costs caused by smoking, \$47 million of which was covered by the state Medicaid. The state also experienced \$192 million in productivity losses as a result of smoking-related disease annually.<sup>35</sup> Between 1995 and 2006, North Dakota adult smoking prevalence was generally below national adult smoking rates (Figure 2), after which it was close to the national average.<sup>13</sup> Per capita cigarette consumption was consistently below national levels until 2005 North Dakota’s per capita cigarette consumption rate surpassed the national average and remained above the national rate as of 2010 (Figure 3).<sup>36</sup> So, in 2010, while about the same fraction of adults were smoking in North Dakota as nationally, North Dakotans were heavier smokers.



**Figure 2:** North Dakota’s Adult smoking prevalence, 1995-2010<sup>13</sup>



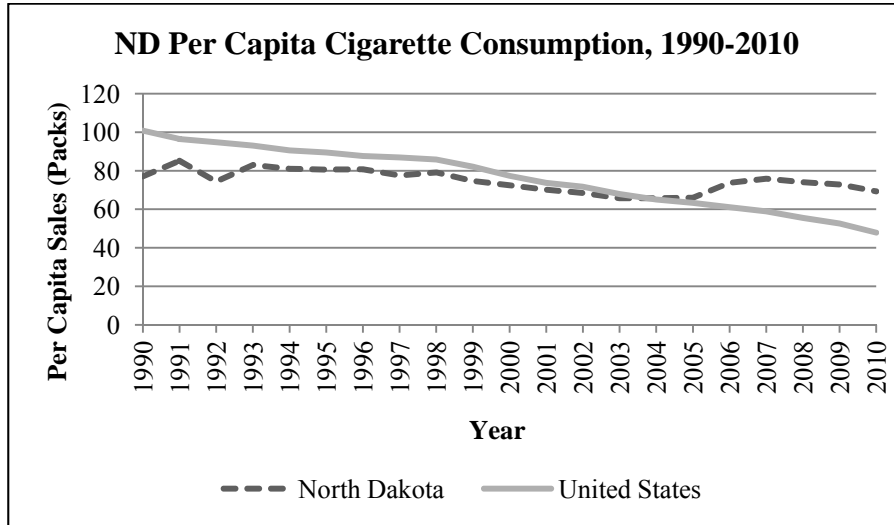


Figure 3: North Dakota per capita cigarette consumption, 1990-2010<sup>12</sup>

In 2010, the North Dakota smoking prevalence was 17.4 percent; of these smokers, 47.2 percent were American Indian/Alaskan Native, 32.8 percent were Hispanic, and 16.1 percent were White.<sup>37</sup> CDC noted that sample sizes for African Americans and Asian/Pacific Islanders may have been present but had too small of a sample size to report accurately.

Though on the decline, North Dakota’s youth smoking prevalence has historically been high compared to U.S. rates. From 1999 to 2009, there was only one year (2005) when North Dakota had a lower youth smoking rate than the U.S. average (Figure 4). In 2009, youth smoking rates increased to 22.4 percent<sup>3</sup> but in 2011, decreased to 19.4 percent,<sup>2</sup> the lowest rate since

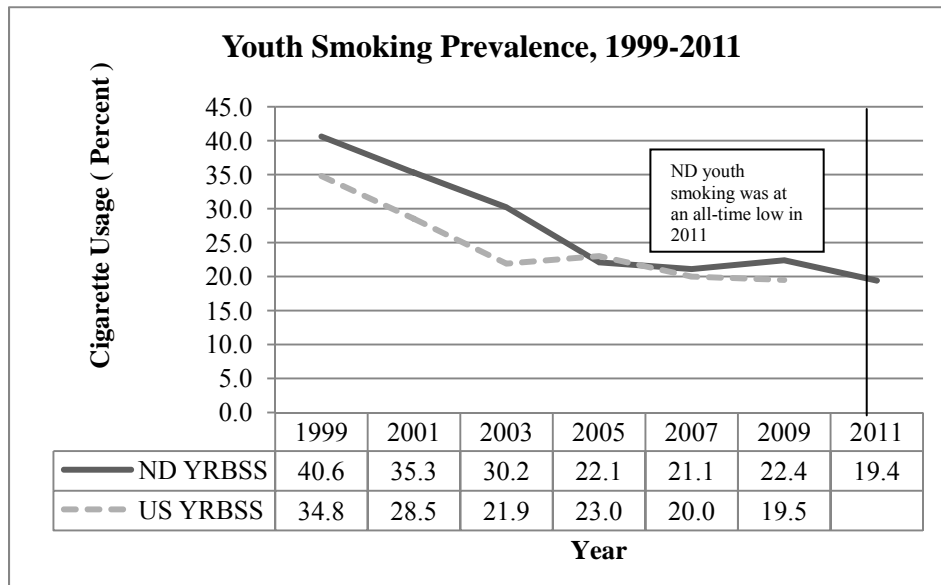


Figure 4: North Dakota youth smoking prevalence, 1999-2011<sup>1-3</sup>

**Notes:**

In 2009, youth smoking rates increased to 22.4 percent but in 2011, decreased to 19.4 percent, the lowest rate since North Dakota first administered CDC’s Youth Risk Behavior Surveillance Survey (YRBSS) in 1995. National 2011 YRBSS data was not available at the time this report was completed so no national comparison was possible.

North Dakota first administered CDC’s Youth Risk Behavior Surveillance Survey (YRBSS) in 1995. North Dakota’s youth smokeless tobacco use prevalence consistently far exceeded national rates from 1999 to 2009, at times by nearly twice as high (Figure 5). In 2009, the state’s youth smokeless tobacco rate was 15.3 percent<sup>3</sup> while the national average was 8.9 percent.

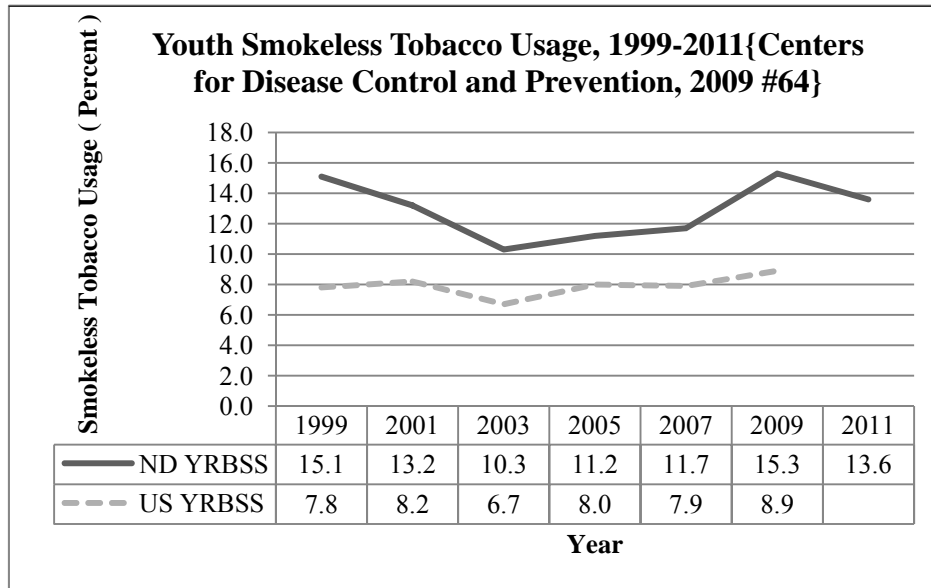


Figure 5: North Dakota youth smokeless tobacco usage, 1999-2011<sup>1</sup>

**Notes:**

National YRBSS data was not available at the time this report was completed so no national comparison was possible.

In 2011, ND YRBSS results showed a decrease from 15.3 percent to 13.6 percent.<sup>2</sup> The Tobacco Use Supplement to the Current Population Survey (TUS-CPS) reported that adult smokeless tobacco rates changed little between 1992 and 2007. In 1992, 2.9 percent of North Dakota adults used smokeless tobacco, slightly higher than the national rate of 2.6 percent. By 2007, North Dakota’s adult smokeless use rate had increased to 3.9 percent while the national rate had decreased to 2.4 percent.<sup>38</sup> These are small changes but, nevertheless, an increase in smokeless tobacco use in North Dakota.

**Conclusion**

As of 2012, North Dakota’s tobacco state level tobacco control laws were weak when compared to the rest of the U.S. Its cigarette tax (44¢/pack) was one of the lowest in the country and had not been increased since 1993. The state clean indoor air law, enacted in 2005, prohibited smoking in most public places and workplaces but exempted bars, bars within restaurants and several other locations and was behind nearly half of the country which had statewide smokefree laws that covered restaurants and bars.

Despite being behind in state level policies and having high tobacco use rates, North Dakota local municipalities, in 2008, began passing smokefree laws that covered public places and workplaces, including bars. From 2008 to 2011, seven localities passed smokefree ordinances that included bars and, as a result, 37 percent of the state’s population was protected

by a comprehensive ordinance. North Dakota made this progress, at least in part, because when federal CDC grants were accounted for, it was one of the only two states in the U.S. that funded tobacco control programs at CDC's 2007 recommended level (\$9.3 million annually for North Dakota) and, as is discussed below, a large amount of this money went to local coalitions to work on strengthening local tobacco control policies. From 2009 to 2011, North Dakota adults and youth used tobacco products at higher rates than the rest of the U.S. but both adult and youth rates were decreasing. As of 2012, North Dakota had the funding to be in a good position to reduce its overall tobacco use, and to reduce disease and economic costs due to tobacco use.

## CHAPTER 2: TOBACCO INDUSTRY INVOLVEMENT IN NORTH DAKOTA

- North Dakota lobbyists are not required to report how much they were paid by their clients, which makes it impossible to track changes in the tobacco industry's expenditures on lobbying over time.
- From 2000 to 2010 the tobacco industry contributed primarily to North Dakota political party organizations, mostly Republican (72 percent), and rarely contributed directly to individual legislative candidates.
- The largest increase in tobacco industry campaign contributions took place in the 2009-2010 election cycle when the legislature was considering Measure 3-approved tobacco control program funding; Republican political party organizations accepted \$38,850, an increase of nearly 430 percent from the 2007-2008 election cycle.

### Tobacco Industry Allies and Lobbyists

As tobacco control advocates throughout the U.S. became organized around clean indoor air laws and tobacco tax increases in the mid-1970s, the tobacco industry lobbyists and its ally organizations mobilized to defeat or weaken these proposals.<sup>39-43</sup> The Tobacco Institute (TI), which the major tobacco manufacturers formed in 1958 to be the industry's lobbying arm, led most of the legislative opposition to tobacco control measures in North Dakota from as early as 1982 until 1998 when it was dissolved as a result of state litigation against the tobacco industry leading to the Master Settlement Agreement. In North Dakota, as in other states, the tobacco industry's lobbyists opposed tobacco control policies and worked to interfere with the work of tobacco control advocates to secure strong laws and implement effective tobacco control programs.<sup>14</sup> The North Dakota Tobacco Wholesalers Association, another sector of the tobacco industry, actively opposed tobacco control measures along with TI.

The tobacco industry also funded third party allies and front groups to assist the industry in its attempts to derail strong tobacco control policy proposals all over the country.<sup>44, 45</sup> In North Dakota, the tobacco industry built alliances with (and often financed) the North Dakota Hospitality Association, North Dakota Grocers Association, North Dakota Petroleum Marketers Association, North Dakota Retail Association, and the Greater North Dakota Association (State Chamber of Commerce).<sup>14</sup> These third party groups promoted the tobacco industry's interests through the 1990s while allowing the industry to remain out of the public eye because of its poor public image and lack of credibility.

In the early 2000s, the North Dakota Coin Machine Operators Association and the North Dakota Coin and Tavern Association were outspoken opponents of tobacco regulation and worked to defeat clean indoor air legislation. As of 2011, Rep. Dwight Wrangham (R-Bismarck) was the Executive Director of the North Dakota Coin and Tavern Association and had a history actively opposing smokefree policies at the state and local level.<sup>46, 47</sup> He also sat on the House Agriculture and the Finance and Taxation standing committees.

As of 2011, North Dakota Century Code Chapter 54-05.1 defined a "lobbyist" as any person who "[a]ttempts to secure the passage, amendment, or defeat of any legislation by the legislative assembly or the approval or veto of any legislation by the Governor of the state" and

“[a]ttempts to influence decisions made by the legislative management or by an interim committee of the legislative management.”<sup>48</sup> Lobbyists were required to register with the North Dakota Secretary of State’s Office. Philip Morris, U.S. Smokeless Tobacco and Reynolds American had registered lobbyists in North Dakota from 2007-2011. (Only 2007-2011 data was available online.) (Table 1) Only their names were available, not what they were paid for or spent conducting lobbying activities or who or what issues they lobbied for or against.

<b>Table 1:</b> Registered Tobacco Industry Lobbyists, 2006-2011 <sup>7, 49</sup>	
<b>Company</b>	<b>Lobbyist</b>
<i>Philip Morris / US Smokeless Tobacco</i>	
	Garth R. Alston
	William J. Delmore
	Andrea Heller*
	John M. Olson
	Thomas D. Kelsch
	Thomas F. Kelsch
	Todd D. Kranda
	Eric D. Shapland*
	Thomas T. Nelsch
	Toby Spangler*
<i>Reynolds American</i>	
	Stanley R. Arnold
	Patrick Buell
	Robert Fackler
	Lance A. Hagen
	David H. Remes
	Allan Stenehjem
	Lisa Stenehjem
	Richard W. Weber
<b>Notes:</b> *Indicates lobbyists registered for Philip Morris but not US Smokeless. Altria/Philip Morris acquired US Smokeless Tobacco in 2009 but lobbyists continued to register separately as lobbyists of both companies. No other tobacco companies had registered lobbyists.	

## Campaign Contributions

The tobacco industry uses campaign contributions to politicians and political parties in most states to oppose tobacco control issues.<sup>50, 51</sup> In North Dakota, corporations, limited liability companies, and associations, including labor unions and trade and professional organizations were prohibited from making direct campaign contributions to political parties, political committees, organizations or individual candidates. However, if these organizations formed political action committees (PACs), they were free to contribute unlimited funds through their PACs.<sup>52</sup> Candidates and political parties were required to report the gross total of all contributions received and expenditures made. However, if the gross total contributions from a single contributor to an individual candidate, political party or political committee did not exceed \$200, the recipient did not have to disclose who made the contribution; in that case the recipient

only had to report the size of the contribution. This rule made it difficult to track contributions made by the tobacco industry to individual candidates because, while candidates, political parties and political committees reported accepting contributions from the tobacco industry from 2000-2010, the industry may have made a large number of contributions of \$200 or less, which would not be reported as an industry contribution.

Welle et al.<sup>14</sup> were also unable to secure complete campaign contribution data for their 2004 report. Prior to 1999, contribution reporting was decentralized. Legislative candidates reported accepted contributions to the county auditor’s office in their county of residence until 1999 when state law required all candidates to report contributions to the State Secretary of State’s Office. County records were disorganized and, as a result, a cohesive presentation of contributions prior to 1999 was not possible.

### *Total Campaign Contributions*

The National Institute on Money in State Politics collected campaign contribution data from the North Dakota Secretary of State’s office from 2000-2010 and compiled the results in its *Follow the Money* online database to improve the access to public records.<sup>7</sup> From 2000 to 2010 (spanning six election cycles), the tobacco industry reported contributions of \$83,650 to political parties and election campaigns (Table 2, Table 3) (As noted above, these reports do not include contributions under \$200) Campaign contributions increased annually after 2002, often times by large amounts (Figure 6). The largest increase in contributions took place in the 2009-2010 election cycle when the tobacco industry contributed \$48,850 (\$38,850 from Altria/PM) to political campaigns, an increase of 147 percent from the 2007-2008 election cycle when the tobacco industry spent \$19,750 on campaign contributions.

In the 2009 Legislative Session, the Legislative Assembly considered legislation to appropriate funding for the new Measure 3-created Tobacco Prevention and Control Executive Committee. Legislators, particularly House Majority Leader Al Carlson (R-Fargo), attempted to repeal Measure 3 that voters enacted in 2008, but ultimately agreed to the appropriation at the very end of the Session as a result of public pressure and pressure from Governor John Hoeven (R, 2000-2010). Rep. Carlson reported accepting \$250 in the 2001-2002 election cycle and was one of only two legislators to report accepting tobacco control campaign contributions from 2000 to 2010.

**Table 2: Total Reported Tobacco Industry Contributions by Company<sup>7</sup>**

	2000	2002	2004	2006	2008	2010	Total
Tobacco Companies	Contribution						
Altria/Philip Morris	\$1,500	\$250	\$1,500	\$3,750	\$5,550	\$38,850	\$51,400
Brown & Williamson	\$1,000	\$0	\$1,000	\$0	\$0	\$0	\$2,000
US Smokeless Tobacco	\$0	\$500	\$1,450	\$4,100	\$4,200	\$0	\$10,250
Vector Tobacco	\$0	\$0	\$0	\$0	\$10,000	\$10,000	\$20,000
<b>Total</b>	<b>\$2,500</b>	<b>\$750</b>	<b>\$3,950</b>	<b>\$7,850</b>	<b>\$19,750</b>	<b>\$48,850</b>	<b>\$83,650</b>

**Note:** In 2009 US Smokeless Tobacco merged with Altria/Philip Morris.

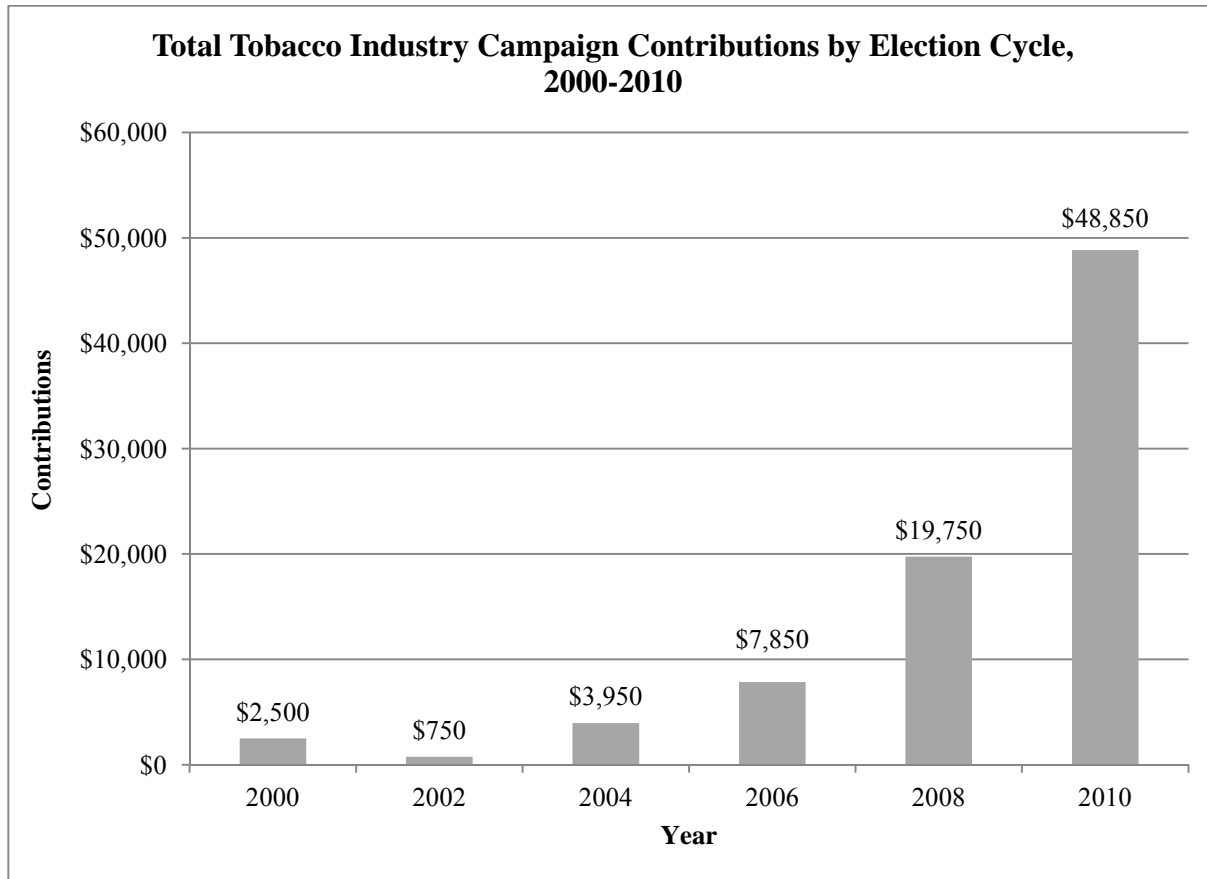
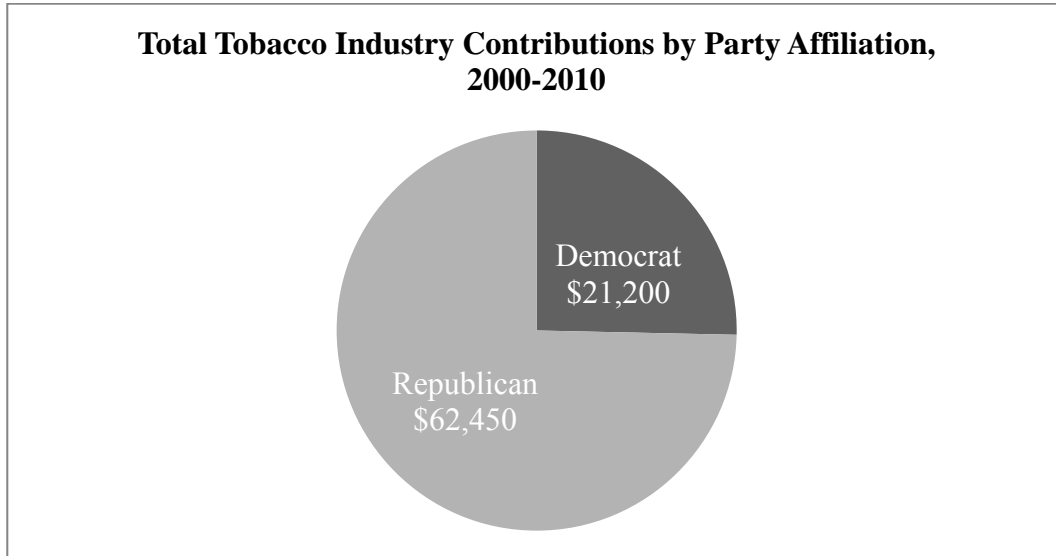


Figure 6: Total tobacco industry campaign contributions by election cycle, 2000-2010<sup>7</sup>

The tobacco industry greatly favored contributing to Republican committees and individuals over Democrats (Figure 7), likely because Republicans consistently controlled both houses of the Legislative Assembly.

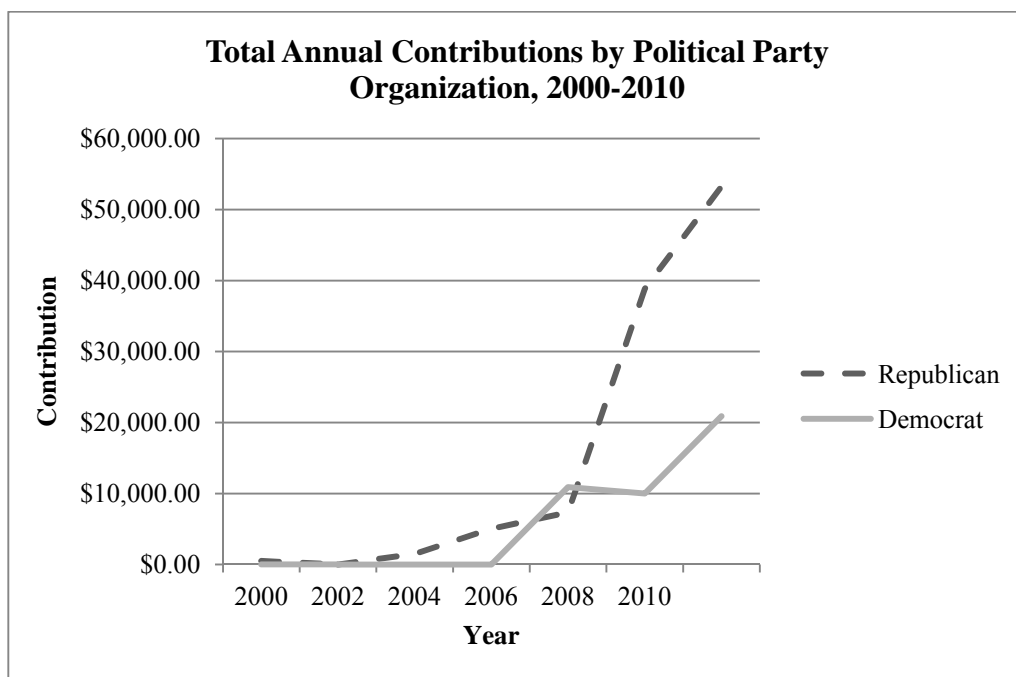
	2000	2002	2004	2006	2008	2010	Total
<i>Political Party Organizations</i>							
	\$500	\$0	\$1,500	\$5,050	\$18,250	\$48,850	\$74,150
<i>Statewide Candidates</i>							
	\$2,000	\$500	\$2,450	\$2,800	\$1,200	\$0	\$8,950
<i>Legislative Candidates</i>							
	\$0	\$250	\$0	\$0	\$300	\$0	\$550
<b>Total</b>	<b>\$2,500</b>	<b>\$750</b>	<b>\$3,950</b>	<b>\$7,850</b>	<b>\$19,750</b>	<b>\$48,850</b>	<b>\$83,650</b>



**Figure 7:** Total tobacco industry contribution by party affiliation, 2000-2010<sup>7</sup>

#### *Contributions to Political Party Organizations*

In North Dakota, the tobacco industry contributed primarily to political parties and political committees, here referred to collectively as political party organizations, and rarely contributed to individual candidates over the 10-year period. The industry favored political party organizations over individual candidates consistently from 2000-2010, with the level of contributions to political party organizations increasing over the years. As mentioned above, campaign contributions increased dramatically (Figure 8) between the 2007-2008 and



**Figure 8:** Total annual tobacco industry campaign contribution by political party organization, 2000-2010<sup>7</sup>



2009-2010 election cycles and most of this increase was to political party organizations.

The tobacco industry contributed a total of \$74,150 to political parties, committees and caucuses during this period, 89 percent of all contributions reported (Table 4). Democratic committees received \$20,900 while Republican committees received \$53,250. Only \$550 went directly to state legislative candidates and \$9,500 to candidates for statewide offices (Governor, Lieutenant Governor and Attorney General). Republicans controlled both houses of the Legislative Assembly during the 2000-2010 election cycles. It is not possible to track which party members received tobacco industry money after the party committees received the contribution. The influence that the tobacco industry has over political parties' stances on tobacco control policy issues as a result of these contributions is unclear.

<b>Table 4: Total Tobacco Industry Contributions To Political Parties, Committees and Caucuses, 2000-2010<sup>7</sup></b>							
<i>Democrat</i>	<b>2000</b>	<b>2002</b>	<b>2004</b>	<b>2006</b>	<b>2008</b>	<b>2010</b>	<b>TOTAL</b>
North Dakota Democratic-Nonpartisan League (NPL) Party	\$0	\$0	\$0	\$0	\$10,000	\$10,000	\$20,000
North Dakota Senate Democratic-Nonpartisan League (NPL) Party Caucus	\$0	\$0	\$0	\$0	\$900		\$900
<b>Democrat TOTAL</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$10,900</b>	<b>\$10,000</b>	<b>\$20,900</b>
<b>Republican</b>							
North Dakota Republican Party	\$500	\$0	\$1,500	\$950	\$2,500	\$8,500	\$13,950
North Dakota Republican Party (Building Fund)	\$0	\$0	\$0	\$0	\$2,500	\$28,000	\$30,500
North Dakota Senate Republican Caucus	\$0	\$0	\$0	\$1,900	\$1,350	\$550	\$3,800
Republican Caucus of North Dakota	\$0	\$0	\$0	\$1,200	\$0	\$0	\$1,200
Republican House Caucus of North Dakota	\$0	\$0	\$0	\$1,000	\$1,000	\$1,800	\$3,800
<b>Republican TOTAL</b>	<b>\$500</b>	<b>\$0</b>	<b>\$1,500</b>	<b>\$5,050</b>	<b>\$7,350</b>	<b>\$38,850</b>	<b>\$53,250</b>
<b>Political Parties TOTAL</b>							<b>\$74,150</b>
*Blank fields represent no reported contribution for that year.							

Tobacco industry contributions to political party organizations increased, at times dramatically, when the Legislative Assembly considered tobacco-related issues. In 2005, the Legislative Assembly passed a clean indoor air law that prohibited smoking in workplaces and public places but that exempted bars and a few other locations. During the 2005-2006 election cycle, Republican political party organizations reported accepting \$5,050 from the tobacco industry, an increase of 237 percent from the previous election cycle. Democrat political party organizations did not report any contributions until the 2007-2008 election cycle when they reported accepting \$10,900. In 2007, the Legislative Assembly briefly considered a bill to strengthen the 2005 clean indoor air law and to remove its exemptions, which may explain for these contributions. The most significant increase in contributions to political party organizations took place in the 2009-2010 election cycle when Republican political party organizations' accepted contributions increased from \$7,350 in the previous election cycle to \$38,850, an increase of nearly 430 percent. This increase was likely related to the 2009 Legislative Session

when the legislature considered the appropriation for the Measure 3-approved tobacco control program.

*Contributions to Legislative Candidates*

From 2000-2010, the tobacco industry made only two reported contributions (above \$200) to state legislative candidates (Table 5). This limited number of legislative contributions is uncommon; in most states the tobacco companies contributed heavily to legislators, most commonly to legislators in powerful legislative positions. In the 2001-2002 election cycle, Rep. Al Carlson (R-Fargo), then Vice Chair of the Government Operations Division of the House Appropriations Committee, accepted a \$250 contribution. Carlson later chaired the committee and, by 2009, was the House Majority Leader. Carlson was the most visible opponent of appropriating funding for the new Center for Tobacco Prevention and Control Policy created by Measure 3, which voters approved in 2008. The only other campaign contribution made to a legislator was to Sen. David Paul O’Connell (D-Lansford) during the 2007-2008 election cycle (\$300). O’Connell was the only Democrat to accept a contribution from the tobacco industry during this period. O’Connell was the Senate Minority Leader. The industry typically favors contributing to the campaigns of elected officials in leadership positions because they are more influential during the legislative process.

**From 2000-2010, the tobacco industry made only two reported contributions to state legislative candidates.**

**Table 5:** Tobacco Industry Campaign Contributions to Legislative Candidates, 2000-2010<sup>7</sup>

Year	Candidate	Party	House Chamber	Amount
2002	Al Carlson	R	House	\$250
2008	David Paul O'Connell	D	Senate	\$300
TOTAL				\$550

It is unclear why the tobacco industry did not contribute more heavily to individual legislative campaigns during this period through PACs. Other industries did contribute to legislators’ election campaigns. It is likely that the tobacco industry has been able to wield influence in the legislature through its contributions to political parties, which amounted to 89 percent of total reported industry campaign contributions. By influencing parties, which in turn, provide funding to their party members sitting in the Legislative Assembly (party leadership can restrict the flow of funding to those party members if their votes are not in line with party expectations), the industry may have been able to influence the policy process better than if it were to contribute to legislators’ campaigns directly.

*Contributions to Gubernatorial Candidates and other Statewide Office Candidates*

The tobacco industry contributed a total of \$4,950 to gubernatorial campaigns from 2000-2010, only to Republican, incumbent candidates (Table 6). John Hoeven (R-2001-2010) did not report receiving campaign contributions from the tobacco industry in his 2000 campaign, but did receive contributions in 2002 for his 2004 re-election bid.

**Table 6:** Tobacco Industry Contributions to Gubernatorial Campaigns, 2000-2010<sup>7</sup>

Year	Recipient	Party	Office	Incumbent	Won / Lost	Amount
2000	Edward T., Schafer	R	G	Yes	Did not seek re-election	\$1,000
2002	John Hoeven	R	G	Yes	Not Election Year	\$500
2004	John Hoeven and Jack Dalrymple	R	G/LTG	Yes	Won	\$950
2006	John Hoeven and Jack Dalrymple	R	G/LTG	Yes	Not Election Year	\$1,300
2008	John Hoeven and Jack Dalrymple	R	G/LTG	Yes	Won	\$1,200
TOTAL						\$4,950

The tobacco industry also contributed to some other candidates for statewide offices (Table 7) including Republican Wayne Stenehjem’s multiple successful campaigns for Attorney General and Republican Cory Fong’s successful bid for State Tax Commissioner.

**Table 7:** Tobacco Industry Contributions to Other Statewide Elected Offices, 2000-2010<sup>7</sup>

Year	Recipient	Party	Office	Amount
2000	Wayne Stenehjem	R	AG	\$1,000
2004	Wayne Stenehjem	R	AG	\$1,500
2006	Wayne Stenehjem	R	AG	\$1,000
	Cory Fong	R	Tax Comm.	\$500
TOTAL				\$4,550

### ***Tobacco Control Policy Scores***

We normally construct “tobacco policy scores” for members of the legislature by conducting confidential polls of knowledgeable individuals and use these scores to assist in interpreting the events in a state. Unfortunately, not enough individuals in North Dakota were willing to provide scores to compute reliable averages.

### **Conclusion**

North Dakota’s weak laws regulating lobbying and campaign contribution reporting make it difficult to ascertain the involvement of the tobacco industry in political affairs. Lobbyists registered with the state as employees for specific companies, but they did not have to report how much they were paid. It was therefore not possible to assess the tobacco industry’s level of interest and involvement with different policy issues. Additionally, elected officials and political committees were not required to report who provided contributions less than \$200. This lack of information made it impossible to present a total picture of campaign contributions to influence the policymaking process.

The largest increase in total contributions took place in the 2009-2010 election cycle when the tobacco industry contributed \$48,850 (\$38,850 from Altria/PM) to political campaigns, an increase of 147 percent from the 2007-2008 election cycle, likely in response to the Measure 3 initiative campaign led by tobacco control advocates in 2008 to secure tobacco control program funding and to form a new, independent tobacco control agency.

Of those contributions we can conclusively connect to the tobacco industry, most were given to North Dakota political parties, committees and caucuses. From 2000 to 2010, the tobacco industry contributed a total of \$74,150 to political parties, committees and caucuses, 89 percent of the total contributions reported. By contributing to political parties, committees and caucuses, it is possible that the tobacco industry was able to influence the decisions of elected officials upstream by influencing political party priorities. Political organizations generally set the policy agenda for their party members and contributions may have influenced the position of political parties on tobacco issues. Additionally, political parties often provided funding to party members through direct contribution. However, by filtering contributions through political organizations, it was not possible to trace direct candidate contributions back to the tobacco industry.

**The largest increase in total contributions took place in the 2009-2010 election cycle when the tobacco industry contributed \$48,850 to political campaigns, an increase of 147 percent from the 2007-2008 election cycle.**



## CHAPTER 3: TOBACCO CONTROL ADVOCACY AND PROGRAM HISTORY

- North Dakota created the DOH Tobacco Prevention and Control Program in 1989 but did not fund it at a level that could have an impact until the 2001-2003 biennium when the Legislature created the Community Health Grant Program.
- Beginning in 1985, when Tobacco Free North Dakota formed, tobacco control advocates usually had a statewide tobacco control coalition, though the coalition's name and level of organization depended on whether funding and leadership were available.
- Though still below CDC *Best Practices* funding levels, from 2001 to 2008 the Community Health Grant Program substantially funded local communities to work on tobacco control for the first time.
- The Legislature appropriated MSA funds to the DOH to run a Quitline and other cessation programs but refused to fund a statewide media campaign.
- Local Public Health Units pooled their money to create a statewide media campaign that increased public understanding of the dangers of secondhand smoke and support for expanding the 2005 statewide clean indoor air law to cover bars.

### **The state Department of Health and Tobacco Control Policymaking: 1980s and 1990s**

#### ***The Department of Health and Tobacco Free North Dakota***

Organized tobacco control advocacy in North Dakota began as a partnership between the state Department of Health (DOH) and state public health organizations in late 1985 with the formation of Tobacco Free North Dakota (TFND) (originally named Smoke-free North Dakota) a 501c(3) nonprofit organization; it was the first state level tobacco control coalition in the state.<sup>14</sup> DOH staff and the American Lung Association (ALA) spearheaded development of the coalition in order to advocate for a statewide clean indoor air law. The American Heart Association (AHA), American Cancer Society (ACS), and North Dakota Medical Association were also active members of TFND when it formed.<sup>14</sup> The DOH provided TFND with approximately \$5,000 annually from its Federal Maternal and Child Health Grant; this was the coalition's primary funding.

TFND's original leadership came from Dr. Stephen McDonough (the first President of the coalition), who was Chief of the Preventive Health Section and Director of Maternal and Child Health, from Marcie Andre, Executive Director of the North Dakota chapter of the American Lung Association, and other tobacco control advocates who were still active in 2012, particularly Kathleen Mangskau, later chair of the Tobacco Prevention and Control Executive Committee (formed in 2008 with the passage of the voter-initiated Measure 3). The DOH's role in TFND from the onset was processing statistical data for the creation of the first state tobacco control plan. The DOH's role evolved as Tobacco Free North Dakota began to use the plan to promote stronger tobacco control policies.

**The DOH's role evolved as Tobacco Free North Dakota began to use the plan to promote stronger tobacco control policies.**

Building on national support for a tougher stance on tobacco use as a result of US Surgeon General C. Everett Koop's call for a smokefree society by the year 2000, the DOH created the state's first tobacco control plan, *Tobacco, Health, and the Bottom Line: The North Dakota Plan for a Tobacco Free State*<sup>53</sup> in 1986, which set goals for the state to reach by 1990.<sup>14</sup> The plan called for the reduction of tobacco use, including reducing adult cigarette use to below 21 percent by 1990, through the implementation of voluntary school and business tobacco usage policies, the passage of stronger statewide smokefree legislation, a 10¢/pack increase to the cigarette tax (from 18¢/pack to 28¢/pack), and extensive education and cessation programs directed at all population segments.<sup>53</sup>

Dr. McDonough viewed the state plan as a tool to aid TFND in its efforts to convince the public, state leaders, and other potential advocacy organizations of the need to address tobacco use. The state plan and the formation of TFND forced tobacco control issues into the forefront, leading to the formation of the DOH Tobacco Prevention and Control Program in 1989.

In 1987, advocates had succeeded in passing a statewide clean indoor air law that required designated smoking and nonsmoking areas in places of public assembly and expanded the definition of "place of public assembly" to include nearly all places, including restaurants with a seating capacity of greater than 50 people; bars and private rooms in nursing homes were exempt.<sup>14</sup> This clean indoor air law would be considered weak by 2012 standards but was significant in 1987. The same year, advocates also convinced the legislature and Governor to enact a nine cent cigarette tax increase (from 18¢/pack to 27¢/pack) and a wholesale tax increase from 11 percent to 20 percent for other tobacco products, though none of the new revenue went to tobacco control programming.

Advocates also met their goal in the first state plan of decreasing adult cigarette prevalence from 26 percent in 1986 to less than 21 percent by 1990; in 1990, North Dakota's adult smoking prevalence rate was 20.5 percent.<sup>38</sup> (Adult cigarette prevalence rate rose intermittently in subsequent years, peaking at 23.2 percent in 1996.<sup>13</sup>) As a result the state's success in meeting several of their 1990 goals, North Dakota became a national model for tobacco control, receiving the Secretary of the US Department of Health and Human Service's Award for Excellence in 1988.<sup>14</sup>

### ***The DOH's Local Focus***

The Tobacco Prevention and Control Program (TPC) in the North Dakota Department of Health (DOH) was created in 1989. (The DOH reorganized its tobacco control program several times from 1989 to 2012. In 2003, the DOH created the Division of Tobacco Prevention and Control<sup>54</sup> and, around 2011, reorganized tobacco control again as a program within the Division of Chronic Disease.) The DOH hired one tobacco coordinator, Eric Solberg in 1989.<sup>14</sup> Employees of the DOH, like Dr. Stephen McDonough, had been active with Tobacco Free North Dakota since it formed in 1985, but the state had not yet committed any state resources to fund any full time tobacco-specific program positions. The Legislature did allow the DOH to use \$5,000 annually from its federal Maternal and Child Health grant to fund TFND to work on state-level policy work.<sup>14</sup> The DOH Division of Tobacco Prevention and Control focused on state-level tobacco control policy making in its first several years of existence.

Following the success of TFND in the late 1980s, the tobacco industry intensified its work tracking and attempting to block tobacco control policy efforts in North Dakota. In 1993, after facing strong tobacco industry opposition in the state legislature from 1989 to 1992 while trying to strengthen the state's clean indoor air law,<sup>14</sup> the DOH TPC began funding local coalitions to advocate for stronger local clean indoor air policies. The tobacco industry is historically more politically influential at the state and federal levels than at the local level.<sup>55, 56</sup> The DOH TPC re-directed the majority of its CDC Preventive Health Block grants, which had been funding statewide policy work, to the local level, providing six local public health units (LPHUs) (local health departments, but not subsidiaries of the state DOH) with grants of \$5,000 each for local coalition-building and to work on youth access issues. The DOH continued to use its federal Maternal and Child Health grant to fund TFND to work at the state level.<sup>14</sup>

North Dakota also participated in CDC's IMPACT (Initiative to Mobilize for the Prevention and Control of Tobacco Use) Program from 1993-1999, which provided the state approximately \$230,000 annually for tobacco control coalition building and program work. The DOH's Tobacco Prevention and Control Program distributed at least half this annual funding to LPHUs and trained LPHU staff on the importance of coalition building and policy change.<sup>14</sup> Early advocacy at the local level focused on passing cigarette vending machine restrictions and other youth access laws, while LPHUs worked to educate their communities on the importance of smokefree environments. Welle et al. concluded that this was a successful strategy because it resulted in 38 new youth access laws, many of which put in place rules regarding cigarette sale licensing, the placement of cigarette vending machines and restrictions on sales to youth, and at least 14 clean indoor air ordinances in North Dakota, some of which contained provisions that made city and/or county buildings 100 percent smokefree.<sup>14</sup>

**Early advocacy at the local level focused on passing cigarette vending machine restrictions and other youth access laws, while LPHUs worked to educate their communities on the importance of smokefree environments.**

Several cities in Barnes County (where Valley City is located) passed smoking restrictions in select government buildings in the late 1990s and Bismarck passed a clean indoor air city policy in 2000 that made public buildings, their entryways, and public vehicles 100 percent smokefree. Minot (a city) passed a clean indoor air ordinance in 2001 that prohibited smoking in restaurants but allowed for restaurants to maintain separately ventilated smoking rooms. Bars and a number of other locations were exempted from the Minot ordinance.<sup>14</sup>

Many local coalitions also encouraged voluntary smokefree policies in public places including restaurants and bars. The Bismarck Tobacco Free Coalition increased the number of voluntary smokefree restaurants from 28 in 1997 to 73 in 2000.<sup>14</sup>

TFND, which worked at the state level, existed throughout the 1990s,<sup>14</sup> but its level of activity fluctuated depending on whether its coalition leadership judged the passage of state-level tobacco control policies (youth access and smokefree air laws) to be politically possible.<sup>57</sup> In 1995, TFND actively supported strengthening the statewide youth access law to penalize retailers who sold tobacco products to minors, and in 1997, supported an expansion of the state clean indoor air law to prohibit smoking in most public places instead of providing for smoking



sections. Both bills were killed by the tobacco industry and its ally organizations, which, in the 1990s, included the North Dakota Grocers Association, North Dakota Retail and Petroleum Marketers Association, and the North Dakota Hospitality Association.<sup>14</sup>

In 1998, Governor Ed Schafer (R, 1992-2000) appointed Murray Sagsveen, a lawyer whose law firm represented the tobacco industry,<sup>58</sup> to be North Dakota's State Health Officer (1998-2000). Sagsveen prohibited the DOH staff from publicly speaking about potential uses of funds from the 1998 Master Settlement Agreement that brought North Dakota approximately \$24 million per year. Dr. Stephen McDonough, the DOH's leading and most public tobacco control program leader and a key TFND leader, was fired from the DOH in 2000 for publicly speaking out against Sagsveen and other DOH management on several issues; one issue was the failure of the DOH to get MSA funding appropriated to the DOH Division of Tobacco Prevention and Control for tobacco control programs. Under Sagsveen, the DOH stopped funding TFND with its Maternal and Child Health grant.<sup>14</sup>

The DOH staff and tobacco control advocates wanted to secure at least \$8.2 million in MSA funds for a tobacco control program, the amount CDC recommended in its 1999 *Best Practices for Comprehensive Tobacco Control Programs*.<sup>15</sup> However, with DOH staff silenced by Sagsveen, and without a focused effort by the voluntary health organizations and other health groups, the state did not allocate any MSA funding explicitly for tobacco control programs in 1999.<sup>14</sup> The DOH's staff had been providing important leadership and funding to TFND, and TFND now began to lack focus with the absence of leadership and funding. The state voluntary public health agencies (American Cancer Society, American Heart Association and the American Lung Association) did not provide funding or staff to lead the coalition.<sup>14</sup>

**The DOH's staff had been providing important leadership and funding to TFND, and TFND now began to lack focus with the absence of leadership and funding.**

Despite being disorganized, in 2001, members of TFND again advocated for MSA funding for a comprehensive tobacco control program and were successful in getting the Legislative Assembly to pass legislation that created the Community Health Grant Program which provided funding for local health programs that were required by the creating legislation to spend 80 percent of funding appropriated to the program on tobacco control programs (discussed in depth below in the section on DOH tobacco control programs). Kathleen Mangskau, who became the DOH Tobacco Prevention and Control Program Director in 2001, felt that the increase in funding to local tobacco control programs was a major positive step,<sup>14</sup> but also explained in 2011 and 2012 interviews for this research that the legislation was too restrictive by requiring that 40 percent of all funds appropriated be spent on school tobacco control programs and that the overall level of funding was too low compared to *Best Practices* recommendations.<sup>15, 57</sup> Some tobacco control leaders felt left out of the funding negotiations with Governor John Hoeven (R) by the American Heart Association (AHA), who the tobacco control leaders felt was most involved,<sup>59, 60</sup> though Welle et al. documented that the American Lung Association (ALA) also supported the proposal.<sup>14</sup> TFND lacked funding and leadership (which previously came from the DOH) during the MSA funding appropriation negotiations, and in 2003, stopped filing IRS tax forms<sup>61</sup> and became inactive.

In 2001, the American Cancer Society, American Heart Association, American Lung Association, North Dakota Medical Association (NDMA), North Dakota Nurses Association, North Dakota Public Health Association, and Blue Cross/Blue Shield of North Dakota formed the North Dakota Tobacco Policy Initiative (NDTPI) to work on tobacco control policy and to replace TFND which had been funded and led primarily by DOH staff. The Robert Wood Johnson Foundation (RWJF) awarded NDMA a capacity-building SmokeLess States grant from 2001 to 2003 (approximately \$200,000 total<sup>18, 19</sup>) to promote tobacco control policies in North Dakota, primarily at the state level.<sup>14</sup> The primary tobacco control policy campaign that NDTPI led was an unsuccessful 2003 campaign to increase the state's cigarette tax. RWJF stopped funding NDTPI in 2004 and NDTPI became inactive. A similar group of state health organizations later cohesively organized around a 2005 statewide clean indoor air bill as part of the Healthy North Dakota Tobacco Policy Subcommittee.

### **The State Department of Health and Tobacco Control Policy Making: Post-Master Settlement Agreement Negotiations and Allocations**

#### ***Healthy North Dakota***

As of 2004, tobacco control advocacy was being spearheaded by Healthy North Dakota, a broad collaboration between government and non-governmental health organizations. Healthy North Dakota was launched by Governor John Hoeven (R, 2000-2010) in 2002 to promote healthy living behaviors, including a substantial tobacco control component.<sup>62</sup>

Healthy North Dakota had a tobacco control committee that was comprised of several subcommittees with a range of focuses that included policy, cessation, youth tobacco use, disparities, data management and other tobacco products.<sup>63</sup> The Tobacco Policy Subcommittee was created to work on policy and became the predominant state-level tobacco control advocacy coalition. It was a volunteer committee and, while the DOH organized it and paid a staff person to organize the committee, other groups, particularly ALA, took the lead on the advocacy efforts. Janel Schmitz, Executive Director of ALA North Dakota, led the

**The Tobacco Policy Subcommittee was created to work on policy and became the predominant state-level tobacco control advocacy coalition.**

work of the Tobacco Policy Subcommittee and AHA and ACS also played active roles.<sup>57, 64</sup> Other organizations included the North Dakota Medical Association, North Dakota Nurses Association and the North Dakota Society for Respiratory Care. These state health organizations provided the primary lobbyists for the Subcommittee. Most of the other members were Local Public Health Unit tobacco control leaders who did not have lobbying responsibilities.<sup>16</sup>

The greatest tobacco control policy success of Healthy North Dakota's Tobacco Policy Subcommittee was the 2005 state clean indoor air law which prohibited smoking in most workplaces and public places, except for bars and a few other locations, discussed in more detail below.

In 2008, with the passage of Measure 3, the voter initiated measure which created an independent tobacco control agency, Karalee Harper, Director of the DOH Chronic Disease Division, removed the tobacco component from Healthy North Dakota. DOH personnel were

increasingly concerned that DOH would be accused of illegal lobbying,<sup>63</sup> a common tactic that the tobacco companies used to intimidate health departments,<sup>65</sup> for its work on tobacco control education and advocacy. Harper felt that the new agency, led by the Tobacco Prevention and Control Policy Executive Committee, was more suited to work on policy issues.<sup>63</sup>

In 2008, current and former tobacco control program leaders from the state and local levels, and some state health groups, including ALA and ACS, reactivated TFND's 501(c)3 status and began to reorganize and elect a TFND Executive Board, but it did not have any funding, so the coalition's activities were limited to the volunteer efforts of the TFND Executive Board during the Measure 3 ballot measure campaign in 2008 and an advocacy campaign during the 2009 Legislative Session to get funding appropriated for the new tobacco control program that Measure 3 created.<sup>66</sup> In 2010, the new Tobacco Prevention and Control Executive Committee and its implementing body, the Center for Tobacco Prevention and Control Policy (the Center), provided TFND with a \$72,398 grant<sup>67</sup> in October 2010 to hire an Executive Director, Megan Smith Houn. As of 2012, TFND was once again the active statewide coalition but with an unknown capacity and level of support from organizational members from throughout the state.

## **DOH Money and Programs Following the Master Settlement Agreement**

### ***New Funding Streams***

#### *CDC's National Tobacco Control Program Grant*

In 1999, CDC's Office on Smoking and Health (OSH) launched its National Tobacco Control Program (NTCP) to provide annual grants to states to establish coordinated tobacco control programs. CDC NTCP grants were awarded to state health departments and began in FY 2000. As part of the launch of NTCP, the Office on Smoking Health published its 1999 *Best Practices for Comprehensive Tobacco Control Programs*.<sup>15</sup> *Best Practices* provided state programs with state-tailored funding and program recommendations. In 1999, CDC recommended that North Dakota spend between \$8.2 million and \$16.5 million on its tobacco control program.<sup>15</sup> CDC released an updated version of *Best Practices* with modified program components and funding levels in 2007, which recommended that North Dakota spend a minimum of \$9.3 million annually on tobacco control programs.<sup>28</sup> While the CDC recommendations were for what the states should be spending on tobacco control, CDC also provided North Dakota with around \$1.2 million annually toward reaching the *Best Practices* prescribed annual funding level.

#### *Master Settlement Agreement*

The Master Settlement Agreement, signed on November 23, 1998 between the attorneys general of 46 states and the six major U.S. cigarette companies, settled lawsuits brought by the states to recoup the billions of dollars spent on Medicaid costs due to tobacco-related illnesses, and to seek permanent injunctive relief against industry practices including youth marketing and billboard advertising.<sup>68</sup> (Four states -- Florida, Minnesota, Mississippi, and Texas -- had already

settled separately and were not signatories to the MSA.) Each state filed individual lawsuits with slightly different claims, but the settlement was a collective agreement.

The MSA offered an opportunity to dramatically increase tobacco control program spending in North Dakota. North Dakota received 0.3660138 percent of the annual payments made by the tobacco companies, which amounted to an average of \$24 million annually (Table 8).<sup>69</sup>

TFND, was disorganized, however, and did not succeed at convincing the Legislature to allocate funding for a statewide comprehensive tobacco control from Master Settlement Agreement funds. While TFND and leaders such as Attorney General Heidi Heitkamp (D), who had signed the MSA for North Dakota, wanted the money to be used to fund a tobacco control program modeled on CDC’s *Best Practices for Comprehensive Tobacco Control Programs*,<sup>15</sup> TFND did not present legislation for the Legislature to consider in 1999.<sup>14</sup>

Governor Edward Schafer (R, 1992-2000) and State Health Officer Murray Sagsveen opposed funding a comprehensive tobacco control program, likely because of tobacco industry ties. Schafer opposed smoking restrictions and aligned with Smokers’ Rights Groups,<sup>14</sup> which in many states were organized by the tobacco industry,<sup>70</sup> and Sagsveen was formerly an attorney with the Bismarck law firm Zuger Kirmis & Smith that worked for the Tobacco Institute, the chief lobbying arm of the tobacco industry.<sup>58</sup> Schafer and Sagsveen prioritized using the money for a new state morgue.<sup>14</sup> In 1999, North Dakota enacted HB 1475 which allocated 45 percent of MSA payments for schools (Common Schools Trust Fund), 45 percent for water development

**Table 8: Master Settlement Agreement Funds Received by North Dakota, 2000-2011**<sup>71</sup>

Year	MSA Funds (Tobacco Settlement Trust Fund)	Strategic Contribution Funds (Tobacco Prevention and Control Trust Fund)	Total MSA Funds
2000	29,954,608	0	29,954,608
2001	22,946,177	0	22,946,177
2002	26,780,712	0	26,780,712
2003	26,855,651	0	26,855,651
2004	22,983,256	0	22,983,256
2005	23,326,754	0	23,326,754
2006	21,414,069	0	21,414,069
2007	22,414,049	0	22,414,049
2008	22,683,348	13,797,729	36,481,077
2009	25,014,321	14,138,011	39,152,332
2010	20,816,865	12,274,393	33,091,258
2011	19,736,098	11,186,238	30,922,337
<b>Total</b>	<b>284,925,908</b>	<b>51,396,372</b>	<b>336,322,279</b>

programs (Water Development Trust Fund), and 10 percent for community health projects (Community Health Trust Fund). The 10 percent allocated to the Community Health Trust Fund could be used for tobacco control programs, but there was no such requirement. The Legislature

did not pass legislation to appropriate Community Health Trust money until 2001; for the 1999-2000 biennium the funds sat in the trust fund unspent.

**The 10 percent allocated to the Community Health Trust Fund could be used for tobacco control programs, but there was no such requirement.**

In 2000, Heitkamp organized the Blue Ribbon Tobacco Panel comprised of the voluntary health organizations, and other state health groups, to provide recommendations to the legislature on how to spend the money deposited into the Community Health Trust Fund. Heitkamp was Attorney General at the time but the Panel was not part of the Attorney General's office. The Panel released a report in December 2000<sup>72</sup> which outlined key programmatic elements based on CDC's *Best Practices for Comprehensive Tobacco Control Programs*.<sup>15</sup> However, because of political opposition from Governor Schafer's office, and perceptions within the legislature that Heitkamp was only involved to aid her anticipated gubernatorial campaign, the Legislature ignored the panel's report.<sup>14</sup>

### ***Community Health Grant Program***

In 2001, the Legislature enacted SB 2380, which created the Community Health Grant Program. SB 2380 stated that "[t]he primary purpose of the program is to prevent or reduce tobacco usage in the state by strengthening community-based public health programs and by providing assistance to public health units and communities throughout the state."<sup>73</sup> The program had to follow CDC programmatic guidelines but only to the extent that funding was "available," meaning to the extent that the Legislature appropriated funding. However, the Legislature did not commit to appropriating any specified level of funding.<sup>57</sup>

SB 2380 divided the money allocated to the Community Health Grant Program in a 40-40-20 split. Forty percent of the funds were required to be used for a preventive health program in schools which had to contain a tobacco use component addressed through tobacco-free policies, evidence-based curricula, teacher training, parental involvement and cessation services for students and staff. Forty percent had to be used by LPHUs to develop plans with their elected officials to implement regional health programs, which contained tobacco use components, but could also fund other chronic disease programs. The remaining 20 percent was to be given to LPHUs to supplement their Tobacco Settlement State Aid grants, a preestablished grant program through which the Legislature appropriated general funds to LPHUs. However, no Tobacco Settlement State Aid funding, including these supplemental grants, had to be used for tobacco control programs.

During the 2001 Legislative Session, members of Tobacco Free North Dakota (TFND), which was disorganized and lacked funding and leadership, had requested that the state use its MSA money to fund a comprehensive tobacco control program. The American Heart Association (AHA) and the American Lung Association (ALA) supported the 40-40-20 division included in Governor Hoeven's (R) proposal,<sup>14</sup> which members of TFND argued they were not consulted about, an event which lingered as a basis for coalition disagreements years later.<sup>59, 60</sup> Some tobacco control leaders (mostly those who were current or former program leaders) argued that AHA lobbyist June Herman was most active in the negotiations and blamed AHA and Herman for agreeing to Hoeven's proposal. As a result of AHA's decision to accept the 2001

legislation and subsequent disagreements between Herman and other tobacco control leaders, which are discussed later in later sections, AHA and tobacco control program leaders no longer worked together on state tobacco control policy issues as of 2012.<sup>57, 60, 74</sup>

In a 2012 correspondence for this research, Herman explained, “All active state and local tobacco control program leaders had the opportunity to step forward in a formal manner, either through TFND or seeking a leadership meeting to ask for an opposing position. The decision to engage was left to individual organizations, and individuals/groups chose to be active or passive in the effort.”<sup>16</sup> Additionally, in a 2008 conflict resolution meeting among the state tobacco control partners convened at the suggestion of national tobacco control organizations the Campaign for Tobacco-Free Kids (CTFK), Americans for Nonsmokers’ Rights (ANR) and ACS Cancer Action Network (ACS CAN), Herman argued that AHA had tried to consult with the broader group in 2001 but that the coalition was disorganized and did not have a formal decision-making process to follow.<sup>17</sup>

SB 2380 also created a Community Grant Program Advisory Committee to advise the state Department of Health as it developed the new grant program. The Committee was appointed by the state health officer after consultation with the Governor, and, as required by law, included a combination of tobacco control professionals, students, law enforcement officials and individuals appointed by the North Dakota Indian Affairs Commission, North Dakota Public Health Association, the Superintendent of Public Instruction, the University of North Dakota School of Medicine and Health Sciences and the North Dakota Medical Association (Table 9). The key responsibilities of the Committee were:

- a. Evaluate programs;
- b. Promote media advocacy by working with statewide media associations;
- c. Implement smoke-free policies by involving anti-tobacco groups in promoting the need for smoke-free public buildings;
- d. Work to reduce minors’ access to tobacco in all communities;
- e. Facilitate the coordination of program components with the local level;
- f. Involve state agencies, law enforcement, and local government in the administration and management of the program; and
- g. Assist the state in screening and implementing the grants.<sup>73</sup>

The formation of the Community Health Grant program represented significant progress for tobacco control programming in North Dakota and laid the foundation for later tobacco control programming in North Dakota (that would be increased in 2008 when voters passed Measure 3, discussed later in this report). With the passage of SB 2380 and implementation of the Grant program, the DOH provided grants to all of the state’s 28 LPHUs, as well as to four American Indian tribes and one American Indian Health Service Center to work on tobacco control.<sup>14</sup> For the 2001-2003 biennium, the state appropriated \$5.1 million (\$2.6 million annually) from the Community Health Trust Fund to the DOH for state and local tobacco control programs, \$4.7 million (\$2.35 million annually) of which was for the Community Health Grant Program and distributed to local programs.<sup>75</sup> Still, in 1999, CDC recommended that North Dakota spend a minimum of \$8.2 million annually on tobacco control programs (Table 10).<sup>15</sup> This level of funding from state resources was unsustainable because the Community Health

<i>Committee Member</i>	<i>Representing</i>
Dr. Terry Dwelle, Chair	North Dakota Department of Health
Dr. James Buhr	MeritCare Valley City
Carlotta Ehlis	North Dakota Public Health Association
Karalee Harper	North Dakota Department of Health
June Herman	American Heart Association
Cheryl M. Kulas	North Dakota Indian Affairs Commission
Dr. Nicholas Neumann	University of North Dakota
Drinda Olsen	North Dakota Department of Public Instruction
Sgt. Roger Pohlman	Grand Forks Police Department
Ashley Smette	Postsecondary Student
Kendra Weber	High School Student

Trust fund only received about \$2 million annually from MSA payments (10 percent of each annual MSA payment).

As discussed above, the DOH also received approximately \$1.2 million annually from CDC, which meant the state tobacco control program received a total of \$7.4 million (\$3.8 million annually) when federal grants were accounted for, still less than 50 percent of the \$8.2 million that CDC recommended. This level of funding remained fairly level from 2001 to 2008 except for increases for the tobacco Quitline which was launched in FY 2004 and funded with \$680,000 for the 2003-2005 biennium and at higher levels in subsequent bienniums. The DOH used its \$1.2 million a year from its CDC grant primarily to pay staff salaries (because the Legislative Assembly did not appropriate funding to hire additional staff in its 2001-2003 appropriation) and to supplement grants to local grantees.

### **Implementation of Tobacco Control Programs with the New Tobacco Control Funding**

The DOH Division of Tobacco Prevention and Control's established four primary goals:

- Preventing the initiation of tobacco use among young people;
- Promoting quitting among young people and adults;
- Eliminating nonsmokers' exposure to secondhand smoke;
- Identifying and eliminating tobacco-related disparities among specific population groups.<sup>76</sup>

Prior to the creation of the Community Health Grant Program and the increase in MSA funding for the DOH in the 2001-2003 biennium, the DOH Division of Tobacco Prevention and Control had only CDC funding (about \$1.2 million annually) and had minimal staff consisting of a Director, a part time program assistant, and an administrative assistant.<sup>57</sup> Kathleen Mangskau, Director of the the DOH Division of Tobacco Prevention and Control (2001-2006), was hired in fall of 2001. In order to be able to implement the new programs, she wanted to expand the capacity of the department by hiring additional staff. From 2001 to 2006, Mangskau hired two outreach coordinators, a surveillance and evaluation coordinator, a cessation coordinator and local grants manager. Except for the local grants manager, who was hired in the 2005-2007 biennium with MSA money, these positions were mostly funded with the state's annual CDC grant, not MSA funding. Consistently, Mangskau struggled with the Legislature for the authority

to hire additional staff (which the Legislature must explicitly approve in its biennial appropriation bill). The Legislature was more willing to allow for the program to hire additional staff if they were paid from federal funding sources instead of state sources. Mangskau also believed that the Legislature did not want to appropriate money for staff increases as a way to limit the efficacy of the program once state and local advocates began to have successes passing clean indoor air laws.<sup>57</sup>

### ***Community Programs to Reduce Tobacco Use***

The primary purpose of the Community Health Grant Program was to fund local community health programs. Of the \$7.4 million available for tobacco control programs (MSA and CDC funds) in its first biennium (FY 2001-2003), \$3.8 million was granted to local health departments for local tobacco control programs (\$1.9 million for school health programs and \$1.9 million for community programs).<sup>75</sup> The DOH also received \$940,000 in supplemental Tobacco Settlement State Aid funding, that it was required to distribute to local health departments to be spent at the discretion of the local officials; the Tobacco Settlement State Aid *could* be used for tobacco control programs but tobacco programs were not required (Table 10).<sup>73</sup> This meant that only 80 percent of local grants were required to be used on tobacco programs. In addition to using its CDC funds for staff and administrative costs, the DOH also used CDC funds to supplement its local tobacco control grants to Local Public Health Units and tribal communities.

**The primary purpose of the Community Health Grant Program was to fund local community health programs.**

The criteria for local grant applicants, which were all based in LPHUs and tribal health centers, remained roughly the same for several years following the creation of the Community Health Grant Program. Local grants had to be used for programs based on CDC's *Best Practices* recommendations and grantees were required to focus on coalition and community partnership building, as well as on strategies to develop and implement policies and change the environment where tobacco use occurred.<sup>83</sup>

In describing the work of its community-based programs in its 2004 annual report, the DOH stated: "Local coalitions and networks create work plans that fit local needs and opportunities to reduce youth access to tobacco; create tobacco-free schools, workplaces and public places; and link tobacco users to cessation programs and services."<sup>84</sup>

As part of its grant requirement, LPHUs had to work with local school boards to implement programs to reduce tobacco use among youth. Their programs had to be developed with student participation. Local public health unit staff worked with school administrators and provided tobacco cessation curricula to schools meant to educate students on the importance of



Table 10: North Dakota Tobacco Control Program Budgets and Expenditures, 1999-2013<sup>21,75, 77-82</sup>

	1999-2000	2001-2003	2003-2005	2005-2007	2007-2009	2009-2011	2011-2013 (Budgeted)
<b>TOBACCO CONTROL FUNDING AVAILABLE</b>							
<b>Source</b>							
<i>Community Health Trust Fund (Original MSA Money Appropriated to DOH)</i>							
<b>Program category / specific appropriation</b>							
Tobacco Prevention and Control (lump sum)						2,302,098	3,510,495
<b>Cessation</b>							
Tobacco Cessation (specific line item)		250,000	704,000	395,000	260,000	0	0
Tobacco cessation coordinator and operating expenses				111,000	139,397	139,397	0
Quitline / Quitnet			680,000	884,000	1,069,000	1,069,000	0
<b>Community Health Grant Program</b>							
School Health		1,880,000	1,880,000	1,880,000	1,880,000	0	0
Community		1,880,000	1,880,000	1,880,000	1,880,000	0	0
Tobacco Settlement State Aid		940,000	940,000	940,000	940,000	0	0
Community Health Grant Program Advisory Committee		100,000	100,000	100,000	100,000	0	0
<b>TOTAL MSA Money Available for Tobacco Control Programs</b>		5,050,000	6,184,000	6,190,000	6,268,397	3,510,495	3,510,495
<b>Grants Received for Tobacco Control</b>							
Centers for Disease Control and Prevention NTCP Grant	**	2,364,934	2,277,189	2,651,540	2,368,941	2,299,626	2,712,965
American Legacy Foundation Grant			30,000	66,000	76,650	0	0
<i>Tobacco Prevention and Control Trust Fund (Strategic Contribution Funds appropriated to the TPC Executive Committee)</i>					62,403	12,882,000	12,922,614
<b>TOTAL Tobacco Control Funding Available in state</b>	**	7,414,934	8,491,189	8,907,540	8,776,391	18,692,121	19,146,074
<b>TOBACCO CONTROL EXPENDITURES</b>							
<b>Department of Health</b>							
<i>Community Health Trust Fund Money Appropriated to DOH (MSA)</i>							
Tobacco Prevention and Control (lump sum)**						683,967	
<b>Cessation</b>							
Tobacco Cessation (specific line item)		45,947	57,080	132,325	173,142	0	
Tobacco cessation coordinator and operating expenses				109,557	119,833	60,744	
Quitline / Quitnet			460,367	832,186	1,090,097	2,342,593	

	Baby and Me Tobacco Free			0	0	0	0	0	125,000	Incomplete. Data was collected mid-biennium before complete expenditures were available.
	<b>Community Health Grant Program*</b>									
	School Health		1,854,553	1,851,415	1,867,182	1,854,515	0			
	Community		1,866,524	1,874,781	1,877,654	1,877,217	0			
	Tobacco Settlement State Aid		940,000	940,000	940,000	940,000	0			
	Program Advisory Committee		30,758	94,760	99,246	66,302	0			
	<b>Total MSA Money Spent</b>		4,737,782	5,278,403	5,858,150	6,121,106	3,337,304			
<b>CDC / Other Grant Expenditures</b>										
	Centers for Disease Control NTCP Grant			1,268,546	1,181,479	969,824	844,495			
	Media (to PETF)			132,740	**	**	**			
	Surveillance and Evaluation***	**	**	**	**	**	**			
	Salaries	**	**	**	**	**	**			
	Other administrative costs	**	**	**	**	**	**			
	Total CDC Fund Expenditures (Totals provided by DOH)	1,619,821	2,112,763	2,277,189	2,651,540	2,368,941	2,299,626			
	American Legacy Grant			29,484	47,169	0	0			
	<b>TOTAL DOH EXPENDITURES</b>	1,619,821	6,850,545	7,585,076	8,556,859	8,490,047	5,511,930			
	<b>Tobacco Prevention and Control Executive Committee (The Center) Expenditures</b>									
	Grants to Local Public Health Units						6,001,512			
	Special Initiative Grants						1,163,414			
	Tobacco Settlement State Aid Local Grants						940,000			
	<i>Grants Total</i>						8,104,926			
	Professional Fees and Contracts						475,894			
	Salaries and Wages						407,168			
	Operating Costs					38,815	294,028			
	TOTAL					38,815	9,282,016			
	<b>TOTAL STATE TOBACCO CONTROL EXPENDITURES</b>	1,619,821	6,850,545	7,585,076	8,556,859	8,528,862	14,793,946			

**Notes:**

\*The Community Health Grant Program was no longer funded after the 2007-2009 biennium. The DOH Division of Tobacco Prevention and Control received a lump sum appropriation during the 2009-2011 and the 2011-2013 bienniums that the DOH could use for tobacco control programs at its discretion. Because of Measure 3, these lump sum appropriations were comprised of MSA money and were 80 percent of the funds that the state annually deposited in the Community Health Trust Fund (10 percent of the state's total MSA receipts).

\*\*Detailed data requested from but not provided by the DOH.

\*\*\*Portions of these programs were funded by both MSA and CDC funds but the DOH did not provide these data to the researchers.

\*\*\*\*DOH local grants reportedly ceased in spring of 2011. However, the DOH reported budgeting \$1,098,000 for local tobacco control grants. The DOH did not provide clarification despite the researchers' repeated requests.

tobacco cessation. LPHUs were also required to educate school administrators on the importance of implementing smokefree policies.

For the required broader community component, LPHUs, per their grant agreements, sought organizational and individual partners in their communities and worked to develop local coalitions to promote local tobacco control policies and the importance of smokefree environments and tobacco cessation. These coalitions were required to work in cooperation with local elected officials. The state DOH program's tobacco outreach coordinators provided technical assistance to LPHUs for this local activity and provided assistance on local policy campaigns. Outreach coordinators worked directly with local grantees, assisted with coalition building, assisted on policy campaigns and helped local grantees to understand *Best Practices*. In the 2003-2005 biennium, the DOH also contracted with Minot State University to provide technical assistance for local policy campaigns so that LPHUs would have sufficient guidance in their campaigns managing local grants. In the 2005-2007 biennium, the Legislature honored the DOH's request and appropriated \$111,000 (salary and operational costs) for the DOH Division of Tobacco Prevention and Control Program to hire an additional local grants manager.

Following the increase in funding and technical assistance for local coalition building, there was an increase in local activity. Bismarck, Fargo, Grand Forks and West Fargo each passed local clean indoor air ordinances in 2004-2005 that were stronger than state law. The Grand Forks and Bismarck ordinances, passed soon after the 2005 state clean indoor air law, ended the exemption for bars within restaurants in those communities. These cities later returned and passed comprehensive smokefree air laws. Beginning in 2008, Fargo and West Fargo passed smokefree air ordinances that prohibited smoking in public places and workplaces, including bars. As of 2012, North Dakota had a total of seven comprehensive local ordinances (discussed in later sections).<sup>85</sup>

DOH outreach coordinators worked with the four tribal health units and Indian service areas primarily on smokefree school issues and had some success getting smokefree school policies implemented; passing smokefree laws on tribal land was complicated because tribes are sovereign nations and operate under autonomous government systems.<sup>57</sup>

#### *Problems with the Community Health Grant Program Funding Restrictions*

According to the 2001 SB 2380, the DOH's Community Health Grant Program had to follow *Best Practices* to the extent that funding was available. CDC wanted states to develop infrastructure and strong coalitions that were equipped to advocate for stronger tobacco control policies and made that a focus of their deliverables.<sup>83</sup> However, the 2001 legislation required the DOH to use 40 percent of the funds for a narrow focus on school programs.<sup>73</sup> This limited the freedom of experienced tobacco control program leaders to use the funds where they were needed for other programs essential for a strong and effective comprehensive tobacco control program as defined by the CDC.<sup>57</sup>

**The DOH's Community Health Grant Program had to follow *Best Practices* to the extent that funding was available.**

In a 2011 interview for this research, Kathleen Mangskau, former Director of the DOH TPC Program, explained that despite the citation to *Best Practices* in SB 2380, the bill did not entirely follow CDC's recommendations and forced the DOH to direct some of its funding to inappropriate purposes. Mangskau spoke specifically about the requirement that forty percent of the Community Health Grant funds go to school programs with a heavy focus on curricula. Mangskau recalled in the interview, "it was focused on curriculum. But again, if you look back at *Best Practices* in that time, curriculum was part of it. It's become less because they've [CDC] learned that it's not as effective as other [programmatic areas]." Mangskau explained that while the 1999 *Best Practices* contained a school curriculum component<sup>15</sup> (which was integrated into its "State and Community Interventions" section in the 2007 *Best Practices* update<sup>28</sup>), tobacco control program leaders were forced to devote too much of their resources to curriculum and other school cessation programs that were being shown to be less effective than efforts such as promoting policy change.<sup>57, 66</sup>

When the Community Health Grant Program funding was initially disbursed to LPHUs in the 2001-2003 biennium, most of the LPHUs strictly abided by the 40 percent schools requirement. Mangskau explained that she and the DOH TPC Program worked to decrease the emphasis on schools by encouraging LPHUs to focus on community programs and to consider schools to be part of the community. However, the prospect of LPHUs stopping funding to schools at times created tension between LPHUs and local school districts that wanted to continue receiving Community Health Grant funding. To ameliorate the tension, the DOH asked LPHUs to only gradually decrease school funding as they shifted focus to community work. This gradual reduction in funding to schools was only successful in part in getting LPHUs to focus less on schools and more on broader, community-focused programs with an emphasis on passing policy; some LPHUs maintained a literal interpretation of law that required 40 percent to go to schools. Mangskau explained that refocusing program priorities onto *Best Practices* programs was a major reason for the 2008 Measure 3 campaign to create a new tobacco control program.<sup>57</sup>

The Tobacco Settlement State Aid that LPHUs received did not have to be used for tobacco control programs but the DOH, at the time, encouraged LPHUs to do so.<sup>57</sup> Kathleen Mangskau, who at the time was the head of the DOH TPC Program, asked LPHUs to use the Tobacco Settlement State Aid for tobacco control programs. When talking with LPHU leaders, Mangskau argued that LPHUs were required to use Tobacco settlement State Aid funds on tobacco control because the Community Health Grant Program legislation stated that "The program must, to the extent funding is available, follow guidelines concerning tobacco prevention programs recommended by the centers for disease control and prevention [sic]."<sup>73</sup> and Tobacco Settlement State Aid comprised 20 percent of the Community Health Grant Program funding. Mangskau explained in a 2011 interview for this research that this argument worked for a period, but eventually, because of limited local funding for other health programs, LPHUs began to diversify their uses of the Tobacco Settlement State Aid, and tobacco control became less of a focus.<sup>57</sup> Mangskau explained that LPHUs with strong tobacco leaders were able to internally direct Tobacco Settlement State Aid funds to tobacco control programs, but LPHUs with weaker tobacco control leaders were not.

## *Cessation Programs*

### *Group and Individual Cessation Programs*

Local public health units were permitted to work on local cessation programs which allowed them to use some of their local grant money to work directly with residents in their communities on tobacco cessation.<sup>57</sup> The DOH also received funding for the City/County and State Employee Cessation program, which allowed it to run group and individual tobacco cessation counseling programs for public employees at the state and local level. The program received \$704,000 for the 2003-2005 biennium, the same biennium that the DOH received funding for the state Quitline. However, as research began to show that direct cessation counseling was less cost-effective than telephone-based Quitlines, the DOH asked the Legislature to appropriate more funding for the Quitline and less for the direct cessation counseling programs.<sup>57</sup> In the 2005-2007 biennium, the Legislature agreed and reduced funding for the City/County and State Employee Cessation Program from \$704,000 to \$395,000 and increased Quitline funding from \$680,000 to \$884,000. There was a net reduction for cessation programs in the 2005-2007 biennium, but the DOH also received additional funding for a local grants manager who provided accounting services for the DOH's 61 local grants.<sup>66</sup>

### *Quitline*

The 2003 Legislative Assembly authorized the formation of a state Tobacco Quitline, a free telephone service that provided tobacco cessation counseling to North Dakota residents who wanted to quit. The Quitline launched in September 2004.<sup>86</sup> Through the Quitline program, the DOH also offered nicotine replacement therapy (NRT) which included nicotine patches, nicotine gum, and nicotine lozenges to participants. State Medicaid funds covered NRT for eligible populations and the DOH offered limited free NRT for everyone who called regardless of Medicaid eligibility. For the 2003-2005 biennium, the Legislative Assembly appropriated \$680,000 in additional funding for the Quitline. This funding increased with each successive biennial budget to \$1,069,000 in the 2011-2013 biennium (Table 10).<sup>75</sup>

The DOH put out a national request for proposals (RFP) to find a vendor to operate the state Quitline because they did not have a vendor with the organizational structure and trained counselors available in state. Of approximately 20 applications, the Mayo Clinic, based in Rochester, Minnesota, received the highest score and was selected by the DOH to run the program. Kathleen Mangskau, then Director of the DOH Division of Tobacco Prevention and Control Program, was in the process of writing a contract for the Mayo Clinic when she received a call from Dr. Terry Dwelle, State Health Officer, that the Governor's office had determined that the Quitline had to be run by an in-state organization and the Mayo Clinic was not in-state.<sup>57</sup> Mangskau felt that Governor Hoeven decided to keep the Quitline in-state because he was up for re-election and believed it would be politically damaging if the DOH hired an out-of-state vendor. State Health Officer Dr. Terry Dwelle and Deputy State Health Officer Arvy Smith wrote in a 2012 letter to the authors of this report that other states reported to the North Dakota DOH that there were weaknesses in Mayo's clinical counseling services and advised the DOH to keep in-state counselors.<sup>87</sup>

In response, the DOH arranged for the University of North Dakota School of Medicine and Health Sciences (UND) to supervise several Quitline counselors. (UND had not submitted a bid in response to the original RFP.) Mangskau recalled in an interview for this research, “It was election season, and the Governor wanted to assure that business was staying in state. And as a result, we had to look for a way to make this work, and so we talked to Mayo Clinic, and they were – they worked with us very well, and that’s how we ended up with this UND connection.”<sup>57</sup>

The DOH worked out a joint contract with Mayo and with UND where much of the administrative organization, the computer system and a portion of the counseling for the Quitline was operated by the Mayo Clinic but where UND also had Quitline counselors on staff which offered counseling services to North Dakota callers. Mayo Clinic counselors functioned as the primary counselors in the beginning as UND trained its counselors, and then gradually, UND’s counselors took on a larger role with Mayo counselors providing backup support. Dr. Eric Johnson and Dr. Donna Añel of UND served as consultants for the Quitline; Johnson and Añel managed UND’s tobacco cessation counselors and visited with physicians throughout the state, encouraging them to inform their patients about the Quitline.<sup>63</sup> Johnson explained in a 2011 interview for this research that by getting healthcare providers to “ask, advise and refer” patients to the Quitline services, the state has increased the number of smokers utilizing the programs with 35 to 40 percent of the service’s users saying that they were referred by a healthcare facility or provider as of 2011.<sup>88</sup>

In 2009, North Dakota ended its contract with Mayo and switched to Healthways, based in Tennessee, which, in addition to providing Quitline phone counseling services, introduced Quitnet, an internet-based cessation counseling service.<sup>88</sup> The decision to switch vendors was in part because of the desire of program leaders to incorporate Quitnet. UND continued provide some of the Quitline phone counseling services in North Dakota. There was no budget for a statewide media campaign so the DOH did not run any health communications media campaign other than advertisements for the Quitline, which the DOH paid for with its Quitline appropriation (Figure 8). As of 2011, the DOH coordinated with Healthways to create television and print advertisements promoting both Quitline and Quitnet.<sup>88</sup>

**There was no budget for a statewide media campaign so the DOH did not run any health communications media campaign other than advertisements for the Quitline.**

From the winter of 2005 (first available data) to 2009, Quitline usage throughout North Dakota increased. In 2005, there were 2,342 calls to the Quitline with a 12 month quit rate of 30.5 percent. By 2009 the number of calls had increased to 5,162 callers who had a 12 month quit rate of 33.5 percent.<sup>89</sup> As of June 2010, the DOH reported that the 36.1 percent of Quitline callers were still tobacco free six months after receiving counseling.<sup>86</sup>

**North Dakota Tobacco**  
**QUITLINE**  
 1-800-QUIT-NOW

The North Dakota Tobacco Quitline is a **FREE** service available to help North Dakota smokers and spit-tobacco users quit using tobacco.

**YOU CAN QUIT.**  
**WE CAN HELP.**

Figure 8: North Dakota Tobacco Quitline Advertisement (Flyer)<sup>9</sup>

## Media Campaign

### Public Education Task Force on Tobacco

Media campaigns, which are part of CDC's *Best Practices*, are proven to increase knowledge of tobacco issues, improve understanding of anti-tobacco messages, increase anti-tobacco beliefs, and decrease smoking rates.<sup>90,91</sup> Kathleen Mangskau, former DOH Tobacco Prevention and Control Program Director, believed that the State Legislative Assembly refused to fund a statewide media campaign because legislators knew that a media campaign would reduce tobacco use.<sup>57</sup>

North Dakota elected officials had a history of opposing funding for tobacco control media campaigns. Prior to the creation of the the Community Health Grant Program in 2001, Governor Edward Schafer (R, 1992-2000) and State Health Officer Murray Sagsveen (who departed with Schafer in 2000) opposed funding a media campaign.<sup>14</sup> Sagsveen justified this opposition in his 2000 testimony to the Interim Budget Committee on Health Care regarding the distribution of MSA money, arguing that national media campaigns being conducted by the American Legacy Foundation were already serving North Dakota citizens, as were Minnesota's media campaigns, which were seen in eastern North Dakota. Sagsveen did not disclose that the American Legacy Foundation had told him that Legacy's advertisements did not provide enough coverage to justify not having a North Dakota state media campaign.<sup>14</sup> Governor Hoeven, who succeeded Schafer, usually did not include tobacco control media campaigns in his executive budget (except for the 2007-2009 biennium) and

Legislators, at times, opposed tobacco control advertisements and asked to have the DOH to stop them.<sup>57</sup> Since the 1960s, the tobacco industry has known that tobacco control media campaigns are effective, and has worked hard to prevent the creation of media campaigns, limit the scope and efficacy of campaigns that it could not prevent, and eliminate existing campaigns entirely, often times by getting funding diverted, in states all across the U.S.<sup>92</sup>

### *Forming the PETF, 2002*

North Dakota's public health programs are decentralized.<sup>93</sup> There are 28 local public health units (LPHUs) that, as required by law,<sup>94</sup> serve the state's 53 counties. Some LPHUs serve several counties because parts of the state, particularly in the western half, are sparsely populated. LPHUs function independently and, while they received funding from the DOH, they are not subsidiaries of the state agency. The DOH serves as an advisor to the LPHUs. The state DOH also contracts with four American Indian Tribes and one American Indian service area which provided public health services to American Indian populations.<sup>95</sup>

In early 2002, because the Legislative Assembly had still not appropriated money to the DOH for a statewide media campaign, a group of LPHU tobacco coordinators and state DOH staff, including DOH Division of Tobacco Prevention and Control Director Kathleen Mangskau, collectively decided to form a local-led task force that would fund and manage a statewide media campaign from their local grants that had been awarded by the state DOH. The initial group of local leaders recruited the remaining LPHUs and worked with the DOH to create the Public Education Task Force on Tobacco (PETF). PETF was primarily funded by the 28 LPHUs pooling their funding, most of which had been provided to them from the state Department of Health as part of the Community Health Grant Program.<sup>82</sup> The state DOH also provided PETF \$132,740 from its annual CDC grant and the American Lung Association provided \$5,000 during PETF's first year. Upper Missouri District Health Unit, one of the LPHUs, agreed to serve as the fiscal agent for the PETF and was the legal manager of the PETF's funding.

**A group of LPHU tobacco coordinators and state DOH staff ... decided to form a local-led task force that would fund and manage a statewide media campaign from their local grants that had been awarded by the state DOH.**

The PETF elected an oversight committee with the following make up:

- 2 members representing the North Dakota state Department of Health;
- 3 representatives of public health administrators;
- 4 tobacco site coordinators from the Local Public Health Units, one of which representing the Native American population.

The oversight committee elected a Chair who presided over the committee's meetings. The first committee Chair was Pat McGeary, a Tobacco Control site coordinator in Bismarck-Burleigh Public Health Unit in Bismarck; she served until 2003. Tobacco control site coordinators Nancy Thoen, of Jamestown, Carolyn Kaltenberg of Grand Forks and Vicki Valdo



Rosenau of Valley City served as subsequent chairs of the PETF.<sup>96, 97</sup> The committee also elected a Vice-Chair, Recording Secretary and a Fiscal Manager.<sup>98</sup>

The PETF oversight committee created short-term, intermediate and long-term goals:

- Short-term goal: To increase knowledge, attitudes and actions regarding exposure to secondhand smoke.
- Intermediate goal: To increase the readiness of each North Dakota community to support and initiate city and county legislation and voluntary efforts that support smoke-free policies in public places, including schools, daycare centers, restaurants and work sites.
- Long-term goal: To reduce tobacco-related morbidity and mortality by reducing exposure to secondhand smoke, and the prevalence of tobacco use in North Dakota.<sup>99</sup>

The PETF oversight committee handled contracts with marketing and public relations firms and distributed informational handouts and sound bites to local public health units designed to equip local tobacco control program leaders to talk with the media about the campaign.<sup>99</sup> Kelly Buettner-Schmidt, who was contracted by the DOH to provide technical assistance to LPHUs working on tobacco control policy campaigns, attended meetings to update the committee on local campaigns throughout the state.<sup>100</sup>

From 2002 until 2009, when the Center for Tobacco Prevention and Control Policy formed and took the lead on the statewide media campaign, the PETF campaigns focused on the health consequences of secondhand smoke.<sup>99</sup> The PETF chose secondhand smoke as a key issue because of increased interest among state and local tobacco control leaders to see stronger clean indoor air laws passed at the state and local levels and the need for public education throughout the state. The PETF wanted its campaign to protect nonsmokers from secondhand smoke by educating the community so that people would voluntarily not smoke in indoor places, and also to inform the public about how passing stronger smoking laws at the state and local level could provide that protection.<sup>101</sup>

The PETF's initial primary target audience was North Dakota residents aged 18-54 as well as policy "decision makers." Its secondary target was the American Indian community and populations with low socioeconomic status (SES).<sup>101</sup> In 2006, PETF expanded its age focus to all adults above 18 years of age in order to educate all adults on the importance of smokefree public places.<sup>102</sup> The PETF enlisted public relations and marketing firms, Odney and GL Ness, to produce new advertisements or adapt advertisements from other states. Advertisements were launched on television, radio and in print.<sup>82</sup> From 2003 to 2005, two of the advertisements (one print and one radio) won Addy awards, an award given by the American Advertising Federation. Also, another of PETF's television spots was selected at the CDC's National Conference on Health Communication, Marketing as the advertisement "Most likely to motivate action against secondhand smoke."<sup>97</sup>

PETF spent \$500,000 (65 cents per capita<sup>99</sup>) on its first campaign which ran from September 2002 until April 2003. The PETF's budget was similar until 2009 because local funding did not increase until Measure 3 passed in 2008. This was less than the \$1-\$3 per capita

CDC recommended at the time<sup>15</sup> but this was all that local tobacco control advocates could afford given their limited budgets.<sup>82</sup>

Before the launch of their 2002 media campaign, the PETF hired Winkleman Consulting, based in Fargo, to survey North Dakota residents on their opinions on the importance of smokefree environments. Winkleman conducted a statewide telephone survey of 1200 people before and 1200 after the completion of the campaign in order to test whether the campaign had an effect on public opinion regarding smokefree issues. Before the media campaign, 43 percent of North Dakotans interviewed believed that smoking should not be allowed in restaurants; after the campaign, this increased to 64 percent in support of smokefree restaurants.<sup>103</sup> This survey showed that an increase in public approval for smokefree restaurants followed implementation of the statewide media campaign.

The PETF primarily used television advertisements that it obtained from ClearWay Minnesota<sup>104</sup> and the Centers for Disease Control and Prevention's Media Resource Center.<sup>105</sup> From 2005 until 2009, PETF favored advertisements that targeted smoking in bars as a problem. Bars were exempted from the 2005 statewide clean indoor air law, and the PETF wanted to increase public education on the importance of smokefree bars. One such advertisement featured a golfer driving a ball at full force through a crowded bar while smoking a cigarette, pointing to the fact that people are not comfortable allowing others to harm them in other ways and so should not permit others to harm them with secondhand smoke. Another advertisement featured a man lighting a cigarette in a bar, only to have oxygen masks fall from the ceiling like in an airplane emergency (Figure 9).



Figure 9: Public Education Task Force television advertisement focused on smokefree bars.<sup>5</sup>

#### *Opposition to the PETF*

Tobacco industry allies, including the North Dakota Coin and Tavern Association (CATA), the North Dakota Hospitality Association and some individual bars, criticized PETF for their advertisements promoting smokefree bars. Nicki Weissman, Executive Director of the Hospitality Association said in 2006 that PETF's advertisements were "harassing the bar people" not providing education.<sup>106</sup> Rep. Dwight

Wrangham (R-Bismarck), who was also the Executive Director of CATA and the North Dakota Coin Machine Operators Association (NDCMOA), and Rick LaFleur, President of NDCMOA, were also outspoken in their opposition to PETFs advertisements and smokefree bars.<sup>107</sup> The

“North Dakota Coin Association” reported contributing \$250 in the 2009-2010 election cycle to the North Dakota Senate Republican Caucus but it is unclear which of the two coin associations made the contribution.<sup>7</sup>

Coin associations represent the interests of companies who produce and stock coin-operated vending machines. The vending machine industry has worked with the tobacco industry to oppose tobacco control laws since the 1990s.<sup>108</sup> The North Dakota Coin and Tavern Association also represented the interests of bars and taverns which were tobacco control third party allies.<sup>45</sup>

Wrangham reportedly coined the slogan in North Dakota, “We are not pro-smoking; we are pro-smoker,” presented smokers as the victims of nicotine addiction and claimed smokefree environments discriminated against smokers who needed help.<sup>107</sup> This argument ignored the fact that smokefree environments help smokers quit<sup>109-111</sup> and simply repeated the “smokers’ rights” arguments that the tobacco industry created and promoted by financing front organizations beginning in the late 1970s.<sup>70, 112</sup> Minot Smokers’ Rights, a smokers’ rights organization based in Minot in the 1990s, made the same arguments.<sup>14</sup>

Wrangham and the CATA encouraged their members to place signs in their bars that read “If you think secondhand smoke is a hazard to your health you should not enter.”<sup>113</sup> The PETF argued that the word “think” created doubt that secondhand smoke was dangerous. Wrangham responded that, “Think is good word [sic], it is what people do. They think and they make choices.”<sup>113</sup> Wrangham and other members of CATA also worked to convince tobacco control program leaders to divert their funding away from the media campaigns funded by PETF in favor of more cessation programs, which are much less cost-effective at reducing smoking than is policy change.<sup>114, 115</sup> These opponents of the PETF were unsuccessful in getting its program leaders to divert funding to less effective programs.

**These opponents of the PETF were unsuccessful in getting its program leaders to divert funding to less effective programs.**

Some legislators, including Rep. Jim Kasper (R-Fargo), questioned the legality of the PETF using public funding for policy-related issues like smokefree air education and smokefree air policies which might be used to influence public policy. Carolyn Kaltenberg, tobacco control site coordinator in Grand Forks, in 2006 was Chair of PETF and responded to Kasper’s arguments in a letter to him. Kaltenberg cited Attorney General Wayne Stenehjem’s Opinion 2004-L-36 which said that the media campaign was legal and what the Legislature intended when it created the Community Health Grant Program in 2001.<sup>116</sup> Rep. Francis Wald (R-Dickinson) had originally requested the Attorney General deliver an opinion to resolve a question of whether Southwest District Health Unit (in Dickinson, ND) illegally used public funds when it funded a secondhand smoke education campaign at the same time Dickinson, ND voters were considering an initiated measure to prohibit smoking in public places. Stenehjem’s wrote in his opinion that, in funding LPHU’s community programs, the DOH was required to encourage LPHUs to include in their plans “Community programs that: ... Conduct educational programs at the local levels; Promote government and voluntary health policies, such as clean indoor air, youth access, and treatment coverage; ... [and] deter smoking in public places.”<sup>116</sup>

Attorney General Stenehjem went on in his opinion to highlight the state DOH's legal responsibility to "promote media advocacy" and the need for smokefree public buildings, and to involve local government in the administration and management of the program.<sup>116</sup>

Kathleen Mangskau also explained in a 2011 interview for this research, "we would even get calls from the Governor's office that would say pull those [advertisements]. And they usually came from legislators that would call the Governor's office and say pull those [advertisements]... The nice thing that running them through the Public Education Task Force, when the Governor's office called me and said 'pull those ads,' I said, 'we don't have that authority...those were created and are being run by local public health departments.'"<sup>57</sup> Kelly Buettner-Schmidt reported in a 2012 correspondence for this research that Mangskau informed the PETF that legislators had requested that the PETF pull advertisements and that advertisements were not pulled because the PETF refused to do so.<sup>100</sup>

In 2006, the DOH's annual report discussed the PETF and wrote, "The public education campaign is important because it promotes tobacco-use cessation; creates and sustains public awareness; and counters pro-tobacco industry influences."<sup>76</sup>

In 2008, voters enacted Measure 3, which created the Tobacco Prevention and Control (TPC) Advisory Committee, which was funded with Strategic Contribution Funds that North Dakota began receiving in 2008 as supplemental payments from the Master Settlement Agreement. The TPC Advisory Committee created a state plan that included a statewide media campaign and the Center for Tobacco Prevention and Control Policy (The Center, the implementing body for the new state plan) took the lead on implementing media throughout the state. As of 2012, the PETF remained in existence and continued to contribute to the state's media campaign, but it was not the lead.

### *PETF Evaluation*

The PETF contracted with Winkelman Consulting in Fargo, North Dakota to conduct polls on the effectiveness of the media campaigns in 2002, 2003, 2004, 2006, 2008 and 2010. Polling was completed during "normal" media schedules and consistently measured support for smokefree places and in 2006, after PETF began to focus its advertisements on promoting smokefree bars, Winkelman added questions to test statewide support for expanding the 2005 statewide clean indoor air to include bars.

In 2010, Winkelman Consulting released a report that presented the changes in public perception on smokefree issues between 2002 and 2010.<sup>102</sup> The report found that over this time respondents who believed that secondhand smoke was "very harmful" to nonsmokers visiting public places allowing smoking increased from 31.5 percent to 47.4 percent while those that believed secondhand smoke was only "somewhat harmful" dropped from 29.8 percent to 18.1 percent (Table 11).<sup>102</sup>

<b>Table 11:</b> Winkleman poll results on feelings regarding the effects of secondhand smoke on nonsmokers, 2002-2010. <sup>102</sup>						
What do you feel is the impact secondhand smoke will have on the health of a nonsmoker if the nonsmoker frequently visits public places where smoking is allowed?						
Year	Response					
	Very harmful	Harmful	Somewhat harmful	Not very harmful	Not at all harmful	Not sure, no response
2002	31.5	25.6	29.8	6.6	3.7	2.9
2003	37.1	24.4	27.1	7.6	1.8	2.0
2004	35.4	27.7	27.0	7.3	1.6	1.0
2006	50.1	24.1	16.1	4.1	2.6	2.9
2008	41.4	31.6	14.7	5.7	3.2	3.4
2010	47.4	24.9	18.1	4.7	2.8	2.1
Note: 2002-2004 measured responses of 18-54 years olds. 2006-2010 included all respondents over 18 years old.						

From 2002 to 2010, the percentage of respondents who believed that secondhand smoke was “very harmful” to the health of nonsmoker employees working in environments that allowed smoking increased from 45.5 percent to 58.9 percent, while those who believed it was only “somewhat harmful” dropped from 19.4 percent to 13.3 percent (Table 12).

<b>Table 12:</b> Winkleman poll results on feelings regarding the impact of secondhand smoke on nonsmoker employees, 2002-2010. <sup>102</sup>						
What do you feel is the impact secondhand smoke will have on the health of a nonsmoker if the nonsmoker works in a public place where smoking is allowed?						
Year	Response					
	Very harmful	Harmful	Somewhat harmful	Not very harmful	Not at all harmful	Not sure, no response
2002	45.5	25.1	19.4	5.0	2.4	2.6
2003	52.8	23.3	17.2	4.6	0.7	1.4
2004	56.2	24.0	14.8	3.0	1.1	0.9
2006	63.7	19.6	9.5	2.7	2.1	2.4
2008	52.0	24.5	13.3	5.0	2.9	2.3
2010	58.9	21.6	13.3	2.9	1.9	1.4
Note: 2002-2004 measured responses of 18-54 years olds. 2006-2010 included all respondents over 18 years old.						

In 2006, the PETF expanded its messaging to include the importance of all bars going smokefree because bars had been exempted from the 2005 statewide clean indoor air law. From 2006 to 2010, the percentage of respondents who “strongly supported” expanding the state smokefree law to “prohibit smoking in all North Dakota workplaces, including bars and lounges” increased from 48.8 percent to 59.2 percent (Table 13).

**Table 13:** Winkleman poll results for North Dakota’s level of support for expanding the state law to include bars, 2006-2010.<sup>102</sup>

How would you describe your reaction to expanding the state smoke-free law to prohibit smoking in all North Dakota workplaces, including bars and lounges?

	Strongly support	Somewhat support	No reaction	Somewhat oppose	Strongly oppose	Not sure
2006	48.8	16.8	5.0	10.7	17.3	1.3
2008	47.2	17.2	8.5	9.4	16.2	1.4
2010	59.2	13.3	6.7	5.2	15.3	0.3

Note: Included all respondents over 18 years old.

These data indicate that North Dakota adults’ perception of the harms of secondhand smoke and adults’ support for expanding the statewide clean indoor air law to include bars increased following PETF media campaigns focused on those issues.

***Evaluation and Surveillance***

The 2001 Community Health Grant Program legislation said that DOH could only devote five percent of its resources to evaluation and surveillance, however, the DOH could use its CDC funds for these purposes. The DOH surveyed North Dakota’s tobacco use trends by conducting statewide prevalence surveys. The DOH annually administered and collected data for the CDC’s Behavioral Risk Factor Surveillance System (BRFSS) which monitored adult tobacco use, and, during odd-numbered years, administered the Youth Risk Behavior Surveillance System and the North Dakota Youth Tobacco Survey, which monitored youth tobacco use.<sup>63</sup> The Legislature would not appropriate MSA funding for the DOH to hire an evaluation and surveillance staff person but allowed Kathleen Mangskau, DOH Division of Tobacco Prevention and Control Director, to use CDC funds to make the hire.

**The Legislature would not appropriate MSA funding for the DOH to hire an evaluation and surveillance staff person but allowed Kathleen Mangskau, DOH Division of Tobacco Prevention and Control Director, to use CDC funds to make the hire.**

Through this data gathering, in 2005 DOH recognized that marginalized populations, namely low socioeconomic status individuals, pregnant women, American Indians, rural populations, as well as 18-24 year olds, had the highest rates of tobacco use in the state. The DOH applied for, and was granted, a supplemental CDC grant to study and form an action plan for addressing disparate populations’ tobacco use. DOH worked with the University of North Dakota School of Rural Health to develop the study.<sup>117</sup> DOH reached out to tribal organizations, local public health units, universities and state agencies, such as the DOH’s Women, Infants and Children (WIC) Program, the North Dakota Adolescent Suicide Prevention Project/Tribal Mentoring Program and Migrant Health Service and other organizations representing marginalized populations.<sup>117</sup> The resulting action plan identified five objectives for addressing tobacco use disparities in North Dakota (Table 14) that the DOH integrated into a new state tobacco control five-year plan to be implemented from 2008 to 2013.

Objective 1	By June 2008, determine best or promising practices in two population groups to reduce tobacco-related disparities and work to sustain and expand to additional populations with high incidence of tobacco use.
Objective 2	By June 2008, engage two disparate population groups to promote existing programs through strategic partnerships and work to sustain and expand to additional populations with high incidence of tobacco use.
Objective 3	By June 2008, develop a plan to improve the quality of data on tobacco-related disparities.
Objective 4	By June 2007, develop a plan to identify funding for programs, staff and research to address tobacco-related disparities.
Objective 5	By June 2007, develop two partnerships and collaborative opportunities among programs serving special populations to build the understanding and trust among disproportionately affected groups, service providers and stakeholders to achieve our common goals.

*The Department of Health's 2008 Five-Year Tobacco Control Plan*

In 2007, in part to address the disparity objectives that it had identified (previous section), the DOH Tobacco Prevention and Control Program adopted *On the Path to a Healthier Tomorrow - North Dakota's Strategic Plan for Tobacco Use Prevention and Reduction*,<sup>95</sup> a statewide, five-year plan for 2008-2013 that established goals (Table 15) and action steps for reducing tobacco use and passing stronger voluntary and legislated tobacco control policies.<sup>95</sup> The new DOH plan was created with the input of local tobacco coordinators, longtime state tobacco control program leaders, state health groups, state branches of the national voluntary health organizations including the American Cancer Society, American Heart Association and the American Lung Association.

1) Prevent the initiation of tobacco use among youth and young adults.
2) Fully protect the public from exposure to secondhand smoke.
3) Assist tobacco users with quitting.
4) Eliminate disparities in tobacco use among specific populations in North Dakota.
5) Increase the capacity and infrastructure of tobacco prevention and control programs statewide to the CDC-recommended level.
6) Prevent preemption.
7) Develop new and increase existing tobacco-related data capabilities.

Measure 3, which passed in 2008, created the Tobacco Prevention and Control (TPC) Advisory Committee and charged it with creating a new state plan to supplement the programs of the DOH. The plan created by the TPC Advisory Committee with the assistance of the DOH, and which was built on the DOH's *On the Path to a Healthier Tomorrow* plan, was called *Saving Lives, Saving Money*<sup>118</sup> and is discussed in later sections. The DOH agreed to work from the TPC Advisory Committee's plan instead of its *On the Path to a Healthier Tomorrow* plan.

## Conclusion

After the MSA, in 2001, the North Dakota Legislature passed SB 2380 that created the Community Health Grant Program. From 2001-2008, the Legislative Assembly appropriated more funding for state and local tobacco control programs than ever in the state's history. The legislation that created the Community Health Grant Program, which received the majority of the state's tobacco control program funding, required that 80 percent of the funds appropriated to the program be given to localities for local tobacco control programs to be divided between school and broader community-based focuses. LPHUs were required to spend this 80 percent on local tobacco control programs that included coalition building and activities devoted to policy change. Beginning in the 2001-2003 biennium, LPHUs began receiving \$4.7 million biennium (\$2.35 million annually) (Table 10). The DOH increased its staff with its annual CDC funding and hired several additional program staff. Among the new staff, the DOH hired two outreach coordinators and a local grant manager to provide technical assistance to local public health units for coalition building, policy campaigns and cessation program implementation. Likely as a result of this increased funding and new technical assistance, four cities (three of which were among the most populated in the state), passed clean indoor air ordinances in 2004 and 2005; none of these ordinances prohibited smoking in all bars but two of them (Bismarck and Grand Forks) expanded the 2005 state clean indoor air law by prohibiting smoking in bars within restaurants.

Despite being pleased with the increase in funding for tobacco control programs,<sup>14</sup> the funding was not at the level that some tobacco control program leaders, who wanted a program based on CDC recommendations (\$8.2 million), felt was enough. Kathleen Mangskau, director of the DOH Division of Tobacco Prevention and Control from 2001 to 2006 also felt that the Legislature's requirements that 40 percent of the funding be spent on schools was too restrictive and limited the ability of experienced tobacco control leaders to implement programs known by program officials and CDC to be effective.<sup>57</sup>

The DOH conducted surveillance of tobacco use in North Dakota by administering statewide surveys. Because of the disparate use of tobacco among ethnic minorities, the DOH received funding from CDC to draft a state plan to address tobacco use disparities. The DOH's 2008-2013 five-year plan, *On the Path to a Healthier Tomorrow*, created in partnership with local tobacco coordinators, longtime state tobacco control program leaders and state health groups, was put on hold in 2008 with the passage of Measure 3; DOH worked with the Measure 3-created TPC Advisory Committee to write a new state plan based on *On the Path to a Healthier Tomorrow* and is the subject of later sections in this report.



The 2001 increased funding for statewide programs represented major progress in North Dakota, but the Legislative Assembly continued to refuse to appropriate funds for a statewide media campaign. This unwillingness of state policymakers to fund a statewide health communications plan led local tobacco coordinators to form the Public Education Task Force on Tobacco (PETF) in 2002 which pooled its funding to launch statewide media campaigns. The PETF was based out of the decentralized local public health units, which were not a part of the state DOH; this provided program leaders with autonomy, allowing them to maintain hard-hitting advertisements even when elected officials wanted them stopped. Polling data revealed that after PETF's advertisements were launched, public understanding of the dangers of secondhand smoke increased and support increased for expanding the 2005 statewide clean indoor air law to cover bars.

## CHAPTER 4: STATEWIDE SMOKEFREE AIR LAW

- In 2005, the Healthy North Dakota Tobacco Policy Subcommittee was successful in getting the Legislature to pass a statewide clean indoor air law that prohibited smoking in public places and workplaces but that exempted bars and enclosed bars within restaurants, hotels and bowling alleys.
- ACS and AHA, which were members of the Subcommittee, at the request of members of the Legislature, wanted to focus on local level smokefree air laws before returning for a comprehensive statewide law, but the 2005 bill sponsor did not want to wait.
- In 2007, an introduced smokefree air bill did not have support in the Legislature and went nowhere.

In 2001 and 2003, the North Dakota Legislative Assembly considered bills sponsored by Rep. Joyce Kingsbury (R-Grafton) to make public places, private workplaces and restaurants smokefree, while exempting bars, private clubs and several other locations.<sup>14</sup> Facing opposition from restaurant and bar owners, tobacco retailers, and a neutral position from the North Dakota state Department of Health (DOH), these bills were defeated. Kathleen Mangskau, former Director of the DOH Division of Tobacco Prevention and Control, and, as of 2011, a member of the Center for Tobacco Prevention and Control Executive Committee, explained that weak bills with exemptions for bars were introduced by Rep. Kingsbury without consulting with state tobacco control advocates, many of whom wanted a comprehensive smokefree law that included bars.<sup>57</sup> While tobacco control advocates supported the idea of a statewide smokefree air law in 2001 and 2003, they failed to launch a large campaign to press legislators to pass a comprehensive smokefree bill with no exemptions. Rep. Kingsbury's bills in 2001 and 2003 were voted down quickly in the legislative process; neither bill was passed out of the House.

In 2004, this situation changed when tobacco control advocates in Healthy North Dakota began to work with legislators planning to introduce a comprehensive clean indoor air law in the 2005 Legislative Session. The Healthy North Dakota Tobacco Policy Subcommittee met with Sen. Ralph Kilzer (R-Bismarck) and presented him with comprehensive smokefree air language with no exemptions and began educating other legislators on the importance of a comprehensive law. Much of the work with legislators was handled by the voluntary health organizations, particularly ALA, but also ACS and AHA, which had registered lobbyists on staff. These organizations also mobilized their members prior to the 2005 Legislative Session to contact their legislators and ask for a comprehensive law, particularly a law to make restaurants smokefree.<sup>119</sup>

**Much of the work with legislators was handled by the voluntary health organizations, particularly ALA, but also ACS and AHA, which had registered lobbyists on staff.**

### **The State Labor Commissioner and Workplace Smoking Regulations**

In 2004, Dr. Byrum Cartwright, a dentist and local tobacco control advocate in Fargo, contacted state tobacco control advocates with the idea of requesting that the State Labor Commissioner issue a statewide rule requiring workplaces to be smokefree.<sup>57</sup> Cartwright interpreted the state's statutes to give the Labor Commissioner this regulatory power and decided

to seek a written legal opinion from the Attorney General's office for clarification on the state law. North Dakota law requires the Attorney General to provide written legal opinions on state law at the request of a state legislator or the governing body or city attorney of a city.<sup>120</sup> Advocates asked Sen. Tim Mathern (D-Fargo) to request the legal opinion.

On April 14, 2004, North Dakota Attorney General Wayne Stenehjem (R) released a legal opinion saying that the State Labor Department could regulate smoking in the workplace, giving the State Labor Commissioner the power to require smokefree workplaces.<sup>121, 122</sup>

Tobacco control advocates throughout the state, including the American Heart Association (AHA),<sup>122</sup> asked the Labor Department to issue rules regulating smoking in the workplace. Kathleen Mangskau, then Director of the DOH Division of Tobacco Prevention and Control, explained in a 2011 interview for this report that she and other tobacco control staff within DOH were also supportive of the Labor Commissioner issuing workplace smoking rules.<sup>57</sup> However, Sen. Bob Stenehjem (R-Bismarck) argued that legislation could be accomplished more quickly than an administrative regulation because the legislature could change rules more quickly, and that the Legislature should consider legislation prohibiting smoking in the workplace.<sup>123</sup> Sen. Bob Stenehjem was Attorney General Wayne Stenehjem's brother. Additionally, Labor Commissioner Mark Bachmeier testified at an August 2004 meeting of the interim Criminal Justice Committee that other agencies understood health issues better than the Labor Department and that the Legislative Assembly should decide on smokefree workplaces.<sup>124</sup>

During the 2004-2005 interim study session, Sen. Stenehjem, Chairman of the Legislative Council, the interim study section of the Legislative Assembly, asked the interim Criminal Justice Committee to consider making a recommendation to the Legislative Council regarding smokefree public places and workplaces. If the interim Criminal Justice Committee made a recommendation, the Legislative Council would present it to the Legislative Assembly for consideration when the Legislative Assembly resumed session in 2005.

On August 10 and 11, 2004, the interim Criminal Justice Committee heard testimony from supporters and opponents of a strong clean indoor air law and allowed both sides to present their arguments for bill provisions. The interim Criminal Justice Committee received testimony from Bill Shalhoob of the the North Dakota Hospitality Association who opposed smoking regulations in bars and argued that businesses would experience economic losses if the state passed a law that prohibited smoking in bars and other public places. The opposition made this argument despite the fact that, for decades, it has proven to be baseless.<sup>125</sup> The rest of the testimony supported comprehensive smokefree language that included bars. Rep. Mark Dosch (R-Bismarck) who was also a hotel owner in Bismarck, testified that the bar in his hotel had recently gone voluntarily smokefree and had seen a 25 percent increase in sales.

The voluntary health organization lobbyists and tobacco control program leaders were also present and provided strong testimony for 100 percent smokefree language that included bars. Janel Schmitz, Executive Director of the American Lung Association (ALA), North Dakota, and Chair of the Healthy North Dakota Tobacco Policy Subcommittee testified in support of a comprehensive law that included bars. June Herman of the American Heart

Association (AHA), Deborah Knuth of the American Cancer Society (ACS), David Peske of the North Dakota Medical Association, Kathleen Mangskau, Director of the DOH Division of Tobacco Prevention and Control, and Dr. Nick Neumann of Bismarck also testified for a comprehensive smokefree ordinance that included bars. Lori Brierley, Director of Tobacco Prevention for the First District Health Unit in Minot and Ron Garcia of the Minot City Council also testified in favor of a smokefree law. In 2001, Minot passed the strongest law in the state up until that point that prohibited smoking in restaurants except in separately ventilated rooms. Minot's law exempted bars. Brierley and Garcia testified that Minot restaurants' business had increased following the smoking ordinance. These tobacco control advocates also emphasized the importance of ensuring that any law passed did not have preemption and would not interfere with the ability of local municipalities to pass stronger ordinances.<sup>124</sup>

Despite this testimony, many members of the Criminal Justice Committee argued that smoking in bars should be decided by the establishment owners or left for local governments to decide upon. In September 2004, the Criminal Justice Committee voted in favor of recommending a bill for the Legislative Assembly to consider in the next legislative session that prohibited smoking in enclosed workplaces and public places but exempted bars and private clubs.<sup>126</sup>

### **The 2005 Legislative Session**

During the 2005 Legislative Session, Reps. Lawrence Klemin (R-Bismarck) and Joyce Kingsbury (R-Grafton) and Sen. John Traynor (R-Devils Lake) introduced HB 1216, which would have amended the state labor code and made regulating smoking in the workplace one of the State Labor Commissioner's explicit powers.<sup>127</sup> These legislators supported smokefree requirements and introduced this provision with the support of tobacco control program leaders and state voluntary health organizations in an attempt to provide a path for smokefree workplace rules without contentious smokefree air legislation. However, Labor Commissioner Leann Bertsch (who had replaced Mark Bachmeier) told the House Industry, Business and Labor Committee, which was considering the bill, that it was an issue for the Legislative Assembly and was quoted in the press saying, "I would rather not have to [issue regulations on smoking in the workplace]."<sup>128</sup>

Without support from the Department of Labor and from the legislature, the bill failed to pass the House. Rep. Jim Kasper (R-Fargo), a consistent opponent of tobacco control policies, was an outspoken opponent of this proposal as well.<sup>129</sup> Without the endorsement of the Labor Commissioner, tobacco control advocates did not believe that a labor regulation would be a viable route for regulating smoking in the workplace and instead focused their attention on passing smokefree legislation.<sup>57</sup> This proposal, in addition to not being passed from the House, was largely overshadowed by the high profile clean indoor air bill that the Legislature also considered (and passed) in the 2005 Legislative Session.

**Without the endorsement of the Labor Commissioner, tobacco control advocates did not believe that a labor regulation would be a viable route for regulating smoking in the workplace and instead focused their attention on passing smokefree legislation.**

## *2005 Smokefree Air Legislation*

### *HB 1030 and SB 2300*

At the start of the 2005 Legislative Session, the Associated Press (AP) polled members of the Legislative Assembly on whether they agreed or disagreed with the statement, "Smoking should be banned in all indoor public workplaces." Seventy-seven percent of responding Senators and 58 percent of Representatives agreed with the statement. This AP poll indicated to tobacco control advocates, who were encouraging legislators to pass a comprehensive smokefree law, that there was support among legislators.<sup>16</sup>

When the 2005 Legislative Session commenced, the Legislative Council introduced the clean indoor air bill draft that had been recommended by interim Criminal Justice Committee as HB 1030; the bill prohibited smoking in "places of public access" which included restaurants but exempted bars, private clubs and a few other locations.<sup>130</sup> Additionally, Sens. Ralph L. Kilzer (R-Bismarck), a physician, and Gary A. Lee introduced SB 2300, a stronger bill that prohibited smoking in public places and places of employment including bars and private clubs (Table 16).<sup>131</sup>

Sen. Kilzer explained in a 2011 interview for this research that he introduced SB 2300 because he was asked to do so by the North Dakota Medical Association (of which he was an active member) and other health professionals, including respiratory therapists, who wanted smoking restricted.<sup>132</sup> Other tobacco control advocates and state leaders, including Arvy Smith, State Deputy Health Officer, also said in interviews for this research that there the Healthy North Dakota Tobacco Policy Subcommittee was working with Sen. Kilzer regarding legislation language.<sup>57, 119, 133</sup> Kathleen Mangskau, then the DOH Division of Tobacco Prevention and Control Director, explained in a 2011 interview for this research that Healthy North Dakota was working with Sen. Kilzer months prior to the start of the Legislative Session and had presented him with bill language to prohibit smoking in all public places and places of employment, including bars. Healthy North Dakota was satisfied with SB 2300's introduced language because its exemptions (retail tobacco stores and outdoor places of employment) were minor. With two clean indoor air bills introduced, Healthy North Dakota supported SB 2300, the stronger of the two bills.

HB 1030, the Legislative Council's bill, was sent to the House Government and Veterans Affairs Committee. On Friday, February 11, 2005, Rep. Jim Kasper (R-Fargo) introduced an amendment to preempt the ability of local governments to regulate tobacco. (State preemption is a well-established tobacco industry strategy to block effective tobacco control measures.<sup>43, 108, 134-136</sup>) The amendment stated that, "The [local] governing body may not adopt regulations with respect to the smoking of tobacco products in tobacco retail stores, livestock auction markets, truckstops, or in or on the grounds of hospitals licensed under chapter 23-16."<sup>137</sup> Kasper's amendment also prohibited the state labor commissioner from regulating smoking tobacco products in the workplace, which had been the subject of some interim session considerations of the Legislative Council and a provision that had been supported by Healthy North Dakota as a way to get a smokefree workplace rule in place. The amendment passed out of committee 8-6.

**Table 16:** SB 2300 Evolution Through the North Dakota Legislative Assembly<sup>131, 139, 141, 145</sup>

	<i>Date</i>	<i>Locations Covered</i>									<i>Enforcement</i>	<i>Penalty</i>	
		Public Places	Places of Employment	Restaurants	Bars	Private Residences	Hotel Rooms	Retail Tobacco Stores	Nursing Homes	Outdoor employment areas (not sports arenas)			Separately enclosed truck stops
SB 2300 (Introduced)	1/17/2005	✓	✓	✓	✓				✓		✓	State agencies following a mutually agreeable protocol	Establishment owner pays: \$100 (1st offense); \$200 (2nd offense); \$500 (subsequent offenses)
SB 2300 (Senate Industry, Business and Labor Committee)	2/15/2005	✓	*	✓	**				✓		✓	State agencies following a mutually agreeable protocol	Establishment owner pays: \$100 (1st offense); \$200 (2nd offense); \$500 (subsequent offenses)
SB 2300 (House Floor)		✓	*	*					✓		✓	State agencies following a mutually agreeable protocol	Establishment owner pays: \$100 (1st offense); \$200 (2nd offense); \$500 (subsequent offenses)
SB 2300 (Enrolled after Conference Committee Changes)		✓	*	*								State agencies following a mutually agreeable protocol	Establishment owner pays: \$100 (1st offense); \$200 (2nd offense); \$500 (subsequent offenses)

**Notes:**

\*Not comprehensive. Allowed for exemptions.

\*\*Exempt until 2007

The preemption was fought by legislators including Rep. Kari Conrad (D-Minot). Rep. Kasper called the preemption “an oversight” that could be corrected while the bill was in the Senate.<sup>138</sup> All of the organizations in Healthy North Dakota actively opposed the preemption and, already supporting SB 2300, mobilized their lobbyists (hired by the voluntary health organizations) to defeat HB 1030. Preemption was also unpopular among many North Dakota legislators who supported local autonomy. Likely as a result of the Healthy North Dakota’s opposition and opposition from legislators, HB 1030 was defeated on the House floor 45-47.

SB 2300, unlike HB 1030, was introduced as a strong bill without major exemptions, as a result of an active participation by tobacco control advocates.<sup>119, 131</sup> When SB 2300 was heard in the Senate Industry, Business and Labor Committee, however, it was amended to allow smoking in bars until August 1, 2007; the bill was ultimately passed on the Senate floor and sent to the House.<sup>139</sup> Sen. Kilzer explained in an interview for this research that bar owners were vocal in their opposition to a law restricting smoking in their establishments and argued that the proposal was an assault on personal freedoms.<sup>132</sup> The phase-in for bars was a compromise Sen. Kilzer made. Karalee Harper, Director of the DOH Tobacco Prevention and Control Program reported in a 2012 correspondence for this research that Healthy North Dakota did not take a position on this addition.<sup>140</sup> Charitable gambling associations also strongly opposed the bill because they feared that they would lose money by going smokefree.

After passing to the House, the House Human Services Committee heard SB 2300 and further amended it to exempt patients in hospitals who had the permission of their attending physician and residents of nursing homes who had the permission of their facility’s management. This amendment was introduced by Rep. Gary Kreidt (R-New Salem), Vice Chairman of the House Human Services Committee, who was also a nursing home administrator. Rep. Kreidt was also a key opponent, in 2009, of an appropriation bill for the Measure 3-created Tobacco Prevention and Control Executive Committee, though his connection to the tobacco industry is unknown.<sup>57</sup>

The House Human Services Committee also expanded the definition of bars to include separately enclosed bars within hotels or restaurants in addition to freestanding bars.<sup>141</sup> As a result of a strong opposition from bar owners and the hospitality industry, the House removed the provision originally present in SB 2300 that phased out the bar exemption in 2007, making bars indefinitely exempt from smoking regulations. Healthy North Dakota strongly opposed the amendments for hospitals and nursing homes and the removal of the bar phase out in 2007, and met with legislative leaders in unsuccessful attempts to remove the exemption for hospitals and nursing homes.<sup>57</sup> SB 2300 was not amended to include preemptive language as HB 1030 had been. The House approved the Human Services Committee’s amendments, but the final language would be agreed upon in Conference Committee.

**Healthy North Dakota strongly opposed the amendments for hospitals and nursing homes and the removal of the bar phase out in 2007, and met with legislative leaders in unsuccessful attempts to remove the exemption for hospitals and nursing homes.**

## *Tobacco Control Advocate Activities and the Opposition*

Throughout the legislative session, tobacco control advocates sought earned media to support the campaign. The voluntary health organization members of Healthy North Dakota also ran paid media (radio and print ads) to educate the public about the importance of going smokefree.<sup>57</sup> AHA paid for the advertisements but shared attribution for the advertisements with ALA. Healthy North Dakota distributed these advertisements to legislative leaders.<sup>16, 119</sup> The coalition used email listserves to mobilize members to appear at hearings to provide testimony, and to contact legislators and ask them to support a comprehensive bill, and increased their efforts once exemptions were added in order to try to get the exemption for bars removed.<sup>119</sup> In committee hearings, ALA, ACS, AHA and the North Dakota Medical Association testified in support of the law. Kathleen Mangskau, then director of the DOH Division of Tobacco Prevention and Control (TPC), reported that the State Health Officer Dr. Terry Dwelle and Deputy Health Officer Arvy Smith were supportive of a statewide law.<sup>57</sup> Schmitz recalled that AHA and the North Dakota Medical Association were most involved with lobbying legislators and following up on changes as the bill moved through the Legislature. AHA and the Medical Association then updated the rest of the advocates at their weekly meetings.

The role of the DOH in the campaign to pass SB 2300 is unclear. Mangskau explained in a 2011 interview for this research that she was involved and actively worked with Healthy North Dakota to pass the bill. Mangskau testified at the committee hearings in support of a smokefree air bill that included bars. Arvy Smith, Deputy Director of Health, also described DOH's role as actively involved and explained that the DOH supported the passage of the bill, even after exemptions for bars and other locations were added. Smith's son, who had asthma, gave testimony and asked the Legislature to pass the bill.<sup>133</sup> However, Janel Schmitz, former Executive Director of the North Dakota chapter of ALA who spearheaded Healthy North Dakota's 2005 smokefree policy effort, reflected in a 2011 interview for this report that, while the state DOH actively provided information to the Legislature as it considered SB 2300, it remained neutral and did not urge the Legislature to pass the bill.<sup>119</sup>

While Healthy North Dakota entered the Session with the goal of achieving a comprehensive smokefree air bill with no exemptions, it did not have a firm coalition "deal breaker" agreement that defined minimum acceptable provisions that had to be in the bill to justify supporting it or provisions (such as preemption) that would lead them to oppose the bill. ACS reported in 2012 correspondence for this research that preemption amendments and amendments that exempted ventilated areas were its dealbreakers.<sup>142</sup> AHA reported that local tobacco coordinators that worked in Local Public Health Units, who were not lobbyists but involved with Healthy North Dakota, considered ventilated areas and separate smoking rooms to be dealbreakers.<sup>16</sup> Nevertheless, Schmitz recalled that "we [Healthy North Dakota] never said, 'Well, if it's only in restaurants and not other business places, we're walking away.' We never said anything like that."<sup>119</sup>

There was significant visible opposition to the bill, especially from the North Dakota Coin and Tavern Association, which had Rep. Dwight Wrangham (R-Bismarck) as its Executive Director,<sup>46, 57</sup> and the North Dakota Hospitality Association, as well as from numerous bar and restaurant owners. These business owners testified at the hearings for the bill and strongly



opposed regulation.<sup>143</sup> The North Dakota Hospitality Association had a long history working for the tobacco industry in opposition to tobacco control proposals.<sup>14</sup>

### ***Conference Committee and the Final Result***

Near the end of the Session, when SB 2300 was in Conference Committee, the members of Healthy North Dakota disagreed over what actions to take regarding SB 2300. At that point the bill still prohibited smoking in most public places and workplaces, but permanently exempted freestanding bars and separately enclosed bars within restaurants, bowling alleys (added in conference committee) and hotels, as well as hospital patients and nursing home residents who had the permission of their physicians, nursing home residents who had the permission of the management of their facility, and truck stops. Mangskau explained that, “in the final negotiation, some [members of Healthy North Dakota] said, ‘Totally comprehensive or kill the bill.’ Others said, ‘No, let's take the approach where we're going to get everything but bars and truck stops.’ And so they wanted to move forward because they felt that was a good portion of the population that would be protected.”<sup>57</sup>

Initially, ACS was not willing to accept the added exemptions to the bill.<sup>144</sup> However, most of the other groups were willing to accept a bar exemption if a comprehensive law was not possible. The North Dakota Medical Association was willing to accept bar exemptions to get the bill passed and to return later to get bars.<sup>57</sup> There was also a difference of expectations between state and local tobacco control coordinators and the lobbyists of the voluntary organizations. Most of the lobbyists for the voluntaries, except for ACS, Schmitz explained, were willing to compromise with legislators and willing to accept exemptions for bars and truck stops, as they believed it was the only way a clean indoor air bill would pass.<sup>119</sup> However, as Healthy North Dakota's Conference Committee conversations progressed, ACS decided to support the bill despite the exemptions.<sup>142</sup> The state and local tobacco control coordinators, including Kathleen Mangskau and other local tobacco program leaders, wanted a comprehensive law with no exemptions but did not want to kill the bill for the bar exemption.<sup>16, 57</sup> Healthy North Dakota had its local members calling the members of the conference committee and asking for a comprehensive bill with no exemptions up to the end of the session. The lobbyists working for the health groups also worked closely with legislators and continued working to get bars put back into the bill, but the consensus of the coalition was that they would not try to kill the bill if they could not get bars restored to the bill.

**The lobbyists working for the health groups also worked closely with legislators and continued working to get bars put back into the bill, but the consensus of the coalition was that they would not try to kill the bill if they could not get bars restored to the bill.**

The Republican Party, which controlled both chambers of the Legislative Assembly, historically opposed tobacco control policies, but was, at the time, disorganized on the issue. Healthy North Dakota was able to secure more Republican votes than necessary to get SB 2300 passed, but Healthy North Dakota was not successful in getting bars added back into the bill.<sup>119</sup> Additionally, while in Conference Committee, SB 2300 was amended to prohibit the State Labor Commissioner from instituting regulations for smoking in the workplace, one of the provisions that was added to HB 1030.<sup>145</sup> Healthy North Dakota supported the ability of the Labor

Commissioner to regulate workplace smoking because it would create a way to get a workplace smokefree law in place without dealing with the issue in the Legislature, but ostensibly could not get this language removed. The bill passed by the full Legislative Assembly 61-32 on April 18, 2005.

Kathleen Mangskau recalled that in the end all of the groups in Healthy North Dakota were disappointed that the enacted bill was not comprehensive, but were pleased to have passed a law that protected most of the state, and worked to ensure a smooth implementation took place. However, the coalition was intent to return in future sessions to strengthen the law.<sup>57</sup> Janel Schmitz of ALA differed with Mangskau and recalled the 2005 law as a tremendous victory.<sup>146</sup>

## **2007 – Returning to Strengthen the Bill**

Prior to the start of the 2007 Legislative Session, Sen. Ralph Kilzer (R-Bismarck), the lead sponsor of the enacted 2005 clean indoor air law, announced plans to introduce legislation to strengthen the state law to cover all public places. Sen. Kilzer introduced SB 2164 in 2007 which would have removed the bar exemption in the 2005 clean indoor air law.<sup>147</sup> In 2007, the Healthy North Dakota Tobacco Policy Subcommittee remained the primary coalition of tobacco control advocates and program leaders.

Healthy North Dakota's members did not agree on whether or not to pursue an expanded statewide law.<sup>57</sup> AHA and ACS, which had been active in Healthy North Dakota in 2005, did not testify in support of SB 2164 or sign onto a letter of support with other state tobacco control advocates in 2007.<sup>17</sup> June Herman, Director of Advocacy for AHA, recalled in a 2011 interview for this research that AHA and ACS believed that North Dakota was not ready at the state level and should focus its efforts at the community level before moving forward with another statewide bill.<sup>64</sup> Both AHA and ACS recalled in 2012 correspondences for this research that following the 2005 Legislative Session, a large number of legislators stated that they wanted local tobacco control leaders to show strong local support for smokefree bars by passing local laws that prohibited smoking in bars before they would support an expanded statewide law.<sup>16, 142</sup> As of 2007, no locality had passed an ordinance prohibiting smoking in all bars.

**Healthy North Dakota's members did not agree on whether or not to pursue an expanded statewide law.**

ACS explained in a 2012 correspondence for this research that a pre-session ACS poll indicated only 50 percent of voters supported expanding the state law to cover bars, which ACS interpreted as showing that more local education and local policy work was needed.<sup>142</sup> AHA and ACS also explained in 2012 correspondences for this research that the Senate Judiciary Committee only provided supporters of SB 2164 with a brief period for testimony and that AHA and ACS both had other bills under consideration in different committees. ACS's bill was a Senate Concurrent Resolution opposing employers providing youth employees with smoking breaks.<sup>142, 148</sup> AHA and ACS also explained conference calls with local public health units indicated that the locals were disorganized and not prepared for a statewide campaign.<sup>16, 142</sup> Sen. Kilzer did not want to wait for more community education, organizing or local policy success to take place and decided to move forward with SB 2164 anyway.<sup>16, 17, 142, 144</sup>

The North Dakota Hospitality Association, a consistent opponent of tobacco control policies, opposed the proposal. Nicki Weissman, Executive Director of the Hospitality Association, said that government intervention was not needed and the decision should be left to business owners.<sup>149</sup> The North Dakota Hospitality Association and the North Dakota Coin and Tavern Association, which were the predominant opposing organizations representing bar owners, argued that the law should not be strengthened to include bars.<sup>150</sup> (Welle et al., documented the long history of the North Dakota Hospitality Association's close working relationship with tobacco industry.<sup>14</sup>) The North Dakota Coin and Tavern Association's relationship with the tobacco industry is unknown.) Rep. Dwight Wrangham (R-Bismarck) was Executive Director of the North Dakota Coin and Tavern Association as of 2011. Rep. Wrangham had not reported accepting tobacco industry contributions between 2000 and 2010.

The bill received a "Do Not Pass" vote in the Senate Judiciary Committee and subsequently failed 15-30 when it returned to the Senate floor. Sen. Kilzer, in a 2011 interview for this research, said that the bill did not receive any support because of rural legislators who wanted bars to continue to allow smoking because of their importance as places of congregation. Kilzer continued and said that a majority of legislators wanted to leave the question of stronger smoking restrictions up to individual communities.<sup>132</sup>

Following this 2007 defeat, smokefree indoor air advocacy shifted to the community level (described in detail below). By the end of 2011, 37 percent of the North Dakota population was protected by comprehensive smokefree laws without the exemptions in the state law.

In 2008, Karalee Harper, Director of the DOH Division of Tobacco Prevention and Control (hired in 2006 after the voluntary retirement of Kathleen Mangskau), helped tobacco control leaders reinstate Tobacco Free North Dakota's 501(c)3 nonprofit status which it had lost because it had not filed tax forms in several years and removed the Tobacco Policy Subcommittee from Healthy North Dakota. Both the DOH and other state tobacco control leaders supported reinstating TFND. On the part of the DOH, the purpose of reinstating TFND and dissolving Healthy North Dakota's Tobacco Policy Subcommittee was to allow the DOH to distance itself from policy work. DOH leaders were concerned that they would be accused of illegally lobbying.<sup>63</sup>

## **Conclusion**

In 2005, Healthy North Dakota, which consisted of state tobacco control health groups and program leaders, succeeded in getting the state to pass a statewide clean indoor air law that prohibited smoking in most public places and enclosed work places, but was not the comprehensive law Healthy North Dakota wanted: the law excluded free-standing bars, bars within restaurants, bowling alleys and hotels, and truck stops. Sen. Ralph Kilzer returned in 2007 without the organized support of Healthy North Dakota, to strengthen the 2005 law, and lost. ACS and AHA did not actively support the 2007 bill because of a lack of support in the Legislative Assembly where many members wanted localities to pass smokefree bar ordinances before considering the issue again at the state level which may have resulted from ACS's poll showing only 50 percent support for smokefree bars. Additionally, ACS and AHA felt that local coalitions were unprepared to support a statewide campaign. Instead, ACS and AHA wanted to

focus efforts on the local level. Beginning in 2008, as later sections will discuss, local tobacco control leaders began having success passing comprehensive local smokefree air laws. As of 2012, the state law still exempted bars and several other locations.



## CHAPTER 5: MEASURE 3 - A NEW TOBACCO CONTROL PROGRAM

- In 2008 state and local partners reactivated Tobacco Free North Dakota as the statewide coalition.
- In 2008, a group of tobacco control program leaders formed the Support Tobacco Prevention Committee and launched a successful campaign to pass Measure 3, an initiative that secured new MSA payments for a fully funded comprehensive tobacco control plan and created a new tobacco control agency, separate from the DOH, to implement the plan.
- The programs implemented by the new agency were to complement existing DOH programs.
- Measure 3 did not provide for a clear division of roles for the new agency and the DOH.

### Addressing Problems with the Statewide Tobacco Control Coalition

Following the 2007 Legislative Session, a group of state tobacco control leaders began meeting to discuss the problems with the state tobacco control coalition which had existed under several names, but at the time, was the Healthy North Dakota Tobacco Policy Subcommittee; until 2001, the state coalition had been Tobacco Free North Dakota. The group included former state program leaders Jeanne Prom (DOH TPC Program Director, 1992-2001) and Kathleen Mangskau (DOH TPC Program Director, 2001-2006) and Vicki Valdo Rosenau (Valley City, ND), Javayne Oyloe (Williston, ND), Kelly Buettner-Schmidt (Minot, ND), Carol Russell (who formerly headed the California DOH Tobacco Control Section Local Programs Unit and had returned to her home in North Dakota), and Heidi Heitkamp (former North Dakota Attorney General who negotiated the Master Settlement Agreement).<sup>151, 152</sup>

These tobacco control leaders were concerned about what they saw as the continuing deterioration of organized tobacco control advocacy at the state level in North Dakota and the failure of the tobacco control coalition to be effective.<sup>59, 60</sup> Tobacco Free North Dakota (TFND), the statewide tobacco control coalition that formed in 1985, had gone dormant in 2001 after TFND lost DOH funding and staff support in the late 1990s, and was unable to secure MSA funds for a fully funded CDC *Best Practices* program in the 2001 Legislative Session. These tobacco control leaders argued that in 2001, without consulting the broader coalition, the American Heart Association (AHA) had agreed to Governor John Hoeven's (R, 2000-2010) plan to create the Community Health Grant Program for tobacco control and other health programs funded with MSA money, but at a level much lower than *Best Practices'* recommendation and with restrictions on the types of programs to be funded.

In 2011 and 2012 interviews for this research, Kathleen Mangskau, Director of the DOH Division of Tobacco Prevention and Control from 2001 to 2006, explained that in actually implementing the programs, the program had been limited by the sub-*Best Practices* funding level, as well as the legislation's requirement to focus 40 percent of funds on school programs.<sup>57</sup> Another 10 percent of the funds were Tobacco Settlement State Aid grants which local public health units (LPHUs) did not have to use for tobacco control programs. In addition, the legislation did not guarantee continuous funding for tobacco control programs: the Legislature still had to appropriate funds every two years.

These tobacco control leaders blamed AHA in particular because they felt AHA had been most involved in the decision to accept the legislation. Distrust of AHA from this event that this group of state tobacco control leaders harbored continued to limit the ability of the coalition to work together. Most recently in 2007, some members of the Healthy North Dakota Tobacco Policy Subcommittee had been upset that AHA had not taken a more visible level of support for a proposed smokefree air bill which exasperated this distrust.<sup>17</sup>

Additionally, these tobacco control leaders also felt that being based in the DOH made the Healthy North Dakota Tobacco Policy Subcommittee weak because DOH leaders, which sat on the Healthy North Dakota Tobacco Policy Subcommittee, were concerned about working on policy.<sup>74</sup> Indeed, the new DOH TPC Director, Karalee Harper (beginning in 2006), wanted the program to be less focused on policy issues out of concerns that the DOH would be accused of illegally lobbying.<sup>63</sup>

*Complaints Made to the American Heart Association*

On June 15, 2007, this group of tobacco control leaders (except Russell) (Table 17) sent a letter to Madeleine Solomon, State Advocacy Consultant and Tobacco Liaison for national AHA, and Maureen Cassidy, Vice President of Advocacy for national AHA, that argued that June Herman, AHA Director of Public Advocacy in North Dakota, had undermined the state’s tobacco control program and advocates’ past policy efforts.<sup>153</sup>

<b>Table 17:</b> Signatories to the 2007 Letter to the national American Heart Association	
Name	Tobacco Control Role
Heidi Heitkamp	ND Attorney General (1993-2001)
Jeanne Prom	DOH TPC Program Director (1992-2001)
Kathleen Mangskau	DOH TPC Program Director (2001-2006)
Kelly Buettner-Schmidt	Volunteer, Employed at Minot State University
Javayne Oyloe	Volunteer
Vicky Voldal Rosenau	Volunteer

National AHA had a conference call with the signatories to the letter on June 28, 2007. In a follow up email to the conference call on June 29, the signatories outlined their major complaints.<sup>154</sup> The biggest complaint in the email, and the predominant complaint cited during interviews for this research, was that June Herman had negotiated away a large percentage of MSA funds in a 2001 backroom deal that prevented TFND from obtaining funding for a CDC *Best Practices* program.<sup>57, 59, 60</sup>

The tobacco control leaders argued that they had been lobbying the Legislature to fund a CDC comprehensive tobacco control program and did not get it because of Herman’s decision.<sup>17, 59</sup> Heidi Heitkamp acknowledged in a 2011 interview for this research that the American Lung Association agreed to the legislation that divided the MSA funding but reported that AHA was more involved in the negotiations.<sup>59</sup> However, June Herman argued in 2012 correspondence for this research that state and local tobacco control program leaders had not been excluded from the legislation discussions and that everyone involved had the opportunity to step forward and offer an opposing position but that none had.<sup>16</sup> Herman explained that TFND had been on the decline since the DOH had discontinued its Child and Maternal Health grant to TFND in the late 1990s

and that TFND lacked leadership after DOH leadership prohibited DOH staff from working on MSA issues.<sup>16</sup> Additionally, in a 2008 conflict resolution meeting among the state tobacco control partners convened at the suggestion of national tobacco control organizations the Campaign for Tobacco-Free Kids, Americans for Nonsmokers' Rights and the American Cancer Society, Herman argued that AHA had tried to consult with the broader group in 2001 but that the coalition was disorganized and did not have a formal decision-making process to follow.<sup>17</sup>

The follow up email asked the national AHA leaders to either assign a new lobbyist in North Dakota to work on tobacco control issues or for AHA to stop working on tobacco control issues in the state.<sup>154</sup> Madeleine Solomon and Maureen Cassidy of national AHA met with the tobacco control leaders but did not grant their request that June Herman be removed or that AHA stop its involvement in tobacco issues.<sup>155</sup>

### ***Reactivating Tobacco Free North Dakota***

In August 2007, this same group of tobacco control leaders met to discuss the importance of restructuring their state coalition so that it could be effective on policy issues and to consider moving the coalition out of the DOH where it would be free to work on policy. Jodi Radke of the Campaign for Tobacco-Free Kids (CTFK) and Annie Tegen, Program Manager at Americans for Nonsmokers' Rights (ANR) were also part of these meetings.<sup>156</sup> On August 21, 2007, former Attorney General Heidi Heitkamp sent an email to the other tobacco control leaders, urging the group to make passing stronger tobacco control policies the core focus of the coalition.<sup>157</sup> (These meetings of tobacco control leaders led to the creation of a plan to pass a voter-initiated measure campaign (Measure 3 in 2008) to secure money for a new tobacco control program.)

Since AHA refused to stop working on tobacco control issues, some consensus building was needed. At the suggestion of CTFK, ANR, and National ACS and ACS Cancer Action Network (ACS CAN),<sup>57, 156</sup> there was a two-day conflict resolution meeting in January 2008 in an effort to resolve their issues with June Herman of AHA. The tobacco control leaders who wrote the 2007 letter to AHA were present along with other state and local advocates, Jodi Radke, Director for the Rocky Mountain / Great Plains Region of the Campaign for Tobacco Free Kids, Cathy Callaway, Associate Director, national ACS Cancer Action Network (ACS CAN), and Deb Knuth, Director of Government Relations for ACS and ACS CAN of the Great West Division, and June Herman of AHA.<sup>17</sup> In addition to continued anger over the original MSA appropriation, the group of tobacco control leaders who sent the letter to national AHA expressed distrust of AHA for not testifying or signing onto a letter of support for the unsuccessful smokefree air bill proposed in the 2007 Legislative Session.<sup>17, 158</sup>

**As the discussions regarding coalition restructuring continued, it became apparent that the tobacco control leaders and the DOH both wanted policy work to be distanced from the DOH.**

As discussed above, the DOH wanted to reduce its involvement with policy work to avoid potential allegations of illegal lobbying.<sup>63</sup> As the discussions regarding coalition restructuring continued, it became apparent that the tobacco control leaders and the DOH both wanted policy work to be distanced from the DOH.<sup>74</sup> The tobacco control leaders, working with



Karalee Harper of DOH, reactivated Tobacco Free North Dakota (TFND), which had been the state tobacco control coalition from 1985 to 2001. TFND had fallen dormant and lost its 501(c)(3) nonprofit educational organization status after ceasing to file its IRS tax forms in 2001. Deb Knuth of ACS expressed a desire to work with the group to reorganize TFND. With TFND being reactivated, Harper removed the Tobacco Policy Subcommittee from Healthy North Dakota and distanced DOH further from policy work.<sup>63</sup> TFND fully re-formed with a board of directors in March 2008,<sup>66</sup> but it did not have a funding source to pay an executive director, hire staff or run campaigns.

Though the conflict resolution meeting succeeded in bringing state health groups and individuals together to reorganize TFND, it did not improve the relationship between June Herman of AHA and the other tobacco control leaders. Herman did not work with the tobacco control leaders as they reorganized the coalition. Herman explained in a 2012 correspondence that AHA wanted to observe whether the state partners' reorganization produced a robust coalition containing many members with advocacy capabilities, which AHA felt was lacking in prior coalitions. Herman felt that she and AHA would be blamed for any problems with a new coalition.<sup>16</sup>

### **Master Settlement Agreement Strategic Contribution Funds**

The Master Settlement Agreement (MSA) included provisions for "Strategic Contribution Funds" (SCF) which required participating companies to collectively pay \$861 million annually from 2008-2017<sup>159</sup> on top of their regularly scheduled annual payments. This money would be divided between the MSA participating states. The SCF payments were included in the MSA to reward states for contributing their time and finances to the litigation against the industry and negotiations for the MSA. A panel of three former Attorneys General awarded each state a percentage of SCF based on "each Settling State's contribution to the litigation or resolution of state tobacco litigation, including, but not limited to, litigation and/or settlement with tobacco product manufacturers."<sup>159</sup> North Dakota was scheduled to receive 1.7 percent of the annual total,<sup>160</sup> which was the highest per capita percentage of SCF payments among all of the states that participated in the MSA. The state received a high percentage of SCF because of the role of the state's attorney general as a negotiator of the settlement.<sup>59</sup>

Without action, the SCF would have been continually deposited into the tobacco settlement trust fund and would have been allocated according to the original MSA legislation. In 2008, North Dakota received \$13.8 million in SCF payments which were treated the same as regular MSA payments and divided between the Community Health Trust Fund (10 percent), the Water Development Trust Fund (45 percent) and the Common Schools Trust Fund (45 percent). Despite the \$1.38 million in additional funds that the Community Health Trust Fund received, the Legislature did not increase funds for tobacco control programs.<sup>161</sup>

Kathleen Mangskau reported in a 2011 interview for this research that before she retired from DOH in 2006, she put together the DOH Tobacco Prevention and Control Program's 2007-2009 biennium budget request. The state had anticipated receiving \$12,716,000 in FY 2008 (it anticipated less than it actually received) for its first SCF payment. Under the original MSA system of division, the Community Health Trust fund would receive \$1,271,600 (10 percent of

the total payment). Mangskau requested that the DOH Tobacco Prevention and Control Program use the entire anticipated \$1,271,600 of additional funding for the Community Health Trust Fund to fund tobacco control programs. As part of Mangskau's request, the DOH would hire a new youth program coordinator (\$110,000), launch a youth-focused website and other youth-focused programs (\$41,600), augment the Quitline and provide additional nicotine replacement therapy (\$170,000), begin administering an Adult Tobacco Survey (\$150,000), and fund a new statewide countermarketing media campaign (\$800,000).<sup>162</sup> The proposed media campaign would be geared towards both youth and adults.<sup>57</sup>

June Herman of AHA stated in a 2012 correspondence for this research that Mangskau did not consult the state voluntary health organizations or seek their support for her proposal. Additionally, Herman reported that AHA and ACS tried to discuss the Strategic Contribution Fund payments with the Healthy North Dakota Tobacco Policy Subcommittee in 2005 and 2006 but that they were told by Healthy North Dakota leadership that the new payments were being managed through the DOH's budgeting process. The voluntaries were reportedly not engaged to provide support for the proposal.<sup>16</sup>

Mangskau reported that after she left DOH, Deputy State Health Officer Arvy Smith and State Health Officer Terry Dwelle cut the request to \$551,600 for the new youth program coordinator and a countermarketing campaign, \$70,000 for the Quitline enhancements and \$75,000 for the Adult Tobacco Survey.<sup>57</sup> It is unclear why DOH cut the budget request or whether DOH Tobacco Prevention and Control Director Karalee Harper, who took over in 2006, protested this cut. Even this reduced budget request did not survive the 2007 legislative session: the House removed the funding for the new youth program coordinator and the counter marketing campaign from the DOH's appropriation.<sup>163</sup> The only increase in funding that survived in the 2007-2009 biennium for tobacco control was an increase of \$185,000 to the Quitline.<sup>75</sup>

### ***A Voter-Initiated Measure Campaign***

In August 2007, when tobacco control leaders met to discuss ways to strengthen their statewide coalition, former Attorney General Heidi Heitkamp (1993-2001) presented them with a plan to secure the Strategic Contribution Funds for a comprehensive tobacco control program. Having failed to get the legislature to fully fund a tobacco control program at CDC's recommended levels, Heitkamp proposed that the group draft and circulate an initiated measure and let voters decide.<sup>59</sup> Heitkamp's plan was to campaign for an initiated measure (which would become Measure 3) that would create a new tobacco control advisory committee separate from the North Dakota DOH to develop a new state program funded at CDC-recommended levels from the Strategic Contribution Funds that would supplement existing DOH activities. The advisory committee would then elect an executive committee that would hire staff and implement the program.<sup>59</sup>

#### *Writing Measure 3*

The tobacco control leaders carefully chose language when writing Measure 3. Heitkamp also recruited Rosellen Sand, a former Assistant Attorney General who had worked for Heitkamp when she was Attorney General, to work with the group. Heitkamp and Sand, both attorneys,

drafted Measure 3 in collaboration with the larger group of state and local tobacco control leaders.<sup>57</sup> Measure 3 created a nine-member, Governor-appointed Tobacco Prevention and Control (TPC) Advisory Committee, to create a new, comprehensive plan “consistent with the Centers for Disease Control *best practices for comprehensive tobacco prevention and control programs* and does not duplicate the work of the community health grant program”<sup>164</sup> being implemented by the DOH. The measure also stated that “funding for the comprehensive plan must supplement and may not supplant any funding that in the absence of this Act would be or has been provided for the community health trust fund or other health initiatives.”<sup>164</sup> This requirement was designed to ensure that the Legislature continued to fund the DOH to work on its existing tobacco control programs.

The Governor would be required to make appointments to the TPC Advisory Committee from nominations provided by the North Dakota Society for Respiratory Care, the North Dakota Public Health Association’s Tobacco Control Section, the North Dakota Medical Association and the North Dakota Nurses Association (Table 18). The Governor would select the youth and public members independently. The Advisory Committee would vote for three of its members to serve on the TPC Executive Committee, which would hire staff and implement and administer the new plan. The Executive Committee members would serve for three-year, staggered terms.<sup>164</sup>

<b>Table 18:</b> Criteria for the TPC Advisory Committee membership
1 practicing respiratory therapist familiar with tobacco related diseases
4 non-state employees with expertise in tobacco prevention and control
1 practicing medical doctor familiar with tobacco related diseases
1 practicing nurse familiar with tobacco related diseases
1 youth between the ages of 14 and 21
1 member of the public with a demonstrated in interest in tobacco prevention and control

Measure 3 would deposit the SCF payments to the Tobacco Prevention and Control Trust Fund, which Measure 3 created, to fund the comprehensive statewide tobacco prevention and control program that Measure 3 charged the TPC Advisory Committee with creating.<sup>164</sup> (This allocation was \$14.1 million in April 2009 and \$23.5 for the 2009-11 biennium.) As a result of Measure 3, the funds would be appropriated by the Legislature only to fund the creation and implementation of the comprehensive statewide tobacco prevention and control program, unless both houses of the Legislature amended Measure 3 by a two-thirds vote to change the allocation. This limitation is part of the North Dakota Constitution;<sup>165</sup> seven years after its passage the Legislature could amend Measure 3 with a simple majority vote (i.e., after December 4, 2015).

**Measure 3 would deposit the SCF payments to the Tobacco Prevention and Control Trust Fund, which Measure 3 created, to fund the comprehensive statewide tobacco prevention and control program that Measure 3 charged the TPC Advisory Committee with creating.**

Measure 3 required: “The comprehensive plan must be funded at a level equal to or greater than the centers for disease control [sic] recommended funding level. Funding for the comprehensive plan must supplement and may not supplant any funding that in the absence of

this chapter would be or has been provided for the community health trust fund or other health initiatives.”<sup>164</sup> Based on the 2007 CDC *Best Practices*, the recommended funding for North Dakota was \$9.3 million a year.<sup>28</sup>

Although the TPC Executive Committee was charged with implementing the CDC-specified tobacco control program, the Executive Committee would not control the Tobacco Prevention and Control Trust Fund where the SCF money would be deposited. Measure 3 was written so that the funding was allocated to the Trust Fund but that the Legislature still had to appropriate the money to the Executive Committee each biennial legislative session (every two years). This was a deliberate decision on the part of the authors of the measure. Heidi Heitkamp explained in a 2011 interview for this report that there was a well-established series of court cases in North Dakota which questioned whether voters could appropriate money through an initiated measure or whether the Legislature had to appropriate the funds, and that the court had not yet ruled definitively on the issue.<sup>59</sup>

In a 1981 North Dakota Supreme Court decision, the Court dealt with a similar ballot measure (Measure 6) that distributed oil extraction tax revenue among three programs by specific percentages. Oil companies sued to void the tax on the grounds that the measure appropriated the revenue by the percentage distribution. The Court found that distribution to be a lawful *allocation* of revenue that would then be *appropriated* by the legislature in a manner “that may be necessary to accomplish the purposes of this Act.”<sup>166</sup> Measure 6 also contained language mandating that the “Act will be appropriately funded by the Legislative Assembly.” The Court stated that such mandate was not necessary because “the actual process of appropriating funds to accomplish the measure’s objectives is left to the legislature.” The Court added: “In reaching this conclusion we make no determination as to whether or not Article X, Section 12(1) [appropriation requirement for spending state moneys], North Dakota Constitution, places the exclusive power of appropriation in the legislature thereby prohibiting the people from appropriating public moneys.”<sup>166</sup>

Heitkamp explained in a 2011 interview for this research:

I didn't want to fight the fight of ‘the legislature doesn't even appropriate this money’ because it's public money and I actually think the legislature should appropriate. I think the legislature should have oversight, and they do...If you go back and take a look at the Measure 6 cases...there's a whole line of cases where the Legislative Council has basically said ‘you cannot appropriate in an initiated measure.’ I disagree with that as a matter of law, but I didn't want to be litigating that, and I foolishly thought that if we didn't appropriate in the measure, that they still would do what the people told them to do if we won...I wish we had taken on that challenge, because I think I would've won the court case, but it would've involved delay on the programs, which had already in my opinion been delayed 50 years...and the legislature should be a partner in this. They should have oversight; they should be part of this planning and review. What the measure says which they don't like is that CDC determines the best practices, and they think that they ought to be able to determine best practices.<sup>59</sup>

Kathleen Mangskau, former DOH Division of TPC Director and future Tobacco Prevention and Control Advisory Committee and Executive Committee member, further

explained, “The legislature believes it’s their job to appropriate the money and we wanted to engage them. We never dreamed they wouldn’t do what the people said,”<sup>57</sup> referring to the 2009 battle in the Legislature to secure the Measure 3 funding.

Knowing that the SCF would continue only through 2017, the tobacco control leaders, Heitkamp and Sand designed Measure 3 to provide the funding for long-term tobacco control programming in North Dakota. The state was to receive around \$14 million annually of SCF funds, but would only require \$9.3 million annually to meet CDC’s *Best Practices* recommendations. The tobacco control leaders envisioned requiring less than \$9.3 million from the new trust fund in order to implement a comprehensive program when combined with preexisting DOH programs. The language of Measure 3 required the deposit of all SCF into the Tobacco Prevention and Control Trust Fund, allowing for any residual funds that the Legislature did not appropriate to the TPC Executive Committee to remain in the Trust Fund and accumulate to fund tobacco control programming after 2017.

Because the new program Measure 3 would create would supplement the DOH program, the authors of Measure 3 also wanted to ensure that the DOH continued to receive original MSA funding and that those funds continued to be spent on tobacco control programs. Measure 3 required 80 percent of the 10 percent of the original MSA funding (from the Community Health Trust Fund) be appropriated annually to the DOH for tobacco prevention and control programs to protect tobacco control funding in years after SCF payments were scheduled to end.<sup>57</sup> From FY 2002 through FY 2009, the Legislature had appropriated approximately 80 percent of these Community Health Trust Funds to fund tobacco control programs through the Community Health Grant Program. However, the Legislature did not legally have to continue appropriating the funds for tobacco programs and could divert the funds for other health programs (Table 10). The tobacco control leaders were concerned that Legislature would begin to divert this funding stream to other programs and so added this provision to the measure in order to provide a safeguard to the DOH funding.<sup>57</sup>

In writing Measure 3, the authors limited the focus to the issue of funding and the creation of the new program in an effort to minimize the involvement of the tobacco industry.<sup>57</sup> The MSA stated that:

After the MSA Execution Date, no Participating Manufacturer may support or cause to be supported (including through any third party or Affiliate) the diversion of any proceeds of this settlement to any program or use that is neither tobacco-related nor health-related in connection with the approval of this Agreement or in any subsequent legislative appropriation of settlement proceeds.<sup>159</sup>

This provision prohibited the tobacco industry from lobbying the legislature regarding the use of MSA funds. The authors hoped that by limiting Measure 3 to securing the SCF money and forming a new program, but not addressing other tobacco control policies like smokefree air, the provision of the MSA prohibiting the tobacco industry from lobbying on the use of MSA funds would minimize the industry’s involvement in opposing Measure 3 and its required legislative appropriation.<sup>57</sup>

Sen. Ralph Kilzer (R-Bismarck), a multiple-time smokefree air bill sponsor, had met with the program leaders to discuss Measure 3 before the campaign was launched and asked the authors to include smokefree air provisions.<sup>57</sup> Had Measure 3 included smokefree air language which was not relevant to MSA funding, Heidi Heitkamp believed that the tobacco industry could have lobbied against them.<sup>59</sup>

There was no visible campaign of organized opposition to the Measure 3 campaign and no funding was spent on an opposition campaign. During the 2009 Legislative Session, as the Legislature considered the Measure 3 appropriation, there was strong opposition from some legislators, particularly House Republicans. In the 2009-2010 election cycle, the tobacco industry contributed \$48,850 (\$38,850 from Altria/Philip Morris) to political campaigns, an increase of 147 percent from the 2007-2008 election cycle. All of the increased contributions in the 2009-2010 election cycle were given to Republican political party organizations.

**There was no visible campaign of organized opposition to the Measure 3 campaign and no funding was spent on an opposition campaign.**

Statutory initiated measures do not require additional implementing legislation in North Dakota; a voter-approved initiated measure becomes law 30 days after the election in which it is passed.<sup>165</sup> If voters approved Measure 3, it would become law without legislative action. However, the language of Measure 3 still required the Legislative Assembly to appropriate the tobacco control funding, which became a point of contention later.

### *The Rationale for an Independent Program*

It was important to the authors of Measure 3 that the new state plan be implemented by a program separate from the state DOH in order to be free from the political influence. Jeanne Prom, former DOH Division of Tobacco Prevention and Control Director (1992-2000) and Executive Director of the Center for Tobacco Prevention and Control Policy, the Measure 3-created program, explained in a 2012 correspondence for this report that the authors of Measure 3 wanted the new state plan to be “implemented by an agency overseen by tobacco control and health experts drawn from non-political organizations. This meant the new program would need to be separate from the state DOH, which was led by a political appointee.”<sup>167</sup> Prom explained in a 2011 interview that, “there's a reason there's a recommendation that it be an agency that's insulated from political factors as much as possible. It's because it can be more effective. When I was at the Health Department, we couldn't run media.”<sup>160</sup> The Legislature had consistently refused to appropriate funding for a statewide media campaign run by the DOH, and Legislators on several occasions tried to stop television advertisements being run by the Public Education Task Force on Tobacco, the committee funded and managed by the 28 local public health units, particularly advertisements that focused on making bars smokefree (discussed above).

As part of this rationale for an independent program, the authors of Measure 3 were influenced by the 1997 report by the Advisory Committee on Tobacco Policy and Public Health chaired by former U.S. Surgeon General C. Everett Koop (1982-1989) and former Food and Drug Administration Commissioner David Kessler (1990-1997).<sup>167</sup> The Koop-Kessler report recommended that tobacco prevention and control programs be located in the private sector and

funded by the tobacco industry.<sup>168</sup> These conclusions preceded the MSA between the states and the tobacco industry.

In the years that followed the MSA, several states (Indiana,<sup>40</sup> Ohio,<sup>169</sup> Mississippi<sup>170, 171</sup> and Minnesota<sup>172, 173</sup>) created independent trust funds or agencies for their burgeoning programs in efforts to minimize political interference with their tobacco control programs. Despite unprecedented success from these programs, these independent tobacco control programs were systemically dismantled by politicians, many of whom who were paid large campaign contributions by the tobacco industry.<sup>92, 172, 173</sup>

Additionally, DOH leadership, including Karalee Harper, DOH Division of Chronic Disease Director, wanted policy work to be handled by a tobacco control coalition outside of the DOH.<sup>63</sup> Also, in 2009, Deputy State Health Officer Arvy Smith decided to keep a new, policy-focused local tobacco control grants program external from the DOH because of concerns that Governor Hoeven and other elected officials could be upset by the DOH working on policy, though she stated in a 2011 interview for this research that the Governor had not told her that the DOH should not work on policy (discussed in later sections on forming the Measure 3 program).

### ***Support Tobacco Prevention Forms: Getting Measure 3 onto the Ballot***

The tobacco control leaders who conceptualized and wrote Measure 3, finalized the initiative language and adopted the name Support Tobacco Prevention (STP) in early 2008 (Figure 10). STP submitted the Measure 3 language to the Secretary of State's office in on April 15, 2008 and held a press conference at the Secretary of State's office to publicize their ensuing campaign. The press conference received coverage in the *Bismarck Tribune*.<sup>174</sup> The state required that 12,844 signatures be obtained by August 5, 2008 to get the initiative on the November 2008 state ballot.<sup>175</sup> When STP submitted the Measure 3 language, it had a sponsoring committee of 56 people, consisting of the state tobacco control leaders and local tobacco control volunteer advocates, many of which were also local tobacco coordinators and other health providers.<sup>164</sup> Shortly after submitting the finalized language, Support Tobacco Prevention registered with the Secretary of State's office as an official measure committee with Heidi Heitkamp as chair and Rosellen Sand as treasurer.

STP only used volunteers to gather the signatures needed to get Measure 3 onto the ballot and did not have substantial funding until fall 2008. The committee received one contribution for \$110 from Graphic Lettering & Trim in July 2008 but did not receive any other campaign contributions until fall 2008 when Measure 3 was already on the ballot and STP was campaigning to get it passed.<sup>176</sup> Most of the volunteers were local coalition members. These volunteers canvassed their neighborhoods and attended public events like state fairs and had one-on-one discussions with voters.<sup>47, 177</sup> ALA and March of Dimes mobilized members to circulate the initiative to gather signatures.



Figure 10: Support Tobacco Prevention Image<sup>8</sup>

ACS did not endorse or support the campaign, and in one instance, escorted Sharon Buhr, then President of Tobacco Free North Dakota, off the premises of its Relay for Life event because she was gathering signatures after ACS Cancer Action Network (ACS CAN) asked Measure 3 volunteers not to.<sup>59, 142</sup>

Deborah Knuth, Director of Government Relations for ACS and ACS CAN of the Great West Division, explained in a 2011 interview for this research that ACS did not want to pay the financial costs of the campaign and preferred that the tobacco control funding issue be handled by the legislature instead of the voters.<sup>144</sup> Knuth also recalled that the state tobacco control leaders who were spearheading the campaign did not welcome input from ACS and the other national partners and that ACS was not consulted before the petition language was finalized and submitted to the Secretary of State's office.<sup>144</sup> Heidi Heitkamp, Kathleen Mangskau and Jodi Radke of the Campaign for Tobacco-Free Kids (CTFK) recalled it differently, emphasizing that ACS had several opportunities to review the initiative language and to participate in the campaign but chose not to.<sup>57, 59, 178</sup>

AHA, whose working relationship with tobacco control leaders had been further damaged by the tobacco control leaders' failed 2007 attempt to have June Herman replaced as AHA's North Dakota lobbyist, remained neutral on Measure 3. Heidi Heitkamp recalled that "we knew we wouldn't have their [AHA's] institutional support, we wouldn't have any campaign help from them, but we never once had any concern at all about whether they would openly call a press conference and oppose us. Okay, so Heart really, to their credit – and what I keep reminding all of my colleagues, this is the thing we asked for – to never have to deal with June [Herman] again, and we haven't."<sup>59</sup>

Despite not having the support of ACS and AHA, Measure 3 was successful in gathering signatures and STP delivered 17,154 signatures to the North Dakota Secretary of State by the August 5, 2008 deadline, over 4300 more than the 12,844 signatures required.<sup>179</sup> STP held a press conference when they submitted the signatures,<sup>60</sup> but it did not generate statewide press coverage.

### ***The Campaign Ensues: Getting Measure 3 Passed***

The Measure 3 campaign was financed almost entirely by the tobacco control leaders who wrote it. STP received \$19,893 in total contributions (Table 19), some of which were in-kind donations.<sup>180</sup> STP's shoestring budget was only enough to pay for a few print and radio advertisements. STP primarily depended on earned media to gain statewide exposure for the campaign. The Campaign For Tobacco-Free Kids (CTFK) contributed funding for the creation of the radio advertisements and STP used other contributions to place them all over the state, including in rural areas.<sup>178</sup>



<b>Table 19:</b> Campaign Contributions to Support Tobacco Prevention, 2008 <sup>176</sup>	
<b>Contributor</b>	<b>Amount</b>
<i>Organizations</i>	
American Lung Association of ND	\$2,553
Graphic Lettering and Trim	\$110
Mercy Medical Center	\$117
ND Society for Respiratory Care	\$1,500
People to Save The Sheyenne River Inc.	\$200
STAMP (Stop Tobacco's Access to Minors Program, Minot)	\$1,543
<i>Individuals</i>	
Darwin K. Lange	\$2,000
Dr. J.B. and Sharon Buhr	\$1,699
Heidi Heitkamp	\$3,814
Jack McConnell	\$1,000
Jason Bergstrand	\$312
Jeanne Prom	\$332
Kathleen A. Mangskau	\$1,000
Lorraine A. Jacobson	\$200
Pat Finken	\$225
Pat McGeary	\$250
Rosellen M. Sand	\$1,011
Steven K. Hamar, M.D	\$150
Thomas A. Dickson	\$250
Vicki Rosenau	\$349
Unidentified Donations	\$1,278
<b>TOTAL</b>	<b>\$19,893</b>

By September 2008, the STP Committee had 47 endorsements or letters from prominent health organizations and state leaders (Table 20).<sup>181</sup>

<b>Table 20:</b> Organizations and Leaders in Support of Measure 3 as of September 2008 <sup>181</sup>
American Lung Association of North Dakota
North Dakota Nurses Association
Missouri Valley ND Oncology Nurses, Bismarck
ND Medical Association
North Dakota Academy of Family Physicians
ND Academy of Pediatrics
March of Dimes
ND Governor John Hoeven
North Dakota Society of Respiratory Care

North Dakota Education Association
Richland County Board of Health, Wahpeton
City County Health District Board of Health, Valley City
Sargent County Board of Health
ND Alliance for Health, Physical Education and Recreation and Dance
Richland County Commission
Richland County Tobacco Free Coalition
North Dakota Dental Association
North Dakota Farmers Union
Terry Dwelle, M.D., ND State Health Officer
North Dakota Pharmacists Association
ND Public Health Association,
Upper Missouri District Health Unit, Williston
ND Dental Hygienist Association
H. David Wilson, M.D., Dean of UND School of Medicine
UND School of Medicine Medical Center Advisory Council
Campaign for Tobacco-Free Kids
Tobacco Free North Dakota
North Dakota Counseling Association
Bismarck Tobacco Free Coalition
S.A.F.E. Coalition, Fargo
Faith United Against Tobacco
Blue Cross Blue Shield of North Dakota, CEO Mike Unhjem
Alliance for Tobacco Free Lifestyles (ATFL) Coalition, Dickinson
Southwestern District Health Unit Board of Health, Dickinson
Cancer and Substance Abuse Task Force, Dickinson
ND AARP
Health 8s Coalition, Dickinson
Southwest Coalition of Safe Communities, Dickinson
Head of the Red Safe Communities Coalition, Wahpeton
Traill County Safe Communities Coalition
Mercy Recover Center, Williston
Mercy Hospital, Valley City
ND Nutrition Council
Wahpeton City Council
Grand Forks Unitarian Universalist Fellowship
Central Valley Board of Health, Jamestown area
Valley City School Board

State Health Officer Dr. Terry Dwelle, representing the DOH, responded to written requests for support with a letter to STP campaigners indicating that he supported increasing funding for tobacco control,<sup>182</sup> but would not sign on as an endorser of Measure 3.<sup>57, 60</sup>

## *Support Tobacco Prevention Campaign Activities*

In September 2008, less than 60 days prior to the November 4 vote, the Campaign for Tobacco Free Kids (CTFK) provided an in-kind donation to the campaign by paying for statewide polling and message testing to test the receptivity of North Dakota voters to using the Strategic Contributions Funds to pay for a comprehensive tobacco control program.<sup>57, 183</sup> CTFK commissioned the Mellman Group, based in Washington DC, to conduct the poll which interviewed 400 potential voters from September 10-14, 2008.<sup>184</sup>

The poll revealed that 47 percent of North Dakota voters supported Measure 3 (with 30 percent strongly supporting), 24 percent opposed it (16 percent strongly opposed), and 28 percent were undecided. The results showed that voters were more likely to support Measure 3 when they were told that the funds were coming from the MSA and when they were told the amount that the state spent on tobacco control and how it compared to the \$9.3 million CDC recommended. Voters were also more likely to support Measure 3 after learning that it would provide funding for programs to deter youth smoking. The poll found that voters were most receptive to Measure 3 when it was presented by public health groups such as ALA, AHA and ACS. Nurses and medical associations were also influential with voters. Only 31 percent trusted Heidi Heitkamp, the former Democrat Attorney General who negotiated and signed the MSA, when listening to discussions on Measure 3.<sup>184</sup>

Participants were then read the following details about Measure 3:

As you may know, Measure 3 would require that a portion of the money North Dakota receives from tobacco companies as a result of the tobacco settlement would be used to create a comprehensive statewide tobacco prevention and control program to discourage kids from smoking and help adults quit. Funding for tobacco prevention programs in North Dakota would increase from its current level of \$4.4 million dollars to \$9.3 million dollars, the amount recommended by the U.S. Centers for Disease Control.

After hearing the details of the initiative, 66 percent of voters supported Measure 3 (43 percent strongly supporting), 20 percent were opposed (13 percent strongly opposed), and 13 percent were undecided. The campaign learned that by tailoring their messaging they could gain the support of the large “undecided” population indicated by the September baseline measurement. Fifty-eight percent of voters were more receptive to Measure 3 when informed that it would secure SCF money from the MSA and not taxpayer dollars. Additionally, 56 percent of voters found the argument that the original intent of the MSA was to fund tobacco control programs to be convincing.

CTFK’s messaging poll tested the best ways for advocates to stave off attacks from opponents who argued that increasing tobacco control funding with SCF money would siphon away MSA money then being used for water development projects. The North Dakota Water Coalition was neutral on the Measure 3<sup>59</sup> but some legislators opposed Measure 3 because of the issue of water development funding.<sup>132</sup> Specifically, Measure 3 specified that if there was not enough funding for the new Executive Committee to implement the comprehensive tobacco

control program, the treasurer would take the necessary funds from the Water Development Trust Fund to fund the Executive Committee.<sup>164</sup>

The poll found that when responding to questions relating to water development funding, voters were more receptive to passing Measure 3 when the issue of water development funding was not engaged at all as opposed to when arguments were made that the water development trust fund money would not be compromised. Following a critique on the issue of water development, 71 percent of voters supported Measure 3 when the issue of smoking prevention was re-enforced and the issue of water development funding was not discussed. However, when placed on the defensive and arguments were presented that stated that water development projects would still receive \$36 million in 2008, only 59 percent of voters supported Measure 3.

STP reported spending \$12,422 (Table 21). The campaign only had enough funding for a small-scale media campaign (radio advertisements), but these message testing results informed the state and local leaders how to best promote Measure 3 when talking with the public one-on-one, in press conferences, and in the many op-ed articles advocates published in the newspapers throughout the state. STP also developed talking points and documents to help local volunteers explain the difference between the original MSA payments and the SCF funds that were scheduled to continue through 2017.<sup>185</sup> After receiving the

**STP also developed talking points and documents to help local volunteers explain the difference between the original MSA payments and the SCF funds that were scheduled to continue through 2017.**

message testing data, STP members tailored their many op-ed articles to phrase their arguments in ways that would be favorable to Measure 3. Op-ed articles in the *Grand Forks Herald* from STP leaders like Heidi Heitkamp and Carol Russell and local tobacco leaders like Sharon Buhr from Valley City and Theresa Knox from Grand Forks reiterated that Measure 3 would use new SCF money, not the original MSA money and not tax money, for tobacco control programs which would save money and lives in North Dakota.<sup>186-189</sup> STP ran radio advertisements for Measure 3 using the same talking points.<sup>190</sup>

<i>Expenditure</i>	<i>Amount</i>
Odney Advertising	\$6,833
The Mellman Group	\$2,000
Forum Communications	\$927
NDSCS Print Services	\$875
Lori Brierley	\$737
Heidi Heitkamp	\$750
Pat McGeary	\$222
Expenditures less than \$100	\$78
<b>TOTAL</b>	<b>\$12,422</b>

On September 22, 2008, CTFK released a report that explained the importance of funding North Dakota's tobacco control program at CDC-recommended levels (\$9.3 million annually<sup>28</sup>) and called Measure 3 a "Win-Win Solution" for the health of North Dakota residents and the economy.<sup>191</sup> The report predicted that in five years, the passage of Measure 3 and the funding of tobacco control programming at CDC-recommended levels would reduce healthcare costs by \$113 million, including \$11.9 million in reduced state Medicaid expenditures. This was an informational tool that STP used when discussing Measure 3 with the media and with legislators. For example, Kathleen Mangskau, in her September 24, 2008 testimony before the North Dakota Legislative Council, presented the CTFK report as supplementary information. The Legislative Council was meeting to discuss the fiscal impact of the initiated measures being put to a public vote on the November 2008 ballot.<sup>192</sup>

Due to its limited budget, STP primarily relied on earned media to publicize and advocate for Measure 3. As part of this effort to attract earned media, STP held press conferences, just as it had during the signature gathering period. Once it had secured 47 endorsements from prominent organizations and leaders, STP held two press conferences on September 29, 2008, one in Fargo and another in Bismarck, to announce the support of "more than 40 state and local health groups, leaders, and groups interested in improving health in North Dakota."<sup>193</sup> The Bismarck press conference was hosted by ALA which CTFK's message testing had shown was an influential organization for increasing public support for the campaign.<sup>184, 194</sup>

STP held another press conference on October 22, 2008 to announce the support of four North Dakota education organizations, including the ND Education Association, the ND Alliance of Health, Physical Education, Recreation and Dance Teachers, the ND Counseling Association, and the Valley City School Board. STP had youth organizations present and used the press conference to explain that Measure 3 would stop kids from smoking.<sup>193</sup> Statewide and local tobacco coordinators supported the campaign for passing Measure 3 by writing op-ed articles in major city newspapers including the *Grand Forks Herald*.<sup>186</sup> STP also met with newspaper editorial boards throughout the state. As a result of these meetings, newspapers such as the *Bismarck Tribune*<sup>195</sup> and the *Minot Daily News*<sup>177, 196</sup> came out in support of Measure 3.

STP printed campaign materials that explained the details of Measure 3 and distributed them throughout neighborhoods and to businesses. STP printed postcard-sized hand-outs, educational flyers to mail out and to hang on door-knobs, yard signs to advertise the Measure and encouraged voters to vote "yes" on Measure 3. STP hired Odney Advertising to create a radio advertisement, which ran throughout the state. The advertisement said that North Dakota promised to protect kids from tobacco when it signed the MSA, that "North Dakota has broken its promise" by not fully funding tobacco control programs and said that the American Lung Association and more than 40 other organizations supported Measure 3.

### *Opposition to Measure 3*

In 2008, Measure 3 was the only tobacco-related initiative on the ballot and there was no visible opposition to Measure 3 from the tobacco industry or its traditional third party ally organizations which has been typical throughout the U.S.<sup>135, 197-199</sup> There was no visible

opposition campaign and no money spent by opposition to defeat Measure 3 or support any other initiated measure.

Nearly all of the visible opposition to Measure 3 was from legislators. From the initial launch of STP's campaign on April 15, 2008, House Majority Leader Rick Berg (R-Fargo) was, the most outspoken opponent to Measure 3, arguing that it would duplicate existing DOH tobacco control programs in the Community Health Grant Program and that allocating money and dictating program priorities was the responsibility of the Legislature.<sup>174</sup> Kathleen Mangskau responded in an April 26, 2008 op-ed article that, "The plan mandated by the initiated measure expressly prohibits duplication of efforts already being conducted by the Community Health Grant Program. Rather, it will enhance those efforts by filling in the gaps in the current programming."<sup>200</sup> North Dakota's weak campaign contribution reporting laws make it unknown whether Rep. Berg received high levels of contributions from the tobacco industry.

Less than one month before the November 4 election, on October 10, 2008, Rep. Berg wrote Attorney General Wayne Stenehjem, asking for his office to review Measure 3 to determine if 1) Measure 3 required the legislature to appropriate funds at CDC-recommended levels; 2) whether the executive committee created by Measure 3 was limited in its spending and if it could hire lobbyists and make political contributions; 3) if money would indeed be taken from the state's Water Development Trust Fund for the new tobacco control program if the Tobacco Prevention and Control Trust Fund did not have sufficient money to pay for the tobacco control plan.<sup>201</sup> Berg told the press, "I don't think it's constitutional to allow some agency outside of our state to set the level of state spending... My concerns, when I look at this, is either these (provisions) were poorly thought through when it was drafted, or done intentionally, to give authority that goes beyond what normal agencies have."<sup>202</sup>

The North Dakota Attorney General's office responded to Rep. Berg's questions on October 31, 2008. In reference to Berg's first question – Does Measure 3 require the Legislature to appropriate the funds needed to meet CDC's *Best Practices* recommendation? – the AG's office wrote:

Although initiated measure No. 3 places money into the tobacco prevention and control trust fund and provides a rather explicit directive to the Legislative Assembly to provide a certain level of funding for the comprehensive statewide tobacco prevention and control program, the measure does not appropriate the money in the fund. Only the Legislative Assembly may make a specific appropriation of the money placed in the tobacco prevention and control trust fund. The decision to appropriate the money and the determination of the amount of any appropriation ultimately lies with the Legislative Assembly.<sup>203</sup>

The TPC Executive Committee would need to convince the Legislature to appropriate funding every two years when the budget was passed.

Heidi Heitkamp was quoted in the press saying, "His [Berg's] motivation is that he doesn't want to spend tobacco money on tobacco control. He does not want to invest in those programs."<sup>202</sup> Heitkamp and other STP members like Carol Russell argued in the press that Rep. Berg had waited to ask these questions until close to the election to cast doubt on the legality and

appropriateness of Measure 3 just before voters would be deciding on it.<sup>188, 202</sup> The STP Committee also responded to Berg's questions on their website.

**Measure 3 passed on Tuesday, November 4, 2008 with 54 percent of voters supporting it.**

The Attorney General's opinion went on to answer Berg's other questions. For Berg's second question - Does Measure 3 include limits on staff compensation, amounts of loans that may be granted by the TPC Executive Committee, or the duration of lease agreements and does the Measure 3 prohibit the hiring of lobbyists or the making of political contributions to candidates or ballot measures? – The Attorney General's office responded by referencing the Measure 3 language that stated that the TPC Advisory Committee could "employ staff and fix their compensation, accept grants, property, and gifts, enter contracts, make loans, provide grants, borrow money, lease property, provide direction to the state investment board for investment of the tobacco prevention and control fund, and take any action that any private individual, corporation, or any liability company lawfully may do except as restricted by the provisions of this Act."<sup>203</sup> The limits of these expenditures would be "limited to the availability of appropriated funds" as appropriated by the Legislature.

The opinion also stated that because an "employee, officer, board member, volunteer, or agent of the state who is acting in that individual's official capacity" is not considered a lobbyist and restricted by state lobbyist regulations, that "any individual who is a member of the [TPC] executive committee or an agent of the [TPC] executive committee likely would not fall within the definition of a lobbyist."<sup>203</sup> The opinion said that the TPC Executive Committee and its employees could not use state property while engaging in political activity, which focused mainly on supporting candidates for political office.

In reference to Berg's third question – if money would be taken from the state's Water Development Trust Fund for the new tobacco control program if the Tobacco Prevention and Control Trust Fund did not have sufficient money to pay for the tobacco control plan – the Attorney General's office responded that, "Because the answer to the situation presented in the third question likely would be dependent upon the facts of the situation, we are unable to provide an answer to that question."<sup>203</sup> It is unclear what affect Berg's questions, which received some public attention, had on the campaign. Regardless, Measure 3 passed on Tuesday, November 4, 2008 with 54 percent of voters supporting it.<sup>204</sup>

## **Conclusion**

In 2007, a group of North Dakotan tobacco control leaders met to discuss the status of the state tobacco control coalition which the group felt was deteriorating as part of Healthy North Dakota, the state-spearheaded health program that had a paid DOH staff member who worked with the coalition. This group also decided that it could no longer work with AHA's longtime lobbyist June Herman because of longstanding grudges about the 2001 MSA appropriation bill and subsequent disagreements on tobacco control policy issues, most recently in the 2007 legislative session over a smokefree air bill. This group of tobacco control leaders and sent a letter to national AHA requesting a meeting to discuss Herman, and subsequently requested that AHA assign a new lobbyist to work on tobacco control or stop working on tobacco control issues altogether in North Dakota. Ultimately, a conflict resolution meeting was held in winter 2008

with leaders from national tobacco control organizations, in efforts to improve relations with June Herman and strengthen the state coalition. The meeting resulted in the decision to reinstate Tobacco Free North Dakota as the state tobacco control coalition which allowed the DOH to remove the Tobacco Policy Committee from Healthy North Dakota which DOH wanted to do because it was concerned about being accused of illegal lobbying. However, the meeting was unsuccessful in mending the working relationship with June Herman and AHA did not rejoin the coalition or work with TFND as it reformed.

As part of these coalition meetings, the group of tobacco control leaders that sent the letter to national AHA, agreed to launch an initiative campaign to secure the Strategic Contribution Funds that North Dakota would receive from 2008-2017 as additional payments under the Master Settlement Agreement for a new tobacco control program. The new tobacco control program would complement the limited tobacco control programs that the DOH was already running but it would exist in a new tobacco control agency, separate from the DOH. This initiative was named Measure 3 and spearheaded by the Support Tobacco Prevention Committee which was comprised of the original group of tobacco control leaders and supported by local volunteers throughout the state. The Measure 3 campaign was not opposed or threatened by weaker initiatives, which is often a tobacco industry strategy used to ensure the passage of weak tobacco control laws. Measure 3 was a success but the legislature was still required to appropriate the funding for the new program, which created challenges for the new agency while it was still in its infancy.





## **CHAPTER 6: IMPLEMENTATION OF MEASURE 3 AND THE NEW TOBACCO CONTROL PROGRAM**

- Even though Measure 3 required that the Legislature appropriate funding for the TPC Executive Committee biennially, Senate Republicans attempted to amend Measure 3 and to give the money to the DOH.
- The TPC Executive Committee worked to get the Senate to make the appropriation while concurrently writing the new state plan.
- Support Tobacco Prevention and Tobacco Free North Dakota mobilized the local advocates who got Measure 3 passed and generated public pressure for the Legislature to make the appropriation; they succeeded in the final days of the Legislative Session.

### **Appointment of the Tobacco Prevention and Control Advisory Committee**

Measure 3 became law without legislative action. Statutory initiated measures do not require additional implementing legislation in North Dakota; a voter-approved initiated measure becomes law 30 days after the election in which it is passed.<sup>165</sup> However, Measure 3 still required the Legislative Assembly to appropriate the tobacco control funding, which became a point of contention in the 2009 Legislative Session.

Measure 3 created a Governor-appointed, nine-member Tobacco Prevention and Control (TPC) Advisory Committee charged with creating the new state plan for tobacco control and prevention. Measure 3 required that the Governor-appointed committee consist of:

- A. A practicing respiratory therapist familiar with tobacco related diseases;
- B. Four non-state employees that have demonstrated expertise in tobacco prevention and control;
- C. A practicing medical doctor familiar with tobacco related diseases;
- D. A practicing nurse familiar with tobacco related diseases;
- E. A youth between the ages of 14 and 21;
- F. A member of the public with a previously demonstrated interest in fostering tobacco prevention and control.<sup>164</sup>

To make it more likely that the TPC Advisory Committee would consist of members supportive of effective tobacco control programs, Measure 3 required the North Dakota Society for Respiratory Care, North Dakota Public Health Association, North Dakota Medical Association and the North Dakota Nurses Association submit names for members A through D for the Governor to choose from, ensuring that the Committee was primarily comprised of people supported by the public health community.<sup>60</sup> Once the nominating organizations submitted their nominations to the Governor's Office, the Governor had three weeks to make the appointments. On November 5, 2008, the day after Measure 3 passed, Support Tobacco Prevention, the coalition of tobacco control leaders who got Measure 3 passed, had a conference call with members of the North Dakota Public Health Association, North Dakota Society for Respiratory Care and the North Dakota Medical Association to discuss the process for nominating TPC Advisory Committee members.<sup>205</sup>

On the conference call, STP discussed the importance of submitting the names to the Governor as soon as possible to ensure that there was no delay in beginning work drafting the new tobacco control plan and implementing the program. Additionally, STP wanted the TPC Advisory Committee appointed by the time the 2009 Legislative Session began in January to ensure that the Advisory Committee could participate in discussions regarding its appropriation.<sup>205</sup> The TPC Advisory Committee would have no money until the Legislature appropriated funding. Unless the TPC Advisory Committee received an emergency appropriation, the Committee would be personally paying for anything necessary to develop the new state plan.<sup>57</sup> Governor John Hoeven (R, 2000-2010) appointed all of the members of the TPC Advisory Committee in December 2008 (Table 22). The appointments became effective January 1, 2009.<sup>206</sup>

**Unless the TPC Advisory Committee received an emergency appropriation, the Committee would be personally paying for anything necessary to develop the new state plan.**

<b>Table 22:</b> Criteria for Tobacco Prevention and Control Advisory Committee membership and Original Roster, 2009 <sup>164, 207</sup>	
<i>Representative</i>	<i>Member</i>
1 practicing respiratory therapist familiar with tobacco related diseases (North Dakota Society for Respiratory Care nominee)	James Taylor
4 non-state employees with expertise in tobacco prevention and control (North Dakota Public Health Association nominee)	Jeanne Prom
	Kathleen Mangskau*
	Javayne Oyloe*
	Lorraine Jacobson
1 practicing medical doctor familiar with tobacco related diseases (North Dakota Medical Association nominee)	Dale Klein, MD
1 practicing nurse familiar with tobacco related diseases (North Dakota Nurses Association nominee)	Pat McGeary*
1 youth between the ages of 14 and 21 (Governor's choice)	Nathan Marion
1 member of the public with a demonstrated interest in tobacco prevention and control (Governor's choice)	Kermit Lidstrom, PhD
*Indicates a member of the Tobacco Prevention and Control Executive Committee.	

At its first meeting on January 8, 2009, the TPC Advisory Committee elected Javayne Oyloe, Tobacco Coordinator in Williston, ND, Kathleen Mangskau, former DOH Division of Tobacco Prevention and Control Director and Pat McGeary, Tobacco Coordinator in Bismarck, ND, to comprise the TPC Executive Committee, with Mangskau elected the Chair of the TPC Executive Committee.<sup>208</sup> The TPC Advisory Committee started working on the new statewide plan, which Measure 3 required be delivered to the Legislature within six months of the committee's initial meeting (by July 2009).

## Getting the Measure 3 Funding Appropriated

Measure 3 allocated all future MSA Strategic Contribution Fund (SCF) receipts to the Measure 3-created Tobacco Prevention and Control Trust Fund, but the Legislature still had to appropriate the money from the Trust Fund to the TPC Executive Committee to implement the new state plan. What followed was a battle to keep Measure 3 from being altered by the Legislature despite the fact that the state constitution protects voter legislative initiatives for seven years from legislative change unless a two-thirds majority in both houses approves the change.<sup>165</sup>

### **SB 2063**

The Governor's Executive Budget proposed to appropriate \$18.6 million to the TPC Executive Committee (\$9.3 million for each of two years) from the Measure 3-created Tobacco Prevention and Control Trust Fund (The state anticipated receiving \$26.4 million for the Trust Fund during the 2009-2011 biennium). The Senate Appropriations Committee introduced SB 2063 on January 6, 2009 which reflected the Governor's budget and included an \$18.6 million appropriation.<sup>209</sup> The Senate then referred SB 2063 to the Human Services Committee.

Rather than supporting the Governor's proposal, the TPC Executive Committee requested that the Legislature only appropriate \$12.9 million for two years (\$6.45 million annually) and the Senate Human Services Committee reduced the appropriation to reflect the request. The TPC Executive Committee's strategy in requesting less than the \$9.3 million was to accrue funding for the new program for after 2017 when the Strategic Contribution Funds would end. In her January 20, 2009 testimony before the Senate Human Services Committee when it considered SB 2063, Kathleen Mangskau, recently elected Chair of the TPC Advisory and Executive Committees, explained that the rest of the funds "would remain in the trust to fund tobacco prevention and control beyond the nine remaining years the Strategic Contribution Fund payments are coming to the state. At this funding level and if the CDC support for tobacco control remains about the same as it currently is, the funding should support programs for more than 16 years."<sup>206</sup>

The TPC Executive Committee justified this decision by considering their funding stream as only a portion of the funds being spent on tobacco control in the state which, when combined with the funds appropriated to the DOH and the CDC NTCP grant received by the DOH annually, met the \$9.3 million CDC *Best Practices* recommendation (Table 10).<sup>57</sup>

The TPC Advisory Committee had no money initially, so it also requested retroactive spending authority to pay for materials and consultants used in developing the new state plan, which Advisory Committee members had personally paid out of their own pockets. The Senate Human Services Committee agreed and included a retroactive appropriation of "\$62,403, or so much of the sum as may be necessary, to the comprehensive tobacco control advisory committee for the purpose of defraying the expenses of the committee, developing, implementing, and administering the comprehensive tobacco control and prevention plan, and contracting with a consultant to facilitate the development of the comprehensive plan, for the period beginning with January 1, 2009, and ending July 1, 2009."<sup>210</sup>

Kathleen Mangskau, the Chair of both the TPC Advisory and the Executive Committees, explained in a 2011 interview for this research, “We did six months with no money, where we never knew if we were going to get paid because the legislature hadn't appropriated [the money]. So pretty much we informed all the advisory committee members if they don't appropriate, this could be a volunteer effort on your part.”<sup>57</sup> Indeed, for the first six months, TPC Advisory Committee members personally paid all testimony, copying, and administrative costs.

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At the request of the TPC Advisory Committee, the Senate Committee also added an emergency clause, which would allow the Executive Committee to get its appropriation as soon as the state received its next SCF payment (April 2009) instead of waiting until July when the appropriation would normally take effect. The TPC Executive Committee was also granted the authority to hire four full-time employees, which was the request of the Advisory Committee. SB 2063 passed unanimously with all of the amendments of the Human Services Committee on the Senate Floor 46-0. The TPC Advisory Committee's requests were not opposed in the Senate.

### ***SB 2063: Gutted in the House***

When SB 2063 moved to the House, it was referred to the House Appropriations Committee. As she had when SB 2063 was heard in the Senate, TPC Advisory and Executive Committee Chair Kathleen Mangskau testified before the House Appropriations Committee. Mangskau presented the progress made by the Advisory Committee and its work with the DOH in creating a state plan that addressed the inadequacies of the DOH program, including the lack of a statewide media campaign and sufficient local funding for coalition building. Mangskau again requested \$12.9 million of Strategic Contribution funds be appropriated biennially to the TPC Executive Committee.<sup>211</sup>

On April 7, 2009, the Appropriations Committee voted to recommend that the full House amend Measure 3 and eliminate the TPC Executive Committee and instead send the Strategic Contribution Fund payments to the DOH to implement tobacco control programs.<sup>212, 213</sup> Under the amendments, the TPC Advisory Committee was left intact to advise the DOH on the tobacco control program, but even the Advisory Committee was to be dissolved in 2017 when the state's Strategic Contribution Funds ceased. These amendments were proposed by Reps. Gary Kreidt (R-New Salem) and Jon Nelson (R-Rugby) to give the money to the DOH to run cessation programs.<sup>214</sup> (Subsequent events, discussed below, revealed that this action was the opening move in an effort to move money to other non-tobacco programs in DOH.)

The DOH did not publicly take a position on the amendments. In a 2011 interview for this report, Karalee Harper, DOH Division of Tobacco Prevention and Control Director and Neil Charvat, Outreach Coordinator for the DOH program, explained that the DOH did not request that the Legislature amend Measure 3 and transfer the money to the DOH program.<sup>63</sup>

The next day, April 8, 2009, the full House adopted the Appropriations Committee's amendments by a 57-34 vote. This House did not need a two-thirds vote in order to adopt the

amendments but would need two-thirds in order to pass the bill to the Senate. Republicans argued that the creation of the TPC Executive Committee was an unnecessary growth of government and would add to bureaucracy and expenditures.<sup>215</sup> Rep. Gary Kreidt (R-New Salem), who co-sponsored the amendments, was quoted in the media saying that the House amendments improved what the voters had approved<sup>216</sup> and Rep. Jon Nelson (R-Devils Lake), the other co-sponsor of the amendments, argued that the state did not need another agency to address tobacco when the DOH programs already existed.<sup>217</sup> Other opposition to the appropriation mainly came from Rep. Al Carlson (R-Fargo), the House Majority Leader.<sup>214, 218-220</sup> Carlson was one of the two legislators who reported receiving tobacco industry contributions between 2000 and 2010.

As discussed previously, the tobacco industry increased campaign contributions to Republican political party organizations precipitously during the 2009-2010 election cycle (\$48,850 total – an increase of 147 percent from the 2007-2008 election cycle), suggesting increased efforts by the industry to obtain the legislative decisions not to support the TPC. There was also a clean indoor air bill introduced in 2009 that would have expanded the state law to prohibit smoking in bars and hotels, as well as a bill that would have prohibited smoking in cars with children; both bills received little support and did not survive passed introduction. The tobacco industry had not made such high levels of campaign contributions in years when smokefree air bills received strong consideration from the Legislature, suggesting that it was stopping the TPC Executive Committee appropriation, not the smokefree air bill, which motivated the increase in campaign contributions.

We cannot assess whether the tobacco companies increased their lobbying presence during the 2009 Legislative Session because lobbyists did not have to report their compensation from employers. The MSA prohibited the tobacco industry from working to divert MSA money to programs that were not tobacco related or health related.<sup>159</sup> However, because these amendments would have transferred the money to the DOH for tobacco programs (as opposed to cutting the amount of money), the tobacco industry could have lobbied legislators on this issue.

As noted previously, in the 2009-2010 election cycle, the tobacco industry contributed. All of the increased contributions in the 2009-2010 election cycle were given to Republican political party organizations.

### ***Tobacco Control Activities Defend Measure 3***

On April 7, 2009, the same day that the House Appropriations Committee voted to amend Measure 3, Support Tobacco Prevention (STP), the committee that got Measure 3 passed, immediately responded publicly with a press conference at the State Capitol to highlight the amendments, arguing that the Committee had shown “complete disregard for the will of the people” for attempting to amend a voter-enacted initiative.<sup>221</sup> STP wanted the Senate to restore the funding for the tobacco control program the voters specified when they passed Measure 3. They were prepared to continue the fight into Conference Committee negotiations. STP had maintained its communication networks with the local tobacco coordinators and advocates who had supported Measure 3 and had its network of local volunteers contact their legislators in support of preserving the original Measure 3 language.

At STP's press conference, the coalition singled out House Majority Leader Al Carlson (R-Fargo) for opposing appropriation of the funding for the new program and calling it wasteful. The coalition had three main objections to the House's amendments: 1) the diversion of funding from tobacco control; 2) the removal of the Tobacco Prevention and Control Executive Committee as the program implementation entity; and 3) the failure of the Legislature to appropriate funding to pay the costs Tobacco Prevention Advisory Committee members had borne to develop the new program.<sup>222</sup>

At the same time as STP's press conference, other legislators, including Rep. Lee Kaldor, were quoted in the *Bismarck Tribune* arguing for the Legislature to fund the program. Kaldor said, "Did they spank us? They spanked us, and I don't like it any more than the rest of you do. The fact is the people said we need something very strong and very stable."<sup>212</sup> Kaldor was a strong proponent for funding the TPC Executive Committee and restoring the infrastructure that Measure 3 created and had a history of supporting tobacco control policies, including smokefree air laws.<sup>217</sup> On April 15, 2009, the *Grand Forks Herald* published a letter to the editor from Kaldor that criticized an earlier editorial in the *Herald* that stated that the Legislature was within its rights to ignore a voter-approved initiated measure. Kaldor wrote, "A successful initiated measure is not a request; it is a directive... The measure's passage was not a mistake. North Dakota voters can read and comprehend."<sup>223</sup> Later, on April 26, Kaldor held a press conference at the State Capitol to urge the House to pass a bill that would appropriate the Measure 3 funding as specified by the voters.<sup>224</sup>

**"A successful initiated measure is not a request; it is a directive... The measure's passage was not a mistake. North Dakota voters can read and comprehend."**

Other Measure 3 supporters, including local tobacco control coordinators and Pat McKone, director of the ALA Upper Midwest Division, former State Health Officer, Dr. Jon Rice, and Dr. Stephen McDonough, a former tobacco control program leader at the DOH, also wrote letters to the editor which were published and which called public attention to Legislature's failure to pass the funding bill.<sup>223, 225-228</sup>

In some of their letters, the Measure 3 supporters said that the legislators who voted to amend the Measure 3 language were doing the bidding of the tobacco industry. The Measure 3 supporters said that the DOH was also to blame for succumbing to intimidation from legislators like Rep. Al Carlson who promoted policies favorable to the tobacco industry and sought to minimize the impact of the state's tobacco control programs.<sup>229</sup> These comments led Dr. Terry Dwelle, State Health Officer, to write a letter to the *Grand Forks Herald* challenging allegations that the DOH was under the influence of the tobacco industry. Dwelle wrote, "Neither I nor my staff have ever met with or been influence by representatives of the tobacco industry. As state health officer, I support any efforts to reduce the impact of tobacco on the citizens of our state."<sup>230</sup>

The state leaders of STP who led the Measure 3 campaign, some of whom sat on the TPC Executive Committee and spoke on behalf of the TPC Advisory Committee, put pressure on the Legislature to make the appropriation. Tobacco Free North Dakota (TFND) had been revived in 2008 and had elected a Board of Directors but still had no funding. However, Sharon Buhr,

President of TFND, actively worked with the other state tobacco control leaders as a registered lobbyist in 2009. STP also received lobbying assistance from Jodi Radke of Campaign for Tobacco-Free Kids, Director of Advocacy for the Rocky Mountain / Great Plains Region who registered as a lobbyist in North Dakota in 2009.<sup>49</sup>

Deb Knuth of ACS registered as a lobbyist for TFND in addition to ACS in 2009 but did not work on the appropriation issue and did not take a position. In an interview in 2011 for this research, Deborah Knuth of ACS explained that ACS had been neutral on the issue of funding the Center, being equally supportive of giving the money to the DOH as long as North Dakota funded tobacco control programs at CDC's prescribed level.<sup>144</sup>

ALA supported protecting the Measure 3 funding for the TPC Executive Committee, mobilizing their members to contact their legislators to support of preserving Measure 3 as passed.<sup>60</sup> AHA was not visible in support or opposition to the appropriation to the TPC Executive Committee or any of the amendments to SB 2063.

### ***SB 2063 is defeated***

The House defeated SB 2063 by a vote of 24-69 on its second (and final) reading on April 9, 2009. STP had had their supporters bring pressure on the House to defeat the amended bill. However, while the amended bill was killed, the TPC Executive Committee was left with no funding mechanism.

At this point in the session, there were several options for appropriating the funding to the TPC Executive Committee: the House could reconsider the amended SB 2063 and pass it with the Appropriation Committee's amendments, send it back to committee to be re-amended, introduce a delayed appropriation bill, or add the appropriation to another bill. Rep. Al Carlson, House Majority Leader and an opponent to Measure 3, said that he would not allow a delayed bill to be introduced. From 2000 to 2010, Rep. Al Carlson was one of the two legislative candidates who reported receiving tobacco industry contributions (candidates only had to report where their contributions came from if they received more than \$200 from that contributor). Carlson reported receiving \$250 in the 2001-2002 election cycle. Due to the opposition from House leadership, the language would have to be added to a bill in the Senate that had already passed the House. Senate Majority Leader Bob Stenehjem was open to adding the appropriation to another bill in the Senate.<sup>231</sup> At that point, both chambers would have to agree to the new language in a conference committee.

After SB 2063 died, the TPC Executive Committee started pressuring the Legislature to add the tobacco control funding to another bill. Kathleen Mangskau, Pat McGeary, both TPC Executive Committee Members, and attorney Rosellen Sand, met with Attorney General Wayne Stenehjem to ensure that the Attorney General's office would represent the Committee if the Committee had to sue the Legislative Assembly for not appropriating the Measure 3 money.<sup>57, 232</sup> The Attorney General's office represents state agencies in lawsuits so Mangskau and Sand's visit served two purposes: 1) To ensure that the Attorney General would represent the TPC Executive Committee in a potential lawsuit against another state agency, and 2) To make it known that they intended to sue if the Legislature ignored the voters.<sup>57</sup> The Attorney General's office said that



they would represent the TPC Executive Committee in the event of a lawsuit. This meeting with the Attorney General and the TPC Executive Committee's plan to sue the Legislature to appropriate the funds, were covered by the press.<sup>232</sup> According to Mangskau, the TPC Executive Committee's meeting with the Attorney General's Office effectively added pressure on the Legislature to appropriate the Measure 3 money; the Legislature did not want to deal with a high profile lawsuit that called into question its decision to go against the voters who passed Measure 3.<sup>57</sup>

### *Proposed Constitutional Amendment*

As the Legislative Session was nearing to a close, there was still no appropriation bill for the TPC Executive Committee and there was another attempt to repeal Measure 3 in the form of a proposed constitutional amendment. On April 27, 2009, Sen. John Andrist (R-Crosby) introduced Senate Concurrent Resolution (SCR) 4038, which proposed a constitutional amendment to dictate how the Strategic Contribution Funds (SCF) were spent. SCR 4038 would have created the "Public Health Trust Fund" for the deposit of all of the annual SCFs. The Legislature would then appropriate funding directly to Local Public Health Units for "tobacco prevention and cessation efforts and other public health programs, including immunization programs, cancer screening and prevention, diabetes screening and control, and aging services."<sup>233</sup> Andrist argued that voters would have approved his amendment if they had been presented with it when Measure 3 was under consideration in Fall 2008. Andrist said that there had not been an adequate campaign against Measure 3.<sup>234</sup> Rep. Lee Kaldor called the proposal a "distraction."<sup>235</sup> The connection between Sen. Andrist and the tobacco industry is unknown.

If the Senate and House both passed SCR 4038, it would go to the voters for a vote.<sup>236</sup> SCR 4038 was referred to the Senate Judiciary Committee where it received a split vote, 3-3, along party lines, and went to the full Senate with no recommendation.<sup>237</sup> On the Senate floor, Democrats opposed the proposal, calling on legislators to fund the TPC Executive Committee as voters had already supported through Measure 3, but SCR 4038 narrowly passed 24-23 and was sent to the House.<sup>235</sup>

STP and its supporters publicly fought SCR 4038 with letters to the editor and opinion pieces.<sup>238</sup> STP also testified in opposition to the proposal in the House committee asking the Legislature to follow the decision of the voters and move forward with Measure 3 as passed.<sup>239</sup>

The constitutional amendment proposal did not have support in the House, so the House Constitutional Revision Committee amended SCR 4038, removing the tobacco funding provisions and substituting language prohibiting people from using state property and resources for political purposes.<sup>239</sup> The next day, the Committee gave it a "do not pass" recommendation.<sup>240</sup> It subsequently died on the House floor.

### *HB 1015 – A new funding bill*

The TPC Executive Committee still needed an appropriation bill in the last days of the session. As STP continued its letter writing campaign and continued calling legislators, the TPC Executive Committee and STP asked Senate Majority Leader Bob Stenehjem (R-Bismarck) and

members of the Senate Appropriations Committee to include the appropriation in HB 1015, the appropriation bill for the Office of Management and Budget, and usually one of the last bills to pass at the end of the Session. The Senate Appropriations Committee did not agree and on May 4, 2009, passed HB 1015 without the TPC Executive Committee Appropriation to the Senate floor. In response, fearing that the Senate would pass the bill without the appropriation, STP called the *Bismarck Tribune*, the *Fargo Forum* and the *Associated Press* and explained the situation in hopes of putting last minute pressure on the Legislature.<sup>241</sup>

On the same day, Reps. Kreidt and Nelson, the sponsors of the House amendments to SB 2063 that would have repealed portions of Measure 3 and transferred the SCF funds to the DOH, met with Kathleen Mangskau to discuss the appropriation.<sup>57</sup> Reps. Kreidt and Nelson proposed that the TPC Executive Committee agree to an amendment to Measure 3 that would remove the requirement that 80 percent of the DOH's MSA money be used on tobacco prevention and control programs in exchange for the \$12.9 million appropriation. Under such an amendment, the Legislature would be able to appropriate money from the Community Health Trust Fund to the DOH for any purpose, as opposed to the Measure 3 requirement that 80 percent go to tobacco programs. According to Mangskau, Reps. Kreidt and Nelson wanted to give MSA money to the DOH for non tobacco-related programs. Mangskau refused their deal or any amendment to the Measure 3 language.<sup>57</sup>

Before the full Senate voted on HB 1015, Senate Majority Leader Bob Stenehjem asked Kathleen Mangskau and some of the leaders of STP to meet with Lieutenant Governor Jack Dalrymple (R) and Don Canton, an advisor to Governor John Hoeven, to reach an agreement. Lt. Gov. Dalrymple asked that the TPC Executive Committee and STP accept an amendment to address the requirement in Measure 3 that the state treasurer transfer money from the Water Development Trust Fund to the TPC Executive Committee if there was not enough in the Tobacco Prevention and Control Trust Fund to fund the comprehensive program.<sup>164</sup> Dalrymple and Stenehjem asked the TPC Executive Committee to propose language that they would accept. The TPC Executive Committee consulted Rosellen Sand who had co-written Measure 3 and the group agreed to language that said "Any moneys deposited in the water development trust fund under section 54-27-25 may be spent only pursuant to legislative appropriations."<sup>80</sup> The TPC Executive Committee agreed to this amendment because they believed that the Legislature was already required to appropriate the money and that they were not sacrificing anything.<sup>57</sup> The language did not amend Measure 3.<sup>241</sup>

TFND and the TPC Executive Committee had to maintain the political pressure for several weeks while the TPC Advisory Committee was concurrently planning and working to launch the new state program, all the while knowing that the Session might end and they might have no funding to implement any of their plans.

On May 4, 2009, before the TPC Executive Committee delivered the language that they would accept to the Senate, House Majority Leader Al Carlson asked to meet with the group and see the proposed language. Carlson ostensibly agreed to the amendment because he and other House members had

**TFND and the TPC Executive Committee had to maintain the political pressure for several weeks while the TPC Advisory Committee was concurrently planning and working to launch the new state program.**

increasingly become concerned with a potential voter backlash over refusing to fund the program created by the voter-initiated measure and feared negative political consequences when they sought re-election.<sup>242</sup> Jeanne Prom recalled in an interview for this research that “in the final hour of this session, we got approved after there was a lot of public letters to the editor [and] talk shows haranguing the legislators – specifically Al Carlson in Fargo – for not respecting the will of the voters.”<sup>60</sup> In the end, Carlson urged the Republican Caucus to agree to the amendment and to appropriate the money to the TPC Executive Committee. Senate Majority Leader Bob Stenehjem agreed to the amendment language as well.<sup>241</sup>

On May 4, 2009, Sen. Bob Stenehjem offered, and the Senate floor adopted, an amendment to HB 1015, which included similar provisions to those the Senate, had originally passed in SB 2063 to appropriate the Strategic Contribution Funds to the Measure 3-created TPC Executive Committee. Specifically, the amendment provided a \$12.9 million appropriation to the TPC Executive Committee with authorization to hire four full-time employees and an emergency clause that provided an immediate retroactive reimbursement to the TPC Executive Committee for its costs incurred in establishing the new state plan.<sup>243</sup> However, the amendment did not include the emergency clause that would pay the TPC Executive Committee its full appropriation immediately as the TPC Executive Committee had wanted; the Executive Committee would have to wait until July 1, 2009 to receive its full appropriation. The final Senate-approved language included the amendment for the Water Development Trust Fund that the TPC Executive Committee and STP had agreed to. Now, with the support of the House leadership as well, HB 1015 passed through Conference Committee with the TPC Executive Committee appropriation intact and Gov. Hoeven signed the bill on May 11, 2009.<sup>241</sup>

Throughout the funding battle, the TPC Advisory Committee and STP asked supporters throughout the state to contact their legislators and to tell them that the supporters expected the Legislature to fund the program the voters had approved. This strategy proved effective; Mangskau explained in a 2011 interview for this research that strong grassroots advocacy was what seemed to motivate the Legislature, more so than the threat of a lawsuit.<sup>57</sup>

Mike Jacobs of the *Grand Forks Herald* published an editorial that opined that a large part of House Republicans’ opposition to appropriating the money stemmed from their dislike of Heidi Heitkamp, who ran for Governor in 2000 on the Democrat ticket and could be a viable candidate in future years.<sup>244</sup>

The TPC Advisory Committee had been forced to concentrate its energy on working to get the Legislature to appropriate funding for its first two years of work while simultaneously planning, developing, and preparing to implement the new program. Kathleen Mangskau explained that, “because the committee had to spend so much time working to try to get this money appropriated, the planning and implementation of the new program was delayed. Instead, we spent our time trying to justify the appropriation that the people had already voted on.”<sup>66</sup> Nevertheless, the TPC Executive received its appropriation, and it could now move forward with the launch of the new program.

## **Conclusion**

In 2008, tobacco control advocates in STP introduced, and voters subsequently enacted, Measure 3. Measure 3 created a new independent tobacco control program and allocated the incoming Strategic Contribution Funds (SCF) to the Measure 3-created Tobacco Prevention and Control Trust Fund to fund the new programs. The TPC Advisory Committee would create the new comprehensive state plan and the TPC Executive Committee would implement the new plan. Despite the voter mandate, in the 2009 Legislative Session, House Republicans balked and attempted to repeal Measure 3 and divert the funding to the Department of Health. Dr. Terry Dwelle, State Health Officer, wrote a letter of support for increasing funding for tobacco control programs, but refused to sign on as a full endorser of Measure 3. The DOH was not actively supportive of Measure 3. Tobacco control advocates remained mobilized throughout the session, getting local advocates to contact their legislators, and generating a large amount of favorable coverage in the press. As a result of public pressure, unwavering tobacco control advocates who threatened to sue the Legislative Assembly if it did not appropriate the money, and a lack of a two-thirds majority in both Houses (which was required to amend a voter-initiated law within seven years of passage), the Legislature funded the new agency and left the Measure 3 language intact.

Passing Measure 3 and winning the battle with the Legislative Assembly over the appropriation was an important success for North Dakota tobacco control leaders. However, tobacco control leaders were forced to devote time and resources to working to get the Legislative Assembly to appropriate funding, which was a distraction at a time when they were working to create the new state plan that Measure 3 mandated. Threats to the new program's funding and its independent structure were anticipated to recur each biennium when the Legislative Assembly met.



## CHAPTER 7: FORMING THE CENTER FOR TOBACCO PREVENTION AND CONTROL POLICY

- In addition to fighting with the Legislature to appropriate its funding, the TPC Advisory Committee spent the first half of 2009 working with the DOH, CDC and national tobacco control program consultants to create a comprehensive plan and an annual work plan based on CDC *Best Practices*. The work plan divided program responsibilities among the state partners.
- The TPC Executive Committee and DOH leaders decided that the TPC Executive Committee would manage a statewide health communications campaign and fund LPHUs to focus on coalition building and stronger local tobacco control policies.
- The DOH would continue to work on surveillance and cessation programs with an emphasis on the state tobacco Quitline.

At the same time that the legislative fight for appropriation was going on, the Tobacco Prevention and Control Advisory Committee (TPC Advisory Committee) was developing its new statewide five-year tobacco control plan. Measure 3 required the Advisory Committee to create a “comprehensive statewide tobacco prevention and control program that is consistent with the centers for disease control best practices for comprehensive tobacco prevention and control programs [sic] and does not duplicate the work of the community health grant program.”<sup>164</sup> The community health grant program was the tobacco control program based in the North Dakota DOH funded with the regular MSA payments (not Strategic Contribution Funds) and with CDC’s annual NTCP grants.

The tobacco control leaders who wrote Measure 3 did not want to replace the DOH Division of Tobacco Prevention and Control (TPC)’s Community Health Grant Program, which had been underfunded and had funding restrictions since it was created in 2001, but rather create complementary activities that would go beyond what DOH had been doing. In the 2009 Legislative Session, the Legislature no longer appropriated the DOH’s tobacco control program funding as part of the Community Health Grant Program and instead provided the DOH with a lump sum for tobacco prevention and control programs. The Community Health Grant Program was not formally repealed; it was just no longer funded. As a result of the Community Health Grant Program being defunded, those programs no longer existed and could not be duplicated by new TPC Advisory Committee and be interpreted as a violation of Measure 3. Measure 3 prohibited supplanting other tobacco control funds so the Legislature was still required to fund the DOH to work on tobacco control programs.<sup>164</sup>

**The tobacco control leaders who wrote Measure 3 did not want to replace the DOH Division of Tobacco Prevention and Control Community Health Grant Program, but rather create complementary activities that would go beyond what DOH had been doing.**

The year before, in 2008, the DOH had released its *On the Path to a Healthier Tomorrow - North Dakota's Strategic Plan for Tobacco Use Prevention and Reduction*,<sup>95</sup> a five-year tobacco control plan. The TPC Advisory Committee used the DOH’s plan as the starting point for crafting its plan, but expanded upon the DOH plan because the Committee did not feel that

the DOH's plan followed *Best Practices* closely enough.<sup>28, 57</sup> Kathleen Mangskau explained that the Committee's largest issue with the DOH's plan was its focus on youth, school curricula, and cessation. At the time that the DOH's plan was drafted, 40 percent of the DOH's tobacco control funding, which was appropriated for the Community Health Grant Program, had to be used for school programs. (This 40 percent requirement ended in the 2009-2011 biennium when the Legislature stopped appropriating funds to the Community Health Grant Program.)

Measure 3 did not require the DOH to be involved with the new tobacco control program, but the TPC Executive Committee requested and the Legislature appropriated its funding with the expectation that the two programs would cooperate to facilitate North Dakota's "comprehensive program." CDC recommended North Dakota fund its tobacco control effort at \$9.3 million annually<sup>28</sup> and for the FY 2009-2011 biennium, the Legislature appropriated \$6.45 million annually to TPC Executive Committee and \$1.75 million annually from the DOH Community Health Trust Fund for tobacco control. Combined with the \$1.15 million annually anticipated from CDC's NTCP grant these appropriations reached the \$9.3 million that CDC recommended.<sup>28, 77</sup>

DOH Tobacco Prevention and Control staff agreed to participate on the five planning committees established by the TPC Advisory Committee<sup>63</sup> to work to incorporate each of the five components of CDC's 2007 *Best Practices for Comprehensive Tobacco Control Programs*<sup>28</sup> into the new state plan. DOH staff, including Director Karalee Harper, regularly attended Advisory Committee meetings.

### **The Division of Roles Between the New Agency and the Department of Health**

In January and February, as the 2009 Legislative Session began to meet, the newly-appointed TPC Advisory Committee met with the DOH and informally divided the various *Best Practice* components between the two agencies.<sup>57, 245</sup> The new statewide plan would integrate with and update the existing DOH plan drafted one year earlier.

The TPC Executive Committee members met with Arvy Smith, Deputy State Health Officer, Karalee Harper, DOH Director of the Division of Tobacco Prevention and Control, DOH Outreach Coordinators Neil Charvat and Kara Dodd, and Cessation Coordinator Michelle Walker (promoted to Director of the DOH Tobacco Prevention and Control Program in 2011). Harper, Charvat, Walker and Dodd also attended most TPC Advisory Committee and some TPC Executive Committee meetings through 2011. The DOH was already handling surveillance as the administrator of the Behavior Risk Factor Surveillance Survey (BRFSS for adults), Youth Risk Behavior Surveillance System (YRBSS for youth) and the North Dakota Youth Tobacco Survey (NDYTS for youth) and it was agreed that they would continue doing so. The DOH was also handling cessation programs and managing the state Quitline and advertisements promoting the Quitline, and was to continue doing so. The TPC Executive Committee would not be funding Quitline operations, but would work with Local Public Health Units to adopt the Public Health Service guidelines to ask, advise and refer patients and clients to the Quitline.

The TPC Advisory Committee wanted to prioritize health communications with a hard-hitting statewide media campaign and also wanted to significantly increase funding for Local

Public Health Units to address tobacco control issues at the local level specifically focused on educating about the health hazards of secondhand smoke, and the need for passing stronger local tobacco control policies, particularly smokefree air ordinances.<sup>57, 60</sup> (Health communications included the media campaign, a frequent target of political interference.<sup>92, 135, 246, 247</sup>) The DOH had no statewide media campaign because the Legislature did not allocate funding explicitly for it; instead the statewide tobacco control health communications came from the Public Education Task Force (PETF) which was organized independently by the Local Public Health Units (LPHUs) pooling their money together (discussed earlier).

In February 2009, the TPC Advisory Committee asked the CDC's Office of Smoking and Health, which wrote the *Best Practices*<sup>28</sup> program guide, to visit in order to discuss what programs could be considered Best Practices and to assist in the construction of a new state tobacco control plan. On February 20, 2009, CDC's Monica Eischen and Judy Ahearn visited North Dakota and conducted a seminar on *Best Practices* for the Advisory Committee.<sup>248</sup>

The TPC Advisory Committee also vetted the plan, seeking input from different state public agencies, private organizations and from the general public. The Committee held five community forums between April and May 2009 seeking public comment on the plan and the new agency. The forums were publicized and policymakers were invited to attend as well.<sup>57</sup> Policymakers attended some of the forums, including in Bismarck and Minot.<sup>66</sup>

### *Negotiations to Divide the Responsibilities*

The TPC Advisory Committee and the DOH Division of Tobacco Prevention and Control met throughout the spring and summer of 2009 in an effort to effectively divide the five sections of CDC's *Best Practices for Comprehensive Tobacco Control Programs* – State and Community Interventions; Health Communication Interventions; Cessation Interventions; Surveillance and Evaluation; and Administration and Management – so that they would be collectively and effectively implemented by the separate agencies in a coordinated manner.

### *State and Community Intervention Local Grants*

Because the DOH had administered local grants since the 2001-2003 biennium through the Community Health Grant Program (created and funded with MSA money by the legislature in 2001) and supplemented with money from its annual CDC grant, there was already an infrastructure and a working relationship between the DOH and the Local Public Health Units in 2009 when the new program was formed. Until the formation of the TPC Executive Committee, DOH and its contractors had been the sole providers of technical assistance to local tobacco control advocate grant recipients.

With the creation of the new agency, the Legislature no longer appropriated funding explicitly for the Community Health Grant Program and instead provided the DOH with a lump sum MSA appropriation for tobacco control programs that the DOH could use at its discretion. The DOH was going to use those MSA funds for state tobacco “cessation programs and services”<sup>249</sup> and continue providing local tobacco control grantees with funding from its CDC grant. However, because the DOH had this preexisting relationship with local tobacco control grantees and a staff that could provide necessary time-consuming administrative work like



writing individual contracts for each LPHU, the TPC Executive Committee planned to transfer its funds for local tobacco control grants to the DOH and arranged with the DOH Division of Tobacco Prevention and Control to have the DOH administer the grants of the TPC Executive Committee's money to LPHUs.

In addition to administering the TPC Executive Committee's funds and continuing to administer its own local CDC tobacco control grants, the DOH agreed to provide technical assistance to the local grantees.<sup>57, 63, 133</sup> The TPC Executive Committee believed that it would be less confusing and easier for local advocates to meet their goals if they only had to meet goals for one funding stream.

Throughout spring of 2009, while waiting for the Legislative Assembly to appropriate its funding, Mangskau and other members of the TPC Advisory Committee met with the DOH in efforts to formalize a formula for administering local grants and to finalize plans for the DOH's implementation of the TPC Executive Committee's local grants.<sup>250, 251</sup> Initially, the plan was that the DOH would administer two streams of grant money and provide technical assistance to grantees: 1) the SCF funds received from the TPC Executive Committee and 2) the CDC NTCP grant.<sup>57</sup> The TPC Executive Committee wanted their grants to support LPHUs in their efforts to educate on the need for passing stronger tobacco control policies. Both agencies agreed that promoting policy change would be the focus of the TPC Executive Committee's funding.<sup>57</sup>

The DOH's position changed throughout these negotiations. As discussed below, the DOH eventually decided that the TPC Executive Committee should administer the grants itself just days before the TPC Executive Committee received its first appropriation. The DOH would provide technical assistance to the grantees as previously agreed.

### *Health Communications*

The TPC Advisory Committee was adamant that the new agency be responsible for administering the health communications component of *Best Practices* because legislators had a history of trying to control the content of tobacco control media campaigns by putting pressure on the DOH.<sup>57</sup> As discussed above, the 28 local public health units, beginning in 2002, formed the Public Education Task Force (PETF) on Tobacco, pooled funding together and ran a statewide campaign. The TPC Advisory Committee anticipated that funding its statewide media campaign would lessen the financial burden on the LPHUs that continued to fund the statewide media campaign. At the same time, the PETF planned to remain intact and to continue working closely with the statewide media campaign led by the TPC Executive Committee.<sup>96</sup>

### *Surveillance and Evaluation*

CDC's *Best Practices* required state programs to have surveillance programs that monitored tobacco use, tobacco-related attitudes, behaviors, and health outcomes.<sup>28</sup> The DOH was responsible for collecting this data on tobacco use and tobacco-related attitudes and behavior. The DOH historically administered adult surveys such as the Behavior Risk Factor Surveillance Survey (BRFSS) as well as youth measurements of tobacco use such as the Youth

Risk Behavior Surveillance System (YRBSS) and the Youth Tobacco Survey (YTS) and would continue to do so because it had staff to manage the data collection and interpretation.

The TPC Advisory Committee would focus on outcomes evaluation of their programs. Measure 3 required that each year, the TPC Advisory Committee review the implementation of the state plan and determine if any necessary alterations were needed. The other state partners, including the DOH and LPHUs, also attended the annual meetings to update the plan.<sup>252</sup> The TPC Executive Committee was also to hire an external evaluator every two years to ensure that the plan was in compliance with *Best Practices*.<sup>57</sup>

### *Cessation*

Cessation activities were divided between the DOH and the TPC Executive Committee. The DOH had used its MSA and CDC money to manage the state Quitline and Quitnet and promoted the Public Health Service's (PHS) Clinical Practice Guideline *Treating Tobacco Use and Dependence*,<sup>253</sup> which included "Ask, Advise and Refer" guidelines, to encourage tobacco users to use Quitline and other cessation services. The DOH would continue to work with private hospitals and clinics to get them to incorporate Quitline promotion into their clinical protocols.

The TPC Executive Committee was to take on the responsibility of administering Tobacco Settlement State Aid, but would focus its funds on LPHUs. The DOH had historically received \$940,000 in MSA funds biennially as part of its Community Health Grant Program and issued grants to LPHUs for health programs which could have a tobacco component, but a tobacco component was not required. For the 2009-2011 biennium, the Legislature no longer funded the Community Health Grant Program, instead providing the DOH with a lump sum appropriation, which did not include the Tobacco Settlement State Aid funds. The TPC Executive Committee would grant \$940,000 (the same amount LPHUs received in earlier years) of its appropriation to fund LPHUs to promote the PHS guidelines in their client-based health counseling programs (discussed in later sections).<sup>66</sup>

### *Administration*

The TPC Executive Committee and the DOH each would require staff and materials and would generate administrative costs. CDC's *Best Practices* says that an effective statewide program can use five percent of its funds for administration. Each agency would absorb its own administrative costs, but the DOH agreed to serve as the fiscal agent for TPC Executive Committee and to provide accounting services for the new agency, and agreed to provide administrative staff that would administer the additional funding for local tobacco control grants that the TPC Executive Committee would fund. Believing this to be the agreement, the TPC Executive Committee requested from the Legislature the authorization to hire only four full-time equivalents (FTEs) for their 2009-2011 biennial budget.<sup>57</sup> For the 2009-2011 biennium, the DOH Division of Chronic Disease had at least seven employees working either full or part-time on tobacco control.<sup>254</sup> The new agency would only be able to hire four full-time employees and would not be able to hire additional staff until the 2011-2013 biennium appropriation, assuming that the Legislature agreed to authorize more employees.<sup>57</sup>

## The New Tobacco Control Program is Finalized Along with a Year One Work plan

The TPC Advisory Committee wanted the new agency to focus on changing tobacco control policy. The five-year plan's targets for reaching most tobacco control policy goals were set for several years later to give the program time to create the necessary infrastructure to achieve these goals. The TPC Advisory Committee set the goal of increasing the cigarette excise tax to \$2 and strengthening the statewide clean indoor air law by June 2013. The Committee also wanted to increase the number of local smokefree ordinances from the two in July 2009 (Fargo and West Fargo, which passed ordinances covering restaurants and bars in 2008)<sup>85</sup> to five by June 2012. To support the necessary local coalition building, the TPC Advisory Committee made grants to the local public health units (LPHUs), one of its two major priorities, along with a strong statewide health communications media campaign.<sup>57</sup>

**The TPC Advisory Committee wanted the new agency to focus on changing tobacco control policy.**

The *Saving Lives – Saving Money* plan built on the *On the Path to a Healthier Tomorrow* that the DOH released in 2008. The DOH was involved in the drafting of the TPC Advisory Committee's *Saving Lives – Saving Money* plan and agreed to work toward the objectives of the new plan. The DOH also planned to develop its own internal working plan to work on programs not included in the TPC state plan using its annual CDC grant (Discussed in later sections).<sup>63</sup>

The TPC Advisory Committee's state plan would consist of four goals: 1) Prevent the initiation of tobacco use among youth and young adults; 2) eliminate exposure to secondhand smoke; 3) promote quitting tobacco use; 4) build capacity and infrastructure to implement a comprehensive evidence-based tobacco prevention and control program (Table 23).<sup>118</sup> Each goal was supported by multiple objectives and subsequent action steps to reach the goal, as well as progress indicators to be monitored.

While drafting the five-year plan, the TPC Advisory Committee, with the assistance of the DOH and CDC, created an annual joint work plan – which was subsequently updated annually through meetings between both agencies<sup>255, 256</sup> – that divided the responsibilities among the new agency directed by the TPC Executive Committee, the DOH, LPHUs and other state partners, and provided clear strategies and action steps for each state partner to take in order to meet the goals and objectives of the overarching five year plan.<sup>257</sup> (For full text, see Appendix A.)

The TPC Advisory Committee officially launched the new five-year state plan on July 07, 2009; the plan was called *Saving Lives-Saving Money: North Dakota's Comprehensive State Plan to Prevent and Reduce Tobacco Use, 2009-2014*.<sup>258</sup> (Appendix A) The DOH's role in state tobacco control was not specifically discussed in the five-year plan but the annual work plans that specified each agency's responsibilities explained the DOH's role.<sup>257</sup>

<b>Table 23: Goals and Objectives of the TPC Advisory Committee Five-Year Plan<sup>118</sup></b>	
<b>Goal</b>	<b>Objectives</b>
<i>Prevent the initiation of tobacco use among youth and young adults</i>	Increase cigarette tax to \$2/pack by June 2013.
	Expand state clean indoor air law to make public places and places of employment smokefree and to expand enforcement by June 2013.
	Increase number of local smoking ordinances for 100 percent smokefree public places and places of employment to FIVE by June 2012.
	Increase percentage of school districts with tobacco-free school policies to 50 percent.
	Increase number of public and private post-secondary institutions with tobacco-free campuses to ELEVEN.
<i>Eliminate exposure to secondhand smoke</i>	Expand state clean indoor air law to make public places and places of employment smokefree and to expand enforcement by June 2013.
	Increase number of local smoking ordinances for 100 percent smokefree public places and places of employment to FIVE by June 2012.
	Prevent preemption in all state tobacco control laws passed.
<i>Promote quitting tobacco use</i>	Increase cigarette tax to \$2/pack by June 2013.
	Expand state clean indoor air law to make public places and places of employment smokefree and to expand enforcement by June 2013.
	Increase number of local smoking ordinances for 100 percent smokefree public places and places of employment to FIVE by June 2012.
	Increase annual use of Quitline to a minimum of TWO percent of all smokers and smokeless tobacco users.
	Incorporate national standards for tobacco use treatment.
	Increase to a minimum of THREE of ND's largest employers who cover tobacco cessation medication and services.
	Increase number of third-party members that include tobacco cessation medications and services as a standard health benefit.
	Add nicotine dependence to addiction treatment and mental health programs.
<i>Build capacity and infrastructure to implement a comprehensive evidence-based tobacco prevention and control program</i>	Develop an administrative structure to manage new program by January 2010.
	Build local infrastructure and capacity to deliver programs at all LPHUs and tribal health centers by June 2010.
	Create and implement high-impact health communication initiative by June 2010.
	Develop statewide surveillance and evaluation plan for the statewide program by January 2010.
	Sustain the comprehensive program in conformance with CDC recommendations.
<b>Note:</b> There is some repetition because many objectives and goals overlap.	

On July 31, 2009, the TPC Executive Committee, which was responsible for implementing the five-year plan, adopted the name Center for Tobacco Prevention and Control Policy (the Center) for the agency that would hire staff to manage the program. As is discussed below, the TPC Executive Committee did not hire any staff for the Center until October 2009

when it hired its Executive Director. The TPC Executive Committee primarily worked on administering local grants during its first several months.

### ***The Department of Health Decides Not to Administer the TPC Executive Committee's Community Grants***

The TPC Advisory Committee and the DOH went through an extensive process of drafting a formal memorandum of understanding (MOU, sometimes referred called a Memorandum of Agreement, MOA) to delineate responsibilities for the TPC Executive Committee's local grants program. The TPC Executive Committee believed, based on meetings with the DOH, that the TPC Executive Committee was going to transfer funds to the DOH for the DOH to administer grants to the LPHUs for local coalition building. In June 2009, Kathleen Mangskau, Chair of the TPC Advisory and Executive Committees, was called to a meeting at the DOH and was informed that the DOH would not accept the new agency's funds and had decided not to oversee its grants program.<sup>57, 140</sup>

In a letter to Local Public Health Unit Directors, Arvy Smith, Deputy State Health Officer explained:

During the 2009 legislative session there was discussion regarding the possibility of passing grants available through Measure 3 funding through the DoH to the local public health units in order to make use of systems already in place at the DoH and avoid inefficiencies of recreating these systems in a new agency. However after further thought, the DoH has decided it is best to directly contract those funds between TPCEC and the LPHUs. We believe this new arrangement for distributing the funds will provide clear lines of authority regarding the use of funds from the Tobacco Prevention and Control Trust Fund.<sup>249</sup>

Arvy Smith, Deputy State Health Officer, said in a 2011 interview for this research that the DOH leadership (comprised of gubernatorial appointees) was concerned that the Governor would be upset if the DOH funded programs geared towards passing tobacco control policies. Smith thought it best that the LPHU funding come directly from the TPC Executive Committee, which was a separate agency.<sup>133</sup> Smith also explained that her decision not to have the DOH administer the local grants so close to the time of the appropriation was not "game playing" and the DOH subsequently assisted the TPC Executive Committee to administer the grants and to provide technical assistance to the local grantees.<sup>133</sup>

However, the TPC Executive Committee did not have the staff to administer the grants. The TPC Advisory Committee was scheduled to meet twice in July 2009 to review the grant applications submitted by LPHUs. Once decisions were made regarding the proposals, each individual approved contract had to be written. Additionally, not all grant applications were immediately approved; some required LPHU revision and resubmission and those prospective grantees required guidance. However, the TPC Executive Committee still had no staff, met once a week and was comprised of members with other full-time jobs. For these reasons, the Committee had planned for the DOH staff to handle this work. Kathleen Mangskau explained, "I posed a question, because we weren't set up to do it at that point. We had no staff. I said, 'well,

what happens if the Center decides they don't want to do it [administer the grants]?' And their [the DOH's] answer was, 'then there won't be a grants program.'"<sup>57</sup>

Mangskau explained further in 2012 correspondence for this research that if the DOH had administered the grants that the TPC Executive Committee could have focused its efforts on establishing an agency office and interviewing and hiring agency staff.<sup>66</sup> Still, the DOH explained in a 2012 correspondence for this research that the TPC Executive Committee still would have had to have reviewed and approved any grants before the DOH could issue them and that the DOH's decision to not administer the grants did not cause the delays that the TPC Executive Committee argued.<sup>140</sup>

Because the DOH agreed to provide technical assistance to the TPC Executive Committee's grantees with the TPC Executive issuing the grants and overseeing their grantee's progress, the DOH and the TPC Executive Committee tried to reach an MOU to divide responsibilities, but continually could not agree.<sup>60, 87</sup> The DOH Division of Tobacco Prevention and Control Director, Karalee Harper, felt it would be confusing for the DOH staff who would be working closely with the new agency led by the TPC Executive Committee but being supervised by DOH leadership.<sup>133</sup> The TPC Executive Committee also reportedly took issue with portions of the draft MOU without specifying the specific areas of disagreement.<sup>87, 140</sup> Harper explained in a 2011 interview for this research that in the absence a formal agreement, the agencies were left with a verbal agreement regarding the division of programmatic responsibilities for the grants.<sup>63</sup> The TPC Executive Committee and the DOH continued meeting in efforts to reach a formal agreement until February 2010 when the two agencies failed to agree to a ninth MOU.

**The DOH and the TPC Executive Committee tried to reach an MOU to divide responsibilities, but continually could not agree.**

The DOH continued providing technical assistance to local grantees until March 2010 when the TPC Executive Committee reissued its local grant guidance as planned. At that time, the TPC Executive Committee began providing technical assistance to its local grantees.<sup>66, 140, 167</sup>

### ***The TPC Executive Committee Begins to Hire Staff for the Center for Tobacco Prevention and Control Policy (The Center)***

The TPC Executive Committee had been preoccupied with fighting for its appropriation until May 2009. Additionally, the DOH decided not to administer the LPHU grants in June 2009 and the TPC Executive Committee was forced to scramble to implement all of its programs and everything was delayed, including the hire of the Center's staff.<sup>167</sup> In mid-October 2009, after months of planning and interviewing, the TPC Executive Committee started to staff their new agency which, in July 2009, the TPC Advisory Committee had named the Center for Tobacco Prevention and Control Policy, or simply "The Center."<sup>259</sup> Thirty applications were received for the Executive Director position. The Executive Committee selected Jeanne Prom, former State Health Department Tobacco Prevention and Control Program Coordinator (1992-2001) as Executive Director of the new agency. Prom had played an integral role in the Measure 3 campaign, as well as during the Legislative Session in the struggle to get the new agency's

funding appropriated and had been an original TPC Advisory Committee member until April 2009 when she resigned from the Committee.<sup>260</sup>

Based on its request to the Legislature at a time when it believed that the DOH would be administering its local grants, the TPC Executive Committee was allowed to hire only four full-time employees to staff the Center. Prom said in a 2010 interview that, “I think one of our lessons learned is we understaffed. The staffing pattern is completely inadequate for what we intend to accomplish.”<sup>60</sup> The TPC Executive Committee hired Prom as the Center’s Executive Director in October 2009 and an administrative assistant in February 2010.<sup>261</sup> The TPC Executive Committee hired a Health Communication Coordinator in June 2010, and a Community Intervention Coordinator to provide technical assistance to local grantees in August 2010. However, this was not enough staff to handle the Center’s workload and the Center planned to ask the Legislative Assembly for the authority to hire 3.5 additional full time employees in the 2011 Legislative Session; the Legislative Assembly ultimately authorized one additional employee.

## **Conclusion**

In addition to fighting with the Legislature to appropriate its funding, the TPC Advisory Committee spent the first half of 2009 creating a new statewide tobacco control plan. The TPC Advisory Committee worked with the DOH, CDC and national tobacco control program consultants to create a plan based on CDC *Best Practices*. The new plan was ultimately called *Saving Lives – Saving Money* and centered on reducing tobacco use and exposure to secondhand smoke through passing stronger tobacco control policies, including stronger local smokefree air laws by 2012 and a comprehensive statewide smokefree law and a tobacco tax increase by 2013. In finalizing the five-year plan, the TPC Advisory Committee worked with DOH and CDC to create a detailed work plan for the first year of operation that divided the work responsibilities among the TPC Executive Committee, the DOH, and other state and local tobacco control partners. The work plan was updated annually after 2009.

The TPC Executive Committee and DOH leaders decided that the TPC Executive Committee would primarily manage a statewide health communications campaign and fund LPHUs to focus on coalition building and stronger local tobacco control policies. The two agencies initially decided that the TPC Executive Committee would provide additional funding for local tobacco control grants to LPHUs, but that the DOH, having a larger administrative staff, would administer the grants and provide technical assistance to the grantees until the TPC Executive Committee hired staff. The DOH Deputy State Health Officer Arvy Smith decided, shortly before the TPC Executive Committee was going to transfer the funds to the DOH, that the DOH would not administer the grants because the grants were to fund LPHUs to work on policy issues, but that it would have its outreach coordinators provide technical assistance to the TPC Executive Committee’s grantees as originally planned. The DOH was concerned about political backlash from the Governor’s office and did not want to be in a position where it would be expected to provide grants for activities that “could be inconsistent with the philosophies of a Governor the DOH takes direction from as a cabinet member.”<sup>140</sup> TPC Executive Committee members argued that the DOH’s last minute decision not to administer the grants forced the TPC Executive Committee to focus all of its time on writing and administering each grant, which

caused a several month delay in hiring staff – the TPC Executive Committee did not hire an Executive Director until October 2009 – which in turn, delayed the implementation of their programs. The TPC Executive Committee could not hire more than four full-time employees and argued that they would have requested the authority to hire more employees if they had known that the DOH was not going to administer the grants.

The TPC Executive Committee and the DOH determined that the DOH would continue to work on surveillance and cessation programs with an emphasis on the state tobacco Quitline, but that the TPC Executive Committee would begin to administer local Tobacco Settlement State Aid grants, which the DOH had previously issued but that the Legislative Assembly no longer funded beginning in the 2009-2011 biennium. The two agencies would maintain their own administrative staffs.





## CHAPTER 8: IMPLEMENTING THE NEW TOBACCO CONTROL PROGRAM

- The Legislative Assembly divided the state’s \$9.3 million (which included federal grants from CDC) funding for tobacco control activities between the DOH and the Center.
- The Center was required by Measure 3 to follow CDC *Best Practices*, and the DOH was required to follow *Best Practices* by the CDC grant that it managed; the DOH did not feel that it was required to spend its MSA funding on tobacco control programs sanctioned by *Best Practices*.
- From 2009 to 2011, the TPC Advisory and Executive Committees and the Center exceeded many of the goals established in the five-year state plan, including the implementation of local legislative and voluntary smokefree policies and increased usage of the state Quitline, ahead of schedule.

The activities of the new program managed by the TPC Executive Committee and its agency, the Center for Tobacco Prevention and Control Policy (the Center), focused primarily on local tobacco control coalition building and advocacy work through its local grants. The TPC Executive Committee wanted to ensure that the local tobacco control grants were administered immediately so that the funding, which would fund the bulk of the new programs, did not sit unspent. The Committee also began working on health communications, which was the statewide tobacco control media campaign. The TPC Executive Committee believed that the legislature would quickly call attention to Committee’s unspent funds, highlight it as a symptom of the TPC Executive Committee having more funding than necessary, and use that to defund the program in subsequent biennia. As discussed above, the TPC Executive Committee did not hire an Executive Director to manage the Center, Jeanne Prom, until October 2009. Prom then hired staff, with the approval of the TPC Executive Committee, to manage the local grants program, the statewide media campaign and to provide administrative support, but not until 2010.

**The TPC Executive Committee wanted to ensure that the local tobacco control grants were administered immediately so that the funding, which would fund the bulk of the new programs, did not sit unspent.**

### Community Grants and Special Initiative Grants to Organizations

#### *Community Grants to LPHUs*

The broad objectives of the Center’s community grant program were “to prevent and reduce tobacco use in North Dakota by strengthening state and community and school-based tobacco prevention and policy activities and assisting public health units in building capacity to coordinate local tobacco prevention and control program initiatives.”<sup>262</sup> The DOH, which originally was going administer the TPC Executive Committee’s local grants, issued a Request for Applications (RFA) at the request of the TPC Advisory Committee in May 2009, shortly after the TPC Executive Committee’s funding appropriation bill passed.<sup>66, 140</sup> The RFA invited applications for potential grantees that would be required to “deliver services in a culturally competent manner and include diverse service providers, including county health departments, schools and higher education institutions, businesses, health care systems and providers, law enforcement, local and statewide non-profit agencies, and others as recommended by Centers for

Disease Control and Prevention’s *2007 Best Practices for Comprehensive Tobacco Control Programs*.<sup>262</sup>

LPHUs that received funding would be required “to focus on: (1) the establishment of local and state policy and system changes to prevent initiation of tobacco use among youth and young adults (2) the establishment of policy and system changes to eliminate secondhand smoke exposure and (3) the establishment of local and state policy and system changes to assisting tobacco users with quitting.”<sup>262</sup> The TPC Advisory Committee created performance measures that local grantees were required to meet (Table 24) and grantees were required to submit a work plan with their applications which set goals known as “Local SMART (Specific, Measurable, Attainable/Achievable, Relevant, Time bound) Objectives” as the CDC recommended.<sup>263</sup>

<b>Table 24:</b> Performance Measures for Center Grantees, 2009-2010 <sup>262</sup>
Communicate with local elected officials regarding policy issues at least twice during the contract period. Communication may be newsletters, meetings, letters, reports, etc. and must be documented.
Submit a one page summary within 30 days after attending an out-of-state training/conference on how you will use the information received in your job, school or community.
Submit any requests for use of the Quitline logo (i.e., newspaper, newsletter, ads, banners, signs, etc.) to Cessation Coordinator for approval prior to publication.
Attend three of the four quarterly Tobacco Prevention and Control site coordinator meetings of the contract period.
Submit progress and expenditure reports by designated deadlines (Quarterly).
Attend all mandatory statewide meetings, trainings and participate on conference calls as determined by the Program.
Submit 3 out of the 4 quarters, accomplishments for the Tobacco-Free Times Newsletter.

Once the DOH decided not to administer the local grants, the TPC Executive Committee reviewed the applications from LPHUs in July and August 2009. As discussed in previous sections, the DOH decided at the last minute not to administer the grants, which the TPC Executive Committee argued created delays because the TPC Executive Committee had no staff to develop and administer the grants and ensure that they were executed.<sup>57, 66</sup> The TPC Executive Committee had awarded each of the LPHU grants by the end of October. However, as it had agreed, DOH outreach coordinators Neil Charvat and Kara Dodd provided technical assistance to the TPC Executive Committee’s LPHU grantees until March 2010.

In the 2009-2011 biennium, the TPC Executive Committee distributed \$6,941,512 (including \$940,000 in Tobacco Settlement State Aid, discussed below) in tobacco control grants to LPHUs. The DOH continued to administer local grants from its annual CDC grant and distributed \$844,495 in local grants for tobacco control programs in the same biennium.

Combined, the TPC Executive Committee and the DOH provided \$7,786,007 for local tobacco control programs, a 38 percent increase from the \$5,641,556 spent on local tobacco control grants in the 2007-2009 biennium. (The DOH had provided \$940,000 biennially in Tobacco Settlement State Aid grants in the 2007-2009 biennium but local grantees were not required to use it for tobacco control programs.)

The TPC Executive Committee took over responsibility for the DOH's Tobacco Settlement State Aid grants that the DOH had issued to LPHUs since 2001 from MSA money that was appropriated to the DOH as part of the Community Health Grant Program. Beginning in the 2009-2011 biennium, when the Legislature stopped appropriating funding to the Community Health Grant Program, the TPC Executive Committee began distributing to LPHUs \$940,000 to replace the State Aid grants previously distributed by the DOH, to promote the Public Health Service's (PHS) Clinical Practice Guideline *Treating Tobacco Use and Dependence*.<sup>253</sup> These guidelines included "Ask, Advise and Refer" guidelines for local physicians and other health-care providers to follow to encourage tobacco users to use cessation services and/or Quitline promotion into their clinical protocols. The DOH stopped issuing Tobacco Settlement State Aid grants to LPHUs, but continued to use its funds to promote the PHS guidelines in hospitals, as it had previously, and worked to integrate Ask, Advise and Refer recommendations into the state's electronic medical records system. It is unknown how much the DOH is using for these programs because the DOH did not provide the authors of this report with complete expenditure data.

The Center hired Kelli Ulberg as its Community Intervention Coordinator in August 2010, over a year after its original July 2009 appropriation, to take over the role of providing technical assistance to local grantees.<sup>264</sup> As part of the Center's role providing technical assistance to local grantees, Ulberg hosted a monthly conference call for all tobacco control partners, including LPHUs, Tobacco Free North Dakota (after it hired an Executive Director in winter 2010 with a grant from the Center) and other state health and community organizations like the North Dakota Medical Association and the North Dakota School Board Association. The Center invited national organizations, including the Campaign for Tobacco-Free Kids and Americans for Nonsmokers' Rights to sometimes join the calls to provide technical assistance. The Center invited North Dakota ACS and ALA to participate, but they rarely joined. AHA was not invited to participate and there was no working relationship between AHA and the state program leaders who passed Measure 3. The state DOH was invited and at times participated.<sup>140</sup>

The Center also hosted grant-writing workshops for LPHU leaders to learn how to seek additional funding sources for their programs, as well as statewide trainings on creating and supporting smokefree policy change. LPHU participants learned about which arguments for smokefree were most persuasive, general action plans to adapt to specific communities, and tips for preparing for and meeting with policy makers in order to convey the importance of the stronger smokefree policies. Local tobacco control coordinators were required to attend and they were encouraged to bring local coalition members with them for the training.<sup>265</sup>

### ***Special Initiative Grants to Organizations***

The TPC Executive Committee created a Special Initiative Grants program primarily to fund organizations throughout the state to work on tobacco control issues.<sup>266</sup> These grants

supported building stronger tobacco control infrastructures and, in many cases, funded organizations that had limited funding to hire personnel to work on tobacco control. The TPC Executive issued a total of \$1,163,414 in Special Initiative Grants in the 2009-2011 biennium (Table 10). The American Lung Association (ALA) had been consistently limited in its activities for several years due to a lack of funding. The TPC Executive Committee gave ALA a \$70,000 grant from October 2010 to June 2011 to allow ALA to increase grassroots education activity in the state and to fund a portion of Kimberlee Schneider's salary, who ALA hired as its manager of advocacy.<sup>78</sup> With money from National ALA, Schneider also registered as a lobbyist in the 2011 Legislative Session and was active on a campaign to prevent the Legislature from amending Measure 3, as well as on Bismarck's smokefree air ordinance campaign that began in 2009 and culminated in 2011 with a comprehensive ordinance. This Special Initiative Grant allowed ALA to increase its presence at the state and local level and to educate policy makers and the community on tobacco control policy issues. ALA received a second Special Initiative grant for \$100,000 in 2011.<sup>167</sup>

Additionally, from October 2010 to June 2011, the TPC Executive Committee provided a Special Initiative Grant of \$72,398 to Tobacco Free North Dakota (TFND), which had been reorganizing as a coalition from 2007-2009, but had not had funding to hire a full-time staff person.<sup>78</sup> With a full-time Executive Director, TFND became a leader in tobacco control policy issues in the state.<sup>57</sup> TFND's Executive Director also registered as a lobbyist with funding from other sources in the 2011 Legislative Session which increased the reorganizing coalition's strength on state tobacco control issues. TFND had never had an Executive Director before.<sup>66</sup> During negotiations to appropriate MSA money in 1999 and 2001, TFND lacked leadership and funding, which were reasons for its inactivity in the years that followed.

**With a full-time Executive Director, TFND became a leader in tobacco control policy issues in the state.**

Other notable Special Initiative Grants included a \$25,000 grant to Americans for Nonsmokers' Rights who provided in-state trainings and technical assistance for local coalitions considering or actively working on smokefree ordinance campaigns, and \$143,597 to Minot State University to contract Kelly Buettner-Schmidt, a long time local tobacco coordinator in Minot and Assistant Professor of Nursing at Minot State University, to function as an additional community intervention coordinator and advise local grantees on managing their local education and advocacy work.<sup>266</sup> These grants provided additional resources for local grantees working on tobacco control policy in their communities.

### ***Health Communications***

The TPC Advisory Committee's five-year plan prioritized establishing a strong health communications campaign and allowed the Center one year (to June 2010) to create and implement a high impact tobacco control media plan. The Public Education Task Force on Tobacco (PETF, the group of LPHUs that had been leading the statewide media campaign since 2002) had limited funds and any funds that the PETF used on statewide media were funds that LPHUs did not have for coalition building and policy work at the local level. Therefore, the TPC Executive Committee planned to hire a Health Communication Coordinator and manage a

tobacco control media campaign from the Center with the money secured by Measure 3. The TPC Executive Committee hired Donna Thronson as its Health Communications Coordinator in June 2010.<sup>267</sup> However, as the TPC Executive Committee was working to establish itself as an agency, it granted a Special Initiative Grant to Upper Missouri Health District (the PETF fiscal manager) in the amount of \$827,419 to continue to manage the statewide media campaign until the TPC Executive Committee could vet a media vendor and develop a new statewide plan.<sup>67</sup>

In summer of 2010, the Public Education Task Force (PETF) surveyed North Dakota residents to measure perceptions of tobacco. In August 2010, the Center contracted with the PETF (Upper Missouri Health Unit) to perform a random survey of 600 North Dakota adults (18+ years old) stratified by county. The primary objectives of the survey were to:

- Identify the best messages for a tobacco control campaign,
- Measure awareness of current tobacco related issues,
- Assess perceptions of various issues related to tobacco,
- Gauge support for an increase in North Dakota's tobacco tax,
- Determine public perception of tobacco companies,
- Establish benchmark data for use in analyzing future studies.<sup>268</sup>

The survey found that a majority of North Dakota adults were concerned about the health effects of tobacco use, especially the diseases caused by exposing loved ones to secondhand smoke. The survey report concluded:

The messages that would work best in convincing North Dakotans that all public places, including bars, should be smoke free are those that contain information regarding the number of cancer causing agents and chemicals in secondhand smoke and everyone having a right to clean air. Other messages that played well with residents related to secondhand smoke hurting loved ones, secondhand smoke causing serious health problems in non-smokers, and needing to eliminate smoking in bars to protect the bar's employees.<sup>268</sup>

The survey also found that North Dakota adults were not concerned with the behavior of the tobacco industry and considered the tobacco industry to be no different than any other corporate activity. In using this information, tobacco control advocates recommended that:

North Dakotans don't seem to have an overly negative perception of tobacco companies. While they [North Dakotans] seem to see some of the dangers of smoking, they separate those thoughts from their opinions regarding the tobacco industry. This is likely due to the traditionally conservative views held by North Dakota residents, which favor individual responsibility and business rights. Given this issue, care must be taken when utilizing any messages that villainize tobacco companies as they have the potential of being perceived as attacks on "innocent" entities.<sup>268</sup>

Experiences in California, Massachusetts, and from the Florida "truth" campaign have shown that, in addition to secondhand smoke, advertisements highlighting the tobacco industry's malfeasances were successful in altering public perception of tobacco issues and in gaining support for tobacco control policies.<sup>269, 270</sup> The Center had not launched any industry-focused

media campaigns when this research was being conducted though it planned to in future campaigns.<sup>271</sup> The Center and the PETF used the results of its survey to plan its health communications campaign which would build on the statewide media campaigns that the PETF had been leading in earlier years with little state program involvement.

The TPC Executive Committee issued a request for proposals for a firm to help develop and implement a media campaign. The Executive Committee received 12 proposals and it considered nine of them (three were unresponsive).<sup>105</sup> Proposals were evaluated based on 1) Marketing, advertising and media placement, 2) public relations, and 3) research, surveillance and evaluation.<sup>272</sup> Odney, a North Dakota-based advertising, marketing and public relations firm with experience running tobacco control media campaigns for PETF received the highest score and was awarded the contract.<sup>271</sup>

The PETF's previous campaign had focused on the health effects of secondhand smoke and the benefits of making all public places and workplaces smokefree. PETF began focusing on smoking in bars in a campaign beginning in 2006 after the Legislature had exempted bars from its 2005 clean indoor air law.<sup>102</sup> The Center's media campaign continued to use similar messages but, in January 2011, added a new campaign focusing on the monetary costs of tobacco incurred by individual taxpayers as a result of tobacco-induced healthcare costs.<sup>271</sup> The cost campaign featured the tagline "Tobacco. We all pay the price." One television advertisement featured a young man buying an 86 cent drink at a convenience store where the cashier insisted on charging him \$564 for the cigarettes (that he was not buying), referring to the per capita cost of smoking borne by North Dakotans (Figure 11). The advertisements featured the two characters referring to each other as "Dude" and the advertisement was dubbed the "The Dude" advertisement.

Since 2002, PETF had contracts with Winkelman Consulting, from Fargo, North Dakota, to survey North Dakotans' responses to tobacco control advertisements.<sup>102</sup> The 2010 Winkelman report found that from 2002 to 2010, respondents age 18-54 who believed that secondhand smoke was "very harmful" to nonsmokers visiting public places allowing smoking increased from 31.5 percent to 47.2 percent. Moreover, when North Dakotans aged 18-54 were asked where smoking should be allowed in private businesses and other non-government buildings, 8.8 percent said in 2002 that smoking should not be allowed in buildings or on grounds; by 2010, 33.5 percent said smoking should not be allowed in those private business buildings or on their grounds.

Beginning in 2002, the PETF had successfully avoided efforts by the Legislature to prevent an effective public health media campaign in North Dakota. As of 2012, the PETF still existed and worked with the Center's Health Communications Coordinator on the statewide media campaign and contributed around \$200,000 biennially to the campaign.<sup>167</sup> North Dakota state and local tobacco control program leaders wanted to emphasize the state-local partnership of the new comprehensive program, and the joint funding of paid advertising.<sup>167</sup>



Figure 11: “The Dude” Advertisement, launched in January 2011.<sup>10</sup>

As a result, statewide media campaigns are tagged with, “Brought to you by the Center for Tobacco Prevention and Control Policy and your local public health unit.”<sup>10</sup> Vicki Valdo Rosenau, Tobacco Coordinator of Valley City and one of the leaders of the Support Tobacco Prevention campaign to pass Measure 3, opined in a 2011 interview for this research that local residents in North Dakota, who were strong proponents of local control, responded more favorably to programs and messages coming from the local level.<sup>96</sup> Tagging advertisements as products of LPHUs also was a way for local coalitions to publicize their local presence.

**Beginning in 2002, the PETF had successfully avoided efforts by the Legislature to prevent an effective public health media campaign in North Dakota.**

The Center also worked with Odney to create a brand for the new agency that would have name recognition throughout the state. Odney created the name “BreatheND” for the Center to use. The Center’s website featured “BreatheND,” as did its email communications with LPHUs and its stationary heading which was used for press releases and communications with the Legislature. “BreatheND” functioned as a brand name, and the agency’s official name, the “Center for Tobacco Prevention and Control Policy,” did not change.<sup>273</sup>



## *Complications Continue Between the DOH and the Center*

### *Two Grants Leads to Confusion Among Local Grantees*

Prior to the formation of the Center, the DOH Office of Tobacco Prevention and Control was the only provider of tobacco control grants to local communities. In 2009, with the Center beginning to fund LPHUs, the DOH discontinued its Community Health Grants Program and began constructing its own, separate plan to expand its state-level tobacco control programs (discussed in later sections).<sup>63</sup> The DOH continued to receive North Dakota's annual CDC grant which, according to CDC policy, had to go to the state health department. The North Dakota DOH continued to use the CDC funds to issue grants to LPHUs until 2011 when it ceased its local grants and began to fund other statewide programs based on a new, separate internal work plan that was still in development in the winter of 2012. (There was no decrease in local tobacco control funding because the TPC Executive Committee increased its grants to compensate for the loss of CDC money at the local level, which is discussed below.)

Thirteen LPHUs received grants from the DOH using CDC funds, and each of the 28 LPHUs received grants from the Center (Measure 3 funding).<sup>57</sup> The two grants were similar as both grants contained similar performance measures and required grantees to communicate with legislators, participate in trainings, give periodic updates on their work, and focus on building local coalitions.<sup>262, 274</sup> The DOH's Outreach Coordinators Neil Charvat and Kara Dodd, continued to manage most technical assistance for the Center's grants until March 2010.

With the 2008 policy successes in Fargo and West Fargo that passed comprehensive smokefree ordinances (discussed below), many LPHUs wanted to work on passing policy in their own communities. Without clear protocols for the LPHUs to follow and, after March 2010, two different agencies' technical assistance coordinators, local advocates became confused and frustrated regarding who to contact for technical assistance.<sup>63, 133</sup> Nancy Thoen, Tobacco Control Coordinator for Jamestown, North Dakota, recalled in a 2011 interview:

It was just kind of contentious at times when they were trying to hammer out who was going to do what, the Center or the state [DOH], and there was a lot of tension between the two of them, and that was really hard for us locally because at that point, you kind of would almost get two different directions. It was "well, this is the way the state wants something done," but then we would get a different direction from the Center, neither one of them being wrong, just that it's different... That went on for a while. And with the Center ... there was no staff for a while, until they hired Jeannie [Prom], the director, and then for the longest time, it was just Jeannie. There were a lot of communication problems and issues at that time when the state was still involved. From that perspective, when you have one staff person to serve the whole state, there are going to be some issues with communication. It's been a hard transition. [As a result of the DOH and the Center's mutual decision in 2011 to making the Center the sole grant provider,] it's getting better, getting much better.<sup>275</sup>

As is discussed in later sections, the TPC Executive Committee and the DOH agreed in 2011 for the TPC Executive Committee to be the sole grant provider to LPHUs to alleviate confusion at the local level.

### *The Agencies Resolve Not to have a Memorandum of Understanding for the Grants Program*

The two agencies continued to try to establish a clear division of roles for the local grants program but were unable to reach an agreement. Karalee Harper, Director of the DOH's Division of Chronic Disease, which housed the Tobacco Prevention and Control Program, explained in a 2011 interview for this research, "There was an attempt. There was an attempt for a, MOU, a memorandum of understanding. It was decided that that would not work between the two agencies. And so we do not have an MOU."<sup>63</sup> Harper explained in a later interview that the DOH was hesitant to sign the MOU because it wanted to retain its autonomy and to maintain clear lines of division between the DOH and the Center, particularly for clarity of roles and ensuring programs were implemented effectively. Harper explained that the MOU "got to be so encompassing and so intertwined that it was 'who's doing what?' and 'who reports to who?' And again giving the example of Neil [Charvat, Outreach Coordinator] and Kara [Dodd, Outreach Coordinator], I am their supervisor, but if they are supposed to be doing X, Y, and Z per the MOA [MOU] for the Center, then who is responsible for making sure that that gets done?"<sup>133</sup>

In February 2010, the two agencies failed to agree to a ninth version of the MOU.<sup>57</sup> Jeanne Prom explained in 2012 correspondence for this research that at that point, the TPC Executive Committee determined the most efficient use of Center staff and Committee time was to work directly with its local grantees.<sup>167</sup>

### *Disagreements Over Which Program Activities Were "Best Practices"*

The requirement that both tobacco control programs (specified by CDC for DOH for its CDC grant, and by Measure 3 for the Center) follow CDC "best practices" became a point of contention between the DOH and the Center.<sup>57, 133</sup>

The primary programmatic disagreement between the Center and the DOH was the DOH's "Baby & Me Tobacco Free Cessation Program" that the DOH funded with \$125,000 of its biennial MSA funding,<sup>21</sup> and that incentivized tobacco cessation among pregnant women by providing diapers in exchange for remaining tobacco free.<sup>276, 277</sup> In order to receive Baby & Me funding, LPHUs had to submit an application to the DOH.<sup>278</sup> The National Association of County and City Health Officials (NACCHO) considered Baby & Me Tobacco Free, as implemented in New York and Wyoming, to be a "Model Practice" which it defined as an "innovative resource, initiative, program, administrative practice, tool, method of communicating the value of governmental public health, or way of doing business that can be evaluated."<sup>279</sup> A 2011 paper in the *Maternal Child Health Journal* studied New York's Baby & Me Program and determined that the program included evidence-based components and is an effective individual-level tobacco cessation program and should be studied further.<sup>280</sup> From 2010-2012, there were only seven participants in North Dakota's Baby & Me Program;<sup>140</sup> it is unknown how much funding each participant received.

In separate 2011 interviews for this research, TPC Executive committee members Pat McGeary (Tobacco Coordinator for Bismarck) and Javayne Oyloe (Tobacco Coordinator from Williston) reflected the consensus at the Center that Baby & Me did not fall under CDC's *Best Practices* and should not be funded by any program required to follow *Best Practices*.<sup>47, 60, 158</sup>

The Center’s Kathleen Mangskau explained in a 2011 interview for this research:

Our philosophies weren't the same. We are very much *Best Practices*. They [DOH] didn't follow that. They believe in ‘promising practice,’ allowing more flexibility with the [locals]. And we felt, until we get some of these basic things in place that we know are *Best Practices*, we shouldn't be doing those other things...Until we get a state smokefree law, until we get an increased tax, why are we dabbling in things that we don't even know work?<sup>57</sup>

While \$125,000 was not a large percentage of the DOH’s \$3.5 million 2009-2011 appropriation, these interviews with the TPC Executive Committee indicated that the TPC Executive Committee viewed the Baby & Me program as symptomatic of a larger problem within the DOH program and a threat that even more of the DOH’s tobacco control program funding would go to programs not deemed to follow *Best Practices*.

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The Baby & Me program focused \$125,000 of the DOH’s limited funds on an extremely narrow population. In 2009, there were 8,974 live births in North Dakota<sup>281</sup> and 17 percent of North Dakota’s pregnant mothers, or approximately 1,526 people, reported that they were smokers.<sup>282</sup> In contrast, of North Dakota’s 522,603 adults,<sup>283</sup> 97,204 were smokers in 2009 (18.6 percent<sup>38</sup>). It would be more cost-effective to spend the funds devoted to Baby & Me on broad programs<sup>115</sup> that reach large proportions of smokers as opposed to the small few that Baby & Me can possibly reach.

In contrast, Karalee Harper, then DOH Division of Tobacco Prevention and Control Director, in a 2011 interview for this research explained that the DOH considered Baby & Me Tobacco Free to be best practices because of its focus on individual counseling and relapse prevention. Harper explained, “Best Practice, again, is a global thing, if we are doing relapse prevention and we are doing individual counseling that is a Best Practice.”<sup>63</sup> Harper and Arvy Smith, Deputy State Health Officer, also stated that they are legally allowed to work on programs that are not “best practices” as long as they use their funding stream coming from the original MSA annual funds and deposited in the Community Health Trust Fund.<sup>133</sup> They argued that Measure 3’s requirement that 80 percent of the annual funding appropriated to the DOH from the Community Health Trust Fund was to be used for “tobacco prevention and control” programs without specifying that this money be limited to funding “best practices” programs, leaving them free to implement “Baby & Me Tobacco Free,” which was funded with MSA funds.<sup>133</sup>

The tension between the DOH and the Center brings up the question of whether the state’s tobacco prevention and control activities funded as a result of Measure 3 were meant to function as an integrated program or two separate programs. As discussed earlier, Measure 3 created the Tobacco Prevention and Control Advisory Committee and required that its comprehensive plan be funded at least at the minimum CDC recommended level. When the state tobacco control leaders wrote Measure 3, they counted the money coming to DOH as part of the

money to be used to reach the CDC funding level, and envisioned a well-coordinated program. The ultimate purpose of Measure 3 had been to secure additional funding for a new agency to implement the programs that the DOH could not because of political fears among DOH leadership.

The Legislative Assembly, after a struggle, appropriated the funding for the “comprehensive program” between the DOH and Center using three funding streams to achieve the CDC recommended funding level. The Legislative Assembly appropriated funds from the original MSA payments to the DOH via the Community Health Trust Fund (\$1.75 million annually), money from the MSA Strategic Contribution Funds (\$6.45 million annually) to the TPC Executive Committee for the Center, and assumed that the CDC Office on Smoking and Health would continue to make its annual grants to make up the rest of the \$9.3 million minimum requirement that voters approved. This appropriation indicates that the Legislative Assembly, as well as the Center, which requested this funding arrangement, expected the two agencies to run a coordinated program in which all components were considered to be *Best Practices*.

### *The View from the CDC*

CDC’s Office on Smoking Health’s Team Lead Monica Eischen and North Dakota Program Consultant Erin Abramsohn performed a site visit on from May 6-7, 2010, to discuss the program and evaluate the transition to expanding and sharing the program between the two agencies. CDC wanted to “assure activities meet Centers for Disease Control and Prevention (CDC) Office on Smoking and Health (CDC/OSH) best practices for tobacco control, and negotiate strategies to ensure that ND tobacco control activities meet CDC/OSH focus areas.”<sup>284</sup>

Eischen and Abramsohn, in their site visit follow-up letter, commended the DOH for their work with the state tobacco Quitline and its expansion to Quitnet internet tobacco cessation services, both of which were supported by a media promotional campaign and the use of the social marketing forum Facebook. CDC also commended the DOH for their efforts educating local school districts on the importance of comprehensive tobacco-free campuses. In their letter, CDC emphasized the importance of the DOH’s funding of LPHUs, but especially tribal areas, as the funding provided “support of local infrastructure and the capacity to achieve local policy and cessation objectives” and the importance of mobilizing youth coalitions to engage in activities geared toward passing stronger tobacco control policy.<sup>284</sup> CDC reiterated later in the letter that part of their grant agreement with the state was that the tobacco control program had to “continue to educate local coalitions, business owners and school administrators about the economic and health benefits of smoke-free policies and to continue to educate local policymakers on the need for/benefit of smoke-free environments.”<sup>284</sup> CDC also asked the DOH program to increase educational opportunities and resource materials at the state and local level in support of raising the price of tobacco products and passing a statewide comprehensive clean indoor air law.

In their follow up letter from the May site visit, CDC took issue in particular with the “Baby & Me Tobacco Free” program and requested data showing that it was an evidence-based program. However, Erin Abramsohn, former CDC Program Consultant for North Dakota, explained in a 2011 interview for this research that “we [CDC and the DOH] differed on a

couple of things that we did not consider ‘best practices’ or even ‘promising practices,’ which they found in a couple of cases, you know, they consider ‘best practices’ for certain populations.”<sup>285</sup> In response to the question of whether CDC could require the DOH promote only *Best Practices* programs with all of their funds, including non-CDC funds, as a condition of its CDC funding, Abramsohn replied, “We can advise them ... But if it's not CDC money, really they can do what they want.”<sup>285</sup>

CDC also addressed the relationship between the DOH Tobacco Prevention and Control Program and the newly formed Center. CDC had learned that the two agencies were still working off of separate state plans despite the agreement of both to work from the *Saving Lives – Saving Money* plan released by the Center in July 2009 and wanted the agencies to work off of the same plan.<sup>284</sup>

Karalee Harper explained in a 2011 interview for this research that she interpreted the letter as a glowing review and an accurate portrayal of the status of the DOH program and the directions the program was moving in, but that CDC’s in-person feedback was not positive.<sup>63</sup> The DOH felt that the continuation of their CDC funds were being threatened during CDC’s May 2010 site visit.<sup>286</sup> Moreover, CDC had scheduled time to meet with both the DOH and Center in the same meeting to which Arvy Smith, Deputy State Health Officer, and Karalee Harper, objected because the DOH was a CDC grantee and the Center was not. Smith argued that the Center had no fiduciary role for the funds and that it was inappropriate to “evaluate your employees in front of the other employees.”<sup>133</sup> CDC refused to grant Smith’s request, because at the time, CDC viewed the two agencies as the same program and was not aware of the tension between the agency leaders. The CDC later apologized to the DOH.<sup>286</sup>

On September 2, 2010 Eischen and Abrahamson returned to North Dakota along with Ronney Lindsey, Deputy Director of the Office on Smoking and Health, for a follow up meeting to address Smith’s complaints. The meeting was productive in repairing CDC’s working relationship with the DOH; CDC wrote in their follow up letter to the September site visit that the CDC Office of Smoking and Health understood that there was no Memorandum of Understanding between the DOH and the Center and that there would not be one in the near future but that the two agencies needed to agree on which would implement which programs.<sup>286</sup> In their September letter, CDC wrote that “The recommendation at this point is to keep communication open between the two agencies, this is the first step in moving forward and working together.”<sup>286</sup>

Also in its follow up letter to the September 2010 site visit, CDC wrote that it expected the DOH to work on tobacco control policy issues as was required by their 901 Core cooperative grant agreement work plan.<sup>286</sup> However, the DOH argued that this was the Center’s role as an independent agency and because the state plan was heavily based on work influencing policy change.<sup>63</sup> CDC recognized that the Center would take the lead on policy matters, but that the DOH did have the ability to educate policy makers and should push for stronger point of sale policies, especially regarding cigarette product displays in retail stores.<sup>133, 286</sup>

Most importantly, CDC understood that it was imperative that the two agencies work together because of the continual threat from tobacco control opponents, and, if they did not

prove they were using the funds appropriately, there was “a threat that the tobacco money may be diverted to other issues.”<sup>286</sup>

DOH requested that CDC assign a new program consultant for North Dakota.<sup>63</sup> The CDC Office on Smoking and Health was in the process of hiring new program consultants and structurally reorganizing, and in the efforts of regaining a productive working relationship with North Dakota, agreed to switch personnel, assigning Shawna Shields as the new program consultant.<sup>285</sup>

CDC state program consultants Shawna Shields and Erin Abramsohn, in 2011 interviews for this research, also explained that because Measure 3 did not explicitly include each of the components of what *Best Practices* required for a tobacco control program to be comprehensive, difficulties arose in dividing the roles between the two agencies. While *Best Practices* provided a blueprint for what states should be doing, there was latitude within the context of each state for what specific programs to focus on, and the two agencies differed in their opinions in some respects.<sup>285</sup> Shawna Shields explained that she did not view the two agencies as one program but rather as two entities within one overarching program which has its funding being pooled. Shields explained, “When I've been in other states, you pool your money together because overarching, a statewide comprehensive tobacco control program may have different organizations that play a key part to making that happen. So I see them still as two separate entities.”<sup>285</sup>

The CDC saw the larger issue as the lack of a joint Memorandum of Understanding between the programs which clearly assigned roles, established lines of productive communication between the programs, and ensured collaboration and no duplication of program work.<sup>285</sup> The TPC Advisory Committee and the DOH had annual work plans that divided responsibilities between the two agencies, but the DOH wanted to use its CDC money for other programs that were not included in the TPC Advisory Committee’s state plan and had not been previously included in the annual work plans.

With opposition to the program in the Legislative Assembly waiting to attack the newly funded program (see section below on HB 1353 in 2011), the CDC saw the biggest risk of non-cooperation as increasing the chance that two programs would be destroyed. CDC emphasized the importance of working together in order to collectively survive. However, the legislature appropriated the funding, after tobacco control advocates applied great pressure, in order for the two entities to work together to reduce tobacco use. Program success depends on effective communication and hard-hitting programs that are research-driven and proven to be effective, with no overlap, and both programs have to report to the Legislature on their progress. Shawna Shields added said “I think that both sides need to start with a relative clean slate at this point and try to just figure out how to get along together.”<sup>285</sup>

**The TPC Advisory Committee and the DOH had annual work plans ... but the DOH wanted to use its CDC money for other programs that were not included in the TPC Advisory Committee’s state plan and had not been previously included in the annual work plans.**

*The DOH's 2012 Internal Work plan*

As of spring 2012 the DOH was still developing an updated internal work plan with the assistance of CDC state program consultants. A draft of the internal work plan from the spring of 2011, the most updated that the DOH made available to the authors of this report, presented nine goals/work areas the DOH planned to focus on, four of which were the same as overarching goals listed presented in the Center's five-year plan (Table 25). The CDC grant controlled by the DOH constituted 14 percent of the total funds available for tobacco control in North Dakota, a significant amount of the funds that the Legislature considered a part of the comprehensive program shared by the Center and the DOH.

<b>Table 25:</b> Draft Version of DOH TPC Internal Work plan, 2011 <sup>287</sup>	
<i>Goal / Work Area</i>	<i>Description</i>
Preventing initiation among youth and young adults*	<ul style="list-style-type: none"> <li>•Reduce all types of tobacco use (cigarettes, spit tobacco, cigars) among all youth age groups.</li> <li>•Monitor youth usage of new smokeless tobacco products.</li> <li>•Support a tobacco excise tax increase.</li> <li>•Increase number of school tobacco-free policies.</li> </ul>
Protect public from exposure to secondhand smoke*	<ul style="list-style-type: none"> <li>•Support the Center in strengthening the statewide smokefree law to cover all public places and places of employment.</li> <li>•Support the Center in passing comprehensive local laws that cover all public places and places of employment.</li> </ul>
Promote quitting among tobacco users*	<ul style="list-style-type: none"> <li>•Increase the usage of Quitline/Quitnet throughout the state and improve the accuracy of the evaluation of Quitline/Quitnet.</li> <li>•Increase the number of public and private healthcare institutions using the Public Health Service's "Ask. Advise. Refer" guidelines.</li> <li>•Increase number of Baby and Me participants.</li> <li>•Maintain or increase number of insurance purchasers and payers that reimburse for tobacco cessation programs.</li> </ul>
Identifying and eliminating tobacco-related disparities among specific population groups	<ul style="list-style-type: none"> <li>•Identify collaborative partnerships.</li> <li>•Maintain Quitline/Quitnet as the primary programs for disparate populations.</li> <li>•Strengthen infrastructure to address disparate populations.</li> <li>•Increase to two the number of CDC Best Practice or Promising Practice implemented to reduce tobacco-related disparities in North Dakota populations. (The 1 pre-existing program was Baby and Me.)</li> </ul>
Maintain the capacity and infrastructure of tobacco prevention and control programs statewide to the CDC-recommended level*	<ul style="list-style-type: none"> <li>•Maintain tobacco prevention and control funding.</li> </ul>
Develop new and increase tobacco-related data capabilities	<ul style="list-style-type: none"> <li>•Continue with tobacco-related surveillance (e.g., BRFSS, YRBSS)</li> </ul>

FDA-related activities	<ul style="list-style-type: none"> <li>•Increase existing knowledge on the 2009 FDA legislation.</li> <li>•Develop materials such as fact sheets, reports, etc. to convey information to interested parties.</li> <li>•Fund one pilot project regarding point of sale/FDA.</li> </ul>
E-Cigarettes	<ul style="list-style-type: none"> <li>•Develop a position statement on e-cigarettes.</li> </ul>
Worksite Wellness	<ul style="list-style-type: none"> <li>•Fund one pilot project regarding worksite wellness.</li> <li>•Strengthen worksite policy regarding tobacco use.</li> <li>•Goals regarding increasing Quitline/Quitnet usage and ensuring insurance providers cover tobacco cessation (reflected elsewhere in this table).</li> </ul>
<p><b>Notes:</b>  *Indicates a goal shared by the Center for Tobacco Prevention and Control Policy's <i>Saving Lives – Saving Money</i> five-year plan.</p>	

The DOH indicated in the draft work plan that it would support the work of the Center on policy efforts to pass comprehensive smokefree air laws at the local level and to strengthen the statewide clean indoor air law to include all public places and places of employment.<sup>287</sup> Karalee Harper explained in a 2011 interview that the two agencies roles were continuing to evolve and that the DOH was continuing to adjust its programs in an environment with two programs instead of one.<sup>63</sup> Some of the new DOH programs emerging with its new internal working plan, including activities related to enforcement of the 2009 FDA legislation and potential programs focused on e-cigarettes, did not exist when the Center finalized its *Saving Lives – Saving Money* five-year plan. Harper explained that the TPC Advisory Committee was considering amending its five-year plan to include the new DOH programs and the role that the DOH would play statewide.<sup>133</sup>

The DOH continued to develop its internal work plan over the summer of 2011 and met with Shawna Shields, CDC Program Consultant, in July in order to get the advice of CDC to ensure that they were meeting their “Best Practices” grant requirements. In a follow-up interview for this research, Shields was optimistic and felt that the DOH was using their CDC grant for good programs. Shields highlighted the DOH’s focus on American Indian communities as one of the program’s major positive developments and which would be included in their separate internal working plan.<sup>288</sup> Karalee Harper explained in 2012 correspondence for this research that the DOH’s work with American Indian communities included increasing tobacco control program infrastructure and providing “education and advocacy surrounding policy, which includes smoke free air and/or tobacco free policy in school/campus, tribal buildings/grounds and casinos” as well as work “regarding implementing tobacco tax on the reservations that don’t currently have it and utilizing the funds to assist with health-care needs.”<sup>140</sup> However, no outcomes data were available for these new programs so it is unknown what strides the DOH has made with these developing programs and if they are effective.

In April 2012, the DOH reported through correspondence for this research that in the 2011-2013 biennium, it would use some of its CDC funds for contracts to American Indian tribes (\$60,000 for three tribes and \$10,000 for one tribe); American Indian Youth pilot project (\$25,000); and, worksite wellness programs (\$25,000).<sup>140</sup> These expenditures account for \$240,000 of the DOH’s \$2.7 million that it estimated that it would receive from CDC in the



2011-2013 biennium. Ostensibly, as in previous years, portions of the CDC money would be used for tobacco control personnel salaries (which is one of the purposes of the CDC grant) but, despite the authors' repeated requests, the DOH did not provide any additional information for how much CDC funds would go to salaries or other programs other than the ones listed above. Despite the DOH's plans to work on FDA programs, as of March 2012, North Dakota was one of nine states that did not have, and had not applied for, a contract with the FDA Center for Tobacco Products to inspect retailers for potential youth tobacco sale law violations.<sup>289</sup>

## **Progress being made**

### ***A Memorandum of Understanding to Include New DOH Programs***

In 2011 interviews for this research, Shawna Shields and Erin Abramsohn both expressed the importance of the two agencies agreeing on and executing a Memorandum of Understanding that would include the programs that the DOH was planning. Abramsohn explained that the agencies signing a MOU was “the best-case scenario that we could hope for to keep them both alive”<sup>285</sup> because both the DOH and the Center's tobacco control programs were under continual threat of defunding from the Legislative Assembly. An MOU would provide a clear, formal working agreement for the Legislature which would prove that the money was being used appropriately and may neutralize legislative opponents, generally Republicans, in both the House and the Senate, who argued that the tobacco control efforts received too much money.<sup>285</sup> Abramsohn continued, saying that “if they could figure out a way to complement each other's activities and work together they could have this incredibly strong program because...the Center, sitting where it is outside of the health department, can do ... the advocacy work which most health departments can't do. You [a health department] work for a Governor and you can't do that [advocacy].”<sup>285</sup>

Following her July 2011 site visit, Shawna Shields was optimistic that the two programs were beginning to work together in a constructive way that would ensure an effective tobacco control program. Shields reported that the two entities had begun working toward signing a Memorandum of Understanding that would formally divide the roles and responsibilities of the two agencies and ensure no overlap between the Center and the DOH's new programs. Shields did not believe that there was any program duplication. However, formalizing the Memorandum of Understanding that incorporated the new DOH programs and instituting a plan for external evaluation, while maintaining open lines of communications, would be essential to ensure maximum program efficacy.<sup>288</sup> Still, the DOH reported to the authors of this report in 2012 that the DOH had sent the TPC Executive Committee a draft MOU in July 2011. The Center staff in turn, explained that they sent a revised MOU draft to the DOH in December 2011 and as of April 2012, still had not heard back from the DOH.<sup>140, 167, 290</sup>

### ***One Local Grant from One State Agency***

LPHUs, until the winter of 2011, received two separate grants, one from the Center and one from the DOH (CDC money). In the winter of 2011, the DOH and the Center agreed that there should only be one agency issuing grants to LPHUs because it was confusing for the grant recipients to report to two different agencies.<sup>57, 133</sup> DOH would stop distributing its CDC funding

to LPHUs and the Center agreed to increase its local grants by an equal amount. The DOH would not transfer CDC funds to the Center; however, the DOH would continue to use its CDC funding for other statewide tobacco control programs that would be determined as its internal working plan developed. Karalee Harper explained in a 2011 interview for this research that, “it's been, a growing process in the last two years of who's doing what, especially with local public health.”<sup>63</sup> For the 2011-2013 biennium, the TPC Executive Committee increased its annual local grants by \$345,000 to compensate for the amount the DOH would have provided in local grants. The DOH has used the \$345,000 it would have spent on local grants on programs listed in its internal work plan but because it did not provide detailed budgets and expenditures to the authors of this report, it is not possible to report how the money is being spent.

### ***External evaluation***

In summer 2011, as required by Measure 3, the Center commissioned Kyle Muus of the Center for Rural Health at University of North Dakota School of Medicine and Health Sciences, who partnered with Cordell Fontaine of the University of North Dakota's Social Science Research Institute, to perform the external evaluation of the tobacco control program based upon the TPC Advisory Committee's five-year plan.<sup>21</sup> The external evaluation assessed the success of the TPC Executive Committee and the DOH and other state partners at fulfilling the goals of the TPC Advisory Committee's five year plan, two years into program implementation.

The evaluation cited the following examples of collaboration between the Center and the DOH as positives:

- The Center invites the DOH to all trainings, and all Executive and Advisory Committee meetings; the Center also sends a copy of meeting minutes to the DOH;
- DOH and Center staff were both involved in the writing of the five-year state plan;
- DOH staff were members of the committees that wrote the Center's new statewide Health Communications Plan and the Surveillance and Evaluation Plan;
- DOH staff have attended and provided information at local grants trainings coordinated by the Center;
- The Center and DOH collaborated on updates to the Program Reporting System, the electronic system that state agencies use in North Dakota to catalogue program progress and developments. The Center began providing staff time to chair the joint PRS committee and also would be providing funding for some Program Reporting System upgrades during the 2012-2013 biennium;
- The Center contracts with the DOH Division of Accounting to provide fiscal agent services;
- Center grants to Local Public Health Units have provided funding for additional advertisements for the statewide Quitline and QuitNet, which were operated by the DOH; specifically, the Center provided \$940,000 in grants to all 28 local public health units, requiring units to implement policies so every client was asked about tobacco use and referred to the Quitline/Quitnet;
- Local Public Health Units invested seven percent, or \$209,369 of the \$2,990,985 million they received through the local grants program in 2010-2011 (FY2011), into Quitline/Quitnet and PHS Guidelines activities, nicotine replacement therapy, and

implementation of a systematic referral system to the Quitline in all Local Public Health Units and in private healthcare systems;

- The Center partnered with the DOH's nutrition program on two trainings for health professionals in tobacco, nutrition, and physical activity focus areas;
- In May 2010 and July 2011, the CDC conducted a site visits to North Dakota, meeting jointly with the Center and the Department, which is a CDC grantee;
- The Center continued and expanded its collaboration with the DOH client-based chronic disease prevention programs, primarily at the local level, through policy training and assistance with implementing the PHS Guidelines to systematically ask, advice and refer tobacco users to the Quitline/Quitnet.<sup>21</sup>

However, the evaluation found that:

Even though the Center and the NDDoH possess these collaborative links to one another and each appears to effectively collaborate/communicate with its own local grantees, it appears that, based in part on our personal communications with staff of each agency (separately), the scope and extent of state-level collaboration and communication could be expanded and improved.<sup>21</sup>

Additionally, the external evaluation concluded that:

[T]he North Dakota Tobacco Prevention and Control program [including the two state agencies, the DOH and the Center] possesses many traits of a comprehensive tobacco control program; however, the program has not yet fully met the CDC's vision of a comprehensive tobacco control program. Indeed, full program comprehensiveness by the end of a new tobacco control program's second year of operation may not be a reasonable expectation of a tobacco control program. Areas targeted for consideration of future improvements in program infrastructure and capacity include greater collaboration and integration between state partners and their respective tobacco control programs, updating and revising the system by which program process and outcome indicators are tracked and assessed, and acquiring additional needed tobacco control staff personnel.<sup>21</sup>

Nevertheless, the external evaluation in most other sections was positive, reporting that the program had made progress on each of its four overarching goals (discussed in the next section) and was realistic in its assertion that the Center had only existed for two years and that having perfect collaboration at the level of a *Best Practices* program after two years might not be reasonable.

### ***Overall Program Progress***

Despite difficulties between the two state agencies, as of 2011, North Dakota made progress on tobacco control after the passage of Measure 3 in 2008. By September 2011, two years after the TPC Advisory Committee adopted its five-year plan, TPC had already surpassed many of its five year goals

**By September 2011, two years after the TPC Advisory Committee adopted its five-year plan, TPC had already surpassed many of its five year goals.**

(Table 26). In 2008, there were only two comprehensive local ordinances that included bars (Fargo and West Fargo). The TPC Advisory Committee’s goal had been to increase number of local smokefree laws to five by June 2012. By April 2012, at the time this report was completed, five additional cities (Grand Forks, Bismarck, Napoleon, Devils Lake and Pembina) had passed comprehensive smokefree ordinances that included bars, bringing the state’s number of local comprehensive smokefree laws to seven. The TPC Advisory Committee planned to increase the number of colleges and universities with tobacco free or smokefree policies from six to 11 by December 2013. By September 2011, there were 12 policies in place.

<b>Table 26:</b> North Dakota Tobacco Control Progress Since the Launch of the 2009 Statewide Plan <sup>21, 118</sup>				
	<i>Jun. 2009 (prior to new state plan)</i>	<i>Five Year Plan Goal</i>	<i>Sep. 2011</i>	<i>% change</i>
<i>Smokefree/tobacco-free policies</i>				
Number of comprehensive citywide smokefree ordinances	2	5 (by June 2012)	7	250
Population covered by a comprehensive city smokefree ordinance	119,869 (19%)	N/A	246,873 (37%)	106
School districts w/ tobacco-free policies	60 (33%)	Increase to 50% (by June 2013)	101 (55%)	68
Colleges/Universities w/ tobacco free or smokefree policies	6	11 (By December 2013)	12	100
North Dakota total population supporting a comprehensive statewide smokefree air law	47.2% (2008)	N/A	59.2% (2010)	25
<i>Coalitions</i>				
Number of local coalitions	25	N/A	31	24
Number of total local coalition members	706	N/A	867	23
<i>Smoking prevalence</i>				
Adult smoking rate	18.6%	N/A	17.4 (2010)	6.5
Youth smoking rate	22.4%	N/A	19.4%	13.4
Youth smokeless tobacco rate	15.3%	N/A	13.6%	11.1
Quitline use by smokers	0.66% (2008)	2% (by 2014)	2.4%	264
Notes: N/A means there was no quantified goal listed in the five year plan.				

Pat McGeary, Tobacco Coordinator for Bismarck-Burleigh Public Health Unit and former member of the TPC Advisory and Executive Committees, explained in a 2011 interview for this research that Bismarck-Burleigh was able to increase its staff by one person with the additional funding received as part of the grant it received from the Center, and that having the additional staff person was significant in Bismarck’s ability to pass its comprehensive smokefree ordinance in 2010 and to defend it opponents forced it on to the ballot for a vote in 2011.<sup>47</sup>

As of 2011, since the advent of increased funding by the Center, technical assistance, and grant deliverables requiring coalition-building activities, the number of local tobacco control

coalitions increased by 24 percent, from 25 in 2009 to 31 in 2011. The adult smoking prevalence decreased by 6.5 percent from 18.6 percent in 2009 to 17.4 percent in 2010 and the youth smoking rate decreased by 13.4 percent from 2009 to 2011 (from 22.4 percent to 9.4 percent). Also, the youth smokeless tobacco use rate decreased by 11.1 percent from 2009 to 2011 (from 15.3 percent to 4.2 percent). The TPC Advisory Committee planned to work to increase the state's cigarette tax from 44¢/pack to \$2/pack and to expand the statewide clean indoor air law to make all public places and places of employment smokefree by June 2013,<sup>118</sup> which was expected to comprise the focus of campaigns in 2013. There was no legislative session in 2012.

However, members of the TPC Executive Committee and the Center staff, in 2011 interviews for this research, still felt that the Center was understaffed.<sup>57, 60</sup> The 2011 external evaluation (discussed in the previous section) concluded that the Center being shortstaffed had been an impediment to establishing sufficient tobacco control program infrastructure.<sup>21</sup> However, this Center's ability to hire additional staff required legislative authorization. In 2011, the TPC Executive Committee requested that the Legislative Assembly appropriate the \$12.9 million it had received for the prior biennium, and also asked for the authority to hire 3.5 additional full time equivalent staff (FTEs) to increase the Center's ability to handle its workload.<sup>57</sup> Despite the request of the TPC Executive Committee, the Legislative Assembly's enacted version of HB 1025 authorizing only one additional FTE, which the TPC Executive Committee planned to fill with an additional community intervention coordinator.<sup>81</sup> In exchange for allowing the TPC Executive Committee to hire one additional full-time employee, the Legislature reduced the DOH's tobacco control staff authorization by one full-time employee.<sup>87</sup> It is unclear why the Legislature opposed the TPC Executive Committee hiring additional staff and if it was, in reality, an attempt to limit the efficacy of the program. The Legislature previously opposed using General Fund money for hiring additional staff, but this money was coming from MSA funds, not the General Fund.

Regarding funding the TPC Executive Committee, the Legislature appropriated the \$12.9 million that the TPC Executive Committee requested for the 2011-2013 biennium, seemingly without a fight. Tobacco control LPHU grantees testified at the committee hearings for HB 1025 in both the House and the Senate asking legislators for a continued commitment to funding the Measure 3 program as voters had enacted it. However, House Republicans led another attempt to repeal Measure 3 in 2011 when a group of legislators spearheaded HB 1353, which would have transferred the Strategic Contribution Fund money in the Tobacco Prevention and Control Trust Fund to the University of North Dakota School of Medicine and Health Sciences in the 2011 Legislative Session, which is discussed in the next section.

## **Conclusion**

Measure 3 created the TPC Advisory Committee and the TPC Executive Committee to create a comprehensive state tobacco control plan within six months. The TPC Executive Committee was responsible for implementing the new plan and created the Center for Tobacco Prevention and Control Policy to run the new programs. North Dakota's Department of Health (DOH) Division of Chronic Disease already had a tobacco control program in place, the Tobacco Prevention and Control Program, that had for years, run the state Quitline and funded Local Public Health Units (LPHUs) to address tobacco on the local level and measure tobacco use in North Dakota, but had never been funded at CDC-recommended levels (\$9.3 million annually).

The TPC Advisory Committee's state plan *Saving Lives, Saving Money*, which was implemented by the TPC Executive Committee and the Center for Tobacco Prevention and Control Policy, created with the assistance of CDC program consultants and the DOH, was comprehensive. Additionally, detailed joint work plans agreed upon by the TPC Executive Committee and the DOH provided clarification for the division of program work between the two agencies. Dividing program responsibilities was necessary in order to avoid duplicating work. The Legislative Assembly divided the state program's \$9.3 million (which included federal grants from CDC) between the DOH and the Center, under the apparent intention for the two agencies would work together.

The Center was required to follow CDC *Best Practices* by Measure 3, and DOH was required to follow *Best Practices* by the CDC grant that it managed. CDC program consultants felt that the DOH was using its CDC money for *Best Practices* programs but questioned the use of its MSA funds for programs like Baby & Me Tobacco Free and asked for data showing that it was an evidence-based program. However, CDC claimed that they could advise the DOH not to work on non-*Best Practices* programs with non-CDC funds, but could not make it a condition of their CDC grant. The DOH did not feel that it was legally required to spend 80 percent of its funding on tobacco control programs sanctioned by *Best Practices* as long as the programs were tobacco related.

Not spending all \$9.3 million appropriated on *Best Practices* programs reveals a weakness in the overall state tobacco control program that could be exploited by the tobacco industry and legislators that want to defund tobacco control.

**The DOH did not feel that it was legally required to spend 80 percent of its funding on tobacco control programs sanctioned by *Best Practices* as long as the programs were tobacco related.**

*Best Practices* required fluid communication between state partners. Following CDC's summer 2011 visit, the two agencies had resumed drafting an MOU that included the programs that the DOH planned to work on which were not previously included in the TPC Advisory Committee's five-year plan or the agencies' annual work plans. In spring of 2012, the DOH and the Center reported that they were still working on a new draft MOU that would include the DOH's new internal work plan programs but there were long, multiple month-long lapses in between communication on the MOU. If both agencies establish clear communication and coordination of complementary activities, it would improve North Dakota's ability to achieve a comprehensive, fully funded program that Measure 3 mandated. This could be accomplished through the signing of a formal MOU that incorporates the DOH's additional programs, or through an update to the annual work plan. Despite these stumbling blocks, tobacco control programs have had a net positive affect in North Dakota since the passage of Measure 3 and the creation of the TPC Advisory and Executive Committees and the Center (Table 26) and have already exceeded many of the goals established in the *Saving Live-Saving Money* state plan.

Since the Center was created, tobacco use rates for youth and adults decreased (Figures 2-5, Table 26), total tobacco control grants to local communities increased by 38 percent, and local tobacco control advocates had success getting voluntary and legislative smokefree and tobacco free policies implemented throughout the state. North Dakota only had two comprehensive local ordinances prior to creation of the new agency. Since the new agency was

created, five comprehensive local smokefree ordinances that prohibited smoking in public places and workplaces were enacted, increasing the population of North Dakota covered by a comprehensive law by over 100 percent. There was also a large increase in voluntary tobacco-free school policies. Special Initiative Grants from the TPC Executive Committee to Tobacco Free North Dakota and the American Lung Association enabled these two state partners to hire staff that could work on educating about the need for strengthening tobacco control policy. Not having enough state partners with paid staff who were committed to working on tobacco control issues was a weakness in North Dakota's state level tobacco control work in previous years.

Additionally, the DOH's draft internal work plan indicated that the DOH would use its CDC funding to support strong tobacco control policies at the local and state level, including smokefree laws and a tobacco excise tax increase. The DOH also indicated that it was working with American Indian communities, educating on the importance of passing stronger tobacco control policies. This represents an apparent departmental shift in favor of working on local tobacco control policy again, which it had opposed since 2008 when it removed the Healthy North Dakota Tobacco Subcommittee from Healthy North Dakota, from and helped reactivate Tobacco Free North Dakota. However, the DOH continually failed to provide the authors of this report with detailed budgets and expenditures for all of the programs listed in its draft work plan despite the authors' repeated requests.

## CHAPTER 9: THREATS TO THE NEW PROGRAM

- In the 2011, less than three years after the voters enacted Measure 3, the Legislative Assembly again attempted to dissolve the new tobacco control program and cut back DOH tobacco control funding.
- Tobacco control advocates successfully mobilized a public outcry, contacted legislators, generated public pressure through op-ed articles, and testified at Committee hearings and killed these proposals.

Following the 2009 appropriation battle, the TPC Executive Committee and TFND watched introduced legislation closely for another attack. In preparation for the 2011 Legislative Session, Tobacco Free North Dakota (TFND), met with the TPC Executive Committee and the Center's staff to plan a strategy for monitoring 2011 legislation. TFND and the TPC leaders expected another attack on Measure 3.

In December 2010, as a result of receiving a Special Initiative Grant from the Center, TFND hired Megan Smith Houn, formerly of ACS, to serve as its Executive Director. ALA became politically active in 2011 with the hire of Kimberlee Schneider as its Legislative Counsel (lobbyist) and worked with TFND.<sup>60</sup> ACS did not care where the Measure 3 funding was appropriated, as long as North Dakota tobacco control programs were funded at CDC's recommended levels and followed CDC *Best Practices* program guidelines,<sup>142, 291</sup> and was content with the DOH receiving the money. AHA was not involved because it was not active with the reorganized statewide coalition.

### **The Legislative Assembly Considers HB 1353 to Repeal Measure 3**

The expected attack materialized. In the 2011 Legislative Session, members of the Legislative Assembly attempted to dissolve the Tobacco Prevention and Control Advisory Committee and to give its Strategic Contribution Funds to the University of North Dakota (UND) School of Medicine for a new health sciences facility and to expand training of in hopes that they would provide more healthcare access to rural areas. The bill to do this, HB 1353, was introduced by Reps. Bob Skarphol (R-Tioga), Bill Devlin (R-Finley), Robin Weisz (R-Hurdsfield) and Sens. Tom Fischer (R-Fargo), Ray Holmberg (R-Grand Forks), Judy Lee (R-West Fargo) on January 17, 2011 and it was referred to the House Education Committee chaired by RaeAnn Kelsch (R-Mandan), who was married to Thomas D. Kelsch, lobbyist for Philip Morris and US Smokeless Tobacco.

None of the representatives who introduced HB 1353 had been public leaders in the 2009 appropriation amendments, which would have repealed portions of Measure 3 and transferred its money to the DOH. However, Kathleen Mangskau reported in a 2012 interview for this research that they were all legislators, with the exception of Tom Fischer, who had historically opposed funding tobacco control programs.<sup>57</sup>

As introduced, HB 1353 would have repealed Chapter 23-42 of the North Dakota Century Code which had created the Tobacco Prevention and Control Program in 2008 when voters passed Measure 3. HB 1353 would abolish the Tobacco Prevention and Control Trust



Fund and replace it with a “Health Care Programs Trust Fund” for the deposit of the MSA Strategic Contribution Funds (SCF) to be used for “defraying the expenses of University of North Dakota School of Medicine and Health Sciences projects and programs related to increasing the health care workforce in the state, with a focus on the education of primary care physicians.”<sup>292</sup> HB 1353 also would have repealed the language enacted by Measure 3 that required 80 percent of the MSA funding going to the DOH via the Community Health Trust Fund be used on tobacco prevention and control programs. It also provided the UND School of Medicine \$28.9 million to construct a new health science facility and \$5.8 million for UND “for the purpose of increasing the number of medical and health sciences students at the University of North Dakota School of Medicine and Health Sciences and the number of residency training positions in the state.”<sup>292</sup> The Legislative Assembly needed two-thirds approval in both legislative chambers in order to amend a voter-initiated measure that passed less than seven years earlier.<sup>165</sup>

**The Legislative Assembly needed two-thirds approval in both legislative chambers in order to amend a voter-initiated measure that passed less than seven years earlier.**

Kathleen Mangskau, Chair of the TPC Executive Committee, explained in a 2012 interview for this research that she believed this was less an explicit attack on the Measure 3-created tobacco control program and more an attempt to increase funding to UND by this group of legislators, who did not care about funding tobacco control programs.<sup>57</sup> Nevertheless, this was an attempt to dismantle the Measure 3-created program and take its funding for other purposes, and was thus an attack. In other states, legislators supportive of the tobacco industry’s agenda have similarly attempted to take tobacco control funding and give it to medical projects such as medical schools or biomedical research.<sup>199, 293-295</sup> Another common tactic has been pitting the medical community against public health, which is usually a less powerful lobby. The tobacco industry’s role has not always been visible in these conflicts yet they consistently occur.<sup>40, 135, 296</sup>

The *Grand Forks Herald* supported HB1353,<sup>297</sup> the UND School of Medicine was located in Grand Forks.<sup>298</sup> The *Bismarck Tribune* opposed the bill, not because it supported tobacco control issues, but because it supported the honoring the decision the voters made when they passed Measure 3.<sup>299</sup>

State and local tobacco control coordinators and other state tobacco control advocates, including former Attorney General Heidi Heitkamp, quickly mobilized to save the tobacco control program, publishing numerous op-ed articles throughout the state<sup>298, 300-308</sup> and asking their coalitions to contact their legislators to vote against HB 1353. The advocates’ main message was that the voters had enacted Measure 3 and that the Legislative Assembly should not overturn something that the voters supported. They argued that the program was already seeing some success, and that the state still had a lot of work to do to lessen the burden of tobacco. The DOH did not take a position on the bill, explaining that they supported full funding for a comprehensive program but that it was a legislative issue and not for a state agency to comment on.<sup>65</sup> If HB 1353 was successful, there would have been no comprehensive statewide tobacco control program.

The TPC Executive Committee, Jeanne Prom, Executive Director of the Center, LPHU tobacco coordinators (attending as volunteers), and TFND's state and local supporters attended the House Education Committee

**The DOH did not take a position on the bill.**

meeting on January 31, 2011 when it considered HB 1353. Advocates dressed in red to show their solidarity. Rep. RaeAnn Kelsch, who Chaired the Education Committee, clarified that she was wearing red "because it makes me happy," not because she agreed with the tobacco control advocates.<sup>309</sup> Advocates, including Brenda Warren of TFND and Joseph DeMasi, a Valley City resident who had campaigned for Measure 3 in 2008, spoke at the Committee meeting and asked the Committee to leave Measure 3 intact. DOH staff also attended the hearing.<sup>167</sup> CTFK hired a lobbyist, Gail Hand, for the 2011 Legislative Session to work to protect Measure 3.<sup>178</sup>

In the press, Bruce Levi of the North Dakota Medical Association (NDMA) called the bill an "unfortunate paradox" and explained that NDMA supported the expansion of the Medical School but not with the money funding the tobacco control program. The North Dakota Hospital Association took a similar position.<sup>310</sup> Joshua Wynne, Dean of the UND School of Medicine, spoke in support of the bill, saying it was up to the legislature whether or not to fund tobacco control programs.

On February 23, 2011, the House Education Committee amended HB 1353 and removed the language repealing Measure 3, possibly because of the public pressure applied by the tobacco control community. The Committee briefly considered increasing the state's cigarette tax to provide new funding for the UND School of Medicine but it was removed before the full House voted on the bill. Instead, the full House decided that the proposed new UND programs be paid for with general funds.<sup>311</sup> With ostensibly little opposing pressure to funding the new UND School of Medicine programs with general funds, the House passed HB 1353 without the Measure 3 repeal and it crossed over to the Senate on February 23, 2011 with a 93-0 vote. However, HB 1353 was defeated the Senate for unknown reasons.

### ***HB 1004 – The Department of Health Appropriation Bill***

In the 2011 Legislative Session, while concurrently lobbying the Legislature to reject HB 1353, the TPC Executive Committee, the Center, and TFND also battled a provision in the DOH's appropriation bill, HB 1004, which would have removed Measure 3's requirement that 80 percent of MSA funds appropriated to the DOH be used for tobacco prevention and control programs.

HB 1004, the DOH's 2011-2013 appropriation bill, as introduced was similar to its 2009-2011 appropriation bill. As introduced, HB 1004 provided the DOH with its requested \$6.1 million for tobacco control programs (including CDC money which the Legislative Council included in its appropriation reports). On February 22, 2011, however, the House Appropriations Committee amended HB 1004 to repeal a portion of the language enacted by Measure 3 that required that the DOH spend 80 percent of the annual funding received from the original MSA on tobacco prevention and control programs.<sup>312</sup> The amendment was proposed by Rep. Larry Bellew (R-Minot) who did not have a history of leading opposition to tobacco control programs and policies and whose connection to the tobacco industry is unknown. The provision

in Measure 3 that required 80 percent of DOH funds be spent on tobacco prevention and control had been a sticking point for House Republicans in the 2009 Legislative Session who wanted to be able to give the MSA money to the DOH for other programs. Just as in 2009, some legislators wanted to appropriate the funds to the DOH to work on programs focused directly on heart disease and stroke, instead of tobacco, a cause of both.<sup>313</sup> To repeal language from Measure 3, the Legislative Assembly needed two-thirds of both chambers to support the amendment,<sup>312</sup> which happened in the House on February 23, 2009, when it passed 63-30 and then went to the Senate.

Members of the TPC Executive Committee, including Kathleen Mangskau and Center Executive Director Jeanne Prom, attended committee hearings in the House and in the Senate Appropriations Committee after HB 1004 arrived in the Senate. TFND and the TPC Executive Committee and Center staff argued that they still needed this funding to go to tobacco control because it was necessary to reach the total level of funding needed to reach CDC funding levels as specified in Measure 3. TFND mobilized its grassroots advocacy arm, which included the individual advocates at the local level who had supported the Measure 3 campaign, to contact their legislators with the message, “Keep Measure 3 intact.”<sup>57</sup> Karalee Harper explained in a 2012 correspondence for this research that the DOH continued to support the Governor’s recommended funding levels in the original bill, which also did not include an amendment to Measure 3 language. However, specific actions taken by the DOH to support the Governor’s bill are unknown.<sup>140</sup>

CTFK paid for Public Opinion Strategies to conduct a poll of North Dakota voters to gauge support for amending Measure 3. The poll of 400 voters found that 84 percent supported keeping Measure 3 in place and continuing to fund tobacco prevention programs with tobacco settlement money.<sup>313</sup> CTFK held a press release in March 2011 to publicize the findings.<sup>178</sup>

In a 2011 interview for this research, Sen. Ralph Kilzer (R-Bismarck), who sat on the Senate Appropriations Committee and who had sponsored the successful 2005 clean indoor air legislation, explained that he and other legislators wanted to be able to use the Community Health Trust funds (the original MSA money) for other public health programs like providing vaccines, though he conceded that North Dakota had other money available for those programs.<sup>132</sup> Sen. Kilzer argued that tobacco control programs were receiving too much funding and wasting funds on “way too many TV ads and stuff like that.”<sup>132</sup> Sen. Kilzer also took issue with the way that Measure 3 allowed for Strategic Contribution Funds to sit in the Tobacco Prevention and Control Trust Fund for future use by the tobacco control program. The Senator explained that “hopefully, what will happen is that in appropriation process that this excess of money, which this group has, in the appropriation process will have to turn it back. They’re not going to be able to stockpile it and make it last.”<sup>132</sup>

Despite the sentiment of Legislators who opposed Measure 3 and the amount of funding being given to tobacco control, TFND and the TPC Executive Committee and other tobacco control advocates, repeatedly contacted legislators and asked for them to leave Measure 3 intact.<sup>314</sup> Likely as a result of the pressure applied by TFND, the Senate Appropriations Committee deleted the House amendment that would have repealed the requirement that 80 percent of the DOH’s Community Health Trust Fund appropriation be used on tobacco

prevention and control programs. The Senate adopted the Appropriations Committee report. The House sent it to Conference Committee which retained the Senate deletion of the earlier House amendment. The Legislative Assembly enacted HB 1004 and appropriated \$6.1 million to the DOH for tobacco prevention and control programs for the 2012-2013 biennium. This, when combined with the TPC Executive Committee's funding, was \$18.6 million (\$9.3 million annually), which was CDC's recommended funding level.<sup>28</sup>

## **Conclusion**

In the 2011 Legislative Session, less than three years after the voters enacted Measure 3, the Legislative Assembly again attempted to dissolve the new tobacco control program and also to cut back DOH tobacco control funding. For both attempts, tobacco control advocates successfully mobilized a public outcry, contacted legislators, generated public pressure through op-ed articles, and testified at Committee hearings to kill these proposals. Such attacks will likely continue in the future and remain a threat to the fully funded tobacco control program. Because the Legislative Assembly meets biennially, the next opportunity to dismantle Measure 3 is in 2013.



## CHAPTER 10: LOCAL TOBACCO CONTROL POLICY MAKING

- Following the creation of the Community Health Grant Program in the 2001-2003 biennium and the advent of local tobacco control funding, LPHUs built policy-focused coalitions and cities throughout North Dakota began passing local clean indoor air ordinances.
- In 2008, Measure 3 passed, which provided important new funding for local coalition building and advocacy work.
- From 2009 to 2011, five additional cities passed comprehensive smokefree ordinances, increasing the fraction of the North Dakota population covered by a comprehensive law to 37 percent.

Much of early local tobacco control policy work (1993-1998) in North Dakota dealt with youth access to tobacco laws. However, following the Master Settlement Agreement and the new funding that the Community Health Grant Program required the DOH provide to local public health units for local tobacco control work beginning in 2001, a burgeoning local advocacy movement developed. Local tobacco control advocates understood that smokefree policies were a powerful tool for decreasing cigarette use and changing social norms around tobacco use in general, and, in 2001, with the successful passage of a Minot ordinance that prohibited smoking in restaurants, shifted their focus away from seeking youth access laws and started pressing local governments to pass smokefree ordinances.<sup>14</sup>

**Local tobacco control advocates understood that smokefree policies were a powerful tool for decreasing cigarette use and changing social norms around tobacco use in general.**

As part of their local grant agreements from the 2001-2003 biennium until the Legislature stopped funding the Community Health Grant Program in the 2009-2011 biennium, LPHUs were required to spend at least 40 percent of their funding on community-focused tobacco control programs with an emphasis on coalition building and passing stronger tobacco control policies. The DOH had two outreach coordinators on staff to advise grantees on policy campaigns, and, while the level of funding remained constant until 2009 when Measure 3 passed and the new TPC Executive Committee increased local funding, the DOH's level of activity and emphasis on passing local policies varied depending on the leadership of the Division of Tobacco Prevention and Control which changed from Kathleen Mangskau to Karalee Harper in 2006. Following this leadership transition, the DOH sought to distance itself from state and local tobacco control policy work. In 2008, the DOH worked with tobacco control leaders to file IRS paperwork that would reinstate Tobacco Free North Dakota's 501(C)3 nonprofit status and, in 2008, removed the Tobacco Policy Subcommittee from the DOH's Healthy North Dakota program so that the DOH would not be tied to state level tobacco control policy work. In 2009, the DOH refused to administer the TPC Executive Committee's local grants, instead preferring that the TPC Executive Committee, which could freely work on policy but had no staff, administer the grants. Complications at the state level between the DOH and the TPC Executive Committee, and its operating agency the Center for Tobacco Prevention and Control Policy, led to confusion among LPHUs who received two different grants, one from the DOH and one from the TPC Executive Committee, until 2011 when the TPC Executive Committee became the sole grant provider. Despite this confusion at the local level, local activity flourished from 2009 to 2011.

## **Fargo / West Fargo**

### ***The Beginnings of a Smokefree Air Campaign, 2003-2004***

Beginning in 2003, the Smoke-Free Air For Everyone Coalition (SAFE) based in the Fargo Cass Public Health Department, joined with local health groups and individuals, the state ACS, AHA, ALA, the North Dakota Dental Association and the North Dakota Nurses Association, held a public meeting to build public support for a smokefree ordinance.<sup>315</sup> Additionally, the Public Education Task Force on Tobacco, formed by the 28 LPHUs in 2002, ran more frequent television advertisements in Fargo in 2003 that discussed the importance of smokefree public places and workplaces.<sup>102</sup> The purpose of the increased level of advertisements was to support SAFE's efforts as it worked to build public support for a comprehensive smokefree air ordinance.

In October 2003, SAFE asked the City Commission to consider a smokefree ordinance. Not wanting to pass an ordinance that restricted bars, likely because of strong opposition from bar owners,<sup>316, 317</sup> Mayor Bruce Furness created a 14-member Second-Hand Smoke Task Force, consisting of local business owners (instead of public health officials), to consider the smokefree issue and to create an alternative solution that would protect nonsmokers but would not require legislation.<sup>318, 319</sup> Despite the Mayor's request for a non-legislative solution, in April 2004, the Task Force recommended that the City Commission pass an ordinance that prohibited smoking in public places and workplaces, but one that exempted bars that did not admit minors, hotels and restaurants that served liquor and bowling alleys.<sup>320</sup> Introducing exemptions for establishments that excluded youth and other hospitality establishments were common tobacco industry strategies.<sup>45, 172, 321</sup>

At the same meeting, after hearing the Task Force's recommendations, the City Commission considered, and defeated, three ordinances, one that would have prohibited smoking in all public places and two similar ordinances that prohibited smoking in public places but that exempted separately ventilated areas.<sup>320</sup> Allowing exemptions for ventilated smoking areas was another longstanding tactic of the tobacco industry used to dodge smoking restrictions.<sup>322</sup> Following the defeat of the ordinances, Commissioner Rob Lynch, who did not want to pass an ordinance, suggested that bar owners should voluntarily go smokefree, and Commissioner Jean Rayl, who supported a comprehensive ordinance, suggested that the SAFE coalition run an initiated measure campaign to pass a comprehensive smokefree law.<sup>320</sup>

At the same time, the City Council in neighboring Moorhead, Minnesota, was also considering a smokefree ordinance and the Minnesota tobacco control advocates were pressing Fargo to pass a comprehensive ordinance at the same time. The city leaders of both Fargo and Moorhead believed that if they were going to pass comprehensive ordinances that prohibited smoking in bars, that they needed to pass ordinances at the same time in order to ensure that neither city's bars lost business to competitors that still allowed smoking. Indeed, elected officials of the four major cities comprising the Fargo-Moorhead region (Dilworth, MN; Fargo, ND; Moorhead, MN; West Fargo, ND), a contiguous metropolitan area straddling the North Dakota – Minnesota border, all said they wanted to pass ordinances at the same time.<sup>319, 320</sup>

The tobacco industry has a long history of intentionally instilling fear among local businesses, especially bar owners and other hospitality businesses, by saying that neighboring businesses that still allow smoking will divert patrons away from their establishments. This has been a way to divide communities and derail tobacco control efforts all over the U.S.<sup>40, 41, 169, 172, 323</sup> The tobacco industry and its allies regularly claimed that revenues of bars and restaurants would decline by 30 percent following the passage of clean indoor air laws.<sup>135</sup> However, this was a concocted story that the tobacco industry knew to be false. David Laufer of Philip Morris explained in a 1994 presentation that “the economic arguments often used by the industry to scare off smoking ban activity were no longer working, if indeed they ever did. These arguments simply had no credibility with the public, which isn't surprising when you consider that our dire predictions in the past rarely came true.”<sup>324</sup> In reality, arguments that smokefree laws have adverse economic consequences for businesses have been proven unfounded by thorough, peer-reviewed economic analyses.<sup>125</sup>

Following a June 2004 election, the Fargo City Commission's membership changed and Commissioners Jean Rayl and Rob Lynch (Rayl supported an ordinance and Lynch opposed) were replaced by Commissioners Linda Coates and Mike Williams, both of whom supported an ordinance that included bars. Also in June 2004, Moorhead, MN passed a comprehensive city ordinance that covered all enclosed public places and workplaces without exemptions that was scheduled to go into effect September 1, 2004. The Moorhead City Council, however, agreed to return and amend its ordinance to exempt bars if Fargo passed an ordinance that exempted bars because they were afraid that they would lose business to Fargo if Fargo's bars allowed smoking.<sup>319</sup> Minnesota did not pass a comprehensive statewide law smokefree air law until 2007, but local tobacco control advocates had success passing a wellspring of local clean indoor air laws from 2000 to 2002, many of which prohibited smoking in restaurants, but most did not include bars.<sup>172</sup> In Minnesota, at the same time, clean indoor air proposals were met with similar arguments that smoking prohibition would have an adverse economic affect on Minnesota businesses. Opposition was led in Minnesota by the Minnesota Hospitality Association and its local chapters which were organized and financed by the tobacco industry.<sup>172</sup>

The SAFE Coalition continued meeting with Fargo City Commissioners to press the Commission to pass a comprehensive ordinance. With the election of Commissioners Coates and Williams, SAFE found more support on the Commission, but there was still heavy opposition from bar owners who wanted bars exempted. On Tuesday, July 6, 2004, the Fargo City Commission gave preliminary approval for a clean indoor air ordinance 3-2 to prohibit smoking in indoor public workplaces, including restaurants and bars. Mayor Bruce Furness opposed the ordinance under pressure from bar owners who argued that it would hurt business. Mayor Furness had proposed that the ordinance exempt bars, but the Commission moved forward with a comprehensive proposal that included bars.<sup>317</sup> In order to be finalized, however, the bill had to be read and passed by the Council for a second time.

**There was still heavy opposition from bar owners who wanted bars exempted.**

Tobacco industry ally organizations were not visible in Fargo but were likely the organizing force for the bar owners' opposition in Fargo and in other North Dakota cities. As early as 1991, the tobacco industry considered organizing bars and taverns to be a viable political



strategy for opposing tobacco control proposals<sup>325</sup> though the industry's direct involvement mobilizing the bars has not been visible. However, the tobacco industry had a close working relationship with the North Dakota Hospitality Association, which represents bars, restaurants and hotels, and used the Hospitality Association to run campaigns in opposition to tobacco control polices ranging from sale restrictions to clean indoor air laws.<sup>14</sup> Throughout the U.S., the tobacco industry has worked with, and often financed, hospitality organizations to run tobacco control opposition campaigns and make them appear to be purely grassroots operations.<sup>40, 42, 45, 135, 323, 326</sup>

On Monday, July 19, 2004, at the second reading of the ordinance, a group of bar owners submitted a petition with more than 4,500 signatures (1,880 were required) to put a weakened ordinance on the November general election ballot. The petition submitted by the bar owners would prohibit smoking in most public places and enclosed workplaces but would have exempted free-standing bars, enclosed bars within restaurants and truck stops. (This ordinance was later named Ordinance 1 when it was accepted as a ballot measure). Even with the addition of Commissioners more favorable to a smokefree ordinance, the Commission, not wanting to make the decision on the controversial issue, decided unanimously to instead accept the petition and to refer the issue to a public vote.<sup>327</sup> It was to be the first initiated measure brought to a vote in Fargo since the city's 1971 charter was approved that allowed initiated measures.<sup>328</sup>

Offering weaker, competing initiated measures that are designed to interfere with strong ordinance proposals is a standard tobacco industry strategy that has been repeated across the U.S. beginning with Proposition P in San Francisco in 1983.<sup>135</sup> These initiative campaigns are expensive and are usually led by a front group that the industry creates, or a free-standing organization that the industry enlists, in order to allow the industry, which has a negative public image, to avoid being seen as connected.<sup>56</sup>

There were two additional petitions circulated after bar owners' initial petition was successfully referred to a vote. A second petition (Ordinance 2) would put a measure on the ballot that would prohibit smoking in public places and workplaces but would have exempted free-standing bars, enclosed bars within restaurants that required all patrons present to be at least 21, and trucks stops (Ordinance 1 did not have an age restriction) (Table 27).<sup>329</sup> The fact that the competing ordinance specified age restrictions as a way to continue to permit smoking is a telltale sign of tobacco industry involvement. In 2001, in Duluth, MN, the tobacco industry was able to weaken an ordinance supported by the Duluth tobacco control coalition because the coalition framed their argument for passing the ordinance as a children's health issue as opposed to an economic issue.<sup>172, 321</sup> Framing the argument as a children's health issue made it impossible for the tobacco control coalition to counter the industry's claims that an ordinance would destroy local businesses. The result was a severely compromised ordinance that permitted smoking in enclosed bar areas of restaurants (and totally exempted bars at all times) after 8 pm as long as no one under 18 years old was not present.

Additionally, the SAFE coalition, chaired by Linda Kohls, Executive Director the North Dakota American Cancer Society, began circulating a third petition (Ordinance 3) to put a comprehensive smokefree ordinance (including bars) on the November ballot. The SAFE

	Public places	Workplaces	Restaurants	Bars within Restaurants (enclosed)	Bars (Free-standing)	Truck Stops
Ordinance 1	Covered	Covered	Covered	Exempt	Exempt	Exempt
<b>Ordinance 2</b>	<b>Covered</b>	<b>Covered</b>	<b>Covered</b>	<b>Exempt (No one under 21 admitted)</b>	<b>Exempt</b>	<b>Exempt</b>
Ordinance 3	Covered	Covered	Covered	Covered	Covered	Covered
<b>Notes:</b> Bold indicates the ordinance that prevailed (Ordinance 2)						

coalition thought that three clean indoor air ballot initiatives would confuse voters and did not originally plan to circulate its own ordinance but, knowing that it is difficult to return to strengthen a weak law, decided to support a ballot initiative for a comprehensive smokefree air law that would cover all workplaces and restaurants.<sup>329</sup> All three of the ordinance campaigns succeeded in getting their respective ordinances on the ballot.

Seeking clarification as to which ordinance would go into effect if more than one of the competing initiatives received over 51 percent of favorable votes, Fargo City Attorney Garrylle B. Stewart asked for a legal opinion from North Dakota Attorney General Wayne Stenehjem. Attorney General Stenehjem issued a formal opinion that “the one receiving the highest number of yes votes will prevail.”<sup>330</sup> On October 13, the *Grand Forks Herald* reported that the two groups of bar owners pushing separate ordinances (Ordinances 1 and 2) would join to only focus on the weaker Ordinance 2 to avoid splitting votes between two competing initiatives.<sup>331</sup>

SAFE led a public education campaign through newspaper advertisements and op-ed articles in efforts to get voters to enact Ordinance 3. Also, the Public Education Task Force of Tobacco (PETF) continued to run smokefree education television advertisements that carried messages emphasizing the importance of all public places and workplaces being smokefree. ACS contributed \$25,000 to pay for the advertisements (Figure 12), as well as additional staff, phone lines and a photocopier as in-kind donations to SAFE. SAFE advocates were frequently quoted in the press in support of a comprehensive ordinance. SAFE argued that bars needed to be 100 percent smokefree because the health of bar employees was not worth less than people in other occupations.<sup>334</sup> The state DOH Division of Tobacco Prevention and Control’s contract employee from Minot State University, Kelly Buettner-Schmidt, worked with SAFE and provided technical assistance on coalition building and building public support for an ordinance.<sup>100</sup>

On Election Day, November 2, 2004, Ordinance 2, which prohibited smoking in public places and workplaces, but that exempted truck stops, free-standing bars, and enclosed bars within restaurants that denied entry to people under 21 years old, received 57 percent of favorable votes and, having received the highest number of votes, was enacted. Ordinance 1, which would have prohibited smoking in all public workplaces except bars within restaurants (that had no age restriction for entry) failed with only 46 percent of favorable votes. SAFE’s smokefree proposal (Ordinance 3) received 54 percent of voters in favor.<sup>333</sup> Ordinance 2 went into effect November 19, 2004.<sup>332</sup>

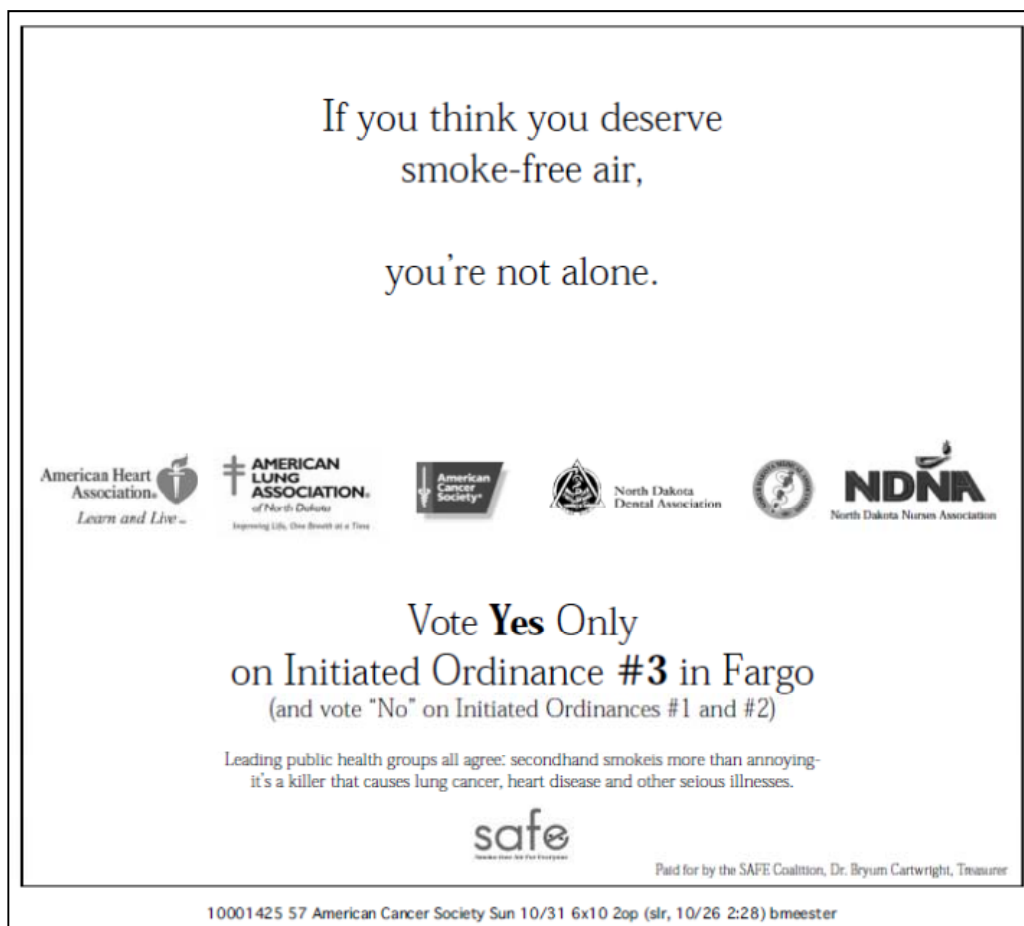


Figure 12: SAFE's Campaign Advertisement in support of Ordinance 3.<sup>11</sup>

West Fargo voters, following the lead of Fargo, also passed a similar initiated measure on November 2, 2004, that prohibited smoking in public places in enclosed workplaces but that exempted bars that did not allow people under age 21 to be present but covered all restaurants. West Fargo's ordinance, which was also supported by SAFE, went into effect in early December.<sup>333</sup> In December 2004, Moorhead, MN which had passed a comprehensive ordinance in May 2004, revisited its ordinance and weakened it to mirror the provisions of Fargo's new ordinance in order to "level the playing field" for the businesses in the neighboring cities.<sup>319</sup>

Linda Kohls, Chair of the SAFE coalition, said that the tobacco control coalition wanted a comprehensive law and would continue to advocate for a comprehensive ordinance.<sup>333</sup> Fargo and West Fargo's 2004 ordinances were the strongest clean indoor air ordinances enacted in North Dakota at that point.

**Fargo and West Fargo's 2004 ordinances were the strongest clean indoor air ordinances enacted in North Dakota at that point.**

## ***2007 – Fargo/ West Fargo Campaign***

In 2006, dissatisfied with the 2005 statewide clean indoor air law that exempted bars and bars within restaurants, bowling alleys and hotels, the SAFE Coalition again asked the Fargo and West Fargo City Commissions to remove the exemptions for bars in its 2004 ordinances.

On November 29, 2006, elected officials of the four major cities comprising the Fargo-Moorhead region (Dilworth, MN; Fargo, ND; Moorhead, MN; West Fargo, ND), as well as several county-level officials, met at the request of the SAFE coalition to form a Regional Task Force to formulate a unified plan for taking all the cities smokefree at the same time. The Regional Task Force drafted a series of questions to present to each city's leaders to gauge their level of commitment to passing smokefree ordinances and their willingness to work with neighboring city leaders to pass laws at the same time.

On January 2, 2007, Fargo's Board of City Commissioners considered the questionnaire presented by the Regional Task Force and unanimously decided that it would support a "more restrictive no-smoking ordinance" if neighboring jurisdictions adopted a similar ordinance.<sup>335</sup> The Fargo and the West Fargo City Commissions informally agreed to move forward with comprehensive ordinances at the same time.<sup>336</sup> At the time, Minnesota's Legislature was beginning to consider a statewide smokefree air law (that passed in May 2007) that would cover all public places (including all restaurants and bars), which if passed, would cover Moorhead and Dilworth and leave Fargo and West Fargo with weaker laws than its neighboring cities.

### *West Fargo Decides to Hold an Advisory Vote*

After Minnesota passed its statewide smokefree air law in May, 2007 (effective October 1, 2007), the SAFE Coalition began working with Brenda Warren, a West Fargo City Commissioner, in efforts to get the West Fargo City Commission to pass a comprehensive smokefree ordinance that included bars. These neighboring cities had wanted to pass ordinances at the same time, so, with Minnesota passing a statewide law, SAFE saw this as a good opportunity to return and try to strengthen West Fargo's 2004 ordinance. City Commissioner Brenda Warren was supportive, became the SAFE Coalition's champion on the Commission and was influential in getting the Commission to consider the issue.<sup>336, 337</sup> Commissioner Warren found little initial support on the West Fargo City Commission for the comprehensive ordinance. However, in late July, Commissioner Bryan Schultz telephoned Warren to say that he, and Commissioner Lou Bennett, both of whom had opposed an expansion to the clean indoor air ordinance, had changed their minds and would vote for the ordinance.<sup>337</sup> As a result of Schultz's call, which led Warren to believe that the ordinance would pass, Warren placed the ordinance on the Commission schedule for the July 30, 2007 meeting.

Despite believing that the votes were present to pass the ordinance, the West Fargo City Commission rejected the proposed ordinance with a 3-2 vote at the July 30 meeting. The Commission instead decided to ask the public to weigh in with a non-binding advisory vote on whether the Commission should pass a smokefree ordinance.<sup>338</sup> Reportedly, Commissioner Bryan Schultz decided at the last moment (after changing his mind days earlier to support the ordinance) to vote against the ordinance after he counted the people present in the audience who

wearing the color meant to represent the opposition to the ordinance. The tobacco control advocates were also all wearing the same color.<sup>336</sup> Warren explained that, in addition to a large presence of SAFE Coalition members, there was a large contingent of bar owners in the audience, many of whom testified in opposition to the ordinance and made personal verbal attacks on Warren in their testimony.<sup>337</sup> Warren also received messages on her home phone machine from bar owners and other ordinance opponents telling her to “back off, or else.”<sup>337</sup>

### *Fargo Takes Steps Forward for an Ordinance*

Also on July 30, 2007, as a result of pressure from the SAFE Coalition and likely pressure from Moorhead and Dilworth, Minnesota (smokefree as of October 2007 as a result of Minnesota’s new smokefree air state law), Fargo City Commissioner Linda Coates, asked the City Commission to consider an ordinance to strengthen Fargo’s ordinance and remove its bar exemption. Commissioner Coates was supportive of an ordinance before the Commission in 2004 but ultimately supported referring the issue to a public vote along with the rest of the City Commission instead of voting for the ordinance. The City Commission voted 5-0 in favor of directing the City Attorney to draft a comprehensive ordinance including bars for its consideration.<sup>339</sup> The Commission also directed the City Attorney to draft a non-comprehensive ordinance which exempted the city’s only cigar bar, JT Cigarro, which wanted to be grandfathered into a new ordinance.

The SAFE Coalition and its state health group partners testified at the July 30 Commission meeting. John Fischer of the SAFE coalition, June Herman, Senior Director of Public Advocacy for the American Heart Association’s North Dakota office and Dr. John Baird, Health Officer for Cass County (which included Fargo) asked the Commission to pass a comprehensive ordinance with no exemptions.<sup>340</sup> (AHA actively supported this ordinance at the same time that the group of tobacco control leaders wrote the national AHA leaders asking that Herman be removed from AHA or that AHA stop working on tobacco control issues, discussed earlier.)

There was again outspoken opposition from bar owners who wanted bars to remain exempt. Bar owners told the City Commission that they would petition any stricter ordinance and bring it to a public vote, hoping the public would reject the proposal.<sup>341</sup> Tobacco control advocates had more difficulty organizing local advocates than they did in 2004. Chelsey Matter, Tobacco Coordinator for Fargo-Cass Public Health, felt that the community was more motivated to organize in 2004 because there were many locations that still allowed smoking. By 2007, many residents in Fargo felt that it was not worth the effort of a campaign that would inevitably result in an exhaustive initiated measure campaign because a stronger ordinance would extend the law to cover bars (which had been exempted from the 2005 statewide clean indoor air law because of an organized bar owner opposition), but most other locations in Fargo were already covered. Even so, SAFE had active members who wanted to close the 2004 exemption and was committed to expanding the ordinance to include all bars.

Mayor Dennis Walaker, not wanting to make the decision, said that he preferred to give voters the decision but agreed to consider the smokefree ordinance being drafted by the city attorney.<sup>341</sup> At the next meeting of the City Commission on August 13, 2007, the Commission

approved the comprehensive ordinance prohibiting smoking in all public workplaces including all bars and truck stops 4-1.<sup>340</sup> The dissenting vote was Mayor Dennis Walaker.

By the next Commission meeting on August 27, 2007, after receiving an outpouring of emails from SAFE Coalition members supporting a comprehensive law with no exemptions, Mayor Walaker had decided to support the comprehensive ordinance. At the meeting, Linda Kohls, Chair of the SAFE Coalition, distributed letters of support from the North Dakota Medical Association, American Stroke Association, American Heart Association, Region V Substance Abuse Prevention Coordinating Committee, North Dakota Public Health Association and the American Lung Association of North Dakota for a 100 percent comprehensive smoking law.<sup>342</sup> The Commission read the ordinance for its second time and amended it, changing the date of implementation from January 1, 2008 to March 1, 2008. At this time, bar owners continued to publicly discuss plans to circulate petitions and get signatures to refer the ordinance to a public vote if the City Commission passed the ordinance on its third reading.

At the September 10, 2007 meeting of the Fargo City Commission, bar owners, most vocally Fargo bar owner Randy Thorson, stated that they had collected 4500 signatures and submitted a petition to pass an ordinance that essentially reinstated the 2004 ordinance with the addition of making the town's cigar bar exempt. A direct connection between Thorson and the tobacco industry is unknown.

However, since the early 1980s, the tobacco industry has used weak tobacco control referenda and voter-initiated measures as way to interfere with strong tobacco control proposals.<sup>135</sup> The industry typically organizes and funds third party organizations, like hospitality organizations, beverage associations and small local groups that appear to be local grassroots organizations, to work to defeat strong laws. These groups either refer ordinances to a public vote, where the industry then invests its significant finances into opposing campaigns, or it supports competing, but weaker initiated measures, that are meant to confuse voters and get weak laws passed.<sup>36</sup>

The hospitality industry (generally bars, restaurants and hotels), often gets involved based on the tobacco industry's claim that smokefree laws have a dramatic economic effect on local businesses which lose patrons that are smokers.<sup>45</sup> This claim has been consistently disproven for decades, but the tobacco industry and its allies continue to purport that the smokefree laws are an economic threat. In reality, smokefree laws have been consistently shown to improve business.<sup>125</sup>

Another group, "Share the Air" led by Barry Nelson, a Fargo-Moorhead resident,<sup>336</sup> announced that it was planning to collect the 2,850 signatures needed to put the comprehensive ordinance being considered by the Commission to a public vote. The SAFE coalition had no knowledge of this new group or its intentions and wanted the Commission to pass the ordinance, not refer it to a public vote.<sup>338</sup> Share the Air had alerted Commissioner Mike Williams in advance that they were circulating the petition which provided the Commission with a way to sidestep taking a vote on the ordinance passed, which referred the ordinance to a public vote.<sup>336</sup>

By October, realizing that they needed to stop the bar owners' weak ordinance on the ballot, the SAFE coalition began working with Share the Air, who was still collecting the

necessary signatures, to put a comprehensive ordinance to a public vote. Share the Air drafted the language without consulting SAFE, so SAFE was unable to have the petition language exactly as they would have liked. SAFE wanted to include retail tobacco stores like JT Cigarro, the local cigar bar, but this was exempted in Share the Air's ordinance. This was the only exemption. The reality was that Share the Air already had 1,000 signatures and, to change the language, the tobacco control advocates would have been forced to start over.<sup>336, 338</sup> Additionally, Matter explained in a 2011 interview for this research that a number of the City Commissioners were supportive of exempting JT Cigarro, so the SAFE coalition decided not to make it an issue that would inhibit the campaign.

Share the Air, the group that independently began pushing the smokefree ordinance, did not understand the effort and resources that would be required to get its ordinance passed once it got onto the ballot. Matter, working with SAFE, explained that Share the Air only planned to get the measure on the ballot and then just planned to leave the question up to the voters and not run a campaign to support the ordinance. Matter knew that there would be opposition from bar owners and that the initiative probably would not pass if they did not run a campaign in support of the smokefree initiative. SAFE understood the significance of Fargo's smokefree ordinance either passing or failing. Matter recalled, "We're talking about the first city in the whole state. If we [Fargo] fail, nobody else is going to try it for forever, or for a number of years. So we need to make sure that it passes and we know that they're [the bar owners] going to have a really nice media campaign and we have to be able to counteract that."<sup>336</sup>

**SAFE understood the significance of Fargo's smokefree ordinance either passing or failing.**

### *Tobacco Control Progress in Fargo and West Fargo*

In December 2007, the Fargo City Commission had placed the bar owners' ordinance on the June 2008 ballot and named it Measure 2.<sup>338</sup> By March 2008, the SAFE Coalition and Share the Air in Fargo had secured 3,600 signatures and submitted them for the city to place their stronger smokefree ordinance on the June 2008 ballot as well. The ordinance did not include the exemptions for bars and truck stops in the bar owners' ordinance that the Commission had already placed on the June ballot. The Fargo City Commission accepted the SAFE coalition's petition signatures on March 24, 2008 after the signatures were verified and placed their ordinance on the June ballot as Measure 1.

The SAFE Coalition remained active throughout spring 2008 and worked to make voters aware of Measure 1 that would be on the June ballot in Fargo. Additionally, as discussed above, the West Fargo City Commission had voted in July 2007, 3-1 to place an advisory non-binding comprehensive smokefree question on its June 10, 2008 ballot (the same day as Fargo). West Fargo's voters would be considering whether or not to prohibit smoking in bars and truck stops which were still exempt from its 2004 ordinance.<sup>338</sup> The West Fargo advisory vote would be nonbinding, but SAFE felt that the West Fargo City Commission would likely follow the will of the voters.

The SAFE Coalition worked with numerous organizations on its campaign which included a direct mail campaign, get-out-the-vote phone call events, a paid radio campaign and

door-to-door canvassing.<sup>178</sup> The Campaign for Tobacco-Free Kids, ACS, AHA and ALA provided assistance to the campaign financially and by mobilizing its members and working on strategy (Table 28).<sup>64, 142</sup> Americans for Nonsmokers' Rights (ANR) also worked with the coalition and provided technical assistance.<sup>178</sup> The Public Education Task Force on Tobacco (PETF), which in 2006, began prioritizing television advertisements focused on the importance of smokefree bars, continued to run advertisements during the campaign in efforts to maintain public support for the ordinance.<sup>102</sup>

<b>Table 28: Financial Contributions of State and National Health Organizations for Fargo, 2007-2008<sup>61, 142</sup></b>	
Amount	Organization
\$25,000	American Cancer Society
\$44,560	American Cancer Society Cancer Action Network
\$35,000	American Heart Association
\$10,000	American Lung Association
\$29,000	Campaign for Tobacco-Free Kids
<b>\$143,560</b>	<b>Total</b>

Meanwhile, the opposing ordinance being supported by the bar owners launched a media campaign with television commercials that promoted smoking in bars as a personal freedom and paired that theme with anecdotes about soldiers returning from war in Iraq, only to be prohibited from smoking in bars. The source of funding for the media campaign is unknown but the tobacco industry has historically funded such local opposition campaigns.<sup>55, 135, 343</sup>

In Fargo, the SAFE Coalition and Share the Air held a press conference on May 12, at which time they launched a new website, smokefreefargo.com, to educate the public about the importance of passing the ordinance. SAFE held several additional press conferences, including one on May 21, 2008 featuring three respiratory therapists and an allergist.<sup>338</sup> SAFE's message was "Yes on 1, No on 2."<sup>338</sup> AHA organized volunteers from its Jamestown, North Dakota office and coordinated phone banking in support of the smokefree ordinances in Fargo and West Fargo. Volunteers called voters in Fargo and West Fargo voters and encouraged them to vote for the ordinances in the two cities.<sup>64</sup>

SAFE's campaign in West Fargo was much smaller. SAFE relied on the *Forum of Fargo-Moorhead*, the shared local daily newspaper for Fargo, West Fargo, Moorhead and Dilworth, to educate West Fargo residents about the ordinance there. The *Forum* supported the smokefree ordinances being voted on in Fargo and in West Fargo, and ran favorable op-ed articles and editorials that promoted both.<sup>344</sup>

On Election Day on June 10, 2008, in Fargo, Measure 1 (the comprehensive ordinance) passed with 61 percent of voters in favor. The bar owners' ordinance, Measure 2, also passed, and received 57 percent of favorable votes. Measure 1 was determined to be the winning ordinance based on the Attorney General's earlier opinion that with conflicting ordinances, the ordinance that received the most total votes was the one to be enacted. Despite the exemption for the JT Cigarro Cigar Bar, Fargo's 2008 ordinance represented a major win for tobacco control advocates in North Dakota.



In West Fargo's advisory vote, 57 percent of voters supported the Commission passing a comprehensive ordinance that prohibited smoking in public places and enclosed workplaces without exemptions for bars or truck stops. On June 16, 2008, the West Fargo City Commission honored the vote of the public and enacted its comprehensive ordinance that the voters approved the ordinance.<sup>338</sup> Fargo and West Fargo became the first cities in North Dakota with strong smokefree laws. Both ordinances took effect on July 1, 2008.

In preparation for the implementation of both ordinances, Fargo Cass Public Health, the Local Public Health Unit in Fargo, released a tool kit for workplaces going smokefree. The tool kit included the language of the new ordinances, explanations of the new smoking laws and suggestions for easing the transition and dealing with customers unfamiliar with the new laws.<sup>345</sup> Chelsey Matter reported in a 2011 interview for this research that implementation of both ordinances had gone smoothly.<sup>336</sup>

In 2008, American Heart Association and the Flight Attendant Medical Research Institute funded the Roswell Park Cancer Institute in Buffalo, NY, to conduct a study measuring air quality (respirable suspended particulate) levels in Fargo bars two months prior to the city implementing its ordinance and two months after implementing it.<sup>346</sup> The key findings of the study were:

- Before the Fargo smoke-free air ordinance, the average level of fine particle indoor air pollution was 45 times higher in Fargo locations sampled compared to the places in smoke-free Moorhead.
- Employees working full-time in the establishments sampled in Fargo before the law were exposed annually to fine particle air pollution levels 4.5 times higher than the safe annual limit established by the U.S. Environmental Protection Agency (EPA).
- Indoor particle pollution levels declined 98% in Fargo as a result of the smoke-free air law to low levels, similar to those found in outdoor air.

In 2010, Fargo-Cass local public health unit commissioned the North Dakota State Data Center at North Dakota State University to conduct a study of the economic impact of the 2008 Fargo and West Fargo ordinances two years after implementation. By analyzing sales and tax data, the study concluded that, despite claims by opponents during the ordinance debates, neither ordinance had any economic impact on Fargo's or West Fargo's bars.<sup>347</sup> Both the air quality report and the economic impact report served as tools for other local advocates to use to convince their elected officials to pass smokefree ordinances.

## **Grand Forks**

### ***Passing an Ordinance - 2005***

In summer 2004, to lay a foundation for Grand Forks to pass a comprehensive smokefree air law, the Grand Forks Public Health Department funded a survey of Grand Forks businesses on the issue that found that 67 percent of businesses surveyed strongly supported a law prohibiting smoking in the workplace.<sup>348</sup> Using this information, and with increasing local activity throughout North Dakota (particularly in Fargo), the Grand Forks Tobacco Free

Coalition (GFTF) began meeting with the Grand Forks City Council to ask Council members.<sup>349</sup> On July 16, 2004, when Fargo and West Fargo were considering comprehensive smokefree ordinances, Grand Forks Mayor Mike Brown publicly supported a comprehensive smokefree ordinance as “a health issue.”<sup>350</sup>

**GFTF understood that Grand Forks businesses would want to pass an ordinance at the same time as East Grand Forks, Minnesota, which shared business clientele with Grand Forks.**

While both GFTF and Mayor Brown supported a smokefree ordinance, neither asked the Council to consider an ordinance in July 2004 because both felt that GFTF needed more time to educate the community on the importance of passing a law.<sup>351</sup> As in Fargo and West Fargo, GFTF understood that Grand Forks businesses would want to pass an ordinance at the same time as East Grand Forks, Minnesota, which shared business clientele with Grand Forks. (The two cities are contiguous, separated by the Red River that is the state line between North Dakota and Minnesota.) Nevertheless, the rumors of a potential ordinance were enough to mobilize opponents. Linda Boss Price, owner of a Grand Forks cigar store, immediately began circulating a petition in her store for customers to sign and was quoted in the press saying she would sue the City Council if it passed a smoking ordinance. Other cigar stores were quoted in the same article opposing the ordinance.<sup>352</sup>

In November 2004, the GFTF Coalition began its public education efforts in order to develop support for a comprehensive ordinance. On November 18, 2004, GFTF held a public meeting and brought in James Repace, an expert on secondhand smoke as indoor air pollution, and Pat McKone, Senior Director of Advocacy for ALA in Duluth, Minnesota, to speak on the importance of going smokefree. GFTF invited the Grand Forks City Council to the forum and Council members Dorette Kerian, Curt Kreun, Hal Gershman and Eliot Glasheim attended.<sup>353</sup> In January 2005, there was statewide media coverage of the Legislature’s consideration of a clean indoor air law introduced by Sen. Ralph Kilzer (R-Bismarck) and supported by the Healthy North Dakota Tobacco Policy Subcommittee, which GFTF used to build support for their local ordinance.<sup>354</sup> ALA assisted GFTF with the campaign and the state DOH Division of Tobacco Prevention and Control also provided limited technical assistance to the coalition.<sup>57</sup> The PETF continued its television advertisements focused on educating the public on the importance of all smokefree locations but it is unknown if it increased its amount of advertisements in Grand Forks as GFTF pursued a smokefree ordinance.

By February 2005, the coalition had spent months educating the public and had developed a working relationship with Council member Dorette Kerian, who became the biggest proponent of an ordinance on the Council. In early February, Council member Kerian asked city attorney Howard Swanson to draft a smokefree ordinance that prohibited smoking in all public places and workplaces, including all bars and restaurants, so that the City Council could consider the smoking issue at the same time that the state Legislature considered its bill (SB 2300).<sup>355</sup> (The 2005 state law, which ultimately prohibited smoking in restaurants, except in bars within restaurants, had not yet passed when Kerian requested the ordinance be drafted.)

On February 28, 2005, the City Council discussed the issue at a meeting that attracted around 70 people, most of whom supported a comprehensive ordinance, though some – mainly

bar owners –opposed it.<sup>356</sup> The Council decided to wait until May 2005 to enact an ordinance to see if the state Legislature would pass a statewide smokefree law that would cover Grand Forks.<sup>357</sup> As a result of the demonstrated public support for a smokefree ordinance, GFTF also developed a relationship with Council member Eliot Glassheim. Council members Kerian and Glassheim wanted to pass an ordinance that prohibited smoking in bars if the state did not. Glassheim argued in the press in February that the state Legislature would have an easier time passing a comprehensive law if cities like Grand Forks did so first.<sup>355</sup>

GFTF continued to work with the City Council and to build public support. The Grand Forks Youth Against Tobacco Coalition, a local youth coalition organized by Grand Forks Public Health Department, began organizing other youth around smoking cessation and prevention, and sought to build a youth arm to the Grand Forks Tobacco Free Coalition.<sup>358</sup> Members of this youth coalition was present at Council meetings and testified in support of the passage of the ordinance. The youth coalition also launched a letter-writing campaign to Council members in support of the smokefree ordinance.<sup>359</sup>

In February, the Grand Forks Tobacco Free Coalition commissioned the University of North Dakota Social Science Research Institute to poll Grand Forks adults regarding their support of a smokefree ordinance. The poll of 403 adults in Grand Forks, ND (352 adults) and East Grand Forks, MN (48 adults) asked which locations should be smokefree. Sixty eight percent supported prohibiting smoking in public locations, but only 38 percent supported prohibiting smoking in bars.<sup>360</sup>

The state Legislature enacted a clean indoor air law on April 25, 2005 (discussed in other sections) which prohibited smoking in many public locations and workplaces but exempted bars, bars within restaurants, bowling alleys and hotels, as well as some other locations. With the new state law in mind, the City Council began again to consider an ordinance and to hear public comment on the smoking issue in May 2005.

Council members Dorette Kerian and Eliot Glassheim continued to lobby other Council members to support an ordinance that included free standing bars, but there was little interest among the other Council members to prohibit smoking in all bars because the survey had found that only 38 percent felt bars and lounges should be smokefree.<sup>361</sup> Another sticking point for Grand Forks Council members was that East Grand Forks, MN, Grand Forks' close neighboring city, was not planning to move forward with a smoking ordinance. Council members and business owners, as usual, feared losing business to cities that still allowed smoking.<sup>362</sup>

Unable to persuade the rest of the Council to pass an ordinance that included bars, Council member Kerian had another clean indoor air ordinance drafted that the Council discussed on May 16, 2005. The new draft ordinance prohibited smoking in enclosed workplaces and public places but exempted bars, bars within hotels and bars within bowling alleys. This was only slightly more restrictive than the 2005 state law. The main advance beyond state law in Kerian's proposal was that Kerian's law would make bars within restaurants smokefree. She did this by changing the definition of "bar." Kerian's ordinance proposal redefined bar designations in Grand Forks and prohibited establishments with Class 1 liquor licenses (general liquor licenses) from admitting anyone under 21 years old. Restaurants could not have a Class 1 liquor

license and admit minors. Restaurants would have to choose whether they were a bar or a restaurant and if they chose bar, they could not admit anyone under 21 years old.<sup>363</sup> Kerian's ordinance also prohibited smoking in outdoor areas of restaurants and prohibited smoking within 25 feet of entrances to public places and did not exempt truck stops as the state law did, as well as some other small provisions. The Council read Kerian's proposal but did not vote on it on May 16, 2005.

GFTF worked closely with Kerian to support the ordinance, but Kerian did not believe that a stronger ordinance than she had introduced was possible. Members of the coalition spoke at the meeting in support of the ordinance.<sup>363</sup> GFTF wanted all bars included in the ordinance, but with East Grand Forks not moving forward with its own ordinance, there was continual fear among bar owners that Grand Forks would lose business, which made the Council hesitant to prohibit smoking in all bars. There was intense pressure from bar and restaurant owners, who appeared in mass at the Council meetings and asked that the city not go beyond the new state law.<sup>363</sup> Opposition to the ordinance in Fargo and West Fargo in 2004 came from bar but not restaurant owners. In contrast, in Grand Forks restaurants also opposed the ordinance which likely was because the ordinance that would close the exemption in the state law for bars within restaurants.

At the June 6, 2005 meeting, Council member Douglas Christensen introduced a slightly different ordinance and moved that it be considered for adoption. (Kerian's ordinance had been discussed in previous meetings but not submitted for a first formal reading.) The largest differences between the ordinances included decreasing the prohibition on smoking near a door from 25 feet to five feet and removing of a prohibition on smoking in outdoor areas of restaurants. Council member Glassheim introduced a successful amendment that restored the prohibition on smoking in outdoor areas of restaurants. GFTF supported this ordinance because it maintained Council member Kerian's definition of bars that made bars within restaurants smokefree. The Commission passed Christensen's ordinance (Ordinance 4067) on its first reading with a 7-0 vote.

On June 20, 2005, at the ordinance's second reading, Council members Kerian and Glassheim proposed an amendment to phase out the bar exemption on August 1, 2006, one year after the ordinance would first be implemented. The amendment failed 2-5 because the rest of the Council wanted bars exempted as a result of pressure from businesses. The Council then passed the ordinance, again by 7-0, with the law to take effect August 1, 2005,

The ordinance was stronger than the state law because it prohibited smoking in bars attached to restaurants. (It left freestanding bars exempt.) The ordinance also prohibited smoking within five feet of doorways and in outside areas of restaurants such as patios and decks.

GFTF was excited about the new ordinance because of its prohibition of smoking in bars within restaurants, which was stronger than the state law. It was also the first locality to pass a stronger ordinance than the law the state Legislature passed just months earlier.<sup>364</sup> Following the ordinance's enactment at the June 20, 2005 Council meeting, Council member Kerian asked GFTF to continue to educate the public on the smokefree issue.<sup>363</sup> Kerian told the coalition to prepare to return within two years to strengthen the ordinance. GFTF was encouraged by

Kerian's request and planned to continue working to educate the public and return to close the exemptions.<sup>365</sup>

### ***Returning in Grand Forks to Strengthen the Ordinance – 2009/2010***

Following the passage of the 2005 ordinance, GFTF continued building its coalition and worked to build public support for a comprehensive ordinance that would prohibit smoking in all bars. In early 2008, the Grand Forks Tobacco Free Coalition began strategizing for a campaign to strengthen the ordinance. Fargo and West Fargo were preparing to pass comprehensive smokefree ordinances including bars (which passed in June 2008) and Minnesota, bordering Grand Forks to the east, passed a comprehensive statewide smokefree law including bars that became effective October 2007. With East Grand Forks, MN now smokefree, there was pressure from East Grand Forks businesses for Grand Forks, ND to go smokefree too, and GFTF felt that it was a good opportunity to capitalize on the momentum.<sup>365</sup>

Following the June 2008 success of SAFE in Fargo and West Fargo, the GFTF invited advocates from SAFE in Fargo to give a presentation to GFTF members to explain SAFE's process for passing smokefree ordinances and to offer lessons that they learned to Grand Forks. GFTF invited the Grand Forks City Council members to attend. Council member Eliot Glassheim attended and continued to be one of the coalition's champions.<sup>365</sup> At the time, Glassheim did not think that there was enough support on the Council to pass a smokefree ordinance and wanted the coalition to circulate a petition for a ballot initiative to ask voters to decide the issue. GFTF understood that opposition from bar owners would likely surface, as it had in most other North Dakota communities considering smokefree ordinances, and that the opposition would support weaker counter-initiatives resulting in a long, difficult campaign.<sup>365</sup> GFTF persisted in their argument that the City Council pass a local ordinance. To develop support on the City Council, GFTF continued to educate Council members and the public to develop the necessary public support.<sup>365</sup>

In July 2009, as a result of public education from GFTF, the Grand Forks Board of Health, which is not a legislative body, passed a resolution supporting a comprehensive smokefree ordinance. In addition, the Grand Forks Public Health Department established passage of a smokefree air law as one of its top priorities. The Grand Forks Mayor's Cabinet on Health and Human Services, a group meant to promote health programs, also passed a resolution of support which the GFTF highlighted when talking with Council members.<sup>365</sup>

GFTF also continued working to generate public support. The coalition revamped its website, began using social networking tools such as Facebook and Twitter, and worked with media consultants to create local smokefree messaging. The advocates worked with Grand Forks-based communications firm SimmonsFlint, to develop a series of television advertisements. However, the Center (the Measure 3-funded program) requested that the advertisements not be aired because the Center wanted a uniform statewide campaign with consistent messaging that had been thoroughly tested and that GFTF should instead use advertisements already developed by the Public Education Task Force on Tobacco. GFTF complied with the request and ran pre-approved advertisements made by the Public Education Task Force on Tobacco focused on the importance of smokefree bars.<sup>365</sup>

In 2012 correspondence for this research, Haley Thorson, Tobacco Coordinator in Grand Forks and Chair of GFTF, wrote:

The local ads created by SimmonsFlint were initially funded by the remaining spend-down dollars from the ND Department of Health Community Health Grant. These dollars covered the cost of the creative and filming. Soon after, the “state tobacco program” was transitioned from the DoH to the Center. Grand Forks’ first grant proposal to the Center included funding for the airing of the locally created ads. Even though this proposal was approved, the Center decided that uniform state-wide ads regarding exposure to SHS would be more appropriate considering the viewing audience for the selected stations were beyond Grand Forks city limits. The content of the local ads was centered around a focal character named Death (a grim reaper), who appeared in identifiable Grand Forks locations where secondhand smoke exposure still remained. Factual secondhand smoke information was voiced-over as well as placed in the on-screen text. Shortly thereafter, the Center developed a clear set of Communication Guidelines to ensure consistent messaging across the state.<sup>366</sup>

The coalition commissioned the Social Science Research Institute of the University of North Dakota to poll Grand Forks adults on whether the city should pass a smokefree ordinance prohibiting smoking in bars. The results from the telephone survey of 779 randomly-selected adults were released in January 2010. It showed a remarkable shift in public opinion on smokefree bars: 67 percent “strongly supported” expanding the Grand Forks clean indoor air ordinance to prohibit smoking in all workplaces, including bars, with another 15 percent “somewhat supported” smokefree bars.<sup>367</sup> A 2005 poll of Grand Forks voters had shown that only 38 percent supported prohibiting smoking in bars.<sup>360</sup>

Mayor Mike Brown was strongly affected by the poll and told GFTF that he was highly supportive of a smokefree ordinance and asked the coalition to work with him to get the Council to pass an ordinance to make bars smokefree. The Mayor’s support led the coalition to work with national partners, Americans for Nonsmokers’ Rights (ANR), who had a Special Initiative grant from the Center to assist with technical assistance, and the Campaign for Tobacco-Free Kids, to develop the specific language to promote. The coalition adopted ANR’s model ordinance to make all workplaces and public places smokefree with no exemptions.<sup>368</sup> The Center for Tobacco Prevention and Control Policy and the DOH each provided some technical assistance in the form of information and strategy with messaging.<sup>366</sup> The coalition anticipated opposition from Council member Terry Bjerke who opposed most types of government regulation and from Council member Mike McNamara who was a member of the local Board of Health and a local radio personality. McNamara would often make oppositional comments to public health initiatives on his radio show after hearing about them first-hand from the Board of Health meetings.<sup>366</sup> Council member Glassheim was the only strong supporter at the time and other Council members were undecided. Mayor Mike Brown would only vote in the case of a tie vote.

Grand Forks Tobacco Free hosted a forum in late January 2010 to publicize the poll results. The coalition invited the City Council members, supporters, and even bar owners, who were the likely opposition, to attend the event.<sup>365</sup> Among local supporters present, Dr. Eric Johnson from the University Of North Dakota School Of Medicine, located in Grand Forks, attended the forum, and emerged as a public proponent of passing a comprehensive ordinance

working closely with the coalition. There was opposition to the ordinance from the North Dakota Hospitality Association, a historic North Dakota tobacco industry ally,<sup>14</sup> as well as independent local bar owners who opposed expanding the ordinance.

Following the forum, Council member Doug Christensen, who had been influential in weakening the 2005 ordinance unexpectedly asked the Grand Forks City Attorney to draft a comprehensive smokefree ordinance that prohibited smoking in public places including all bars. Christensen did not alert any of the advocates that he now supported expanding the ordinance and did not alert anyone to his request to have an ordinance drafted. The coalition was wary of collaborating with Christensen because of his opposition in 2005, but did so because his ordinance was comprehensive and he had already begun the process of getting the Council to consider it.<sup>365</sup>

Anticipating the smokefree ordinance to be divisive and time consuming, the City Council, on the Mayor's recommendation, scheduled a special Work Session to hear the smokefree ordinance. The Work Session was held on February 24, 2010. Local tobacco control advocates spoke in favor a comprehensive ordinance<sup>369</sup> and bar owners and members of the North Dakota Hospitality Association spoke in opposition, citing fears of losing business and the then struggling economy that was already hurting sales.

Thorson, Tobacco Coordinator in Grand Forks and Chair of GFTF, explained in a 2011 interview for this research that the opposition was disorganized, with some bar owners staunchly opposing an ordinance and other bar owners more resigned to the inevitability of the passage of the prohibition of smoking in bars. For example, some bar owners did not support an ordinance but asked that if the Council passes the ordinance that they include a transition period to give the bar owners time to educate their customers on the changes.<sup>365</sup> No formal decisions were made at the Work Session. Some Council members at the Work Session felt that, because it was controversial, a change to the ordinance should come from a public vote, not a Council ordinance.

GFTF continued to encourage the Council to make the decision instead of asking voters to decide. In the meantime, GFTF held conference calls with ANR, CTFK and also ACS CAN to strategize. ACS CAN also assisted GFTF mobilize its grassroots supporters to get them to public events to encourage the Council to pass a comprehensive ordinance.<sup>142</sup>

The Council considered Ordinance No. 4290 for the first time on March 15, 2010, which drew supporters from members of GFTF and opponents who were bar owners and members of the North Dakota Hospitality Association. The primary issue considered by the City Council was whether it should allow smoking in outdoor areas of bars. Bar owners supported allowing smoking outdoors. GFTF did not want to allow outdoor areas of bars but were willing to accept it if workers would not be exposed to smoke and if it was necessary in order to get the Council to pass the ordinance. Council President Hal Gershman was a local retail tobacco seller (retail tobacco stores would be

**GFTF did not want to allow outdoor areas of bars but were willing to accept it if workers would not be exposed to smoke and if it was necessary in order to get the Council to pass the ordinance.**

included in the new ordinance) and recused himself from voting, making Mayor Mike Brown, a supporter of a comprehensive ordinance and a physician, a crucial vote.<sup>365, 370</sup> The Council split on the ordinance 3-3 with Mayor Brown breaking the tie in favor. On April 3, two days before the final Council vote, the *Grand Forks Herald* ran an op-ed by Mayor Brown,<sup>371</sup> supporting the ordinance.

On April 5, 2010, at the second reading, the Council amended the ordinance to exempt outdoor smoking shelters, provided that no food or beverages was sold, served or consumed in the shelters and also outdoor areas of bars (e.g., patios, decks) where patrons could drink but no food could be served or consumed, as long as the areas were at least 15 feet from the door. Aside from these and a few other exemptions, Ordinance 4290 expanded the 2005 law to prohibit smoking in all bars and truck stops and within 15 feet of any entrance to a public place. The Council again voted 3-3 with Mayor Brown casting the tie-breaking vote in favor. The ordinance was to go into effect on August 15, 2010.<sup>372</sup> The ordinance did not specify an enforcement body, so the Grand Forks Police Department was the enforcement agency.

Bar owners immediately began gathering signatures in an attempt to refer the ordinance to a public vote to overturn the Council. Bar owners had 30 days to submit the 3,815 signatures required for the referendum but only succeeded in delivering 2,900.<sup>373</sup> The GFTF Coalition used its Facebook page to encourage followers not to sign the petition when they encountered it being circulated in bars. The coalition called it the “Decline to Sign” campaign.<sup>365</sup> The ordinance was scheduled to go into effect as planned.

In the months leading up to the effective date of August 15, 2010, the Grand Forks Public Health Department launched a public education campaign with postcards and a digital billboard that featured a “countdown to clean air,” which showed the amount of time left before the law went into effect. The coalition distributed signs for businesses to post, alerting their patrons that they would be smokefree as of August 15 (Figure 13). The Grand Forks City Attorney also created a Frequently Asked Questions sheet and a section on its website which described locations where smoking would soon be prohibited which the Grand Forks Department of Health turned into a brochure and distributed it to the public. The Grand Forks Department of Health also obtained resolutions of support from the Convention and Visitor's Bureau and the Chamber of Commerce during the implementation phase; these organizations were influential in obtaining the support of local businesses and eased the transition to smokefree.<sup>365, 366</sup> Haley Thorson reported that the law was implemented smoothly and that, as of 2011, businesses were in compliance with the law.<sup>365</sup>

In 2012, researchers at the University of North Dakota School of Medicine and Health Sciences (UND) released a study commissioned by the Center that measured changes in hospital admissions for heart attacks in Grand Forks, before and after implementation of the 2010 comprehensive law.<sup>374</sup> The UND study found that following the implementation of the law, hospital admissions for heart attacks decreased by 24.1 percent.<sup>375</sup> This association suggested that reduced exposure to secondhand smoke also reduced the number of heart attack incidents among Grand Forks residents. These findings are consistent with those of numerous similar studies in the U.S. and other countries.<sup>376-378</sup>



We're Going Smoke Free!  
Beginning August 15th, this establishment  
will be a smoke free environment.

Grand Forks City Ordinance No. 4290



THANK YOU  
The Management



For more information, please visit [www.tobaccobytes.com](http://www.tobaccobytes.com)



Figure 13: Grand Forks Tobacco Free sign for businesses to alert patrons to the new ordinance.<sup>4</sup>

Bismarck

### ***2005 Clean Indoor Air Ordinance***

In 2005, following the passage of the 2005 statewide clean indoor air law that exempted bars within restaurants, bowling alleys, and hotels to allow smoking as long as they were separately enclosed by a wall, interested community members asked the Bismarck Tobacco Free Coalition (BTFC) to try to get a stronger law passed.<sup>47</sup> BTFC met with members of the Bismarck City Commission, which consisted of four Commissioners and the Bismarck Mayor. Commissioner Connie Sprynczynatyk spearheaded an ordinance at the request of the coalition to prohibit smoking in the bars within locations that the state law exempted. Just as Grand Forks had done, the idea was to tie smoking restrictions to specific liquor licenses. In the proposed ordinance, businesses that held liquor license class F, the license issued to businesses that functioned as combination restaurants/bars, would be prohibited from allowing smoking. Sprynczynatyk preferred to seek provisions modeled after Grand Forks' law rather than seeking a comprehensive law and BTFC strongly supported Sprynczynatyk's proposal.<sup>379</sup>

BTFC met with City Commission members and 21 Bismarck organizations and businesses to seek support for the ordinance. The coalition also organized youth and adults to

launch a letter writing campaign to the City Commissioners and the Mayor asking them to pass the ordinance, and had college students sign petitions of support and testify at City Commission meetings.<sup>47</sup> Other community members working with the BTFC also testified in support of the ordinance. BTFC worked with the American Lung Association (ALA) to mobilize its members (but ALA did not contribute funding) and Americans for Nonsmokers' Rights (ANR) to obtain technical assistance. ANR provided statistical information regarding number of national and local smoke free ordinances and provided assistance with the creation of educational fact sheets for BTFC to use.<sup>379</sup>

Opposition came mainly from free-standing bar owners, even though they would be exempted from the proposed ordinance. Some restaurant/bar combination establishments and the North Dakota Coin and Tavern Association also testified in opposition. Rep. Dwight Wrangham (R-Bismarck), who was also Executive Director of the Coin and Tavern Association, attended the Bismarck City Commission meetings and testified in opposition to the ordinance.<sup>47</sup> The North Dakota Coin and Tavern Association, a group that represented bars and espoused smokers' rights rhetoric,<sup>70, 113, 380</sup> became involved in the 2000s and began opposing tobacco control policies at both the state and local level. The North Dakota Coin and Tavern Association's financial connections to the tobacco industry were unclear, but the tobacco industry has been the primary organizer and financier of smokers' rights and hospitality groups throughout the U.S. to oppose tobacco control proposals.<sup>45, 70</sup>

Despite the opposition, the strong support from community members that BTFC had organized impressed the City Commission, which passed the ordinance without amendment. The ordinance expanded the statewide law by prohibiting smoking in bars within restaurants and was to be enforced by the police department, and Pat McGeary explained in a 2011 interview for this research that enforcement went smoothly and that there were few incidents with noncompliance.<sup>47</sup>

**Despite the opposition, the strong support from community members that BTFC had organized impressed the City Commission, which passed the ordinance without amendment.**

The tobacco control advocates still wanted a comprehensive law that would cover free-standing bars and planned to return to eliminate the remaining exemption for bars.

### ***Bismarck 2010: A Comprehensive Ordinance***

In the years following the 2005 Bismarck ordinance, BTFC was approached by many community members, including bar employees and patrons, who wanted to see all bars become smokefree. The coalition also received interest from local blackjack dealers working at gaming sites inside Bismarck bars. (North Dakota granted gaming licenses to bars which allowed them to have gaming activities including black jack tables.) The blackjack dealers were employees of the bars that had obtained the gaming licenses. As a result, in 2009 BTFC began asking the Bismarck City Commission to consider the smokefree issue again and to introduce a comprehensive ordinance that would cover all public places and places of employment, including all free-standing bars and private clubs.<sup>47</sup>

The American Lung Association (ALA) who had recently hired a new North Dakota staff member, commissioned Odney, a North Dakota-based advertising, marketing and public relations firm, to conduct a random telephone survey of 400 registered Bismarck voters. Of those surveyed, 72 percent supported a citywide law prohibiting smoking inside all workplaces, including restaurants, bars, and truck stops.<sup>381</sup>

In 2009, working with local bar employees and blackjack dealers, the coalition targeted members of the City Commission to convince them to pass a smokefree policy. ACS Cancer Action Network also joined with BTFC and ALA in supporting the ordinance effort. BTFC obtained resolutions of support from Bismarck organizations and letters of support from individual supporters throughout the community and sent them, along with ALA's Bismarck voter survey results, to each Commission member. BTFC also sent research on the health effects of secondhand smoke and the economic effects of smokefree policies on businesses to the Commission members, along with a press release from the Fargo/West Fargo SAFE tobacco control coalition detailing a local study that showed that there was no economic impact on businesses in Fargo and West Fargo following the implementation of its 2008 smokefree ordinances.<sup>381</sup> In addition, at least 15 different bar employees and blackjack dealers sent photos to members of the City Commission of them working in their normal smoky environments.

In December 2009, a public records request was made by an unknown person to obtain all materials the City Commission had on the smokefree issue, which included the organizational letters of support and photos of bar employees and blackjack dealers. The names of those blackjack dealers supporting a smokefree ordinance that would cover bars, were reportedly released, and coincidentally, some of those dealers were transferred to work in facilities which saw far less revenue, affecting their income; they were not told the transfers were as a result of their support for the ordinance, but the dealers and the rest of BTFC saw these transfers as retaliation for supporting the ordinance.<sup>47</sup>

City Commissioner Connie Sprynczynatyk planned to sponsor the ordinance, as she had in 2005, and drafted language for a comprehensive smokefree ordinance that covered all public places and places of employment, including free-standing bars. The ordinance needed three votes to carry a majority on the five-member City Commission. BTFC was strongly confident that Mayor John Warford would vote for the ordinance. However, as the ordinance was being informally discussed, it began to lose the support of two Commissioners whose names were not provided.<sup>47, 382</sup> Pat McGeary, Bismarck Burleigh Public Health Tobacco Prevention Coordinator, and coordinator of BTFC, and an original member of the Measure 3-created TPC Executive Committee, was unsure why they began to lose support.<sup>47</sup> However, Commissioner Sprynczynatyk decided that she did not have the votes to get the ordinance passed and, after conferring with BTFC which agreed, did not place the ordinance on the agenda. BTFC did not want to risk being defeated with such uncertainty of support from the Commission. The coalition planned to return in 2010.

In 2010, Commissioner Sprynczynatyk was planning not to seek reelection, which meant that tobacco control advocates would need to find a new sponsor. Additionally, there had not been enough votes in 2009 to pass an ordinance, so BTFC was not certain it could secure the votes needed to pass an ordinance when a new Commissioner was elected.

In the June 2010 elections, Brenda Smith and Josh Askvig, were elected to the Commission and both supported a smokefree ordinance. Mayor John Warford, a smokefree supporter, was re-elected, ensuring that the votes were there to pass the ordinance. The smokefree issue became a campaign issue with Smith, Askvig and Warford all supporting a comprehensive law.<sup>379, 383</sup> BTFC wasted no time and began meeting with the Commission members to continue to educate them on the public's interest in a comprehensive ordinance.

The City Commission was receptive to the proposal and Mayor Warford had City Attorney Charlie Whitman draft Ordinance 5781 and placed it on the August 10, 2010 Commission meeting agenda for its first reading, where it passed.<sup>384</sup> Ordinances needed to be read and voted on twice before they could be enacted. Proposed Ordinance 5781 prohibited smoking in all public places and places of employment, including bars.<sup>385</sup> The ordinance also included e-cigarettes and electronic devices used to heat or burn tobacco. Businesses were required to post "no smoking" signs and remove all ashtrays. The ordinance would punish both individuals who smoked and businesses that allowed smoking and would institute a fine of \$100 for a first violation, \$200 for a second violation in the same year, and \$500 for each subsequent violation in the same year. No specific enforcement protocol was provided for in the ordinance, but the enforcement would be handled by the Bismarck Police Department.

The City Commission scheduled a public hearing on the ordinance at the next Commission meeting on August 24, 2010. Before the hearing, on August 19, ACS Cancer Action Network (ACS CAN) and ALA released a report from an air quality study that it commissioned Roswell Park Cancer Institute to conduct in eleven of Bismarck bars, some of which allowed smoking and some of which were smokefree. The study found that bars that allowed smoking had levels of hazardous fine particle pollution that were 43 times higher than smokefree bars and 58 times higher than Bismarck outdoor air.<sup>386</sup> BTFC got media coverage for the study and used the release to highlight the need for the City Commission to pass Ordinance 5781. At the same time, tobacco control advocates, including Amy Heuer, President of BTFC, wrote op-ed articles that were published in the *Bismarck Tribune* that supported the ordinance.<sup>387</sup>

On August 24, 2010, the Bismarck City Commission read Ordinance 5781 for the second time and had a public hearing which allowed the public to testify. Twenty individuals testified, most in support of the ordinance. Pat McGeary said that there were over 110 tobacco control advocates in attendance at the meeting and about 80 opponents, mainly bar owners or employees.<sup>47</sup> Rep. Dwight Wrangham, who was also Executive Director of the North Dakota Coin and Tavern Association, also testified against the ordinance.<sup>388</sup> The ordinance passed 4-1 with only Commissioner Mike Seminary opposing. It was scheduled to go into effect on November 1, 2010.

The passage of the ordinance drew a lot of complaints, as was often the case in most states, from bar owners who wanted to provide a place for their customers to smoke. As a result, at the next Commission meeting on September 14, 2010, Commissioner Parrell Grossman introduced an amendment to the smokefree ordinance (Ordinance 5789 was the amending ordinance) which would allow for the creation of smoking shelters. Smoking shelters, as defined in the amendment, were "Any shelter located as an accessory structure to a bar and constructed pursuant to this chapter where smoking is permitted by a bar owner and which is not an "indoor

area” as defined by this chapter. A smoking shelter does not include bus shelters, park shelters or any other shelter not specifically designated as a smoking shelter as allowed by this chapter.”<sup>388</sup>

BTFC did not want an exemption for smoking shelters, but was willing to concede the exemption to move forward with implementing the new law. The Coalition did not want smoking shelters to become miniature bars with heating and lighting and made sure that the language that the Commission considered clearly did not allow smoking shelters to be “indoor areas.” An indoor area included “all spaces within a building or structure and all other enclosed spaces, including temporary spaces, which are enclosed on all sides by permanent or temporary ceilings, walls, windows, doors or screens, and including sun porches and screen porches.”<sup>388</sup> The amendment passed. The original implementation date for the ordinance was November 1, 2010 but bar owners argued that they needed more time to construct their smoking shelters. BTFC wanted to hold onto the original implementation date and viewed any attempts to delay the start date as attempts to interfere with the ordinance itself. Mayor Warford, the original ordinance’s leading supporter and who worked most closely with BTFC, opposed extending the effective date of the ordinance, explaining that he spoke with contractors who told him that it was extremely doable to get the shelters built within 30 days. The amendment to extend the smoking ordinance’s effective date failed.<sup>47</sup>

#### *The Ordinances are Referred to the Voters*

The added exemption for smoking shelters did not satisfy some bar owners and a committee of bar owners began circulating petitions in early October 2010 to refer the original ordinance and the amendatory ordinance to voters, in hopes that the Commission’s ordinance would be overturned. The opponents needed 970 signatures to refer the ordinance to a vote. Because the smokefree law scheduled to go into effect on November 1 was amended to allow smoking shelters through a separate ordinance, bar owners circulated two petitions, one to ask voters to decide on the original smokefree ordinance (Ordinance 5781), and one to decide on the ordinance that added the smoking shelter exemption (Ordinance 5789) which bar owners argued did not give them enough time to build the smoking shelters.<sup>389</sup> Mike Motschenbacher, President of the North Dakota Hospitality Association, an avid opponent of the ordinance, wrote an op-ed in the *Bismarck Tribune* attacking BTFC, arguing that bar owners and bar employees did not want the ordinance and that BTFC wanted people to keep smoking so it would continue to be funded.<sup>390</sup> The North Dakota Hospitality Association historically worked closely with the tobacco industry and functioned as a third party ally that attempted to defeat tobacco control proposals.<sup>14</sup> Indeed, the hospitality industry has served as a chief ally of the tobacco industry since the 1980s.<sup>45</sup>

**The North Dakota Hospitality Association historically worked closely with the tobacco industry and functioned as a third party ally that attempted to defeat tobacco control proposals.**

Pat McGeary, Coordinator of BTFC during the ordinance campaign and Bismarck Burleigh Public Health Tobacco Prevention Coordinator, wrote a response in the *Bismarck Tribune* saying that BTFC was a volunteer coalition and explained that “it’s not a political issue; it’s a simple health issue.”<sup>391</sup> The bar owners turned in 1,876 valid signatures for the smokefree ordinance petition and 1,838 valid signatures for the smoking shelters petition, which suspended

the implementation of the ordinances two weeks before they were scheduled to go into effect. The ordinances would go to a public vote.<sup>392</sup>

The Bismarck City Commission set the public vote for April 19, 2011.<sup>393</sup> The smokefree ordinance was labeled “Measure 1” and a “yes” vote upheld the smokefree ordinance. The smoking shelter ordinance was “Measure 2.” BTFC decided on the message “Vote Yes For Health” with the help of its state and national partners.<sup>142</sup> ANR put out an action alert for North Dakota advocates to use, asking voters to come out and to “Vote Yes for Health” on Measure 1 and alerted voters to the locations of the two polling locations in the city where they could cast their votes.<sup>394</sup> ANR did not mention Measure 2 because BTFC had already agreed to the smoking shelter exemption and did not want to confuse voters. At the same time, the opposition continued to publicly support repealing the ordinances. The North Dakota Hospitality Association reported that it conducted a survey and found that there were fifty job openings at Bismarck bars that were already smokefree and argued that bar employees had a choice where they worked and could work in a smokefree bar if they wanted to and that the city did not need the ordinances passed in fall 2010.<sup>395</sup>

Public discussion in the media regarding the referenda became so intense that the *Bismarck Tribune* announced on April 13 that it would no longer be accepting letters to the editor the on smoking vote scheduled for April 19.<sup>396</sup> Still, despite their April 13 statement, the newspaper published articles written by several health advocates in the days leading up to the vote. Kimberlee Schneider of ALA wrote an op-ed article asking voters to vote yes on Measure 1 and Dr. Laura Archuleta wrote an article describing chronic obstructive pulmonary disease explaining that it was caused by smoking and secondhand smoke exposure.<sup>397, 398</sup> ALA, AHA, ACS CAN, ANR and CTFK provided technical assistance for this campaign and mobilized their Bismarck members to vote. ALA also provided office space for campaign volunteers.<sup>379</sup>

On April 19, 2011, voters upheld Ordinance 5781 with 60 percent supporting the smokefree ordinance. Additionally, Measure 2 which exempted smoking shelters (Ordinance 5789) was rejected by voters with 51 percent of voters in opposition.<sup>399</sup> The result was the enactment of the comprehensive ordinance originally passed by the City Commission with no smoking shelter exemption. The ordinance went into effect on April 27, 2011.<sup>85</sup> The passage of the referendum added to the momentum of smokefree policies throughout the state and meant that 36 percent of the state’s population would be protected by a comprehensive smokefree ordinance in April 2011.<sup>400</sup>

## **Napoleon**

In 2010, Napoleon, a town with a population of 792,<sup>401</sup> passed a comprehensive smokefree ordinance that included bars, rejecting most statewide advocacy support. Napoleon City Attorney Gerald Kuhn had previously proposed a smokefree ordinance to the Town Council in 2009 but the Council decided not act on it.<sup>97</sup> Kuhn submitted the 2010 ordinance proposal to the Town Council because of complaints from citizens about secondhand smoke.<sup>402</sup> Kuhn drafted the language based on Fargo’s smokefree ordinance but augmented it, prohibiting smoking within 25 feet from buildings.

When the Council decided not to act on the ordinance in 2009, a small group of local tobacco control advocates decided to try to pass a smokefree air initiative for Napoleon. Gerald Kuhn and several private citizens did all of the signature gathering, mainly outside of churches on Sunday mornings.<sup>97, 275</sup> As a small town, only 81 signatures were needed in order to get the issue on the ballot; they got double that.<sup>275</sup> There was also an informal group of local health agencies that organized and distributed information to educate the public on the importance of passing a smokefree law. Nancy Thoen, Tobacco Prevention Coordinator for the Central Valley Health District which covered Logan County where Napoleon was located, assisted local advocates, but mostly behind the scenes at the request of the advocates who felt that the proposal would not pass if Napoleon residents believed that the issue was originating from outside of their community.<sup>275</sup> (Other communities, like Linton, North Dakota, which was working towards a smokefree ordinance in 2011, wanted the assistance of regional and statewide tobacco control coordinators, and was not opposed to the Central Valley Health District having a public presence.<sup>275</sup>)

Despite the wariness of Napoleon tobacco control advocates to have state and national organizations visibly involved, they agreed to allow Thoen, ACS and AHA to be involved with technical support as the campaign continued. Thoen and the voluntary health organizations advised the local advocates in the weeks prior to the vote. Thoen, ACS and AHA also published three op-ed articles in Napoleon's weekly newspaper, the *Napoleon Homestead*, a week prior to the vote to build support and urge residents to vote.<sup>275</sup> There were two bars in the town, Freddie's and The Downtowner, and the owner of Freddie's opposed the measure because he was worried about losing business to bars in other towns that allowed smoking.<sup>402</sup> The owner of The Downtowner wanted to go smokefree, but not without Freddie's going smokefree.<sup>402</sup>

On June 8, 2010, voters approved the ordinance 263-94 (74 percent in favor).<sup>403</sup> Thoen reported that other small rural communities started expressing interest in passing smokefree ordinances after Napoleon went smokefree. Pembina, a town of 592,<sup>404</sup> passed a comprehensive smokefree ordinance similar to Napoleon's without controversy;<sup>275</sup> it became effective in February 2011.<sup>85</sup> Thoen also believed that small towns like Napoleon passing smokefree ordinances would have an impact in the state Legislative Assembly. She explained, "I really think that will help the state, the rest of the state come along, because like I said, the rural areas are where we have seen the lack of support from legislators in the past."<sup>275</sup>

## **Devils Lake**

In the spring of 2010, the Lake Region Tobacco Free Coalition (LRTF), began building a database of the names and contact information of local residents who contacted the coalition indicating that they supported passing an ordinance in Devils Lake. The coalition had not planned to push for an ordinance immediately, but by April 2010, community members in Devils Lake began writing to the Devils Lake City Commission members, asking them to pass a smokefree ordinance that would end the bar exemption. Just as in other North Dakota cities that considered smokefree ordinances, some Commission members and bar owners wanted voters to participate in a non-binding, public advisory vote on the issue.<sup>405</sup> LRTF, along with Mayor Fred Bott, a voting member of the Commission, and Commissioner Tim Heisler, wanted the Commission to vote on the issue itself. Mayor Bott, who had been mayor for over twenty years,

was leaving office, and was a strong supporter of the ordinance.<sup>406</sup> The Lake Region Tobacco Free Coalition received technical assistance from ANR and CTFK who strongly advised having the Commission pass the ordinance rather than referring the issue to a vote which could be costly and derailed by competing initiatives sponsored by smokefree opponents.

It was an election year and tobacco control advocates were skeptical whether the Commission would pass an ordinance making bars smokefree, a controversial issue, so close to an election. Sure enough, shortly after the City Commission decided to address the issue of smoking in bars, bar owners began gathering signatures to put the issue to a vote on the November ballot.

**Shortly after the City Commission decided to address the issue of smoking in bars, bar owners began gathering signatures to put the issue to a vote on the November ballot.**

ALA commissioned Keating Research to survey Devils Lake adults which found 67 percent in favor of a law to end the bar exemption and 66 percent wanted the Commission to pass the ordinance. Tobacco control advocates used these findings in its attempts to get the Commission to pass an ordinance itself, but, despite arguments that a majority of voters wanted a comprehensive law, only two of the five Commissioners wanted the Commission to pass the ordinance.<sup>405</sup> Jodi Radke of the Campaign for Tobacco-Free Kids (CTFK) worked on the campaign and recalled in 2012 correspondence for this research that a bar owner had conducted an informal survey of patrons who had indicated that they would not return if it went smokefree. The Commission was reportedly influenced by this informal survey.<sup>178</sup>

On Monday, May 3, 2010, the City Commission voted 3-2 to put the issue to the voters for an advisory vote.<sup>405</sup> Commissioner Craig Stromme, who proposed that the issue be sent to an advisory vote, did so because he believed the smokefree bars were so contentious that it would inevitably be decided by a public vote anyways.<sup>407</sup> The Commission drafted an ordinance for voters to consider which prohibited smoking in public places and places of employment, and included all restaurants, bars and truck stops. The ordinance allowed for smoking shelters outside of bars and did not specify how far the shelters had to be from businesses.<sup>408</sup>

Opposition came mainly from the Lake Region Beverage Retailers Association, a new organization in Devils Lake which formed shortly before the vote. Amy Berg, a Devils Lake tobacco coordinator, reported in a 2011 interview for this research, that the beverage association, which consisted of a few local bar owners, was not strong and its opposition consisted mostly of radio and print advertisements and signs opposing the ordinance as the November vote approached.<sup>406</sup> It is unclear who organized the new beverage association, but, as discussed earlier, the tobacco industry has historically organized and funded coalitions as key third party allies to oppose tobacco control policies, including beverage associations.<sup>45, 56</sup>

LRTF had little funding for a big education campaign. Coalition members printed sticky notes with information about the ordinance, asking voters to vote yes, which were placed on the front page of newspapers. The coalition also organized nursing students to distribute literature about the ordinance throughout the community. ALA actively supported the coalition, along with ANR, CTFK and ACS CAN by providing technical support to the coalition on strategy.<sup>406</sup> These



organizations held conference calls with LRTF and advised them on strategy throughout the campaign. CTFK also provided some funding to pay for these campaign materials and advertisements.<sup>183</sup>

On November 2, 2010, the advisory vote to pass a smokefree ordinance in Devils Lake passed with 58 percent of the vote in support. The City Commission respected the advisory vote and voted to enact the ordinance at its December 6, 2010 meeting and a final time on December 20, where the ordinance passed with a 3-2 vote. The ordinance went into effect on July 1, 2011.

## **Conclusion**

Following the creation of the Community Health Grant Program in the 2001-2003 biennium which provided LPHUs with funding for local coalition building and policy-focused activities, as well as the addition of outreach coordinators to state DOH Division of Tobacco Prevention and Control's staff to provide technical assistance to local coalitions, local cities throughout North Dakota began passing local clean indoor air ordinances (Table 29). However, the level of DOH involvement varied.

In 2004, Fargo and West Fargo, facing competing, weaker initiatives, were unable to get voters to pass a comprehensive smokefree ordinance that included bars. However, following the 2005 statewide clean indoor air law that prohibited smoking in most public places and workplaces, but that exempted bars and bars within restaurants and several other locations, Bismarck and Grand Forks succeeded in passing their own, stronger ordinances. Bismarck and Grand Forks, with well organized coalitions, and the assistance of ALA and Americans for Nonsmokers' Rights, passed ordinances that removed the state exemption for bars within restaurants. In the years that followed ACS, AHA and CTFK also assisted with local campaigns as these coalitions returned to pass comprehensive ordinances.

In 2007, tobacco control advocates in Fargo and West Fargo initiated efforts to pass comprehensive smokefree ordinances that would remove the exemptions for bars and truck stops left in the 2005 statewide clean indoor air law. The success of the advocates in Fargo and West Fargo in getting ordinances enacted by voters in June 2008 became a model for other localities in the state to follow. Economic studies of Fargo's bar revenue following its ordinance demonstrated no effect on businesses, providing further support for other communities to pass their own comprehensive laws.

In 2008, the DOH shifted its stance on tobacco control policy and no longer wanted DOH staff to be connected to tobacco control policy out of concerns of potential political repercussions from Governor John Hoeven's (R) office. This shift was manifested in the DOH's decision to remove the tobacco component from the DOH's Healthy North Dakota program and the DOH's 2009 decision not to administer the TPC Executive Committee's grants for LPHUs to work on tobacco control policy.

2008 was a pivotal year for grassroots tobacco control policymaking in North Dakota. While local tobacco control coalitions organized by LPHUs succeeded in passing ordinances in

Fargo and West Fargo, a collaborative of statewide and local advocates campaigned for Measure 3, which ultimately passed and provided for important new funding for local coalition building and advocacy work. The creation of the Center, funded by Measure 3, which prioritized local policy change and technical assistance for local advocates, provided a further catalyst for local success. From 2009 to 2011, five additional cities (Bismarck, Devils Lake, Grand Forks, Napoleon and Pembina) passed their own comprehensive smokefree ordinances, increasing the total population covered by a comprehensive law to 37 percent.

**Table 29:** Local smokefree ordinances in North Dakota, 2004-2011<sup>20, 85</sup>

City	Year Enacted	Location Covered				Notes
		Public Places	Restaurants	Free-Standing Bars	Bars in Restaurants	
<i>State law</i>	2005	✓	*			<i>Exempted bars and enclosed bars within restaurants, bowling alleys and hotel and a few other locations.</i>
Fargo	2004	✓	*			Exempted bars, enclosed bars within restaurants that excluded entry to people under 21 and a few other locations.
	2008	✓	✓	✓	✓	
West Fargo	2004	✓	✓			Exempted bars that excluded entry for people under 21.
	2008	✓	✓	✓	✓	
Grand Forks	2005	✓	✓			Expanded state law to prohibit smoking in restaurants.
	2010	✓	✓	✓	✓	Allowed for outside smoking shelters.
Bismarck	2005	✓	✓			Expanded state law to prohibit smoking in restaurants.
	2011	✓	✓	✓	✓	
Devils Lake	2011	✓	✓	✓	✓	Allowed for outside smoking shelters.
Napoleon	2010	✓	✓	✓	✓	
Pembina	2011	✓	✓	✓	✓	



## CHAPTER 11: DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

- The Public Education Task Force on Tobacco's creative decision to pool their resources and create a state media campaign increased support for tobacco control programs and policies and contributed to passage of the 2005 statewide clean indoor air law and local smokefree ordinances.
- The leaders that developed and campaigned for Measure 3 were wise to do so; states with limited program funding should consider running initiatives if legislators refuse to appropriate adequate funding for tobacco control.
- Despite early difficulties, the TPC Executive Committee and the DOH are generally working together well but should increase their level of communication, especially as DOH expands its programs, to ensure that their activities complement each other and are mutually supportive.
- The TPC Executive Committee and Tobacco Free North Dakota, by mounting aggressive and visible campaigns to mobilize support defended the program against legislative efforts to gut Measure 3 in 2009 and 2011
- While there is much work left to be done, the fact that many of the TPC Advisory Committee's goals were met ahead of schedule and tobacco use rates among youth and adults declined in recent surveys is an indication that this tobacco control program is maturing and having a positive effect on public health.
- Opponents will likely return in future legislative sessions and tobacco control advocates should not assume that North Dakota's programmatic successes will prevent future attacks.
- Public health advocates and the Department of Health must be willing to take a publicly active role to protect both the Center and DOH tobacco control programs; attacks on one weaken both.
- Tobacco control advocates have the support of the public in their favor, which passed Measure 3 and supported numerous smokefree laws, and should continue to use that support to their advantage with legislators to protect and expand their efforts.

In 2001, the North Dakota Legislative Assembly created the Community Health Grant Program to fund Local Public Health Units (LPHUs) and American Indian Tribes to work on tobacco control programs with unprecedented funding levels.<sup>14</sup> In 2001, the Legislature also appropriated the DOH additional funding to work on statewide cessation programs and to run a state Quitline, appropriating \$5.1 million (\$4.7 million for LPHU and tribal grants) in the 2001-2003 biennium and subsequently increasing its appropriation each session through the 2007-2009.

The Legislature required that 40 percent of local funding be used on generally ineffective,<sup>409, 410</sup> school programs and did not allow the DOH to use its state funds to implement a statewide media campaign. (The tobacco industry has worked all across the U.S. in efforts to stop media campaigns.<sup>92, 246</sup>) Nevertheless, this new local funding, some of which had to be used to promote tobacco control policy, catalyzed major program and policy successes, particularly by building local coalitions to promote smokefree environments. LPHUs formed the Public Education Task Force on Tobacco (PETF) to pool local funds and create a statewide media campaign, something the Legislature refused to fund the state Department of Health (DOH) to

run. The PETF media campaign helped build support for smokefree locations following the launch of their statewide campaign in 2003.

DOH used its state-level MSA funds and its annual CDC grant, for hiring additional staff to conduct surveillance and provide technical assistance to local grantees. This technical assistance, combined with the support of the North Dakota voluntary health organizations, and national tobacco control partners the Campaign for Tobacco-Free Kids (CTFK) and Americans for Nonsmokers' Rights (ANR), facilitated local policy efforts to increase the local smokefree activity that began in the late 1990s. Local smokefree policy successes increased beginning in 2004, just three years after the creation of the Community Health Grant Program. Fargo and West Fargo passed clean indoor air ordinances in 2004 that prohibited smoking in public places and most restaurants, but that had exemptions for bars and other locations; however, they were the strongest ordinances in the state at the time. This expanding statewide movement enabled advocates to return in 2008 and pass Measure 3, a statewide ballot initiative that secured money for a fully funded statewide tobacco control program and created a new statewide tobacco control agency that expanded beyond the DOH's tobacco control effort. From 2001 to 2010 (the last available data), during this period of increased funding and statewide and local activity, adult smoking rates declined.

**This expanding statewide movement enabled advocates to return in 2008 and pass Measure 3, a statewide ballot initiative that secured money for a fully funded statewide tobacco control program and created a new statewide tobacco control agency that expanded beyond the DOH's tobacco control effort.**

Tobacco Free North Dakota (TFND), the statewide tobacco control coalition created in 1985, varied in its level of activity between 1985 and 2012. Following the Master Settlement Agreement in 1998, tobacco control advocacy lacked a sustained statewide coalition. TFND fell dormant following the 2001 Legislative Session as a result of a lack of consistent leadership and funding. The DOH provided a forum for a statewide tobacco control coalition when, in 2002, it created the Healthy North Dakota Tobacco Policy Subcommittee consisting primarily of state voluntary health organizations and local tobacco program leaders as well as a DOH employee; it became the active statewide coalition in 2004.

In 2005, the Healthy North Dakota Tobacco Policy Subcommittee succeeded in getting the Legislature to pass a clean indoor air law that prohibited smoking in most public places and places of employment that contained some exemptions, most notably for bars and enclosed bars within restaurants, hotels and bowling alleys. The 2005 bill did not include preemption and it was reasonable to plan to return to strengthen the law in subsequent legislative sessions. Meanwhile, in 2005, Grand Forks and Bismarck passed clean indoor air ordinances that expanded the 2005 statewide clean indoor air law by prohibiting smoking in bars within restaurants. Because of the continuing advocacy efforts at the local level, the Healthy North Dakota Tobacco Policy Subcommittee was right to support the statewide clean indoor air legislation despite its limited exemptions.

In 2007, Sen. Ralph Kilzer (R-Bismarck), the sponsor of the 2005 state legislation, returned with another bill to remove the exemptions. The Healthy North Dakota Tobacco Policy

Subcommittee did not mount an organized campaign to support Sen. Kilzer’s bill. The American Heart Association (AHA) and the American Cancer Society (ACS) preferred focusing on the local level because legislators told them that they wanted to see local governments passing comprehensive smokefree ordinances before considering a comprehensive statewide law again. AHA and ACS agreed that there was not enough local support (based on polling) or local organizational capacity to demonstrate a local mandate for a statewide smokefree air law, and did not actively support the bill in committee hearings. Meanwhile, in 2007 and 2008 AHA, ACS, the American Lung Association (ALA) and the Campaign for Tobacco-Free Kids, were active at the local level and contributed funding for Fargo and West Fargo’s successful smokefree air campaigns.

While the 2007 state bill may have been doomed from the start due to a lack of legislative support, the absence of active support in committee hearings from AHA exacerbated tension among longtime state tobacco control leaders and the AHA, rekindling of disagreements that dated back nearly ten years. (ACS was also absent, but was not criticized to the same degree.) Formal attempts at conflict resolution in 2008 failed to improve the working relationship with AHA, which as of 2012, was not working with TFND.

While the conflict resolution meeting did not repair the relationship between the group of tobacco control leaders and AHA, the meeting did result in the re-formation of Tobacco Free North Dakota (TFND), which tobacco control advocates and the DOH preferred as the state coalition. TFND did not have any staff members employed by the DOH and fit nicely with the desire of the DOH tobacco control program who wanted to relocate policy work outside of the DOH out of concerns that the DOH would be accused of “illegal lobbying,” a common tobacco industry strategy for intimidating health departments and preventing them from engaging in effective tobacco control policy advocacy.<sup>65</sup>

In 2008, in response to the Legislative Assembly’s long-term refusal to fund tobacco control programs at CDC recommended levels, a group of tobacco control leaders, including current and former state and local program leaders and Heidi Heitkamp, the Attorney General who negotiated the MSA, wrote and campaigned for Measure 3 to secure increased funds for new tobacco control programs. They succeeded, making North Dakota one of two states in 2009 (the other was Alaska) that funded its tobacco control program at CDC’s recommended level. In addition, in an effort to protect the new tobacco control program Measure 3 created from political pressure from tobacco industry allies, the measure created the TPC Advisory Committee to write the new state plan and to elect the Tobacco Prevention and Control Executive Committee from the Advisory Committee membership to implement the new plan. The TPC Advisory Committee named the new agency the Center for Tobacco Prevention and Control Policy (the Center).

**They succeeded, making North Dakota one of two states in 2009 (the other was Alaska) that funded its tobacco control program at CDC’s recommended level.**

Measure 3 charged the TPC Advisory Committee with writing a new state plan that did not duplicate DOH tobacco control programs (i.e., the Community Health Grant Program). It also required that funding for the new programs supplement, not supplant tobacco control

funding or other health funding already going to the DOH; the two agencies were expected to cooperate to implement the new comprehensive plan.

The TPC Executive Committee used its funding to augment the DOH's existing, though consistently underfunded, Community Health Grant Program and to expand the PETFs' statewide media campaign. The combination of the TPC Executive Committee's local grants and the DOH's local grants (funded with money from the CDC) resulted in a 38 percent increase in total local tobacco control grants in the 2009-2011 biennium over the previous biennium. This funding increased local capacity and contributed to the passage of five new local smokefree air laws and additional voluntary institutional smokefree policies from 2009 to 2011. Additionally, youth tobacco rates declined from 2009 to 2011, during the first two years of implementing the new programs.

**This funding increased local capacity and contributed to the passage of five new local smokefree air laws and additional voluntary institutional smokefree policies from 2009 to 2011.**

Measure 3 did not specify how to divide roles between the new agency and the DOH, but the two were generally able to overcome and solve operations difficulties by developing annual work plans that defined each agency's role that led to effective cooperation and interaction at the operational level.

The DOH wanted to use its CDC funds to work on programs that were not included in the TPC Advisory Committee's five-year state plan and annual work plans and in 2011 began developing a separate internal workplan. CDC felt that it was important for the DOH and the TPC Executive Committee to agree to a formal Memorandum of Understanding (MOU) that included the DOH's proposed new programs to ensure that there was no program overlap. Despite numerous attempts over three years, the two agencies failed to develop such an MOU. Rather than continuing to pursue a formal MOU, it would appear to be in everyone's best interest to simply include the new DOH programs in the TPC Advisory Committee's five-year plan and each agency's annual coordinated work plans. Both parties would then be operating under a single document.

Despite continuing challenges, the combined efforts of the Center and the DOH succeeded. By 2011, 37 percent of the North Dakota's population was protected by a local comprehensive smokefree air law, nearly twice the fraction in 2009. Many of the goals set in the TPC Advisory Committee's five-year plan<sup>118</sup> had been met and exceeded ahead of schedule. Tobacco use among all age groups in North Dakota declined from 2009 to 2011 and local tobacco control advocates have had local success passing comprehensive smoking laws. Fargo and West Fargo passed comprehensive smokefree ordinances in 2008, the same year that Measure 3 passed, with 54 percent of voters in favor. From 2009 to 2011, five North Dakota cities passed comprehensive laws, two more than the goal of three that the TPC Advisory Committee had set.

Much of this success with local ordinances came from local support and local advocates that spearheaded their campaigns, along with state and national tobacco control partners AHA (who continued to be active at the local level), ACS, ALA, ANR and CTFK who offered

financial and technical support. The Center also provided funding and technical assistance to LPHUs to educate local policy makers on the importance of passing comprehensive ordinances.

Voluntary smokefree and tobacco free policies increased as well. The TPC five-year plan set a goal to increase the number of colleges and universities with tobacco free or smokefree policies from six to 11 by December 2013. By September 2011, there were already 12 policies in place. There were also 23 percent more local tobacco control coalition members throughout the state as a result of increased funding levels and additional technical support from state and national partners. Two major goals in the five-year plan, increasing the state cigarette tax to \$2 and strengthening the state clean indoor air law by June 2013 will likely be focus of the state program in the 2013 Legislative Session.

All this tobacco control activity worked to reduce smoking. By 2010, adult smoking rates in North Dakota had declined to the national average (17.4 in North Dakota vs. 17.3 percent nationally). By 2010, smoking had become concentrated among ethnic minorities: 47.2 percent of North Dakota smokers were American Indian/Alaskan Native, 32.8 percent were Hispanic, and just 16.1 percent were White. So, overall adult smoking is going down but disparities in use remained large. Youth smoking rates were on the decline over the years, though usually way above national rates. ND youth smoking rates fell below US rates once, in 2005, but by 2009, were again higher than national again. Youth smokeless rates have been consistently much higher than national rates: In 2009, North Dakota had 15.3 percent and the US had 8.9 percent smokeless prevalence.

As in other states,<sup>40, 42, 172, 173, 199, 411-413</sup> North Dakota advocates faced legislative attempts to defund and dissolve the new tobacco control program, and had to mobilize to defend Measure 3 repeatedly after passage. In drafting the ballot initiative, the authors of Measure 3 trusted the Legislature to appropriate the funding for the new program every two years. Some legislators viewed this as an opportunity to amend the initiative that voters had just approved.

**In drafting the ballot initiative, the authors of Measure 3 trusted the Legislature to appropriate the funding for the new program every two years. Some legislators viewed this as an opportunity to amend the initiative that voters had just approved.**

In the 2009 Legislative Session, for the first appropriation, House Republicans voted to repeal the Measure 3 language and to instead appropriate the money to the DOH. The Legislature ultimately added the appropriation to another bill. In the 2011 Legislative Session, House Republicans once again attempted to dismantle the new program created by Measure 3 when House Republicans attempted to divert the Strategic Contribution Funds that Measure 3 secured for tobacco control programs and to give it to the University of North Dakota School of Medicine and Health Sciences. The House also tried to repeal most of Measure 3's language that created the TPC Executive Committee. The TPC Executive Committee opposed these attempts and TFND mobilized local tobacco control advocates to urge the Legislature not to repeal Measure 3; these defensive efforts received a lot of public attention, likely the reason that the Legislature's attempts failed to gain enough support to pass. TFND's continual ability to mobilize its network of local volunteers that helped pass Measure 3 in 2008, and its willingness to publicly critique the legislature enabled tobacco control advocates to deflect these attempts to



dismantle the Measure 3-created program and will likely continue to be necessary in future legislative sessions.

Legislative attacks on Measure 3, which have been so far led by Republicans, will likely continue as early as the 2013 Legislative Session, but especially in the 2017 Legislative Session, when the Legislature will no longer be constitutionally required to generate two-thirds support from both chambers to amend Measure 3. Tobacco control advocates must ensure that they continue to maintain and expand their grassroots supporters and be vigilant and ready to launch campaigns to defend Measure 3 every session.

**Legislative attacks on Measure 3, which have been so far led by Republicans, will likely continue.**

The DOH reported in interviews that it supported a fully funded, comprehensive tobacco control program but it did not take a position in 2011 when the Legislature considered defunding the TPC Executive Committee to give the money to the University of North Dakota School of Medicine and Health Sciences. Also in 2011, legislative opponents of the Measure 3 program attempted to repeal portions of Measure 3 that required 80 percent of funding that the DOH received annually from the original MSA be spent on tobacco prevention and control programs. Repealing the 80 percent requirement would have allowed the Legislature to divert \$3.5 million (19 percent of North Dakota's tobacco control funding) to non-tobacco control programs. The TPC Executive Committee opposed these changes in legislative committee but the DOH did not actively oppose the amendments. Had these amendments been successful, North Dakota would no longer have funded tobacco control programs at CDC levels and tobacco control advocates were correct in fighting this proposal. The DOH can, and should, become a vocal supporter of all tobacco control funding in North Dakota, including funding going to the TPC Executive Committee.

Tobacco control advocates should look for ways to go on the offensive in addition to maintaining defensive vigilance. Targeting specific legislators who attack tobacco control programs has been an effective strategy in other states. In Virginia, when facing opposition to proposed smokefree air bills from the Assembly Speaker, the tobacco control coalition hired a community organizer to mobilize tobacco control advocates in the Speaker's district and led a campaign that directly targeted the Speaker and successfully pressed him to stop opposing a smokefree air bill.<sup>42</sup> While the Virginia advocates eventually backed off on this pressure and failed to win strong state legislation, such an approach to targeting obstinate legislators is a good model for North Dakota tobacco control advocates to follow in future campaigns when facing opposition, especially from political leadership.<sup>42</sup>

North Dakota tobacco control advocates would also do well to learn from health advocates' mistakes in Florida.<sup>199, 411</sup> In 2006, after several years of a severely underfunded tobacco control program, Florida tobacco control advocates, with especially strong leadership from American Cancer Society and other voluntary health organizations succeeded in getting voters to pass Amendment 4, a constitutional amendment that required that the state use 15 percent of Florida's 2005 MSA revenue to fund a comprehensive statewide tobacco control program overseen by an advisory committee consistent with CDC's *Best Practices*. Florida's Amendment 4 required implementing legislation and, like in North Dakota, required a continual

appropriation of funds by the Legislature. However, lack of strong advocacy on the part of the Florida's voluntary health organizations in the years following Amendment 4 allowed for the state to continually siphon off a portion of the funding that Amendment 4 specified for tobacco control programs to instead fund low-impact, direct cessation programs and construction projects Florida's example teaches the necessity of having aggressive advocacy in place to protect and preserve funding secured by initiatives.

At times since its 1985 formation, TFND had a broad organizational membership that included hospitals, clinics, physicians, nurses and other public health groups in addition to the state voluntary health organizations. TFND became a more viable coalition in 2010 when it received a Special Initiative Grant from the TPC Executive Committee that enabled it to hire an executive director, something that it had never had before, to provide consistent coalition leadership. However, as of 2012, TFND was still recruiting member organizations, and did not have a large number of additional organization members that could lobby. As TFND restructures, it is important that it continue to reach out to such wide ranging organizations.<sup>414</sup>

**As TFND restructures, it is important that it continue to reach out to such wide ranging organizations.**

The impetus for change in tobacco control programming and policy in North Dakota came from the 2001 Community Health Grant Program that funded LPHUs to promote tobacco control and build policy change infrastructure, North Dakota tobacco control advocates can enhance the power of local advocacy by looking to a similar program in Maine.<sup>415</sup> The Healthy Maine Partnership program created local coalitions of public health organizations, healthcare providers and local schools to improve the promotion of public health in communities, including significant funding for tobacco control programs. Over time, advocates realized that these coalitions could be centers of grassroots advocacy power, and used that power to protect tobacco control funding and promote other tobacco control policy efforts. Maine legislators became invested in their local programs and fully recognized the political clout of the coalitions.

Like North Dakota, other states, including Indiana,<sup>40</sup> Minnesota,<sup>172, 173</sup> Mississippi,<sup>170, 171</sup> Ohio<sup>169</sup> created independent tobacco control program infrastructures following the MSA. In the years since the MSA, these other state agencies have been attacked and systematically dismantled. At times, politicians justified these decisions to dissolve these independent tobacco control programs and to transfer responsibility to their state's health department based on false claims of program duplication and the need to increase program efficiency. These decisions were not typically made based on problems with program efficacy.

North Dakota's weak campaign contribution reporting requirements made it difficult to track relationships between the tobacco industry and North Dakota legislators. Instead, in North Dakota, most campaign contributions were linked to political party organizations, mostly to Republicans, who have been to most active opponents of tobacco control policies. The substantial increase in campaign contributions to Republican political party organizations during the 2009-2010 election cycle, and the opposition to the Measure 3 appropriation by Republican legislators in 2009, suggests that the tobacco industry was able to influence individual legislators through its campaign contributions to political party organizations.

There was also a clean indoor air bill introduced in 2009 that would have expanded the state law to prohibit smoking in bars and hotels, as well as a bill that would have prohibited smoking in cars with children; both bills received little support and did not survive past introduction. The tobacco industry had not made such high levels of campaign contributions in years when smokefree air bills received strong consideration in the Legislature. The Measure 3 appropriation was the new dynamic.

The tobacco industry did not have a visibly increased lobbying presence in the 2009 and 2011 Legislative Session, though it is likely that the industry was influential through lobbying for amending Measure 3. The Master Settlement Agreement (MSA) prohibited the tobacco industry from working to divert MSA money to programs that were not tobacco related or health related. However, the 2009 amendments to the TPC Executive Committee's appropriation bill would have transferred the money to the DOH for tobacco programs, and the 2011 proposal that would have transferred the Measure 3 funding to the University of North Dakota School of Medicine and Health Sciences were "health-related," so the tobacco industry could have lobbied the Legislature to support these proposals. Both failed, likely because of strong, public opposition from the TPC Executive Committee and Tobacco Free North Dakota.

It is clear from the voters' decision to pass Measure 3 and the subsequent local smokefree air laws that North Dakotans want to see tobacco use addressed through hard-hitting, fully funded tobacco control programs and comprehensive smokefree air laws. In other states that had tobacco control programs independent of the state DOH, the tobacco industry did not rest until those programs were dissolved, defunded or moved into the DOH.<sup>40, 170-173</sup> Tobacco control advocates should not assume that North Dakota's programmatic successes will prevent future attacks and must be prepared to mobilize their supporters each legislative session.

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The fact that many of the TPC Advisory Committee's goals were met ahead of schedule and tobacco use rates among youth and adults declined in recent surveys is an indication that this tobacco control program is maturing and having a positive effect on public health. Nevertheless, there is much work left to be done. Tobacco control advocates have the support of the public which passed Measure 3 in their favor and should continue to use that to their advantage with legislators to protect and expand their efforts.

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## APPENDIX

SAVING LIVES – SAVING MONEY:  
NORTH DAKOTA'S  
COMPREHENSIVE STATE PLAN TO  
PREVENT AND REDUCE TOBACCO USE  
2009-2014



**North Dakota Tobacco Prevention and Control Advisory Committee**  
**July 2009**

## **Saving Lives -- Saving Money: North Dakota's Comprehensive State Plan to Prevent and Reduce Tobacco Use**

North Dakota voters passed Initiated Measure #3 on November 4, 2008. The Measure enacted a new law to establish and fund a comprehensive statewide tobacco prevention and control program. The Measure also created a Tobacco Prevention and Control Advisory Committee to develop a plan within 180 days of the initial meeting of the committee. A three member Executive Committee is charged with overseeing the implementation and evaluation of the plan.

The 61<sup>st</sup> North Dakota Legislative Assembly appropriated \$9.3 million per year, the U.S. Centers for Disease Control and Prevention (CDC) recommended funding level, for the comprehensive tobacco prevention and control program.

The North Dakota Tobacco Prevention and Control Advisory Committee is pleased to submit *Saving Lives – Saving Money: North Dakota's Comprehensive State Plan to Prevent and Reduce Tobacco Use 2009 – 2014* to you the people of North Dakota for your review and support. You have entrusted the Advisory Committee with the responsibility of designing a plan to improve the health of North Dakotans by reducing tobacco use – the leading cause of premature death and disease in our state. We pledge to you that we will work with you to implement this comprehensive, evidence-based tobacco prevention and control program based on the CDC *Best Practices for Comprehensive Tobacco Control Programs October 2007*. Using these Best Practices will ensure that together we will reduce tobacco use and the premature death and disease it causes in the most cost effective and efficient manner.

The toll of tobacco in North Dakota is too high.

- Tobacco use is the leading preventable cause of death, disease and disability in North Dakota.
- Each year 877 North Dakota adults die prematurely from illnesses caused by smoking.
- Approximately 11,000 North Dakota youth younger than 18 are projected to die prematurely due to smoking.
- Secondhand smoke kills 80 to 140 North Dakotans each year.
- North Dakota receives approximately \$57 million annually from tobacco taxes, the Master Settlement Agreement and the CDC; however, tobacco use costs North Dakota upwards of \$442 million each year: \$250 million in direct medical expenditures and \$192 million in lost productivity.

This comprehensive State Plan is built on the foundation established in *On the Path to a Healthier Tomorrow, North Dakota's Strategic Plan to Prevent and Reduce Tobacco Use 2008 – 2013* and the work of the North Dakota Department of Health as well as the hundreds of organizations and individuals who have been involved in tobacco prevention and control efforts for more than two decades. Over the next five years, implementation of this State Plan will prevent a greater number of North Dakota youth and young adults from beginning to use tobacco products, decrease the number of tobacco users, and fully protect the public from exposure to secondhand smoke in public places and in their workplaces. The plan includes four goal areas and identifies objectives and action steps that will lead to achievement of those goals. A number

of objectives are repeated throughout the Plan because they are proven-effective strategies to reach multiple goals. These strategies include increasing the price of tobacco products and implementing comprehensive tobacco-free policies. Each goal area begins with a number of indicators that will be used to measure progress toward achievement of the goal area. If state and local policy makers, healthcare providers, schools, colleges, employers and the public fully implement this plan it will significantly prevent and reduce smoking and other tobacco use in North Dakota and produce enormous public health and economic benefits to the state.

There is overwhelming evidence that states that have implemented programs consistent with the CDC *Best Practices* and its recommended funding level have significantly reduced youth and adult tobacco use, improved health and saved lives. The Campaign for Tobacco-Free Kids estimates that funding North Dakota's tobacco prevention and cessation efforts at the CDC-recommended level will result in significant public health benefits. With a sustained effort, we can expect the fully implemented comprehensive plan will within the first five years:

- Reduce youth smoking by 12.7 percent.
- Stop 4,570 North Dakota youth from becoming addicted adult smokers.
- Prompt more than 3,500 adult smokers to quit for good.
- Save more than 2,380 North Dakota citizens from dying prematurely from smoking.

Funding the state tobacco prevention and control program at the CDC-recommended level and implementing this State Plan will strengthen the North Dakota economy by increasing employee productivity and reducing future tobacco-caused healthcare and related economic and other tobacco-caused costs in the state by more than \$113 million, including more than \$11.9 million in future savings in state Medicaid program expenditures.

If North Dakota fully implements this State Plan by building a comprehensive tobacco prevention and control program, we can expect to see a sharp reduction in smoking and other tobacco use in the state. The number of people in the state who suffer and die prematurely because of smoking and other tobacco use will decrease; a healthier and more productive workforce will bolster our economy; and public and private dollars will be saved by cutting government, business, health care and household expenditures caused by smoking and other tobacco use.

Saving Lives – Saving Money is our pledge to the people of North Dakota.

The North Dakota Tobacco Prevention and Control Advisory Committee

Kathleen Mangskau, Chair, Bismarck

Bette Deede, Fargo

Lorraine Jacobson, Milnor

Dr. Dale Klein, Mandan

Dr. Kermit Lidstrom, Bismarck

Nathan Marion, Bismarck

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**SAVING LIVES – SAVING MONEY:  
NORTH DAKOTA’S COMPREHENSIVE STATE PLAN  
TO PREVENT AND REDUCE TOBACCO USE  
2009-2014**

**GOAL 1      PREVENT THE INITIATION OF TOBACCO USE AMONG YOUTH AND YOUNG ADULTS**

**PROGRESS INDICATORS**

Percentage of the public supporting increasing tobacco excise taxes (65% in 2003 – American Cancer Society of North Dakota, Study by Harstad Research)

Percentage of the public supporting 100 percent smoke-free workplaces (64% in 2008 – Secondhand Smoke Study of North Dakota, Public Education Task Force)

Percentage of youth who smoked first cigarette before age 13 (36.9% in 2007 – North Dakota Youth Risk Behavior Survey)

Percentage of schools reporting comprehensive tobacco-free policies (Baseline to be established – North Dakota Tobacco Prevention and Control Program)

***OBJECTIVE 1***

By June 2013, increase the cigarette excise tax to \$2.00 per pack and increase the excise tax on other tobacco products by an equal and proportional amount.  
(\$0.44 since 1993 – North Dakota Century Code)

**ACTION STEPS**

- Develop and implement a tobacco tax policy plan.
- Mobilize local coalitions, including youth, to support increasing tobacco excise taxes.
- Educate the public and policymakers on the need for increasing tobacco excise taxes and how doing so will benefit North Dakota.
- Monitor public support for increasing tobacco excise taxes.
- Provide training and technical assistance to local coalitions and community partners to gain local support for excise tax increases from the public, city and county policymakers, state legislators, youth service agencies and medical/health professionals.
- Track legislative actions.

***OBJECTIVE 2***

By June 2013, amend the North Dakota Smoke-Free Law to implement 100 percent smoke-free public places and places of employment and to expand enforcement of the law.  
(2005 Smoke Free law exemptions – North Dakota Century Code)

**ACTION STEPS**

- Develop and implement a smoke-free policy plan.
- Mobilize local coalitions, including youth, to support amending the smoke-free law to include all public places and workplaces.
- Provide training and technical assistance to local coalitions and community partners to gain support for 100 percent smoke-free public places and workplaces from the public, city and county policymakers, state legislators, youth service agencies and medical/health professionals.

- Educate the public and policymakers on the health benefits of smoke-free environments and the role smoke-free environments play in preventing youth smoking.
- Monitor public support for making all public places and workplaces statewide smoke-free.
- Track legislative actions.

**OBJECTIVE 3**

By June 2012, increase to five the number of communities that have enacted local ordinances for 100 percent smoke-free public places and places of employment.

(Two communities in 2009 – North Dakota Department of Health, Local Ordinance Database)

**ACTION STEPS**

- Develop and implement a smoke-free communities policy plan.
- Mobilize local coalitions, including youth, to support adopting local ordinances making all public places and workplaces smoke free.
- Provide training and technical assistance to local coalitions and community partners to gain support for 100 percent smoke-free public places and workplaces from the public, city and county policymakers, youth service agencies and medical/health professionals.
- Educate the public and policymakers on the health benefits of smoke-free environments and the role smoke-free environments play in preventing youth smoking.
- Monitor public support for making all public places and workplaces in the community smoke free.
- Track policies as they are enacted.

**OBJECTIVE 4 (Developmental) \***

By June 2013, increase the percentage of school districts with a comprehensive tobacco-free school policy to 50 percent.

(Baseline to be established)

**ACTION STEPS:**

- Collaborate with the North Dakota Department of Public Instruction (DPI) Coordinated School Health Program, the North Dakota School Boards Association and other educational associations and organizations to revise and update the comprehensive Tobacco-Free School Policy Tool Kit.
- Mobilize local coalitions, including youth, to educate communities and school boards about the need for and benefits of a comprehensive tobacco-free school policy using the Tobacco-Free School Policy Tool Kit.
- Develop a tracking system to monitor implementation of comprehensive tobacco-free school policies.
- Provide technical assistance to implement and monitor adherence with comprehensive tobacco-free school policies.
- Publicize and recognize school districts with a comprehensive tobacco-free school policy.

**OBJECTIVE 5**

By December 2013, increase the number of public and private post-secondary institutions with tobacco-free campuses to eleven.

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\* The objective is considered developmental if there is no baseline data.

(Seven campuses in 2008 – North Dakota Department of Health, College and University Tobacco-Free Database)

### **ACTION STEPS**

- Educate the Chancellor of the North Dakota University System and other policymakers at public, tribal<sup>†</sup> and private colleges and universities about the components and benefits of a tobacco-free campus.
- Partner with the Chancellor to promote a policy designating all of the campuses in the public college and university system 100 percent tobacco free.
- Mobilize local coalitions, including youth, to support efforts at public, tribal and private institutions to enact a 100 percent tobacco-free campus policy.
- Organize and train members of the campus community, including students, to advocate for tobacco-free campuses.
- Provide technical assistance to implement and monitor adherence with tobacco-free campus policies.
- Develop a tracking system to monitor implementation of comprehensive tobacco-free policies.
- Publicize and recognize post-secondary institutions with 100 percent tobacco-free campuses.

## **GOAL 2 ELIMINATE EXPOSURE TO SECONDHAND SMOKE**

### **PROGRESS INDICATORS**

Percentage of the public who support 100 percent smoke-free workplaces (64.4% in 2008 – Secondhand Smoke Study of North Dakota, Public Education Task Force)

Percentage of workers exposed to secondhand smoke in the workplace (8% in 2009 – North Dakota Adult Tobacco Survey)

Number of complaints about smoke-free law violations (Baseline to be established)

Number of cigarettes sold per capita (1,474 per capita in 2008 – North Dakota Tax Department and North Dakota Tobacco Prevention and Control Program)

### **OBJECTIVE 1**

By June 2013, amend the North Dakota Smoke-Free Law to implement 100 percent smoke-free public places and places of employment and to expand enforcement of the law.

(2005 Smoke Free law exemptions – North Dakota Century Code)

### **ACTION STEPS**

- Develop and implement a smoke-free policy plan.
- Mobilize local coalitions, including youth, to support amending the Smoke-Free law to make all public places and workplaces smoke free.
- Provide training and technical assistance to local coalitions and community partners to gain support for 100 percent smoke-free public places and workplaces from the public, city and county policymakers, state legislators and medical/health professionals.
- Educate the public and policymakers on the health benefits of smoke-free environments and the role smoke-free environments play in preventing youth smoking and in reducing smoking,

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<sup>†</sup> Tobacco is considered a sacred gift with traditional uses specific to each tribe, with each traditional use very different from commercial tobacco use.

especially among pregnant women, low socioeconomic status populations and racial and ethnic minorities.

- Monitor public support for making all public places and workplaces statewide smoke free.
- Track legislative actions.

### **OBJECTIVE 2**

By June 2012, increase to five the number of communities that have enacted local ordinances for 100 percent smoke-free public places and places of employment.

(Two communities in 2009 – North Dakota Department of Health, Local Ordinance Database)

### **ACTION STEPS**

- Develop and implement a smoke-free communities policy plan.
- Mobilize local coalitions, including youth, to support adopting local ordinances making all public places and workplaces smoke free.
- Provide training and technical assistance to local coalitions and community partners to gain support for 100 percent smoke-free public places and workplaces from the public, city and county policymakers and medical/health professionals.
- Educate the public and policymakers on the health benefits of smoke-free environments and the role smoke-free environments play in preventing youth smoking and in reducing smoking, especially among pregnant women, low socioeconomic status populations and racial and ethnic minorities.
- Monitor public support for making all public places and workplaces in the community smoke free.
- Track policies as they are enacted.

### **OBJECTIVE 3**

Prevent preemption (higher levels of government can prohibit lower levels of government from enacting certain laws or regulations) in all state tobacco prevention and control laws.

(Local governments are not preempted from enacting tobacco prevention and control ordinances – North Dakota Century Code)

### **ACTION STEPS**

- Update preemption educational materials.
- Mobilize local coalitions to gather support from communities and organizations to support local resolutions that oppose statewide preemption.
- Train local coalitions about how to prevent and deal with preemption activities, including referenda.
- Track all legislation for preemption language.

## **GOAL 3 PROMOTE QUITTING TOBACCO USE**

### **PROGRESS INDICATORS**

Number of calls to the Quitline (2,322 per year in 2008 – North Dakota Tobacco Prevention and Control Program – Quitline Reports)

Number of fax referrals to Quitline (264 per year in 2008 – North Dakota Tobacco Prevention and Control Program – Quitline Reports)



Percentage of adult smokers advised to quit smoking by a health care provider (58.6% in 2004 – North Dakota Behavioral Risk Factor Surveillance System)  
Percentage of adult smokers who made a quit attempt in the last twelve months (52.2% in 2008 – North Dakota Behavioral Risk Factor Surveillance System)

### ***OBJECTIVE 1***

By June 2013, increase the cigarette excise tax to \$2.00 per pack and increase the excise tax on other tobacco products by an equal and proportional amount.  
(\$0.44 since 1993 – North Dakota Century Code)

### **ACTION STEPS**

- Develop and implement a tobacco tax policy plan.
- Mobilize local coalitions, including youth, to support increasing tobacco excise taxes.
- Educate the public and policy makers on the need for increasing tobacco excise taxes and how doing so will benefit North Dakota.
- Monitor public support for increasing tobacco excise taxes.
- Provide training and technical assistance to local coalitions and community partners to gain local support for excise tax increases from the public, city and county policymakers, state legislators and medical/health professionals.
- Track legislative actions.

### ***OBJECTIVE 2***

By June 2013, amend the North Dakota Smoke-Free Law to implement 100 percent smoke-free public places and places of employment and to expand enforcement of the law.  
(2005 Smoke Free law exemptions – North Dakota Century Code)

### **ACTION STEPS**

- Develop and implement a smoke-free state policy plan.
- Mobilize local coalitions, including youth, to support amending the Smoke-free law to make all public places and workplaces smoke free.
- Provide training and technical assistance to local coalitions and community partners to gain support for 100 percent smoke-free public places and workplaces from the public, city and county policymakers, state legislators and health and substance abuse professionals.
- Educate the public and policymakers on the health benefits of smoke-free environments and the role smoke-free environments play in reducing smoking, especially among pregnant women, low socioeconomic status populations and racial and ethnic minorities.
- Monitor public support for making all public places and workplaces statewide smoke free.
- Track legislative actions.

### ***OBJECTIVE 3***

By June 2012, increase to five the number of communities that have enacted local ordinances for 100 percent smoke-free public places and places of employment.  
(Two communities in 2009 – North Dakota Department of Health, Local Ordinance Database)

### **ACTION STEPS**

- Develop and implement a smoke-free communities policy plan.
- Mobilize local coalitions, including youth, to support adopting local ordinances making all public places and workplaces smoke free.

- Provide training and technical assistance to local coalitions and community partners to gain support for 100 percent smoke-free public places and workplaces from the public, city and county policymakers and medical/health professionals.
- Educate the public and policymakers on the health benefits of smoke-free environments and the role smoke-free environments play in reducing smoking, especially among pregnant women, low socioeconomic status populations and racial and ethnic minorities.
- Monitor public support for making all public places and workplaces in the community smoke free.
- Track policies as they are enacted.

#### **OBJECTIVE 4**

By 2014, increase annual use of the North Dakota Tobacco Quitline to a minimum of 2 percent of all smokers and smokeless tobacco users.

(0.66 % in 2008 – North Dakota Behavioral Risk Factor Surveillance System and North Dakota Tobacco Prevention and Control Program – Quitline Reports)

#### **ACTION STEPS**

- Establish the North Dakota Tobacco Quitline as the primary source of support for all tobacco users making a quit attempt.
- Increase fax referrals to the Quitline.
- Expand Quitline media, promotion and marketing at the state and community levels.
- Evaluate Quitline media, promotion and marketing campaigns.
- Ensure that 100 percent of Quitline clients have access to a minimum 28-day supply of nicotine replacement therapy (NRT).
- Expand evaluation of Quitline services and marketing, including external evaluation.
- Maintain North Dakota Tobacco Quitline consortium.
- Expand Quitline services to include emerging technologies.
- Encourage health care providers, other health, mental health, substance abuse, social service providers and businesses to promote the Quitline to all tobacco users.
- Update the matrix of existing cessation benefits.

#### **OBJECTIVE 5 (Developmental)\***

By 2014, incorporate the systems approach to tobacco treatment recommended in the U.S. Public Health Service *Treating Tobacco Use and Dependence, Clinical Practice Guideline – 2008 Update* in the 28 local public health units and in three of the six largest health care systems. (Baseline to be established)

#### **ACTION STEPS**

- Establish a Cessation Advisory Committee to establish guidelines and procedures for implementing system changes in treating tobacco use.
- Collect baseline data on public and private health care settings' adherence to the tobacco treatment recommendations for health care settings in the U.S. Public Health Service *Treating Tobacco Use and Dependence, Clinical Practice Guideline – 2008 Update*.
- Establish tobacco-free buildings and grounds policies at public and private health care settings.
- Educate and train public and private health care providers to implement provider reminder systems and to deliver the AAR (ask, advise, refer) intervention to their clients.

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\* The objective is considered development if there is no baseline data.

- Promote incorporation of curriculum on treating tobacco use and dependence in medical, nursing, pharmacy and allied health programs.
- Promote certified tobacco treatment specialists as resources for systems change.
- Track the implementation of the *Guideline*'s recommendations in the local public health units and in the large health care systems.

**OBJECTIVE 6 (Developmental)**\*

By June 2013, increase to a minimum of three the number of North Dakota's largest employers who cover tobacco cessation medications and services in their employee health benefits plan(s). (Baseline to be established)

**ACTION STEPS**

- Identify and survey North Dakota's twelve largest employers to determine the types of cessation coverage provided in their employee health benefits plan(s).
- Disseminate/educate about the recommendations for insurers/third-party payer coverage for cessation interventions in the U.S. Public Health Service *Treating Tobacco Use and Dependence, Clinical Practice Guideline – 2008 Update*.
- Educate workplaces, including worksite wellness programs, about the benefits of including cessation as a covered health benefit.
- Advocate with employers to include tobacco cessation medications and services in their employee health benefits plans.
- Track cessation coverage in employee benefit plans.

**OBJECTIVE 7**

By June 2013, maintain the current nine and increase by a minimum of one the number of third-party payers that include tobacco cessation medications and services as a standard health benefit. (Nine in 2007 – North Dakota Tobacco Prevention and Control Program).

**ACTION STEPS**

- Survey all third-party payers to determine the types of cessation medications and services they cover as a standard health benefit.
- Disseminate and educate about the recommendations for insurance/third-party payers to cover the cessation interventions in the U.S. Public Health Service *Treating Tobacco Use and Dependence, Clinical Practice Guideline – 2008 Update*.
- Negotiate with third-party payers to contribute to the cost of operating the Quitline.
- Advocate with third-party payers to include coverage for tobacco cessation medications and services as a standard health benefit in the policies they offer.
- Track the cessation benefits provided by third-party payers.

**OBJECTIVE 8 (Developmental)**\*

By 2014, address nicotine dependence in addiction treatment programs, in mental health treatment programs and in dual diagnosis treatment programs. (Baseline to be established)

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\* The objective is considered developmental if there is no baseline data.

## **ACTION STEPS**

- Establish tobacco-free building and grounds policies at mental health and substance abuse treatment centers.
- Partner with the North Dakota Department of Human Services to educate mental health practitioners and licensed addiction counselors about treating tobacco use as recommended by the U.S. Public Health Service *Treating Tobacco Use and Dependence, Clinical Practice Guideline – 2008 Update* and the North Dakota Chapter of the American Society of Addiction Medicine.
- Include treating tobacco use in the licensed mental health practitioners and licensed addiction counselors' continuing education programs.
- Collaborate with colleges with mental health and addiction counseling training programs and with the training consortiums to educate students and currently licensed mental health practitioners and licensed addiction counselors on implementing the recommendations in *Treating Tobacco Use and Dependence, Clinical Practice Guideline – 2008 Update* and the North Dakota Chapter of the American Society of Addiction Medicine.
- Educate mental health practitioners and licensed addiction counselors on referring tobacco users to the Quitline, including the fax referral system, and other available services.
- Advocate for inclusion of a tobacco use treatment component in the North Dakota Department of Human Services licensing requirements for mental health centers and addiction centers.
- Track the implementation of the U.S. Public Health Service *Treating Tobacco Use and Dependence, Clinical Practice Guideline – 2008 Update* recommendations in mental health and addiction treatment programs.

## **GOAL 4 BUILD CAPACITY AND INFRASTRUCTURE TO IMPLEMENT A COMPREHENSIVE EVIDENCE-BASED TOBACCO PREVENTION AND CONTROL PROGRAM**

### **PROGRESS INDICATORS**

Number of active local coalitions (Baseline to be established – North Dakota Tobacco Prevention and Control Executive Committee [NDTPCEC])

Funding level of the comprehensive Tobacco Prevention and Control Program (\$9.3 million in 2009 – NDTPCEC)

Fully staffed tobacco prevention and control program at the state level (Baseline to be established – NDTPCEC)

Active state tobacco prevention and control coalition (Baseline to be established – NDTPCEC)

Number of surveys routinely conducted and results reported (Five in 2009 [ATS, YRBS, YTS, BRFSS, and SHSS] – North Dakota Tobacco Prevention and Control Program and Public Education Task Force)

Number of local grantees that meet a minimum of 75 percent of their annual objectives (Baseline to be established – NDTPCEC and North Dakota Tobacco Prevention and Control Program)

Number of health communications campaigns implemented (One in 2008 – NDTPCEC)

### **OBJECTIVE 1**

By January 2010, develop an administrative structure to manage the comprehensive North Dakota Tobacco Prevention and Control Program.

(Partial structure in place in 2009)

## **ACTION STEPS**

- Maintain and expand a real time fiscal management system to track the allocation and expenditure of funds in order to ensure program accountability at the state and local levels.
- Hire sufficient qualified and diverse tobacco prevention and control staff and consultants to administer, manage and ensure accountability of North Dakota's statewide, comprehensive, evidence-based Tobacco Prevention and Control Program.
- Review and revise as necessary grant allocation guidelines.
- Provide ongoing technical assistance and training to community partners, grantees, sub-grantees and contractors to ensure delivery of evidence-based initiatives and interventions.
- Integrate where appropriate this State Plan, and additional supplemental plans, with strategic plans of other chronic disease programs.
- Engage Tobacco Free North Dakota and other state coalitions in implementing the State Plan.
- Review and update accountability requirements and reporting mechanisms for statewide and local grantees and contractors.
- Continue to update and implement the North Dakota Tobacco-Related Disparities Plan.
- Update and implement internal and external communications plan(s) as needed.
- Maintain a policy database.

### ***OBJECTIVE 2 (Developmental)\****

By June 2010, build local infrastructure and capacity to collaboratively deliver evidence-based tobacco prevention and control interventions recommended in *Best Practices for Comprehensive Tobacco Control Programs, October 2007* and *The Guide to Community Preventive Services: Tobacco Use Prevention and Control* to reach all local public health units, four reservations and one Indian service area.

(Baseline to be established)

## **ACTION STEPS**

- Expand funding to local public health units, tribes and community partnerships, including traditional and non-traditional partners, to deliver tobacco prevention and control initiatives, including policy interventions.
- Support the hiring of sufficient qualified and diverse tobacco prevention and control program staff and consultants at the local level to work with all North Dakota communities to deliver tobacco prevention and control initiatives, including policy interventions.
- Provide ongoing technical assistance and training to grantees and contractors to ensure delivery of evidence-based initiatives and interventions, including policy interventions.
- Facilitate community-based grassroots promotions, media advocacy, event sponsorships and other community links to support and reinforce statewide campaigns and to counter pro-tobacco influences.
- Strengthen and develop local coalitions to address policy interventions.
- Assure that youth and organizations that serve youth are engaged in local coalition activities.
- Educate policymakers and the public about the evidence-based, recommended interventions, including policy interventions, outlined in *Best Practices* and *The Community Guide*, and the need for sufficient staff at the state and local levels and the benefits of community-based programs and policy interventions.
- Collaborate with local coalitions and other partners to ensure compliance with tobacco-related local ordinances, school district policies, college and university policies and state and federal

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\* The objective is considered developmental if there is no baseline data.

laws.

- Promote collaboration with other community partners to address each others' tobacco-related chronic disease priorities.
- Provide guidance on how to monitor pro-tobacco influences in local communities.
- Track implementation of grant and contract requirements.

### ***OBJECTIVE 3***

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

(Two limited health communications campaigns on secondhand smoke and the Quitline in 2009 – Public Education Task Force and North Dakota Tobacco Prevention and Control Program)

### **ACTION STEPS**

- Secure and maintain support from local public health units and other partners.
- Identify and convene an expert panel to advise the effort.
- Educate policymakers and the public about the components and benefits of a comprehensive tobacco prevention and control program.
- Enhance capacity to develop counter-marketing campaign(s), including sufficient staff, outside contractors and partner support.
- Conduct audience research.
- Conduct market research.
- Test messages.
- Develop and implement a media plan with agencies and contractors, with input from the expert panel, that uses proven strategies to reach 75 percent of the public with sufficient frequency and duration.
- Develop components of promotional plans.
- Investigate emerging communications technologies.
- Coordinate and integrate with local activities.
- Develop an evaluation plan to measure effectiveness of the campaigns, and use results to fine-tune efforts.

### ***OBJECTIVE 4***

By January 2010, develop a comprehensive statewide surveillance and evaluation plan for the comprehensive North Dakota Tobacco Prevention and Control Program.

(No comprehensive surveillance and evaluation plan in 2009 – Tobacco Prevention and Control Executive Committee and North Dakota Tobacco Prevention and Control Program)

### **ACTION STEPS**

- Identify and convene an expert panel to advise the development of the plan.
- Identify and engage stakeholders in the development of the plan.
- Identify key process and outcome indicators to be measured.
- Create an inventory of current tobacco-related data collected by public and private sector agencies and organizations.
- Continue to use current data sources, including the Behavioral Risk Factor Surveillance System, Adult Tobacco Survey, Youth Risk Behavior Survey, and the Youth Tobacco Survey, to monitor the program impact at the state and local level.

- Expand statewide community-specific data collection and analysis and evaluation efforts.
- Use data to identify and focus on groups disparately affected by tobacco use.
- Collaborate with other Department of Health and Department of Human Services programs to collect and share data that will enhance efforts to reduce the burden of chronic diseases.
- Enhance capacity to collect and analyze data to define populations with tobacco-related disparities.
- Disseminate survey findings to local public health unit staff, local coalitions and community partnerships, etc., to support program evaluation and planning efforts.
- Disseminate data and program activity reports to the public and policymakers.
- Prepare and disseminate biennial reports to the Legislature that include results and outcomes of the comprehensive Tobacco Prevention and Control Program enacted by Initiated Measure 3, including evaluation reports on program effectiveness and recommendations from evaluators.

#### ***OBJECTIVE 5***

By June 2014 sustain North Dakota's comprehensive tobacco prevention and control program in conformance with current CDC recommendations.

(CDC funding level of \$9.3 million in 2009 – North Dakota 2009 Legislation)

#### **ACTION STEPS**

- Implement a comprehensive evidence-based tobacco prevention and control program containing all components of *Best Practices* and the recommended tobacco-related interventions in *The Community Guide*.
- Review the State Plan yearly and prepare annual action plans to achieve the objectives in the Plan.
- Educate the public and policymakers about the importance of reducing tobacco use and the resulting health and economic benefits.
- Report annually on the progress and impact of the comprehensive tobacco prevention and control program.
- Sustain program funding at the CDC-recommended level.

Tobacco Prevention and Control Work Plan – Year One

<b>Goal 1: Prevent the Initiation of Tobacco Use Among Youth and Young Adults</b>			
<b>Objective 4</b>			
<b>By June 2013, increase the percentage of school districts with a comprehensive tobacco-free school policy to 50 percent.</b>			
<b>Strategies/Action Steps</b>	<b>Timeframe</b>	<b>Accountability</b>	<b>Measure of Success</b>
1. Meet with Coordinated School Health Core Team	Ongoing	Executive Director/HD Outreach Coordinators	Meetings held
2. Meet with Executive Director of North Dakota School Boards Association	Sept 2009	Advisory Committee Member/ Executive Director/HD Division Director	Meeting held
3. Revise School Policy Tool Kit	Dec 2009	Executive Director/HD Outreach Coordinators/Partners	Tool Kit revised Tool kit revised and new components shared and posted to grantees only site.
4. Assess school districts on tobacco-free policies	Ongoing	Local Coordinators	All school districts assessed
5. Establish baseline data	June 2010	Executive Director/HD Division Director/Data Analyst	Baseline data established Will be available from PRS
6. Train local coordinators at sites meetings	Ongoing	HD Outreach Coordinators	Trainings delivered Training held at Oct. sites mtg.
7. Offer technical assistance to local coordinators	Ongoing	HD Outreach Coordinators	Technical assistance provided
8. Incorporate school policy assessment on progress reports	Ongoing	Executive Director/HD Division Director/ HD Outreach Coordinators	Policy included in progress reports Policy tracking added to PRS 10-09
9. Adopt comprehensive tobacco-free policy in school districts	Ongoing	Local Coordinators/School Boards	Number of policies adopted Will be available when PRS is printed



## Tobacco Prevention and Control Work Plan – Year One

<b>Objective: 5</b> <b>By December 2013, increase the number of public and private post-secondary institutions with tobacco-free campuses to eleven.</b>			
Strategies/Action Steps	Timeframe	Accountability	Measure of Success
1. Schedule visit with Chancellor	Dec 2009	Executive Director/Advisory Committee Chair/Advisory Committee Member	Meeting held; issue on Higher Ed Board Retreat Agenda in July 2010
2. Identify at least one campus	Sept 2009	HD Outreach Coordinators	Campus(es) identified <a href="#">Lake Region State College</a>
3. Gather and review available resources	Dec 2009	Executive Director/HD Outreach Coordinators	<a href="#">implemented 1-2010</a> Research completed
4. Compile a resource list	Dec 2009	Executive Director	Resource list compiled
5. Train on resources at a pre-sites Meeting	April 2010	HD Outreach Coordinators	Training held
6. Organize and train campus communities	Ongoing	Executive Director/Local Coordinators/HD Outreach Coordinators	Campus community organized
7. Technical assistance to implement and monitor tobacco-free policy initiative(s)	Ongoing	Local Coordinators	Technical assistance provided
8. Maintain/update campus tobacco policy database	Ongoing	Executive Director/Local Coordinators	Database current
9. Share info with HD to place on its website	Ongoing	Executive Director/HD Division Director	Information posted to website
10. Publicize efforts	Ongoing	Executive Director/HD Division Director	Success stories published <a href="#">Devils Lake Story published 1-10-09 in newspapers statewide</a>

Tobacco Prevention and Control Work Plan – Year One

<b>Goal 2: Eliminate Exposure to Secondhand Smoke</b>			
<b>Objective 2</b>			
<b>By June 2012, increase to five the number of communities that have enacted local ordinances for 100 percent smoke-free public places and places of employment.</b>			
<b>Strategies/Action Steps</b>	<b>Timeframe</b>	<b>Accountability</b>	<b>Measure of Success</b>
1. Compile/distribute resource list to locals	Dec 2009	Executive Director	List compiled and distributed
2. Develop local policy plan	Ongoing	Local Coordinators/Local Coalitions/Executive Director/Partners	Plan developed
3. Coordinate local campaigns throughout state	Ongoing	Executive Director	Teleconferences occur; listserv active <a href="#">Ongoing</a>
4. Sponsor policy trainings	Ongoing	Executive Director	Number and type of trainings held
5. Educate public and policymakers	Ongoing	Executive Director/HD Division Director/PETF/Local Coalitions/Health Communications Coordinator	Number of campaigns implemented <a href="#">Campaign ongoing in Bismarck</a>
6. Conduct surveys/polls to monitor public support	Ongoing	Local Coalitions/Partners	Number of surveys/polls conducted <a href="#">1 poll conducted in Bismarck and published in Bis Tribue 1-10-2010</a>
7. Provide technical assistance to local coalitions and partners	Ongoing	Local Coordinators/Local Coalitions/HD Division Director	Technical assistance provided
8. Mobilize local coalitions and community partners	Ongoing	Executive Director/HD Division Director	Number of active campaigns <a href="#">1 active campaign-Bismarck</a>

## Tobacco Prevention and Control Work Plan – Year One

9. Assure passage/enforcement of local policy	Ongoing	Local Coalitions/Local Coordinators/Partners	Number of policies enacted
10. Evaluate the impacts of policies	Ongoing	Executive Director/HD Division Director	Fargo and West Fargo evaluated <a href="#">___Studies Completed (which ones?)</a>
11. Create/maintain local ordinance database	Ongoing	Executive Director	Database created and up-to-date.

Tobacco Prevention and Control Work Plan – Year One

<b>Goal 3: Promote Quitting Tobacco Use</b>			
<b>Objective: 4</b>			
<b>By 2014, increase annual use of the North Dakota Tobacco Quitline (Q-line) to a minimum of 2 percent of all smokers and smokeless tobacco users.</b>			
<b>Strategies/Action Steps</b>	<b>Timeframe</b>	<b>Accountability</b>	<b>Measure of Success</b>
1. Analyze Q-line call volume, utilization, etc.	Oct 2009	HD Division Director/ Cessation Committee	Q-line service delivery reviewed/revised
2. Review Q-line protocols	Oct 2009	HD Division Director/ Cessation Committee	Q-line protocols reviewed/revised
3. Establish Q-line as primary source of cessation support	Ongoing	HD/Local Public Health Units(LPUs)	Number of calls to Q-line
4. Develop and release RFP for Q-line vendor	Dec 2009	HD Division Director/ Executive Director	RFP released
5. Distribute <i>Fax to Quit</i> manuals	Ongoing	HD Division Director/ Local Coordinators	Number of manuals distributed
6. Train health care providers in use of <i>Fax to Quit</i> system	Ongoing	HD Division Director/ Local Coordinators	Number of health care providers trained
7. Increase fax referrals to Q-line	Ongoing	HD Division Director/ LPUs/Health Care Providers	Number of fax referrals to Q-line
8. Expand promotion of Q-line	Ongoing	HD Division Director/ Health Communications Team/Local Coordinators	Number of campaigns
9. Expand access to and distribution of	Ongoing	HD Division Director/	Number of NRT units distributed

## Tobacco Prevention and Control Work Plan – Year One

Nicotine Replacement Therapy (NRT)		Q-line Provider	
10. Maintain ND Tobacco Q-line Consortium	Ongoing	HD Division Director	Number of meetings held; number of changes to Q-line implemented
11. Deliver web-based Q-line services	June 2010	HD Division Director	Web-based service available
12. Encourage health care providers, other health, mental health, substance abuse, and social service providers and businesses to promote the Q-line	Ongoing	HD Division Director/ Local Coordinators	Inventory of where Q-line referrals originate
13. Develop RFP for evaluation of Q-line media, promotion and marketing campaigns	June 2010	Executive Director/HD Division Director/ Health Communications Coordinator	RFP developed, to include measuring reach and frequency of Q-line media; number of calls to Q-line
14. Develop RFP for evaluation of Q-line services	June 2010	Executive Director/HD Division Director/ Cessation Coordinator	RFP developed
15. Update the matrix of existing cessation benefits	Ongoing	HD Division Director	Matrix updated

Tobacco Prevention and Control Work Plan – Year One

<b>Objective: 5</b> <b>By 2014, incorporate the systems approach to tobacco treatment recommended in the U.S. Public Health Service <i>Treating Tobacco Use and Dependence, Clinical Practice Guideline – 2008 Update</i> in the 28 local public health units and in three of the six largest health care systems.</b>			
Strategies/Action Steps	Timeframe	Accountability	Measure of Success
1. Establish Cessation Committee to develop guidelines and procedures	October 2009	HD Division Director/ Executive Director	Committee established <a href="#">Committee established 9-09?</a>
2. Develop guidelines and procedures	January 2010	Cessation Committee Executive Director/HD Division Director	Guidelines and procedures developed <a href="#">Guidelines and procedures developed and distributed 10-09 and ongoing</a>
3. Provide funding to all LPHUs to begin implementation of a systems approach in units	Ongoing	Executive Director	Funding in place; policies in place; implementation plan developed <a href="#">Contracts for funding executed 10-09</a> <a href="#">__ policies in places</a> <a href="#">__implementation plans in place</a>
4. Begin to implement a systems approach in one large health care system	June 2010	Local Coordinators	Tobacco treatment system implemented <a href="#">Initial implementation started MeritCare?</a>

Tobacco Prevention and Control Work Plan – Year One

<b>Objective: 6</b>			
<b>By June 2013, increase to a minimum of three the number of North Dakota’s largest employers who cover tobacco cessation medications and services in their employee health benefits plan(s).</b>			
<b>Strategies/Action Steps</b>	<b>Timeframe</b>	<b>Accountability</b>	<b>Measure of Success</b>
1. Identify and survey employers	June 2010	Executive Director/HD Division Director	Employers identified; survey completed

Tobacco Prevention and Control Work Plan – Year One

<b>Objective: 7</b>			
<b>By June 2013, maintain the current nine and increase by a minimum of one the number of third party payers that include tobacco cessation medications and services as a standard health benefit.</b>			
<b>Strategies/Action Steps</b>	<b>Timeframe</b>	<b>Accountability</b>	<b>Measure of Success</b>
1. Identify and survey third party payers	June 2010	Executive Director/HD Division Director	Third party payers identified; survey completed



Tobacco Prevention and Control Work Plan – Year One

<b>Objective: 8</b> <b>By 2014, address nicotine dependence in addiction treatment programs, in mental health treatment programs and in dual diagnosis treatment programs.</b>			
Strategies/Action Steps	Timeframe	Accountability	Measure of Success
1. Initiate assessment of tobacco-free campuses	Ongoing	HD Division Director/ Local Coordinators	Assessment completed
2. Educate clinicians through statewide and local conferences and meetings	Ongoing	HD Division Director/ Executive Director/Local Coordinators	Number of conference presentations

## Tobacco Prevention and Control Work Plan – Year One

<b>Goal 4: Build Capacity/Infrastructure to Implement a Comprehensive Evidence-based Tobacco Prevention/Control Program</b>			
<b>Objective 1</b>			
<b>By January 2010, develop an administrative structure to manage the comprehensive North Dakota Tobacco Prevention and Control Program.</b>			
<b>Strategies/Action Steps</b>	<b>Timeframe</b>	<b>Accountability</b>	<b>Measure of Success</b>
1. Expand real-time fiscal management system	Ongoing	Executive Director/HD Division Director	System in place <a href="#">PRS Expenditure Reporting System in place 10-09</a>
2. Hire staff	Ongoing	Executive Director/Executive Committee	Staff hired <a href="#">ED hired 10-09</a> <a href="#">AA hired 1-10</a>
3. Update Grant Allocations Guidelines	Ongoing	Executive Committee/ Executive Director	Guidelines approved <a href="#">In process</a>
4. Train and provide technical assistance to grantees, sub-grantees, contractors and community partners	Ongoing	Executive Director/HD Division Director/ Local Coordinators	Technical assistance and training provided <a href="#">Grant Writing and Grants Management Tips 10-09</a> <a href="#">Effective Meetings 10-09</a> <a href="#">Coalition Bldg. 1-10</a>
5. Integrate <i>Savings Lives–Saving Money</i> with other chronic disease programs’ plans	Ongoing	Executive Director/HD Chronic Disease Program Managers	<i>Savings Lives–Saving Money</i> integrated with other chronic disease programs’ plans
6. Engage Tobacco Free North Dakota and other state coalitions in <i>Savings Live–Saving Money</i> implementation	Ongoing	Executive Director/Executive Committee/ HD Chronic Disease Program Managers/ HD Division Director/ Coalition Chairs	Tobacco Free North Dakota and other state coalitions actively engaged
7. Update and enhance grantees’ and contractors’ accountability standards and reporting mechanisms	Ongoing	Executive Director/HD Division Director	Revised accounting and reporting systems in place <a href="#">PRS in place 10-09</a> <a href="#">Reprogramming requirements set 1/10</a>

## Tobacco Prevention and Control Work Plan – Year One

8. Review and implement the internal and external Communications Plans	Dec 2009	Executive Director/ Local Coordinators/HD Division Director	Plan updated, disseminated and implemented
9. Review and implement Disparities Plan	Ongoing	HD Disparities Team/ Executive Director/HD Division Director/Local Coordinators	Plan updated and disseminated
10. Maintain state and local policy databases	Ongoing	Executive Director/HD Division Director/Local Coordinators	Databases current

Tobacco Prevention and Control Work Plan – Year One

<b>Objective: 2</b>			
<b>By June 2010, build local infrastructure and capacity to collaboratively deliver evidence-based tobacco prevention and control interventions recommended in <i>Best Practices</i> and <i>The Guide to Community Preventive Services: Tobacco Use Prevention and Control</i> to reach all local public health units, four reservations and one Indian service area.</b>			
<b>Strategies/Action Steps</b>	<b>Timeframe</b>	<b>Accountability</b>	<b>Measure of Success</b>
1. Expand funding to local public health units, tribes and community partnerships	Aug 2009	Executive Director/ Executive Committee	Increased funding allocated <a href="#">Funding allocated and contracts executed 10-09, Special Initiatives 1-10</a>
2. Support hiring of qualified and diverse local staff and consultants	Ongoing	Executive Director/HD Division Director/ Local Coordinators	Number of staff and consultants in place
3. Develop annual training plan	Oct 2009	Executive Director/ Executive Committee/HD Division Director	Plan completed
4. Coordinate training and technical assistance to grantees and contractors	Ongoing	Executive Director/ Executive Committee/ HD Division Director	Technical assistance and training delivered
5. Facilitate local promotions, media advocacy, community links, etc. to support state efforts	Ongoing	Executive Director/HD Division Director/ Health Communications Team	Number of local and state promotional and marketing initiatives linked
6. Strengthen and develop local coalitions	Ongoing	Executive Director/ Local Coordinators/HD Outreach Coordinators	Number of local policies introduced
7. Educate policymakers and public about need for tobacco prevention and control programs	Ongoing	Executive Director/HD Division Director/ Local Coordinators/ HD Outreach Coordinators	Number of campaigns; number of meetings; number of presentations

Tobacco Prevention and Control Work Plan – Year One

8. Track grant and contract requirements	Ongoing	Executive Director/HD Division Director	All grantees and contractors compliant
9. Collaborate with local groups to ensure compliance with local and state laws	Ongoing	Executive Director/ Attorney General/HD Division Director/ Local Coordinators	Tracking systems for state aid and local grants in place and up-to-date Local and state laws enforced Ongoing
10. Promote state and local chronic disease collaborations	Ongoing	Executive Director/HD Division Director/ Local Coordinators	Number of collaborations

## Tobacco Prevention and Control Work Plan – Year One

<b>Objective: 3</b>			
<b>By June 2010, create and implement a tobacco prevention and control health communication initiative that delivers strategic, culturally appropriate and high-impact earned and paid messages in sustained and adequately funded campaigns integrated into the overall comprehensive North Dakota Tobacco Prevention and Control Program.</b>			
<b>Strategies/Action Steps</b>	<b>Timeframe</b>	<b>Accountability</b>	<b>Measure of Success</b>
1. Identify and convene an expert panel	Nov 2009	Executive Committee/ Executive Director/HD Division Director	Expert panel in place
2. Secure and maintain support from local public health units and other partners	Dec 2009	Executive Committee/HD Division Director/HD Outreach Coordinators	Local public health units and partners support health communication initiative
3. Educate policymakers and the public	Ongoing	Executive Director/ Executive Committee/HD Division Director/Local Coordinators	Number of presentations; number of campaigns; number of promotions
4. Enhance capacity to develop campaigns	Ongoing	Executive Director/HD Division Director	Increased funding and staff
5. Conduct market research	Ongoing	Executive Director/Health Communications Team	Market research completed
6. Conduct audience research	Ongoing	Executive Director/Health Communications Team	Audience research completed
7. Test messages	Ongoing	Executive Director/Health Communications Team	Messages tested
8. Develop and implement a media plan	Jan 2010	Executive Director/Health Communications Team/HD Division Director	Media plan in place

## Tobacco Prevention and Control Work Plan – Year One

9. Develop components of promotional plans	Ongoing	Executive Director/Health Communication Team/HD Division Director	Promotional plans fully developed
10. Investigate new technologies	Ongoing	Executive Director/Health Communications Team/HD Division Director	Report on new technologies prepared
11. Coordinate and integrate with local activities	Ongoing	Executive Director/Local Coordinators/HD Outreach Coordinators	Integration of state and local activities
12. Develop an evaluation plan	March 2010	Executive Director/Health Communications Team/HD Division Director	Evaluation plan in place

## Tobacco Prevention and Control Work Plan – Year One

<b>Objective: 4</b>			
<b>By January 2010, develop a comprehensive statewide surveillance and evaluation plan for the comprehensive North Dakota Tobacco Prevention and Control Program.</b>			
<b>Strategies/Action Steps</b>	<b>Timeframe</b>	<b>Accountability</b>	<b>Measure of Success</b>
1. Identify and convene an expert panel	Oct 2009	Executive Director/HD Division Director/ Executive Committee	Expert panel in place
2. Engage stakeholders	Nov 2009	Executive Director/HD Division Director	Stakeholders actively engaged
3. Identify key process and outcome indicators to be measured	Jan 2010	Executive Director/HD Division Director/ Expert Panel	Indicators selected
4. Create evaluation plan based on key indicators to be measured.	Jan 2010	Executive Director/HD Division Director/ Expert Panel	Plan created
4. Continue data collection using current surveys and other instruments	Ongoing	Executive Director/Expert Panel/HD Division Director	Data collected
5. Prepare and release RFPs for independent evaluators	Ongoing	Executive Director/HD Division Director	RFPs prepared and released
6. Begin review of proposals submitted by independent evaluators	Ongoing	Expert Panel/Executive Committee	Review begun



Tobacco Prevention and Control Work Plan – Year One

<b>Objective: 5</b> <b>By June 2014 sustain North Dakota’s comprehensive tobacco prevention and control program in conformance with current CDC recommendations.</b>			
<b>Strategies/Action Steps</b>	<b>Timeframe</b>	<b>Accountability</b>	<b>Measure of Success</b>
1. Implement a comprehensive evidence-based tobacco prevention and control program	Ongoing	Executive Director/HD Division Director/ Executive Committee	Comprehensive program in place
2. Review <i>Savings Live –Saving Money</i> and amend as needed	Ongoing	Executive Director/HD Division Director/ Executive Committee	<i>Savings Lives–Saving Money</i> reviewed
3. Prepare 2010-2011 Action Plan	May 2010	Executive Director/HD Division Director/ Executive Committee	Action Plan prepared
4. Educate public and policymakers about the health and economic benefits of reducing tobacco use	Ongoing	Executive Director/Exec Committee/HD Division Director/Health Communications Team/ Local Coordinators	Number of campaigns; number of meetings; number of presentations
5. Report on program’s achievements	Ongoing	Executive Director/Executive Committee/ HD Division Director/Health Communications Team	Number of reports, number of presentations, number of media stories

North Dakota Comprehensive Tobacco Prevention and Control Work Plan – FY 2011  
UPDATE: 11.18.2010

<b>Goal 1: Prevent the Initiation of Tobacco Use Among Youth and Young Adults</b>			
<b>Objective: 1 (Also Goal 3)</b>			
<b>By June 2013, increase the cigarette excise tax to \$2.00 per pack and increase the excise tax on other tobacco products by an equal and proportional amount.</b>			
Strategies/Action Steps	Timeframe	Lead/Partners*	Measure of Success
1. Assess public support for increasing tobacco excise taxes	11.2010	Executive Director/HD Division Director/Local Coordinators	Assessment completed Minot – 54.3% favor, no amount, 6.10 Bottineau – 55% favor, no amount, 7.10 Cass County – NYA, 11.10 ND -- NYA
2. Develop a tobacco excise tax policy plan	11.2010	Tobacco Free North Dakota/ Executive Director/other Partners	Policy plan in place 12.10 – plan will be developed with partners
3. Review evidence base and update fact sheets and policy documents	12.2010	Tobacco Free North Dakota/ Executive Director/Partners	Evidence-base reviewed and fact sheets and policy documents updated 9.2010 – evidence based reviewed by Campaign for Tobacco Free Kids, \$2 tax fact sheet issued by BreatheND
4. Train local coalitions and community partners on how to put tobacco excise tax issues before their local public	12.2010	Executive Director	Number and type of trainings held 10.2010 – phone training with LPHU grantees on contacting legislators 11.2010 – training held with LPHU grantees and partners
5. Provide technical assistance to local coalitions and community partners	ongoing	Executive Director	Number of technical assistance requests 9-11.2010 – technical assistance offered to an estimated three coalitions
6. Educate the public and policymakers on tobacco excise tax issues	ongoing	Executive Director/Local Coordinators/Tobacco Free North Dakota/Local Coalitions/Partners	Number of contacts; number of meetings; number of campaigns implemented 10-11.2010 – Contacts with ___ legislators made by local coalitions
7. Engage local coalitions and partners	ongoing	Local	Number of contacts; number of meetings;

North Dakota Comprehensive Tobacco Prevention and Control Work Plan – FY 2011  
UPDATE: 11.18.2010

in addressing tobacco excise tax issues		/coordinators/Tobacco Free North Dakota	number of campaigns implemented 10-11.2010 – Contacts with ___ legislators made by local coalitions
8. Monitor and track progress	ongoing	Tobacco Free North Dakota/Partners/Executive Director	Monitoring protocol in place From 10.2010 onward – legislative database created and updated
<b>Objective 4:</b>			
<b>By June 2013, increase the percentage of school districts with a comprehensive tobacco-free school policy to 50 percent.</b>			
<b>Strategies/Action Steps</b>	<b>Timeframe</b>	<b>Lead/Partners</b>	<b>Measure of Success</b>
1. Continue meeting with Coordinated School Health Core Team	ongoing	Executive Director/HD Division Director	Meetings held 8.2010 – meeting attempted; feedback provided but not incorporated into update school policy
2. Secure endorsement of the North Dakota School Boards Association	ongoing	Executive Director/HD Division Director	Endorsement secured 8-9.2010 – NDSBA endorsed school policy as updated by DOH
3. Asses school districts on tobacco-free policies	ongoing	Local Coordinators	All school districts assessed 7-11.2010 -- # school districts assessed
4. Train Local Coordinators	9.2010	Executive Director/HD Division Director	Number of coordinators trained
5. Offer technical assistance to Local Coordinators	9.2010	Executive Director/HD Division Director	Number of technical assistance requests --- # TA offered
6. Continue to include tobacco free school policy status on Progress Reports	ongoing	Executive Director/HD Division Director	Policy status included in Progress Reports Included on all reports
7. Adopt comprehensive tobacco-free policy in school districts	ongoing	Local Coordinators/School Boards	Number of policies adopted 7-11.2010 --
8. Report tobacco free policy status in school districts	ongoing	Executive Director/HD Division Director	Policy status reported 9.2010 – reported to Legislative Budget

North Dakota Comprehensive Tobacco Prevention and Control Work Plan – FY 2011  
UPDATE: 11.18.2010

			Section, partners, testimony on website
<b>Objective 5:</b> <b>By December 2013, increase the number of public and private post-secondary institutions with tobacco-free campuses to eleven.</b>			
<b>Strategies/Action Steps</b>	<b>Timeframe</b>	<b>Lead/Partners</b>	<b>Measure of Success</b>
1. Schedule visit with Chancellor	12.2010	Executive Director/Advisory Committee Chair/Advisory Committee Member	Meeting held; issue on Higher Ed Board Retreat Agenda in July 2011
2. Identify at least one campus	9.2010	Executive Director/ Local Coordinators	Campus(es) identified 10-11.2010 – University of Mary 1.2011 – Dakota College, Bottineau
3. Update and disseminate a resource list	ongoing	Executive Director/MSU	Resource list updated and disseminated
4. Train on use of available resources	ongoing	Executive Director/HD Division Director	Number of training(s) held 7-11.2010 – University of Mary HealthPro student group trained (Note: Fargo Cass Public Health hosted BACCHUS training 6.2010.)
5. Organize and train campus communities	ongoing	Local Coordinators	Campus community organized 7-11.2010 – University of Mary HealthPro student group trained
6. Provide technical assistance to implement and monitor tobacco-free policy initiative(s)	ongoing	Local Coordinators	Number of technical assistance requests
7. Maintain/update campus tobacco policy database	ongoing	Executive Director/Local Coordinators	Database current
8. Publicize efforts	ongoing	Executive Director/HD Division Director	Number of success stories published
<b>Goal 2: Eliminate Exposure to Secondhand Smoke</b>			

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<b>Objective 1: (Also Goal 1 and 3)</b>			
By June 2013, amend the North Dakota Smoke-Free Law to implement 100 percent smoke-free public places and places of employment and to expand enforcement of the law.			
<b>Strategies/Action Steps</b>	<b>Timeframe</b>	<b>Lead/Partners</b>	<b>Measure of Success</b>
1. Compile and report community support for local smoke-free ordinances	10.2010	HD Division Director/ Executive Director	List compiled and community support reported 7.2010 -- List compiled.
2. Report data on statewide attitudes for smoke-free initiatives	10.2010	Executive Director	Statewide attitudes on smoke-free initiatives reported
3. Develop a state smoke-free environments policy plan	10.2010	Executive Director/ Tobacco Free North Dakota/Partners	Policy plan in place 7.2010 – plan developed
4. Review evidence base and update fact sheets and policy documents	12.2010	Executive Director/ Tobacco Free North Dakota/Partners	Fact sheets and policy documents updated 7.2010 – model local survey promoted
5. Train local coalitions and community partners on smoke-free initiatives	12.2010	Executive Director	Number and type of trainings held 7.2010 – training with LPHUs and partners including ANR and CTFK held
6. Provide technical assistance to local coalitions and community partners	ongoing	Executive Director/HD Division Director	Number of technical assistance requests Weekly requests received: five coalitions actively involved in policy.
7. Educate the public and policymakers on smoke-free environment issues	ongoing	Executive Director/HD Division Director/Local Coordinators/Tobacco Free North Dakota/Local	Number of contacts; number of meetings; number of campaigns implemented 8-10.2010 – all coalitions attempted

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		Coalitions/Partners	contact with all legislators
8. Engage local coalitions and partners in addressing smoke-free environment issues	ongoing	Local Coordinators/ Tobacco Free North Dakota	Number of contacts; number of meetings; number of campaigns implemented Five grantees (Grand Forks, Bismarck, Devils Lake, Minot, Medora) actively addressed smoke-free policies.
9. Monitor and track progress	ongoing	Tobacco Free North Dakota/Partners/Executive Director	Monitoring protocol in place 9.2010 – Executive Director reported to Legislative Budget Section.
<b>Objective 2:</b> <b>By June 2012, increase to five the number of communities that have enacted local ordinances for 100 percent smoke-free public places and places of employment.</b>			
<b>Strategies/Action Steps</b>	<b>Timeframe</b>	<b>Lead/Partners</b>	<b>Measure of Success</b>
1. Distribute resource list to locals	ongoing	Executive Director	Number of resources lists distributed 7.2010 – resources provided at training to all LPHUs grantees and partners
2. Develop local policy plan	ongoing	Local Coordinators/Local Coalitions/Executive Director//Partners	Number of plans developed Policy plans developed for Bismarck, Devils Lake
3. Coordinate local campaigns throughout state	ongoing	Executive Director	Teleconferences occur; list serve active Center hosts monthly policy call; list serve is active
4. Sponsor policy trainings	ongoing	Executive Director	Number and type of trainings held 7 & 11. 2010 – policy trainings held on smoke-free, policy priorities
5. Educate public and policymakers	ongoing	Executive Director/HD Division Director/ PETF/Local Coalitions	Number of meetings held; number of presentations; number of campaigns implemented
6. Conduct surveys/polls to monitor public	ongoing	Local Coalitions/Partners	Number of surveys/polls conducted

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support			Polls conducted in Minot, Bottineau
7. Provide technical assistance to local coalitions and partners	ongoing	Local Coordinators/Local Coalitions/HD Division Director/Executive Director	Number of technical assistance requests
8. Engage local coalitions and community partners	ongoing	Executive Director/HD Division Director	Number of active campaigns Statewide health communications campaign ongoing since 7.2010
9. Assure passage/enforcement of local policy	ongoing	Local Coalitions/Local Coordinators/Partners	Number of policies enacted and enforced Grand Forks and Napoleon policies enacted
10. Evaluate and report the impacts of policies		Executive Director/HD Division Director	Fargo, West Fargo and Grand Forks evaluated and reports prepared
11. Maintain local ordinance database	ongoing	Executive Director	Database current
<b>Objective 3:</b> By June 2013, Prevent preemption (higher levels of government can prohibit lower levels of government from enacting certain laws or regulations) in all state tobacco prevention and control laws.			
<b>Strategies/Action Steps</b>	<b>Timeframe</b>	<b>Lead/Partners</b>	<b>Measure of Success</b>
1. Update preemption educational materials	12.2010	Executive Director/ Partners	Materials updated
2. Engage local coalitions to gather support from communities and organizations to endorse local resolutions that oppose statewide preemption.	12.2010	Executive Director/Local Coordinators/ Tobacco Free North Dakota/Partners	Number of resolutions
3. Train local coalitions about how to prevent and deal with preemption activities, including referenda	ongoing	Executive Director/ HD Division Director/ Local Coordinators/Tobacco Free North Dakota/ Partners	Number of trainings
4. Track all legislation for preemption language	ongoing	Executive Director/HD Division Director/ Tobacco Free North Dakota	Tracking system established and maintained

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<b>Goal 3: Promote Quitting Tobacco Use</b>			
<b>Objective 4: By 2014, increase annual use of the North Dakota Tobacco Quitline (Q-line) to a minimum of 2 percent of all smokers and smokeless tobacco users.</b>			
<b>Strategies/Action Steps</b>	<b>Timeframe</b>	<b>Lead/Partners</b>	<b>Measure of Success</b>
1. Analyze Q-line call volume, utilization etc	ongoing	HD Division Director	Q-line service delivery reviewed/ revised
2. Review Q-line protocols	ongoing	HD Division Director	Q-line protocols reviewed/revised
3. Establish Q-line as one of two key sources of cessation support	ongoing	HD/ Local Public Health Units (LPHUs)	Number of calls to Q-line
4. Distribute <i>Fax to Quit</i> manuals	ongoing	HD Division Director/ Local Coordinators	Number of manuals distributed
5. Train health care providers in use of <i>Fax to Quit</i> system	ongoing	HD Division Director/ Local Coordinators	Number of health care providers trained
6. Increase fax referrals to Q-line	ongoing	HD Division Director/ LPHUs/Health Care Providers	Number of fax referrals to Q-line
7. Expand promotion of Q-line	ongoing	HD Division Director/Local Coordinators	Number of campaigns
8. Expand access to and distribution of NRT	ongoing	HD Division Director/Executive Director/Q-line provider	Number of NRT units distributed
9. Provide uninsured and underinsured tobacco users with a 56 day supply of an NRT regimen	ongoing	HD Division Director/ Q-line provider	Fifty six day regimen provided
10. Maintain ND Tobacco Q-line Consortium	ongoing	HD Division Director	Number of meetings held; number of changes to Q-line implemented
11. Encourage health care providers, other health, mental health, substance abuse, and social service providers and businesses to promote the Q-line	ongoing	HD Division Director/ Local Coordinators	Inventory of where Q-line referrals originate



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12. Select evaluator for Q-line services	ongoing	HD Division Director	Evaluator selected
13. Develop the Q-line evaluation plan	ongoing	HD Division Director	Evaluation plan in place
14. Prepare and release RFP(s) for independent evaluator(s) for Q-line	ongoing	HD Division Director	RFPs prepared and released
15. Select Review Panel to review RFPs for Q-line evaluation	ongoing	HD Division Director	Review Panel selected
16. Review submitted proposals for Q-line	ongoing	HD Division Director	Review completed
17. Select independent evaluator(s) for Q-line	ongoing	HD Division Director	Independent evaluator(s) selected
18. Update the matrix of existing cessation benefits	ongoing	HD Division Director	Matrix updated
<b>Objective 5: By 2014, incorporate the systems approach to tobacco treatment recommended in the U.S. Public Health Service <i>Treating Tobacco Use and Dependence, Clinical Practice Guideline – 2008 Update</i> in the 28 local public health units and in three of the six largest health care systems.</b>			
<b>Strategies/Action Steps</b>	<b>Timeframe</b>	<b>Lead/Partners</b>	<b>Measure of Success</b>
1. Maintain Cessation Committee to develop guidelines and procedures.	ongoing	Executive Director	Committee established
2. Update guidelines and procedures	ongoing	Cessation Committee, Executive Director	Guidelines and procedures updated
3. Provide funding to all LPHUs to continue implementation of a systems approach in local public health units	ongoing	Executive Director	Funding in place; policies in place; implementation plan in operation
4. Continue to implement a systems approach in two additional large health care systems	6.2011	HD Division Director/ Executive Director/ Local Coordinators	Tobacco treatment systems implemented in new systems
5. Develop an audit protocol for health care systems to establish baseline data	10.2010	Executive Director	Audit protocol developed
6. Track adoption of tobacco free buildings and grounds policies in health care systems	12.2010	Executive Director/Local Coordinators	Database established; number of health care systems adopting policies
7. Develop a tool to track private health care system implantation of the <i>Guideline's</i> AAR (Ask, Advise, Refer) recommendations	12.2010	Executive Director	Tracking tool developed
8. Track implementation of the <i>Guideline's</i>	ongoing	Executive Director/	Database established; number of

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AAR recommendations in LPHUs and large health care systems		Local Coordinators	LPHUs and health care systems delivering AAR
9. Begin incorporating curriculum on treating tobacco use and dependence into medical, nursing, pharmacy and allied health programs	ongoing	Executive Director/ HD Division Director	Number of programs incorporating curriculum
<b>Objective 6: By June 2013, increase to a minimum of three the number of North Dakota’s largest employers who cover tobacco cessation medications and services in their employee health benefits plan(s).</b>			
<b>Strategies/Action Steps</b>	<b>Timeframe</b>	<b>Lead/Partners</b>	<b>Measure of Success</b>
1. Review and analyze employer survey results	ongoing	HD Division Director	Surveys reviewed and analyzed
2. Disseminate the U.S. Public Health Service <i>Treating Tobacco Use and Dependence, Clinical Practice Guideline – 2008 Update</i> to large employers	ongoing	HD Division Director	<i>Guideline</i> disseminated
3. Advocate with employers to include tobacco cessation medications and services in their employee health benefits plans	ongoing	HD Division Director	Number of meetings attended; number of presentations
<b>Objective 7: By June 2013, maintain the current nine and increase by a minimum of one the number of third party payers that include tobacco cessation medications and services as a standard health benefit.</b>			
<b>Strategies/Action Steps</b>	<b>Timeframe</b>	<b>Lead/Partners</b>	<b>Measure of Success</b>
1. Review and analyze third party payer survey results.	ongoing	HD Division Director	Surveys reviewed and analyzed
2. Disseminate the U.S. Public Health Service <i>Treating Tobacco Use and Dependence, Clinical Practice Guideline –</i>	ongoing	HD Division Director	<i>Guideline</i> disseminated

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<i>2008 Update to third party payers</i>			
3. Advocate with third party payers to include tobacco cessation medications and services as a standard health benefit in their policies	ongoing	Executive Director/ HD Division Director	Number of meetings attended; number of presentations
4. Investigate cost-sharing opportunities for the QuitLine and QuitNet with third party payers and large employers	ongoing	Executive Director/ HD Division Director	Opportunities identified and explored
<b>Objective 8:</b> <b>By 2014, address nicotine dependence in addiction treatment programs, in mental health treatment programs and in dual diagnosis treatment programs.</b>			
<b>Strategies/Action Steps</b>	<b>Timeframe</b>	<b>Lead/Partners</b>	<b>Measure of Success</b>
1. Continue assessment of tobacco-free campuses	ongoing	HD Division Director/ Local Coordinators	Assessment completed
2. Educate directors and clinicians through statewide and local conferences and meetings	ongoing	HD Division Director/ Executive Director/Local Coordinators	Number of conference presentations
<b>Goal 4: Build Capacity/Infrastructure to Implement a Comprehensive Evidence-based Tobacco Prevention/Control Program</b>			
<b>Objective 1:</b> <b>By January 2010, maintain an administrative structure to manage the comprehensive North Dakota Tobacco Prevention and Control Program.</b>			
<b>Strategies/Action Steps</b>	<b>Timeframe</b>	<b>Lead/Partners</b>	<b>Measure of Success</b>
1. Prepare for legislative approval the FY2011-2012 the comprehensive program	11.2010	Executive Director/Advisory	Budget prepared

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budget		Committee	
2. Improve real-time fiscal management system	ongoing	Executive Director	Improvements in place
3. Develop optimum personnel plan, including staff positions and contractors, to implement the comprehensive program	12.2010	Executive Director/HD Division Director/ Executive Committee	Personnel plan in place
4. Hire and retain qualified and diverse staff and consultants	ongoing	Executive Director/Executive Committee	Sufficient qualified and diverse staff and consultants in place
5. Review and modify, if indicated, Grant Allocations Guidelines	6.2011	Executive Committee/ Executive Director	Guidelines reviewed and modified
6. Train and provide technical assistance to grantees, sub-grantees, contractors and community partners	ongoing	Executive Director/HD Division Director/ Local Coordinators	Number of technical assistance requests and number of trainings
7. Continue to integrate <i>Savings Lives–Saving Money</i> with other chronic disease programs' plans	ongoing	Executive Director/HD Chronic Disease Program Managers	<i>Savings Lives–Saving Money</i> integrated with heart disease/stroke, diabetes and oral health plans
8. Engage Tobacco Free North Dakota , other state coalitions and other allied organizations in <i>Savings Lives–Saving Money</i> implementation	ongoing	Executive Director/Executive Committee/Coalition Chairs/ HD Division Director/ Tobacco Free North Dakota leadership	Tobacco Free North Dakota and other state coalitions and organizations actively engaged
9. Improve grantees' and contractors' reporting mechanisms and accountability standards	ongoing	Executive Director/HD Division Director	Improved user-friendly reporting and accountability systems in place
10. Continue review and implementation of the internal and external Communications Plans	ongoing	Executive Director/HD Disparities Team/	Plans updated and implemented; written copies disseminated

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		Local Coordinators	
11. Continue review and implementation of the Disparities Plan	ongoing	HD Disparities Team/HD Division Director/Local Coordinators	Plan updated, implemented and disseminated
12. Maintain state and local policy databases	ongoing	Executive Director/HD Division Director/ Local Coordinators	Database current
<b>Objective 2:</b> <b>By June 2010, maintain local infrastructure and capacity to collaboratively deliver evidence-based tobacco prevention and control interventions recommended in <i>Best Practices</i> and <i>The Guide to Community Preventive Services: Tobacco Use Prevention and Control</i> to reach all local public health units, four reservations and one Indian service area.</b>			
<b>Strategies/Action Steps</b>	<b>Timeframe</b>	<b>Lead/Partners</b>	<b>Measure of Success</b>
1. Evaluate funding formula(s) for disbursing grants to local public health units, tribes and community partnerships	1.2011	Executive Director/HD Division Director/ Executive Committee	Funding formulas evaluated and revised as necessary
2. Support hiring of qualified and diverse local staff and consultants	ongoing	Executive Director/HD Division Director/ Local Coordinators	Number of staff and consultants in place
3. Develop Annual Training Plan for grantees, partners, staff and Advisory Committee	10.2010	Executive Director/ Executive Committee/ HD Division Director	Plan completed
4. Coordinate training and technical assistance to grantees and contractors	ongoing	Executive Director/ Executive Committee/ HD Division Director	Technical assistance and training delivered
5. Facilitate and coordinate local promotions, media advocacy, community links etc. to support state efforts	ongoing	Executive Director/HD Division Director/ Health Communications Team	Number of local and state promotional and marketing initiatives coordinated
6. Strengthen and develop local coalitions	ongoing	Executive Director/HD Division Director/	Number of local policies introduced

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		Local Coordinators	
7. Educate policymakers and public about need for tobacco prevention and control programs	ongoing	ED/Local Coordinators/ HD Division Director	Number of campaigns; number of meetings; number of presentations
8. Provide guidance and training to grantees and local coalitions on monitoring pro-tobacco influences	ongoing	Executive Director/Health Communications Team/HD Division Director	Guidance provided; number of trainings
9. Track grant and contract requirements	ongoing	Executive Director/HD Division Director	All grantees and contractors compliant
10. Collaborate with local groups to ensure compliance with local and state laws	ongoing	Executive Director/ Attorney General/Local Coordinators/HD Division Director	Number of violations
11. Promote state and local chronic disease collaborations	ongoing	Executive Director/HD Division Director/Local Coordinators	Number of collaborations
<b>Objective 3:</b>			
<b>By June 2010, implement a tobacco prevention and control health communication initiative that delivers strategic, culturally appropriate and high-impact earned and paid messages in sustained and adequately funded campaigns integrated into the overall comprehensive North Dakota Tobacco Prevention and Control Program.</b>			
<b>Strategies/Action Steps</b>	<b>Timeframe</b>	<b>Lead/Partners</b>	<b>Measure of Success</b>
1. Maintain support from local public health units and other partners	ongoing	Advisory Committee	Local public health units and partners support health communication initiative Center provides updates and training materials at training and regular meetings, on website
2. Continue consulting with Expert Panel in implementing the Health Communications Plan	ongoing	Advisory Committee	Expert Panel regularly consulted PETF meets monthly

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3. Educate policymakers and the public	ongoing	Advisory Committee	Number of campaigns and promotions 9.2010 – 6.2011 – health communications campaigns running most month according to 10-month plan
4. Enhance capacity to develop campaigns	ongoing	Executive Director/ Executive Committee	Increased funding, staff and contractors
5. Prepare and release RFP(s) for health communications contractor(s)	9.2010	Executive Director	RFP(s) released 9.2010 – RFP released
6. Review submitted proposals	10.2010	Executive Director/Health Communications Team	RFP(s) reviewed 10-12.2010 – applicants reviewed
7. Select health communications contractor(s)	10.2010	Executive Director/ Executive Committee	Contractor(s) selected
8. Create and implement a Media Plan, including conducting market and audience research, and message testing	12.2010	Executive Director/Health Communications Team	Media Plan in place 8.2010 – 10-month campaign approved and implemented
9. Develop components of promotional plans.	12.2010	Executive Director/Health Communications Team	Promotional plans developed 8.2010 – 10-month plan implemented
10. Investigate new technologies.	ongoing	Executive Director/Health Communications Team	Report on new technologies prepared 8.2010 – 10-month plan includes social networking and website technologies
11. Construct a Center website	ongoing	Executive Director/Health Communications Team	Website live 8.2010 --- website live
12. Monitor pro-tobacco influences	1.2011	Executive Director/Health Communications Team/HD Division Director	Information collected and reported ongoing
13. Coordinate and mesh with local activities.	ongoing	Executive Director /Health Communications Team	State and local activities integrated

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14. Develop a Health Communications evaluation plan.	12.2010	Executive Director /Health Communications Team	Evaluation plan in place
<b>Objective 4: By January 2010, develop a comprehensive statewide surveillance and evaluation plan for the comprehensive North Dakota Tobacco Prevention and Control Program.</b>			
<b>Strategies/Action Steps</b>	<b>Timeframe</b>	<b>Lead/Partners</b>	<b>Measure of Success</b>
1. Establish a Surveillance and Evaluation Advisory Committee	9.2010	Executive Director/HD Division Director	Advisory Committee in place
2. Engage new stakeholders	ongoing	Executive Director /HD Division Director	New stakeholders actively engaged
3. Review key process and outcome indicators to be measured	2.2011	Executive Director /HD Division Director/ Expert Panel	Indicators reviewed and modified, if indicated
4. Review evaluation plan	2.2011	Executive Director / Expert Panel/HD Division Director	Evaluation plan reviewed and modified, if indicated 7-11.2010 – evaluation plan developed and finalized.
5. Review current data collection instruments to determine whether further data are needed	ongoing	Executive Director/ Expert Panel/HD Division Director	Data collection instruments reviewed and modified, if indicated 7-11.2010 – review as part of evaluation plan
6. Create and maintain a current inventory of data collected by public and private agencies	ongoing	Executive Director /HD Division Director	Current data inventory available
7. Disseminate data regularly	ongoing	Executive Director /HD Division Director	Data regularly disseminated
8. Prepare and release RFP(s) for independent evaluator(s)	8.2010	Executive Director/ Expert Panel/ Executive Committee	RFPs prepared and released
9. Select Review Panel to review RFPs	8.2010	Executive Committee	Review Panel selected
10. Review submitted proposals	9.2010	Review Panel/	Review completed



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		Executive Committee	
11. Select independent evaluator(s)	9.2010	Executive Committee	Independent evaluator(s) selected
<b>Objective 5:</b>			
<b>By June 2014 sustain North Dakota’s comprehensive tobacco prevention and control program in conformance with current CDC recommendations.</b>			
<b>Strategies/Action Steps</b>	<b>Timeframe</b>	<b>Lead/Partners</b>	<b>Measure of Success</b>
1. Develop and implement a Sustainability Plan	7.2010	Executive Director/Health Communications Team/ Executive Committee/HD Division Director	Sustainability Plan being implemented 7.2010 – sustainability plan developed and implementation ongoing
2. Review <i>Savings Live –Saving Money</i> and amend as needed	ongoing	Executive Director /HD Division Director/ Executive Committee	<i>Savings Lives–Saving Money</i> reviewed
3. Review and modify, if indicated, the comprehensive evidence-based tobacco prevention and control program	ongoing	Executive Director /HD Division Director/ Executive Committee	Comprehensive program reviewed and modified, if indicated
4. Prepare 2011-2012 Action Plan	5.2011	Executive Director /HD Division Director/ Executive Committee	Action Plan prepared
5. Educate public and policymakers about the health and economic benefits of reducing tobacco use	ongoing	Executive Director/ Executive Committee/ Health Communications Team/Local Coordinators	Number of campaigns; number of meetings; number of presentations 8.2010 – 10-month health communications plan includes ongoing education campaigns
6. Report on program’s achievements	ongoing	Executive Director/ Executive Committee/ HD Division Director/Health Communications Team	Number of reports; number of presentations; number of media stories ___ of news releases issued.

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\*The purpose for identifying the lead/partners is to maximize cost effectiveness and avoid duplication.  
Partners may include but not be limited to: ALA, ACS, NDMA, NDSRC, NDNA, MOD, NDEA, DoH

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<b>Goal 1 (G1): Prevent the Initiation of Tobacco Use Among Youth and Young Adults</b>			
<b>G1 Objective 1: (Also G3:Obj1): By June 2013, increase the cigarette excise tax by \$1.56 per pack and increase the excise tax on other tobacco products by an equal and proportional amount.</b>			
<b>Activities</b>	<b>Timeline</b>	<b>Responsible Parties**</b>	<b>Process Outcomes</b>
1. Develop Center's <i>Advisory Team for Tobacco Tax</i> .	Q2	All partners	
2. Develop a policy plan to achieve the tobacco tax increase.	Q2	Advisory Team for Tobacco Tax	
3. Monitor interim legislative actions and health care reform for tax increase opportunities.	Ongoing (or at least quarterly)	All partners	
4. Develop standardized messages for agenda setting appropriate to policy timelines.	Q2	All partners	
<b>G1 Objective 2: Statewide SF Law: See G2:Obj1</b>			
<b>G1 Objective 3: Local SF Ordinances: See G2:Obj2</b>			
<b>G1 Objective 4: By June 2013, increase the percentage of school districts with a comprehensive tobacco-free school policy to 50 percent.</b>			
<b>Activities</b>	<b>Timeline</b>	<b>Responsible Parties*</b>	<b>Process Outcomes</b>
1. Continue meeting with Coordinated School Health Core Team and/or the Department of Public Instruction on tobacco-free policies.	Ongoing	Center, NDDoH	
2. Secure continued endorsement of the North Dakota School Boards Association for a strong model policy.	Q1	Center, NDDoH	
3. Ensure local boards of health support encouraging all schools to adopt or maintain comprehensive tobacco-free policies.	Q1	Grantees	
4. Develop a list of steps grantees should take to help schools adopt	Q2	Center	

tobacco-free policies.			
5. Provide training and technical assistance to grantees.	Q3	Center	
6. Assess school districts on tobacco-free policies and report to Center and Legislature.	Quarterly	Center, Grantees	
7. Promote the adoption of comprehensive tobacco-free policy in school districts.	Ongoing	Grantees	
8. Submit abstract and present at NDSBA annual convention if abstract accepted	October, 2011	Center	
<b>G1 Objective 5: By December 2013, increase the number of public and private post-secondary institutions with tobacco-free campuses to thirteen.</b>			
<b>Activities</b>	<b>Timeline</b>	<b>Responsible Parties*</b>	<b>Process Outcomes</b>
1. Develop a communications strategy to highlight tobacco-free campus success.	Q3	Center	
2. Identify at least one campus to become tobacco-free in FY 2012.	Q1	Grantees	
3. Develop a toolkit for post-secondary trade and technical institutions.	Q3	Center	
4. Provide technical assistance to grantees working with post-secondary institutions.	Ongoing	Center	
5. Organize and train campus communities in enactment and enforcement of tobacco-free policy.	Ongoing	Grantees	
6. Maintain/update campus tobacco policy database.	Ongoing	Center	

<b>Goal 2 (G2): Eliminate Exposure to Secondhand Smoke</b>			
<b>G2 Objective 1: (Also G1:Obj 2 &amp; G3:Obj 2) By June 2013, amend the North Dakota Smoke-Free Law to implement 100 percent smoke-free public places and places of employment and to expand enforcement of the law.</b>			
<b>Activities</b>	<b>Timeline</b>	<b>Responsible Parties*</b>	<b>Process Outcomes</b>
1. Post survey findings of community support for local smoke-free ordinances on Center website.	Q1	Center	
2. Report data on statewide attitudes for smoke-free initiatives.	Q4	Center	
3. Plan for survey of legislators and candidates on smoke-free issues.	Periodically	All partners	
4. Identify timeline of potential local ordinances to plan for state smoke-free environments law.	Q1	All partners	
5. Review evidence base and update fact sheets and policy documents.	Q4	Center, TFND	
6. Train local coalitions and community partners on advancing statewide smoke-free policy.	Q4	All partners	
7. Educate the public and policymakers, including local boards of health, on smoke-free environment issues.	Ongoing	All partners	
8. Secure support from all local boards of health.	Ongoing	Grantees	
9. Develop innovative approaches to grassroots organizing for educating policymakers on smoke-free policies.	Ongoing	Center, Grantees	
10. Develop protocols for communication and decision making with partners.	Q4	All partners	
11. Monitor and track progress toward	Ongoing	All partners	

protecting 50% of ND population with local smoke-free laws.			
<b>G2 Objective 2: (Also G1:Obj3 &amp; G3:Obj 3) By June 2012, increase to eight the number of communities that have enacted local ordinances for 100 percent smoke-free public places and places of employment.</b>			
<b>Activities</b>	<b>Timeline</b>	<b>Responsible Parties*</b>	<b>Process Outcomes</b>
1. Develop a smoke-free ordinance tool kit that includes a step-by-step process and standard survey questions.	Q2	Center	
2. Develop local policy timeline.	Q1	All partners	
3. Coordinate local campaigns throughout state.	Ongoing	Center	
4. Sponsor policy trainings.	Ongoing	Center	
5. Educate public and policymakers, including local boards of health.	Ongoing	All partners	
6. Conduct valid and reliable surveys/polls with standardized core questions to monitor public support and provide comparisons.	Ongoing	All partners	
7. Develop tools and provide technical assistance to local coalitions (e.g. standardized readiness assessment, engaging partners, policy plan, model ordinance language to assure passage and enforcement of local policies).	Ongoing	All partners	
8. Evaluate and report the impacts of policies.	Q2 Grand Forks Q4 Bismarck	All partners	
9. Update local ordinance database.	Ongoing	Center	
10. Conduct statewide randomized air quality study.	Q3	Center	
<b>G2 Objective 3: By June 2013, Prevent preemption (higher levels of government can prohibit lower levels of government from enacting certain laws or regulations) in all state tobacco prevention and control laws.</b>			
<b>Activities</b>	<b>Timeline</b>	<b>Responsible Parties*</b>	<b>Process Outcomes</b>

1. Re-institute pre-emption work group for local and state level policies (includes educational materials) to develop a plan (engaging, training, tracking).	Q4	All partners	
2. Pre-emption work group develops plan to: a) engage local coalitions to gather local resolutions opposing preemption, b) train local coalitions on pre-emption (including referenda), and c) establish tracking protocol.	Q4	All partners	

<b>Goal 3 (G3): Promote Quitting Tobacco Use</b>			
<b>G3 Objective 1: Increase excise tax: See G1:Obj1</b>			
<b>G3 Objective 2: Statewide smoke-free law: See G2:Obj 1; Also G1:Obj2</b>			
<b>G3 Objective 3: Local smoke-free polices: See G2:Obj 2; Also G1:Obj3</b>			
<b>G3 Objective 4: By 2014, increase annual use of the North Dakota Tobacco Quitline (Q-line) and North Dakota QuitNet (Net) to a minimum of 2 percent of all smokers and smokeless tobacco users.</b>			
<b>Activities</b>	<b>Timeline</b>	<b>Responsible Parties*</b>	<b>Process Outcomes</b>
1. Analyze Q-line & Net utilization, etc.	Ongoing	NDDoH	
2. Review Q-line & Net protocols.	Ongoing	NDDoH	
3. Establish Q-line & Net as key sources of cessation support.	Ongoing	NDDoH, Grantees	
4. Explore electronic referral systems.	Ongoing	NDDoH	
5. Increase fax referrals to Q-line.	Ongoing	NDDoH, Grantees, Healthcare Providers	
6. Expand promotion of Q-line & Net.	Ongoing	NDDoH, Grantees	
7. Provide uninsured and underinsured tobacco users with up to a 56 day supply of an NRT regimen through Q-line & Net.	Ongoing	NDDoH,	
8. Provide NRT to supplement the 56-day regimen or to assist individuals with special needs on a case-by-case basis through LPHUs.	Ongoing	Center, grantees	
9. Maintain ND Tobacco Q-line Consortium**.	Ongoing	NDDoH	
10. Encourage health care providers, other health, mental health, substance abuse, and social service providers and businesses to promote the Q-line & Net.	Ongoing	NDDoH, Center, Grantees	
11. Select evaluator for Q-line & Net	Ongoing	NDDoH	



services.			
12. Develop the Q-line & Net evaluation plan.	Ongoing	NDDoH	
13. Prepare and release RFP(s) for independent evaluator(s) for Q-line & Net.	Ongoing	NDDoH	
14. Select Review Panel to review RFPs for Q-line & Net evaluation.	Ongoing	NDDoH	
15. Review submitted proposals for Q-line & Net evaluation.	Ongoing	NDDoH	
16. Select independent evaluator(s) for Q-line & Net.	Ongoing	NDDoH	
17. Update the matrix of existing cessation benefits.	Ongoing	NDDoH	
<b>G3 Objective 5A: By 2014, incorporate the systems approach to tobacco treatment recommended in the U.S. Public Health Service <i>Treating Tobacco Use and Dependence, Clinical Practice Guideline – 2008 Update</i> in the 28 local public health units .</b>			
<b>Activities</b>	<b>Timeline</b>	<b>Responsible Parties*</b>	<b>Process Outcomes</b>
1. Hire or contract for services to provide TA, training, and tools for implementation of PH Service Guidelines in LPHU service areas.	Q2	Center	
2. Work as needed with ad hoc committees of local public health unit personnel on PHS Guidelines implementation in local public health units.	Ongoing	Center, Grantees, NDDoH	
3. Provide funding to all LPHUs to continue implementation of a systems approach in local public health unit service areas.	Ongoing	Center	
4. Continue to work with Department of Health to implement a systems approach in large healthcare systems as	Ongoing	Center, Grantees, NDDoH	

resources allow.			
5. Conduct annual audit of AAR in local public health units.	Q4	Center	
6. Track adoption of tobacco-free buildings and grounds policies in LPHUs and healthcare systems.	Quarterly	Center, Grantees, NDDoH	
7. Develop a tool to track private healthcare system implementation of the <i>Guideline's</i> AAR (Ask, Advise, Refer) recommendations.	Quarterly	NDDoH	
8. Track implementation of the <i>Guideline's</i> AAR recommendations in LPHUs and large healthcare systems.	Ongoing	Center, Grantees, NDDoH	
9. Request and track health care provider resolutions of support for key policy issues in <i>Saving Lives-Saving Money</i> .	Q1	Center, Grantees	
10. Begin exploring the incorporation of treating tobacco use and dependence into nursing curricula.	Q4	Center	
<b>G3 Objective 5B: By 2014, incorporate the systems approach to tobacco treatment recommended in the U.S. Public Health Service <i>Treating Tobacco Use and Dependence, Clinical Practice Guideline – 2008 Update</i> in healthcare systems.</b>			
1. Hire or contract for services to provide TA, training, and tools for implementation of PH Service Guidelines in healthcare systems as resources allow.	Ongoing	NDDoH	
2. Maintain Cessation Committee to develop guidelines and procedures.	Ongoing	Grantees, NDDoH	
3. Continue to implement a systems approach in healthcare systems.	Ongoing	NDDoH	
4. Track adoption of tobacco-free buildings and grounds policies in	Quarterly	Center, Grantees, NDDoH	

healthcare systems.			
5. Develop a tool to track private healthcare system implementation of the <i>Guideline's</i> AAR (Ask, Advise, Refer) recommendations.	Q1	NDDoH	
6. Track implementation of the <i>Guideline's</i> AAR recommendations in large healthcare systems.	Ongoing	Center, Grantees, NDDoH	
<b>G3 Objective 6: By June 2013, increase to a minimum of three the number of North Dakota's largest employers who cover tobacco cessation medications and services in their employee health benefits plan(s).</b>			
<b>Activities</b>	<b>Timeline</b>	<b>Responsible Parties*</b>	<b>Process Outcomes</b>
1. Assess feasibility of addressing objective 6, which likely will be addressed by changes resulting from the Affordable Care Act.	Q2	Center, NDDoH	
<b>G3 Objective 7: By June 2013, maintain the current nine and increase by a minimum of one the number of third party payers that include tobacco cessation medications and services as a standard health benefit.</b>			
<b>Activities</b>	<b>Timeline</b>	<b>Responsible Parties*</b>	<b>Process Outcomes</b>
1. Assess feasibility of addressing objective 7, which likely will be addressed by changes resulting from the Affordable Care Act.	Q2	Center, NDDoH	
<b>G3 Objective 8: By 2014, address nicotine dependence in addiction treatment programs, in mental health treatment programs and in dual diagnosis treatment programs.</b>			
<b>Activities</b>	<b>Timeline</b>	<b>Responsible Parties*</b>	<b>Process Outcomes</b>
1. Continue assessment of tobacco-free campuses.	Ongoing	Center, NDDoH, Grantees	
2. Educate directors and clinicians through statewide and local conferences and meetings.	Ongoing	Center, NDDoH, Grantees	

<b>Goal 4 (G4): Build Capacity/Infrastructure to Implement a Comprehensive Evidence-based Tobacco Prevention/Control Program</b>			
<b>G4 Objective 1: Throughout FY 2012, sustain and enhance a fully functional administrative structure to manage the comprehensive North Dakota Tobacco Prevention and Control Program.</b>			
<b>Activities</b>	<b>Timeline</b>	<b>Responsible Parties*</b>	<b>Process Outcomes</b>
1. Prepare the biennial comprehensive program budget according to CDC Best Practice percentages.	Q1	Center, NDDOH	
2. Enhance real-time fiscal management system.	Ongoing	Center	
3. Develop and implement optimum personnel plan, including staff positions and contractors, to carry out the comprehensive program.	Q1	Center, NDDoH	
4. Review and modify, if indicated, grant allocation guidelines.	Q2	Center	
5. Train and provide technical assistance to grantees, contractors, and community partners.	Quarterly and ongoing	Center, NDDoH, Grantees	
6. Continue to integrate <i>Savings Lives–Saving Money</i> with other chronic disease programs’ plans.	Ongoing	NDDoH, Partners, Grantees	
7. Improve advocacy capacity by continuing to engage Tobacco Free North Dakota, other state coalitions and other allied organizations in <i>Savings Lives–Saving Money</i> implementation.	Ongoing	All partners	
8. Enhance grantees’ and contractors’ reporting mechanisms and accountability standards.	Q1	Center, NDDoH	
9. Continue to implement Communications Plan.	Ongoing	All partners	

10. Continue review and implementation of the Disparities Plan.	Ongoing	NDDoH	
11. Update state and local policy databases.	Ongoing	Center, NDDoH, Grantees	
<b>G4 Objective 2: Throughout FY 2012, maintain local infrastructure and capacity to collaboratively deliver evidence-based tobacco prevention and control interventions recommended in <i>Best Practices</i> and <i>The Guide to Community Preventive Services: Tobacco Use Prevention and Control</i> to reach all local public health units, four reservations and one Indian Health Service (IHS) area.</b>			
<b>Activities</b>	<b>Timeline</b>	<b>Responsible Parties*</b>	<b>Process Outcomes</b>
1. Evaluate funding allocation/formula(s) for disbursing grants to local public health units, tribes and community partnerships.	Q1	Center, NDDoH	
2. Assure adequate staff and consultants to carry out local comprehensive programs.	Ongoing	Center, NDDoH	
3. Develop annual training plan for grantees, partners, staff and Advisory Committee.	Q1	Center, NDDoH	
4. Develop trainings (e.g. Tobacco 101, Coalition Building, Effective Outreach and Advocacy in Small Communities).	Ongoing	Center	
5. Provide technical assistance to grantees.	Ongoing	Center, NDDoH	
6. Facilitate and coordinate local grassroots activities to support state efforts.	Ongoing	All partners	
7. Strengthen and develop local coalitions.	Ongoing	Grantees	
8. Educate policymakers, including local boards of health, and public about need for comprehensive tobacco prevention and control programs.	Ongoing	Grantees	

9. Monitor grantee and contractor work plan activities.	Ongoing	Center, NDDoH	
10. Collaborate with local law enforcement to ensure compliance with local and state smoke-free laws.	Ongoing	Grantees	
<b>G4 Objective 3: Throughout FY 2012, implement a tobacco prevention and control health communication initiative that delivers strategic, culturally appropriate and high-impact earned and paid messages in sustained and adequately funded campaigns integrated into the overall comprehensive North Dakota Tobacco Prevention and Control Program.</b>			
<b>Activities</b>	<b>Timeline</b>	<b>Responsible Parties*</b>	<b>Process Outcomes</b>
1. Maintain support from local public health units and other partners.	Q1	Center, Grantees	
2. Educate policymakers and the public on health, SHS, cost of tobacco, root causes of tobacco epidemic.	Ongoing	Center, Grantees	
3. Implement an annual health communication plan.	Ongoing	Center	
4. Develop a plan to monitor pro-tobacco influences: e.g. number of lobbyists, FTC report for ND, front groups, etc.	Ongoing	Center, NDDoH	
5. Update health communication standards.	Q1	Center	
6. Enhance the Health Communications evaluation component of the Center's evaluation.	Q2	Center	
7. Explore hosting a biennial statewide summit/conference to educate and communicate with stakeholders.	Q2	All partners	
<b>G4 Objective 4: Ongoing through FY2012, implement the evaluation plan, which includes a plan for statewide surveillance.</b>			
<b>Activities</b>	<b>Timeline</b>	<b>Responsible Parties*</b>	<b>Process Outcomes</b>
1. Contract/hire evaluation coordinator.	Q1	Center	

2. Explore establishment of an evaluation advisory committee.	Q1	Center	
3. Review surveillance and evaluation plan and update as necessary.	Q2	Center, NDDOH	
4. Review current data collection instruments to determine whether additional data are needed.	Ongoing	Center, NDDoH	
5. Create and maintain a current inventory of data collected by public and private agencies.	Ongoing	Center, NDDoH	
6. Post and disseminate data as appropriate.	Ongoing	All partners	
7. Work with independent evaluator to evaluate comprehensive program.	Ongoing	Center, NDDoH	
<b>G4 Objective 5: By June 2014, sustain North Dakota's comprehensive tobacco prevention and control program in conformance with current CDC recommendations.</b>			
<b>Activities</b>	<b>Timeline</b>	<b>Responsible Parties*</b>	<b>Process Outcomes</b>
1. Review and update Sustainability Plan.	Q4	All partners	
2. Conduct a midcourse review of <i>Saving Lives –Saving Money</i> and amend as needed.	Q3	All partners	
3. Review and modify the comprehensive evidence-based tobacco prevention and control program based on the evaluation.	Q3	All partners	
4. Prepare 2012-2013 Work Plan.	Q4	All partners	

5. Engage the Advisory Committee members to advocate for the comprehensive program, including adequate staffing, by providing annual reports to the organizations they represent and securing supportive resolutions.	Q2	Center	
6. Update all resolutions from partners to support the comprehensive program (funding, SHS, tax, cessation).	Q4	All partners	
7. Report on program's achievements.	Ongoing	All partners	

\*\*“All Partners” may include but not be limited to: Center for Tobacco Prevention and Control Policy, ND Department of Health, American Lung Association, American Cancer Society, ND Medical Association, ND Society for Respiratory Care, ND Nurses Association, March of Dimes, ND Education Association, Americans for Nonsmokers’ Rights, Campaign for Tobacco Free Kids.

\*\* “Center” indicates the responsible party is the Executive Director of the ND Center for Tobacco Prevention and Control Policy or her designee, including staff and/or contractors.

\*\* “NDDoH” indicates the responsible party is the Chronic Disease Division Director of the ND Department of Health or her designee.

\*\* “ND Tobacco Q-line Consortium” is a committee with the purpose of promoting quitting among adults and young people, leveraging resources to maximize Quitline services and coordinating cessation services across the state to offer consistency/stability as well as increase efficiency and effectiveness.