Division of Public Health Agreement Addendum FY 16–17

	Chronic Disease & Injury, Tobacco Prevention and Control
Local Health Department Legal Name	**DPH Section/Branch Name**
451 Tobacco Prevention - CDC Core Grant	Felicia Snipes Dixon (919) 707-5416 Felicia.Snipes-Dixon@dhhs.nc.gov
Activity Number and Description	**DPH Program Contact** (name, telephone number with area code, and email)
06/01/2016 – 05/31/2017	
Service Period	**DPH Program Signature** **Date** (only required for a negotiable agreement addendum)
07/01/2016 – 06/30/2017	
Payment Period	

☒ **Original Agreement Addendum**
☐ **Agreement Addendum Revision #** ___ (Please do not put the Budgetary Estimate revision # here.)

I. Background:

The Tobacco Prevention and Control Branch (TPCB) collaborates with and builds capacity of partners, including state and local agencies, local health departments and community organizations, to plan and implement culturally appropriate evidence-based strategies to reduce deaths and health problems due to tobacco use and secondhand smoke (SHS). TPCB's four major goal areas are to: 1) Prevent initiation of tobacco use among youth and young adults, 2) Eliminate exposure to SHS, 3) Promote tobacco use cessation among adults and youth, and 4) Identify and eliminate tobacco-related disparities.

Tobacco use remains the number one preventable cause of early death and disease in North Carolina. Smoking is responsible for 14,200 deaths per year – 1 of every 5 deaths in North Carolina – and is a major risk factor for the leading causes of premature death. For each death, 30 more people are sick or disabled because of tobacco use. North Carolina is ranked 29th for cigarette smoking and 36th for smokeless tobacco use among the states (where being ranked 1st is best). North Carolina's direct medical costs from smoking are $3.81 billion each year and the estimated annual health care costs from SHS are $293 million. According to the 2014 US Surgeon General's Report, tobacco product marketing sustains the tobacco epidemic with nearly a million dollars an hour being spent to market this addictive product. While cigarette smoking has declined among North Carolina's young people from 15.5% of high school students in 2011 to 13.5% in 2013, all tobacco use increased dramatically from 25.8% of high school students in 2011 to 29.7% in 2013 due to the use of emerging tobacco products, including electronic cigarettes (Youth Tobacco Survey, 2013). This service is necessary in order to implement evidence-based strategies in each of the 10 Regions to reduce the burden of tobacco use across the state.

Health Director Signature (use blue ink) Date

Local Health Department to complete: (If follow-up information is needed by DPH)	LHD program contact name: ____ Phone number with area code: ____ Email address: ____

Signature on this page signifies you have read and accepted all pages of this document.

II. Purpose:

The purpose of this Agreement Addendum is to provide funding to each of the 10 North Carolina Association of Local Health Directors (NCALHD) Regions of the state, which cover all 100 counties, in order to implement activities in each region based on TPCB's goals.

Each region will be led by a core Regional Tobacco-Free Leadership Team (Regional Leadership Team) of Local Health Directors, a full-time Regional Tobacco Control Manager (Regional Manager), and community partner advisors as identified. The Regional Leadership Team and Regional Managers will coordinate with diverse representatives from key community organizations to develop a more extensive network called a Regional Tobacco-Free Collaborative (Regional Collaborative) including partners representing the various sectors and disparate populations. The budget for the Local Health Department is based on availability of funds from the Centers for Disease Control and Prevention (CDC) and are subject to change. TPCB will measure the following long-term outcomes and work on annual objectives to evaluate achievement of the four major goals:

- Decreased initiation of tobacco use among youth and young adults
  - Increase the number of community colleges and independent colleges and universities with a 100% tobacco-free campus from 49 (52%) to 60 (63%). (Note as of March 2015, Community Colleges' baseline is 35 and independent colleges' baseline is 14)
  - Decrease the percentage of high school students who report never having tried a cigarette but are susceptible to its use from 23.1% to 19%
- Eliminate exposure to secondhand smoke
  - Increase the number of counties and municipalities that advance 100% smoke-free or tobacco-free policies where there is local government authority to regulate smoking and tobacco use.
  - Decrease the percentage of population exposed to secondhand smoke drifting into the home in multi-unit housing from 11.7 to 9.0.
  - Increase the number of presentations to educate and inform decision-makers and the public on smoke-free or tobacco-free polices from 20 to 40.
- Decreased tobacco use among adults and youth
  - Increase percentage of N.C. tobacco users who register in QuitlineNC from 1 % to 1.2%
  - Increase % of adult smokers who have been assisted in quitting by a healthcare professional from 42.7% to 45%
  - Increase the number of insurance purchasers and payers that reimburse for tobacco cessation services from 2 to 5.
- Identify and eliminate tobacco-related disparities
  - Use surveillance and performance data to Identify populations and geographic areas disproportionately affected by tobacco use and assess progress towards program objectives and make key programmatic quality improvements

III. Scope of Work and Deliverables:

The target populations for this Agreement Addendum are groups at risk for and disproportionately affected by tobacco use and secondhand smoke exposure, and the decision makers that can support evidence-based policies, systems and programs. In addition, activities related to maintenance and messaging for compliance with statewide laws including North Carolina's Smoke-Free Restaurants and Bars Law affect the entire population of the state.

The interventions focus is predicated on evidence-based strategies as documented by CDC's *Best Practices for Comprehensive Tobacco Control Programs 2014,* http://www.cdc.gov/tobacco/stateandcommunity/best_practices/pdfs/2014/comprehensive.pdf, *The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General, 2014,* http://www.surgeongeneral.gov/library/reports/50-years-of-progress/full-report.pdf, and *The Guide to Community Preventive Services (The Community Guide)*, www.thecommunityguide.org/index.html.

The Local Health Department shall:

1. **Provide staffing by hiring a Regional Tobacco Control Manager:**
   Each region shall maintain a qualified full-time Regional Tobacco Control Manager (Regional Manager) by June 1, 2016 and inform TPCB staff about any changes in staffing. The Regional Manager shall provide expert leadership, technical assistance, and guidance to counties in the region on evidence-based tobacco control strategies. The Regional Manager shall provide technical assistance through training, facilitation and coaching within the region that works to advance policy change and helps counties develop community partnerships, plan health communications programs/interventions, evaluate progress and promote health equity. TPCB will provide training and assistance to the Regional Manager through in-person meetings and regular conference calls in order to build their capacity to support the region.

2. **Maintain a Regional Tobacco-Free Leadership Team:**
   Each region will be led by a Regional Tobacco-Free Leadership Team (Regional Leadership Team), comprised of Local Health Directors from each county in the region, two to three identified community partner advisors, and facilitated by the full-time Regional Tobacco Control Manager. The Regional Leadership Team will communicate monthly via in-person meetings, conference calls and/or email correspondence in order to guide the process of accomplishing the tobacco control program goals of the region.

   The Regional Leadership Team's work involves assessing needs, opportunities and gaps in order to set tobacco control priorities, creating a plan of action, and evaluating progress. The Local Health Department and Regional Leadership Team will demonstrate leadership by educating the Regional Collaborative, partners, and decision-makers on the benefits of evidence-based tobacco control policies and programs at the local and regional level in coordination with the TPCB staff and Healthy Communities Grantees. Specifically, the Regional Leadership Team will engage stakeholders for effective implementation of tobacco-free or smoke-free regulations wherever the law allows, including local government buildings, indoor public places (defined as an enclosed area to which the public is invited or permitted), local government grounds including parks and recreational facilities, schools, colleges, community colleges, multi-unit housing, mental health/substance abuse facilities, workplaces, restaurants, and bars.

3. **Continue to develop and foster a Regional Tobacco-Free Collaborative including membership representing vulnerable populations:**
   The Regional Leadership Team and Regional Manager will coordinate with representatives from diverse community organizations to develop a Regional Tobacco-Free Collaborative (Regional Collaborative). The Regional Collaborative shall meet on a quarterly basis either in-person or via conference calls. State staff will support the region with training, technical assistance and monitoring. The Regional Manager will work with and through Regional Collaborative partners to develop and execute the annual action plan and build networked partnerships. Each Regional Manager must build the capacity of the Regional Leadership Team and Regional Collaborative to educate on the benefits of evidence-based policies and provide successful implementation. The Regional Collaborative will work in collaboration with TPCB staff to actively practice the

Component Model of Infrastructure (CMI), http://www.cdc.gov/tobacco/stateandcommunity/best_practices/pdfs/2014/sectionA-V.pdf, and its interrelated core components in order to enhance capacity.

The Local Health Department must develop a plan to engage priority populations (e.g., racial / ethnic populations, those living in under-resourced and low-income communities) in the planning, implementation and / or evaluation of at least one strategy within the Regional Collaborative to build support for evidence-based program and policy implementation in the communities served. The plan should include a diverse list of the partners with the members' names, addresses, e-mail addresses, telephone numbers and organizational affiliations as a required deliverable. The partner list must be sent to the TPCB Director of Local Program Development and Regulations by September 1, 2016. The Local Health Department should seek multilevel leadership and networked partners from:

a. Voluntary health agencies and advocacy groups with interests in tobacco control
b. Organizations and community groups representing vulnerable populations to reflect the demographics of the counties and those at higher risk of tobacco use including persons with low-income, less educated, males, adults between the ages of 18-24, African Americans, American Indians, persons with mental illness, substance abuse and/or disability issues, lesbian, gay, bisexual and transgender (LGBT) populations, and pregnant women
c. Survivors and others with personal stories to tell about the health hazards of tobacco use and secondhand tobacco smoke
d. Youth empowerment organizations and youth leaders
e. Boards of Health and / or Human Services Boards, County Commissioners and Municipalities
f. The business sector including Chambers of Commerce, hospitality, tourism, housing, retail, especially blue collar businesses and service industry businesses
g. Public housing authorities, affordable housing management of multi-unit housing, and residents of multi-unit housing
h. School Board and/or School System including youth volunteers
i. Colleges, universities and community colleges
j. Public venues and recreational facilities
k. Health systems serving the community
l. Medical societies, dental society, mental health/substance abuse services, and other health and behavioral health care professional organizations
m. Faith communities
n. Local Health Department management

4. **Develop and implement a Tobacco Prevention and Control Annual Action Plan:**
The Local Health Department will complete a first draft of the Fiscal Year 2015–2016 annual action plan by June 30, 2016. TPCB staff will review the annual action plan and provide recommendations so that a final version can be submitted by August 30, 2016.

The annual action plan shall detail the "who, what, when, where, and how" of program activities designed to advance toward program objectives and program goals. It includes long-term, intermediate, short-term, and annual objectives, which are specific, measurable, achievable, relevant, and time-bound (SMART). For each of the four goal areas (1) Eliminate exposure to SHS, 2) Promote tobacco use cessation among adults and youth, 3) Prevent initiation of tobacco use among youth and young adults, and 4) Identify and eliminate tobacco-related disparities) in the Tobacco Prevention and Control Annual Action Plan, the plan shall indicate key activities that are

likely to move the Region closer to meeting the objectives. For each activity, the Local Health Department's Regional Manager shall include the target population, lead role, partners, timeline, and anticipated output.

TPCB will email the annual action plan template to the Local Health Department's Regional Tobacco Control Manager. This plan template must be completed to fulfill this requirement for both the Fiscal Year 2016-2017 and the 2017-2018 plans.

The first draft of the Fiscal Year 2017–2018 annual action plan is due to the TPCB Director of Local Program Development and Regulations by April 30, 2017. TPCB staff will review the annual action plan and provide recommendations so that a final version can be submitted by June 30, 2017. Annual action plans are subject to change based on legislative decisions and can be modified by the Regional Manager during quarterly reviews with approval from TPCB staff.

5. **Update the completed assessment of the current tobacco control environment in place throughout the region** by using environmental scans, local policy data provided by TPCB, gap analysis, local media/opinion coverage of tobacco control issues and key informant interviews with networked partners. Using the 2015-2016 County Profiles completed, the assessment data should be updated to include:
   a. Evidence of smoke-free/tobacco-free regulations in place for government buildings, grounds and public places and gaps.
   b. Evidence of smoke-free/tobacco-free policies in place for colleges and community colleges and gaps.
   c. Evidence of smoke-free/tobacco-free policies in place for mental health and substance abuse facilities and campuses and gaps.
   d. Evidence of smoke-free/tobacco-free policies in place for public housing and assistance provided to public housing authorities to implement HUD's smoke-free public housing rule.
   e. Evidence of smoke-free/tobacco-free policies in place for affordable housing and gaps.
   f. Evidence of Quitline utilization from the counties in the Region.
   g. Qualitative data gathering on drivers and barriers of evidence-based tobacco control policy, systems and environmental change through elements of key informant interviews, listening sessions, and photovoice to engage community members in capturing and captioning photos taken in their community that illustrate the need for tobacco control and help develop culturally appropriate health communication messages.
   h. Point-of-Sale Assessment Activities to investigate the tobacco retail environment in local communities. If the Local Health Department chooses to participate in Point-of-Sale Assessment activities, the data assessment should include STARS / Counter Tools (as available) Point-of-Sale Assessment Activities to assess the tobacco retail environment in the identified community.
   i. Community audience segmentation data of how tobacco and SHS risk and SHS solutions are covered by the news, opinion and social media in each Region and/or Designated Market Area.

6. **Ensure that activities described in the annual action plan address evidence-based policy, systems and environmental changes supporting tobacco free norms**. Potential examples of these activities include:
   a. Promoting smoke-free/tobacco-free environments for:
      i. government buildings, government grounds/parks, and indoor public places;
      ii. community colleges, universities and colleges;
      iii. public and affordable housing (activities will be designed to support HUD's pending rule on smoke-free public housing authorities);

iv. local mental health and substance abuse treatment facility campuses;
v. restaurants and bars (voluntary polices including smoke-free outdoor dining areas and prohibiting the use of e-cigarettes).

b. Working with State and local partners to maintain support for the North Carolina Smoke-Free Restaurants and Bars Law and preserve the authority granted to local governments to regulate smoking
c. Working with groups that empower youth leaders across North Carolina to educate and inform peers, the public and decision-makers about the dangers of tobacco use and SHS exposure and evidence-based interventions
d. Educating the public and decision-makers on the impact of tobacco price increases
e. Increasing/maintaining compliance with the North Carolina 100% tobacco-free schools law by partnering with youth, parents and school personnel to educate about dangers of tobacco use and emerging tobacco products
f. Working with partners, as appropriate, on the planning phase of the Improving Birth Outcomes Through Evidence-Based Tobacco Use Prevention and Cessation grants to local health departments.

7. **Promote Regional Tobacco-Free Collaborative Activities via Media and Other Communication:**

The Local Health Department's Regional Tobacco-Free Collaborative must develop and implement an active media plan as a part of the annual action plan requirements and must provide copies and examples of media coverage to the TPCB Director of Public Education and Communication within two working days of publication. Due to limited budgets, spending for paid media and paid media content are to be negotiated with and approved by the TPCB's Director of Public Education and Communication. The Local Health Department must utilize ongoing communication through e-mail with TPCB's Director of Public Education and Communication.

The media plan must include every program goal area in support of the Region's policy priority initiatives. This media plan must include:

a. Media relations with mainstream media that reach broad demographics as well as media to reach disparate population groups.
b. Earned media (e.g., actively earning media coverage strategically to educate on evidence-based strategies).
c. A protocol to ensure responsiveness to media contacts/inquiries within the media outlet's deadline by the appropriate local health director, partner, or staff.
d. Media advocacy strategies such as creating events that make the news, placing news stories via media relations, newspaper editorial page advocacy, and strategically placed paid media.
e. Implementation of media strategies using news coverage such as news events, media relations, news releases, opinion pieces, social media, and letters-to-the-editor.
f. Recruitment and training of leaders and community members to cover the North Carolina Designated Market Area in the Region with a team of trained spokespeople to educate the public and decision-makers about the problem of tobacco use and evidence-based strategies. These will include survivors of tobacco-related disease, youth, representatives of populations with tobacco-related disparities, partner organization staff and volunteers, health care providers, and local health directors/Board of Health members.
g. Strategies to utilize facts and communication tools provided by TPCB to support community counter-marketing efforts. Regions shall disseminate messages, testimonials, state/local statistics utilizing national media including, but not limited to: 1) the CDC Tips Campaign and other

national campaigns, 2) the CDC OSH Media Campaign Resource Center, and 3) the Surgeon General's Report (2014) and other scientific reports.

h. Correspondence in the form of a "swiss cheese" letter provided by TPCB to all Public Housing offices in the Region outlining what the Local Health Department can offer to assist with implementation of HUD's pending smoke-free public housing rule. Correspondence will include the www.smokefreehousingnc.com website, Regional Manager contact information, facts and figures about the benefits of smoke-free housing, and QuitlineNC materials (Posters, brochures and cards, as available).

i. Strategies to collect success stories and testimonials from priority population communities.

8. **Participate in TPCB sponsored meetings** (Vision 2020 Conference and Annual Action Planning Meeting), monthly conference calls, quarterly face-to-face meetings, and special events. Regional Managers will also contribute to the development of the TPCB Strategic Plan, Communication Plan, and Evaluation Plan by participating in meetings as needed. Support the participation of Regional Managers on various state-level strategy teams as appropriate. Funds may be allotted from the budget to attend the National Conference on Tobacco or Health.

9. **Build public-private partnerships addressing tobacco control and health equity**. TPCB will provide the Regional Collaboratives with factsheets that help them recruit decision-makers and develop public-private partnerships. Potential examples of these activities include:
   a. Conducting systematic outreach to affordable housing management companies and scheduling follow up meetings and presentations about smoke-free multi-unit housing as requested
   b. Work with the TPCB Director of Tobacco Cessation to recruit healthcare systems, health insurers, and employers to partner with QuitlineNC. Recruitment materials will be provided by TPCB about how quitting smoking reduces tobacco-related disease, death and health care costs and increases the Return on Investment (ROI). The recruitment materials will show how to expand cessation services to worksites in order to develop public/private partnerships.
   c. Educating and informing the public and decision-makers about health and economic benefits of expanding QuitlineNC's reach through targeted fact sheets, meetings and events.

10. **Evaluate Regional progress** by tracking local health outcome data (e.g., Community Health Assessments), completing TPCB monthly reports on performance indicators, and adjusting activities as needed based on quarterly feedback from TPCB in order to achieve maximum results. Include TPCB state staff in planning, implementing, and evaluating activities.

IV. Performance Measures/Reporting Requirements:

Benchmarks will be detailed in the final Fiscal Year 2016–2017 annual action plan approved by August 1, 2016 by the TPCB. If there are tobacco-related changes to the law in the 2016 and 2017 sessions of the North Carolina General Assembly, a substantial revision to these measures may be necessary.

Performance Measure #1: Evidence that Tobacco Prevention & Control capacity and Regional infrastructure is increased or maintained

Performance Indicators:

a. Regional Manager is maintained by June 1, 2016
b. Regional Leadership Team, including multilevel leadership (defined as the people and processes that make up the leadership at all levels that interact with and have an impact on the tobacco control program, e.g., Health Director, Board of Health members, Regional Managers, Health Educators,

etc.), meets or is provided with updates routinely and TPCB staff can convene meetings with the Regional Leadership Team when necessary

c. Regional Collaborative, including networked partnerships (defined as strategic partnerships at all levels, e.g., state, regional, local), is maintained by September 30, 2016
d. Regional tobacco control environmental assessment and strategic planning updated during Fiscal Year 2016-2017
e. Regional Manager and Health Directors in the region communicate regularly on strategies through meetings, emails, and / or conference calls
f. Mid-year and year-end 100% spending plans delivered on time.

Performance Measure #2: Evidence that the Regional Tobacco-Free Collaborative is maintained

Performance Indicators:

a. Meeting minutes and attendance records reflect that the Regional Collaborative meets at least quarterly (in-person or conference calls)
b. Updates to collaborative members and contact information are submitted to TPCB in the monthly reporting tool
c. Correspondence reflects that TPCB staff have been notified of Regional Collaborative meetings, trainings and events on a shared meeting calendar template to be provided by TPCB
d. Regional internal communications plan, to include a plan for conducting regional meetings, compiling progress reports/updates, sharing information and updates, meeting the needs of the region and facilitating peer-to-peer learning among counties/municipalities in your region working on similar strategies is developed by October 1, 2016.

Performance Measure #3: Evidence of increased public and decision-maker knowledge about the dangers of tobacco use, exposure to SHS, tobacco-related disparities, effective tobacco control interventions, strategies and social norm change; and increased health communications interventions and messages to reach populations disproportionately affected by tobacco use, exposure to SHS, and tobacco-related disparities

Performance Indicators:

a. Number of trained media spokespersons in the NC Designated Market Area trained to educate decision-makers, stakeholders, and public
b. Number of speaking opportunities by trained media spokespersons to educate decision-makers, stakeholders, and public
c. Number of tobacco-related pro-health as compared with anti-health opinion articles (editorials, letters-to-the-editor and op-ed pieces). Op-eds (stands for opposite the editorial, where they used to be published) are fairly long newspaper opinion pieces (usually 400 words or longer) written by someone from the community, not employed by the newspaper).
d. Number of messages, testimonials, state/local statistics disseminated utilizing national media including, but not limited to: 1) the CDC Tips Campaign and other national campaigns, 2) the CDC OSH Media Campaign Resource Center, and 3) the Surgeon General's Report (2014) and other scientific reports.
e. Number of paid and earned media efforts targeting populations or areas with high concentrations of smoking prevalence, SHS exposure, and chronic disease
f. Number of social media activities used to complement traditional paid and earned media efforts
g. Number of people reached by social media activities
h. Number of success stories distributed.

Performance Measure #4: Evidence of increased implementation and enforcement of interventions and strategies that support quitting, reduce exposure to SHS, and decrease access and availability of tobacco products

Performance Indicators:

a. Number of new tobacco-free policies (including e-cigarettes) adopted for college / universities, community colleges
b. Number of new counties and municipalities that adopt smoke-free/tobacco-free policies (including e-cigarettes) for local government buildings, grounds, indoor public places
c. Number of Public Housing Authorities that have new comprehensive smoke-free policies
d. Number of new restaurants and bars adopting policies prohibiting e-cigarette use indoors and/or smoking in outdoor areas
e. Number of new smoke-free/tobacco-free policies (including e-cigarettes) adopted for local mental health / substance abuse facilities
f. Number of people reached by these policies
g. Number of technical assistance opportunities in support of the Smoke-Free Restaurants and Bars Law
h. Number of technical assistance opportunities in support of 100% Tobacco Free Schools compliance
i. Number of meetings/presentations conducted in support of implementation and enforcement of evidence-based interventions. This will include assistance with implementation of HUD's pending rule on smoke-free public housing authorities.

Performance Measure #5: Evidence of increased public-private partnerships addressing tobacco control, tobacco-related disparities and health equity

Performance Indicators:

a. Number of registered callers for QuitlineNC in the Region
b. Number of meetings/presentations promoting QuitlineNC to agencies, organizations, businesses, and mental health / substance abuse facilities.

Performance Measure #6: Evidence of increased health care system changes to promote and support cessation.

Performance Indicators:

a. Number of new practices in the Region that are engaged by the Local Health Department and then utilize the fax and electronic referral system to QuitlineNC.
b. Number of enrolled tobacco users in the Region referred to QuitlineNC by healthcare providers
c. Number of regional presentations/trainings to enable healthcare, behavioral health, dental professionals to offer brief 5A's cessation counseling and QuitlineNC referrals
d. Number of technical assistance opportunities (aka academic detailing) to healthcare organizations, community behavioral health systems, their providers, and staff in implementing health systems changes that institutionalize tobacco screening and intervention, including referrals to QuitlineNC.

Performance Measure #7: Evidence of education provided to the public and decision-makers on the impact of tobacco price increases and increased capacity to show how the strategies decrease the health and economic burden of tobacco attributable chronic disease.

Performance Indicators:

a. Number of media messages published or aired including news, editorials, opinion articles ("op-ed pieces"), letters to editors, blogs, columns, and social media postings related to the impact of price of tobacco products on smoking rates
b. Number of planned or opportunistic presentations, mentions, or media messages to educate and inform on the impact of substantial increase in the price of tobacco products.

Reporting Requirements for Deliverables and Performance Measures:
The Local Health Department provides monthly documentation of activities based on a TPCB monthly reporting tool, which is due on the second Monday of each month. Entries must conform to requirements as outlined by the TPCB.

V. <u>Performance Monitoring and Quality Assurance</u>:

The Regional Tobacco-Free Collaborative's progress is evaluated on a quarterly basis by the Tobacco Prevention and Control Branch to denote progress on their annual action plan. This feedback is to ensure adequate performance. The evaluations are discussed at site visits scheduled as needed. A site visit will be scheduled once per year of the Agreement Addendum's service period with the Local Health Department and Regional Leadership Team. Future meetings and site visits will be planned collaboratively. The Local Health Department is also provided with written quarterly feedback and recommendations by the TPCB, based on progress reported and major strengths, weaknesses and areas to be addressed are identified after review by the Tobacco Prevention and Control Branch. Each region submits monthly reimbursement requests through the Aid-to-County database, maintains surveillance and evaluation data, participates in sustainability activities and participates in two 100% spending budget meetings and monthly conference calls. Regional Managers will participate in an in-person Annual Action Planning Meeting and quarterly trainings offered by TPCB. The Local Health Department will also be invited to provide input on the technical assistance provided by the TPCB. TPCB will utilize the monthly reports and request input from the Local Health Department for reports to the CDC as well as to North Carolina Department of Health and Human Services.

Certain situations outlined below may result in inadequate performance and require corrective actions:

a. Non-completion of activities in the annual action plan will require documentation of barriers preventing implementation of activities and require an amended annual action plan within the quarter that the change took place, which must be approved by the TPCB.
b. In the event of a gap in staffing (1 Full-Time Regional Manager is required) or another major change in annual action plan delivery, the Local Health Department should identify staff internally to continue progress and recruit and orient a replacement rapidly. In the event that there is delay, and the Local Health Department cannot show a plan to spend the lapsed salary or other unspent program dollars, those funds are reverted and redistributed through the 100% spending plan.
c. If the Local Health Department does not implement activities in the annual action plan and has not documented barriers explaining why the activities were not completed, the funding for those activities must be returned to the TPCB or will be re-negotiated with TPCB-approved replacement activities and budget.

VI. <u>Funding Guidelines or Restrictions</u>: (if applicable)

CDC Funding Guidelines or Restrictions for these funds are as follows:

1. Funds may not be used to purchase food items.
2. Funds may not be used for lobbying. Federally-funded lobbying, either directly or indirectly (i.e., "grassroots" lobbying), is prohibited by law.

3. Recipients may not use funds to conduct research.
4. Recipients may not use funds for clinical care and pharmaceutical products.
5. Recipients may only expend funds for reasonable program purposes, including personnel, travel, supplies, and services, such as contractual.
6. Awardees may not generally use CDC funding for the purchase of furniture or equipment. Any such proposed spending must be identified in the budget and receive prior approval by TPCB.
7. The Local Health Department must perform a substantial role in carrying out project objectives and not merely serve as a conduit to another party or provider who is ineligible.
8. The Local Health Department must have on-site the Potential Conflict of Interest and Disclosure Form regarding acceptance of funds from tobacco-related entities and the Health Department Tobacco Use Policy. Any changes in these policies must be reported to the TPCB.
9. Budgets for Local Health Departments are based on availability of funds from CDC and are subject to change.
10. CDC funds may not be used to supplant existing state or federal funds.
11. Recipients may not use funds to provide direct cessation services or other direct services other than those through evidence-based quitline services.
12. Recipients may not use funds to purchase nicotine replacement therapy or other products used for cessation.
13. Indirect costs are not applicable to this grant.
14. Recipients are restricted from dealings with corporations with recent felonies or unpaid federal tax liability.
15. Funds may not be used for fundraising.