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STATE COMPREHENSIVE TOBACCO PROGRAM EVALUATION PLANS: A MULTI-STATE SCAN

A Review of State-Specific Approaches and Use of CDC Key Outcome Indicators

Statewide Comprehensive Tobacco Program Evaluation Plans: A Multi-State Scan

SUMMARY FINDINGS

Investments in tobacco prevention and cessation programs have grown enormously in the wake of Surgeon's General reports and the incontrovertible evidence demonstrating the negative health impact of tobacco. Programs to prevent the use of tobacco products correspondingly have diversified to meet the needs of different at-risk populations, and funds to deliver population health programs have generally increased. In this environment, state public health agencies have been charged with implementing very diverse strategies to meet target goals and frequently have been asked to do so with little or no dedicated funding. Support to states has been provided by the Centers for Disease Control and Prevention, but a key finding of this study is that while states may be recipients of CDC funds, they do not unanimously use the key outcome indicators recommended by the CDC in measuring successes and challenges in delivering tobacco prevention and control programs. In addition, some states are not expected by their respective oversight bodies to conduct evaluation studies to determine whether their efforts are resulting in meeting their target or programmatic goals, while others are. For example, some states complete comprehensive evaluation using state resources and staff (Indiana), some partner with their state universities (Texas, Missouri, California), others outsource the work to consortia or private consultants or businesses (Arkansas, Massachusetts), while still others began program evaluation, suspended their work because needed funds were diverted to other programs, and had to begin again (Colorado).

Among states that have evaluation plans, common elements are limited. The most frequent common elements include:

1. linkage of evaluation to at least one of the CDC-endorsed key goal areas (youth prevention, reducing second hand smoke, helping smokers to quit)
2. "dual purpose" use of surveillance activities (such as the Behavior Risk Factor Surveillance Survey) to meet elements of their tobacco-specific evaluation program
3. process measures for individual programs (such as the use of tobacco quit lines that provide telephonic support for tobacco use cessation)

4. measuring changes in cigarette consumption
5. measuring adult and youth smoking prevalence
6. tracking collaboratively developed policy initiatives to protect the public from secondhand smoke

A corollary associated with states that demonstrate more comprehensive evaluation plans is that they tend to have programs that embrace the essential ingredients of all successful initiatives: adequate and sustained funding, an evidence-based action plan, sound guiding principles, broad participation, and systematic channels of coordination and communication. These are the building blocks states use to develop and execute comprehensive tobacco programs that include robust evaluation as an essential element for ensuring quality programming and public health services for their citizens.

INTRODUCTION

PROJECT OBJECTIVES

At the request of the Kansas Department of Health and Environment, a scan of available state-based evaluation plans was initiated. Of particular interest in selecting target states were to include those that: 1) invest substantial resources (i.e., dedicated staff, targeted programs, financial resources) into comprehensive tobacco prevention and control activities; 2) lead the nation in decreasing the use of tobacco among various age, racial and other populations; and 3) border Kansas. States selected for review included:

- Arkansas
- California
- Indiana
- Maine
- Massachusetts
- Texas
- Missouri
- Nebraska
- Colorado
- Oklahoma

The primary goals for the scan included:

- assessment of each state's evaluation plan for tobacco prevention and control program(s)
- review of the states' use of CDC's key outcome indicators as a framework for their evaluation activities (see the following link for a detailed summary of the indicators) http://www.cdc.gov/tobacco/tobacco_control_programs/surveillance_evaluation/key_outcome/00_pdfs/Key_Indicators.pdf
- Determining and describing the various partnerships states use to accomplish their program evaluation(s)
- Collecting costs for evaluation, where possible

Secondary goals for the scan included:

- assessing venues to collect school and/or school district-level tobacco policies across the state of Kansas
- investigating whether the school wellness guidelines might serve as an easy-to-use and routine data collection method

PROJECT METHODS

Tapping the expertise and knowledge of KDHE's staff, approaches to collecting relevant information for the scan was identified. A combination of web-based resources, personal contacts with state staffs responsible for tobacco use prevention and control, and published reports and manuscripts was used to develop a "snapshot" view of each of the target states.

The CDC Office on Smoking and Health produced the "Best Practices for Comprehensive Tobacco Control Programs" in 1999[1]. There are nine components to the BP model: cessation programs, chronic disease programs, community programs, countermarketing, enforcement, school programs, statewide programs, administration and management, and surveillance and evaluation. The document was designed to provide states with recommendations that tie best practices into the national Tobacco Control Program's four primary goals: preventing initiation, promoting cessation, eliminating exposure to secondhand smoke and addressing tobacco-related disparities. The scan was to note the level of engagement in each goal area, and the degree to which BP programs were evaluated.

PROJECT LIMITATIONS

The process of reviewing states' information and interviewing available staff had to be accomplished on a short timeline. Little opportunity for follow-up or in depth review of materials was available.

Because much of the information collected was found through web-based sources, the information available publicly may not be the information that is most up-to-date regarding a state's programs and activities.

A general project limitation of this project is that state programs most often highlight the accomplishments of the program *per se*; very few states showcase their evaluation activities because they generally are thought to be of less interest to the public and other constituents or audiences. It is likely that the scan missed some evaluation efforts because they were either not published along with state program reports or because they tend to be considered less important in the dissemination process altogether.

[1] Centers for Disease Control and Prevention. Best practices for comprehensive tobacco control programs. August, 1999. Atlanta, GA: Centers for Disease Control and Prevention, National center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health (reprint with corrections).

SUMMARY FINDINGS

STATES' USE OF CDC KEY OUTCOMES INDICATORS

The key indicators suggested by CDC are part of the National Tobacco Control Program's (NTCP) mission to encourage coordinated, nationwide activities to reduce the incidence of tobacco-related disease and preventable death[2]. Indicators are grouped into three goal areas: 1) preventing initiation of tobacco use among young people; 2) eliminating nonsmokers' exposure to secondhand smoke; and 3) promoting quitting among adults and young people. For each goal area, specific outcome indicators are identified. For example, goal area 1 has four short-term outcomes, three medium-term outcomes and two long-term outcomes. Goal area 1 has 54 measures that quantify whether the state is making progress towards achieving these outcomes. Of particular value is that each outcome has a set of indicators. Each indicator is rated on an overall quality scale (5 unit scale from "low" to "high") which is a composite measure of the indicator on five different ratings. The rating includes whether the indicator has face validity, if it represents accepted practice, has good utility, has strong evaluation-based evidence and the relative level of resources needed to measure it. Examples of data sources for the indicator, example survey questions, if relevant, and comments that are aimed to assist the evaluation design also are included.

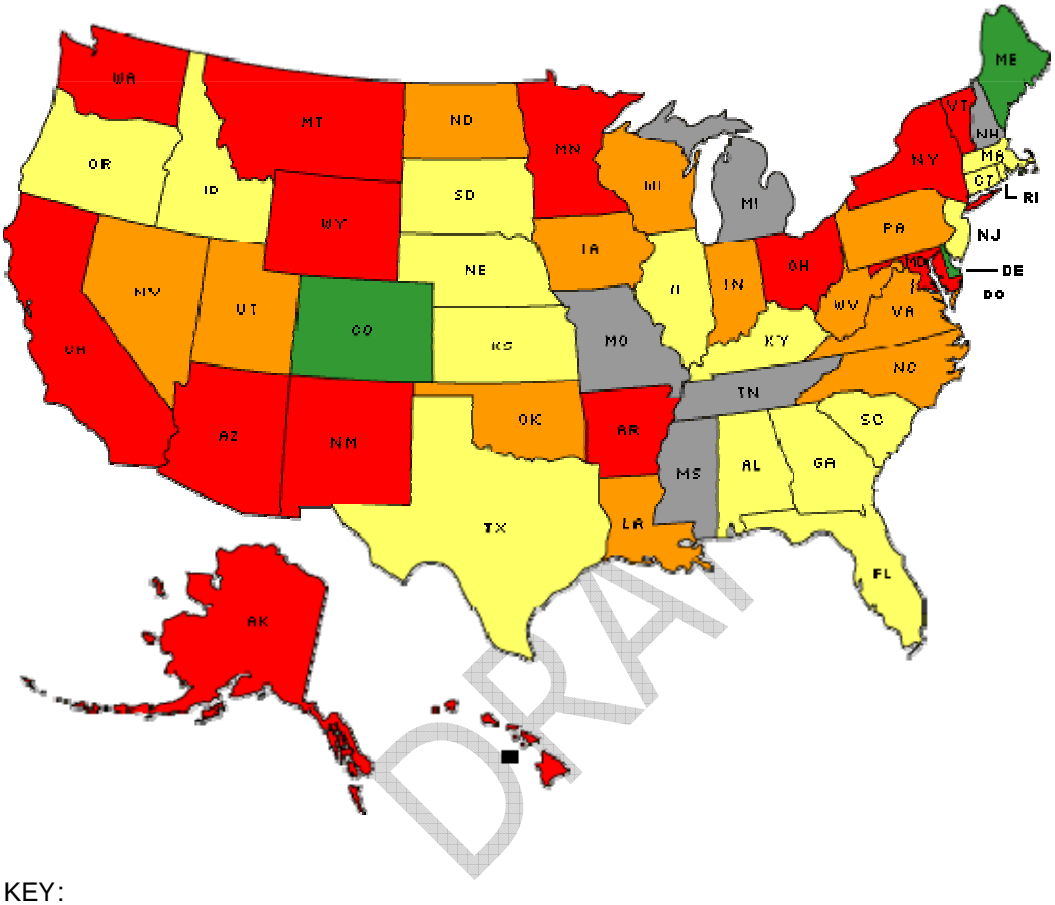
The CDC model approach to evaluation is comprehensive; the 300 page document provides a national standard and framework for states to start with, and it is evidence-based. Detractions include its lack of guidance for implementation, having perhaps too many categories for quick comprehension and value, and it has no funding prioritization. This last point, the lack of guidance on what to do with limited resources, is likely responsible for the diversity of approaches states have taken in implementing various elements of the key indicators guideline. For example, Oklahoma, Arkansas and Indiana repackaged the best practices into their own model which they feel is instrumental in clarifying their message for the public and state legislators. The environmental scan attempted to pick up the degree to which individual states had adopted the key outcomes indicators, and except for Arkansas and Indiana, few were available that include a cross-walk between the BP, their program work, key indicators and their evaluation models.

STATE BY STATE HIGH LEVEL COMPARISONS

To provide an overall perspective, the map below shows each state's current status in allotting state general funds to tobacco prevention recommended by the CDC. Kansas is one of 16 states that have committed less than 25% of the CDC recommended minimum

[2] Starr, G, Rogers, T, Schooley, M, Porter, S, Wiesen, E, Jamison, N. Key Outcomes Indicators for Evaluating Comprehensive Tobacco Control Programs. Atlanta, GA: Centers for Disease Control and Prevention; 2005.

and for FY2007, ranks 43rd in the nation on such spending.[3] The task for this environmental scan was to test whether states that had improved on their CDC goals and perhaps dedicated relatively greater tobacco prevention and treatment dollars (from all sources, tobacco settlement dollars, state general funds, grants, etc.), had similar evaluation programs in place to quantify the impact of their activities.



KEY:

	States that have funded tobacco prevention programs at a level that meets the CDC's minimum recommendation.
	States that have committed substantial funding for tobacco prevention programs (more than 50% of CDC minimum).
	States that have committed modest amounts for tobacco prevention programs (25% - 50% of CDC minimum).
	States that have committed minimal amounts for tobacco prevention programs (less than 25% of CDC minimum).
	States that have committed no tobacco settlement or tobacco tax money for tobacco prevention programs.

[3]A Broken Promise to Our Children: The 1998 State Tobacco Settlement Eight Years Later. http://www.tobaccofreekids.org/reports/settlements/2007/fullreport.pdf. Retrieved 4/11/2007

SELECT STATE EVALUATION MODELS AND COMPARISONS

States that evaluate their tobacco program activities are nothing if not pragmatic. Depending on the local conditions, specific program goals (and associated program indicators selected to measure progress) are generally considered in light of partnership strengths, the political climate, and the level of intensity of pro- or con-tobacco norms of its citizens. Precisely because these factors can alter relatively quickly (based on election cycle, leadership change, etc.), evaluation programs suffer from unstable commitment and changes to program objectives. As a result, Table 1 provides a cross-section of state commitments and activities over the past few years. The state-level data do not unanimously represent the same time-frame from state to state, but in each case, the most recently available data that were accessible are presented.

Teasing apart the source of funding for tobacco-related programs and evaluation is extremely challenging. Funds include tobacco settlement funds that are organized and allocated differently by each state, state general funds (which fluctuate with each state's budget process and cycle), CDC Office on Smoking and Health funds, national foundations (most prominently the Robert Wood Johnson Foundation and American Legacy Foundation), and local foundations that may fund statewide, regional or local programs aimed at various age groups, populations or a special topic (i.e., a secondhand smoke awareness social marketing campaign).

Each state reviewed has a mixed model approach to evaluation of their tobacco programs. Some evaluations monitor process measures, while others include outcomes measures or impact measures. In most cases, evaluation activities are embedded in each specific program and the result is a series of case study-type reports that are not linked together. Evaluations conducted in this fashion are of transient value because they may or may not be conducted in other years, by the same research team using the same methodologies or with the same performance measures. Even in states like California and Massachusetts, two states that have been collecting program performance data for well over a decade, their evaluation studies lack consistency and regularity. The difficulty in maintaining the integrity of a logic model for evaluation is compounded by fluctuations in available funding. In total, the most common outcome evaluation measures are:

1. program effects on cigarette consumption
2. adult and youth smoking prevalence
3. protection of the public from secondhand smoke

Finally it is worth noting that, for states that have them, including tobacco control plans in their state cancer plans is common. This may or may not afford some protection for tobacco when local conditions favor cancer prevention over tobacco programs because of political, economic or social reasons.

	Structure of Evaluation	Key Organizations Conducting Evaluation Studies	Use CDC Goals: 1-youth prevention 2-2nd hand 3-promote quitting	Specific focus on minorities?	Funds: CDC Office on Smoking and Health / *State Evaluation Budget
Arkansas	Private	RAND Corporation; Battelle (Memorial Institute) Centers for Public Health Research and Evaluation	1,2,3	Yes	$1,264,179 / 350,000
California	Public	University of California, Davis and California Department of Health Services	1,2,3	Yes	$594,221 / 3,000,000
Indiana	Private	American Institutes for Research and the Tobacco Use Prevention and Cessation Trust Fund Executive Board	1,2,3	No	$1,340,166 / 750,000
Maine	Public	Partnership for a Tobacco-Free Maine, Maine Bureau of Health	1,2,3	No, Planned; (separate Native American program)	$1,109,090/ NA
Massachusetts	Private	Abt Associates	1,2,3	Yes	$1,829,415 / 500,000
Texas	Public	University of Texas at Austin, University of Houston, University of Texas Health Science Center-Houston, Prairie View A&M University, Baylor College of Medicine, Texas A&M, Kaiser Permanente NW, and Texas Department of State Health Services	1,2,3	Yes (Hispanic/Latino emphasis)	$1,189,591 / 2,250,000
Missouri	Public/Private Partnership	Missouri Foundation for Health and Missouri Department of Health and Senior Services	1,2	No	$1,414,638 / 1,352,189
Nebraska	Public/Private Partnership	Tobacco Free Nebraska and Nebraska Health and Human Services System	1,2,3	Yes	$1,412,520 / 700,000 (in comprehensive plan)
Colorado	Public	Colorado Department of Public Health and Environment	1,2,3	Yes	$1,572,703 / 1,500,000 (in comprehensive plan)
Oklahoma	Public	University of Oklahoma and Oklahoma State Department of Health Tobacco Use Prevention Service (TUPS)	1,2,3	No, Planned; (separate Native American program)	$1,575,462 / 157,750* (*includes surveillance)

Table 1. State-to-state comparison of evaluation activities in CDC Goal Areas.

**"Private" refers to 501c3 organizations that are not directly affiliated with the public state health agency. **All sources. Estimated evaluation budgets are from different sources and possibly different years than that of the CDC funding.*

STATE SUMMARIES

Arkansas: About 30 percent of the state's Tobacco Settlement Trust Fund is dedicated to tobacco prevention and cessation programs. The Arkansas Tobacco Settlement Commission (ATSC) has the responsibility for monitoring and evaluating the performance of the funded programs. ATSC originally contracted with the RAND Corporation to serve as the external evaluator, and RAND produced two reports that focused on program implementation evaluations. The state was dissatisfied with the process evaluation, and the current contractor is Battelle Centers for Public Health Research and Evaluation. The state's current evaluation plan that will guide Battelle's work was made available for review. The plan includes 16 outcomes with associated indicators that reflect selected CDC key indicator measures.

California: California has the oldest and one of the most successful tobacco prevention programs in the nation. Since 1989, the state has been collecting data, albeit with periodic cuts in funding, until 2001 when funds were secured in a Tobacco Settlement Fund. The Fund included appropriations for tobacco prevention efforts, smoking cessation services, and enforcement of tobacco control laws. Evaluation is not required under the Fund, but resources to support evaluation have been made available, and the work has been completed at a dedicated research center, the California Tobacco Control Evaluation Center, at the University of California, Davis.

Indiana: The Indiana Tobacco Prevention and Cessation Agency (ITPC) was formed with 60 percent of the state's tobacco settlement funds dedicated for health-related programming. The balance was set in a trust fund that was to be used for ongoing tobacco and other health programs, but since has largely been used to support state budget shortfalls. The ITPC commissioned a state-tailored plan for a comprehensive evaluation program by the American Institutes for Research in 2002. That plan is the most thorough reviewed for this environmental scan. The ITPC had initial success and financial clout, but soon succumbed to budget cuts. By 2005 as program funding decreased, statewide adult tobacco use began to increase. The current status of the evaluation plan is to revive and modify it as funds are available.

Maine: Maine formed the Partnership for a Tobacco-Free Maine (PTM) in 1997 using cigarette tax funds, but it is now funded with proceeds from the tobacco settlement dollars. Funding for tobacco prevention programs has moved in and out of Trust and General state funds based on state budget decisions, but according to the PTM, the statewide program has continued with the same key objectives and includes assessment and evaluation. The state monitors six key activities closely: statewide media, the Maine Tobacco HelpLine, 31 local partnerships, enforcement activities, No BUTS retailers support program and local youth advocacy programs.

Massachusetts: Along with California, Massachusetts has one of the nation's oldest tobacco prevention programs, begun in 1993 (with some metrics of performance since

1990). The Massachusetts Tobacco Control Program (MTCP) formed in 2002 began at a financial commitment of $48 million for tobacco prevention and cessation programs, and is now funded at $8.3 million (this includes a onetime allocation of $4 million in FY2007). The evaluation of programs is outsourced to Abt Associates, a highly regarded for-profit government and business research and consulting firm with headquarters in Massachusetts. A statewide evaluation plan document was not available for review.

Texas: Texas is one of four states to settle with the tobacco industry prior to and separate from the November 1998 multi-state agreements. Funds were placed into endowments that only allow the interest accrued to be spent on tobacco prevention, but additional state general funds are included in biennial budgets for these programs. Evaluation is not mandated, but the state's Department of State Health Services work in partnership with Texas academic institutions to accomplish statewide program evaluation. Principal investigators at each institution provide specific evaluation expertise to the state. For example, Texas A&M's School of Public Health conducts the formative evaluation of the Youth Tobacco Awareness Cessation Program.

Missouri: Missouri ranks dead last in terms of state spending of tobacco settlement money on tobacco prevention; all of the settlement funds in FY2007 went to the general fund with a portion dedicated to life science research. The recent ballot initiative to increase the state cigarette tax by 80 cents would have provided a tremendous resource had it passed, but instead, the state owes its program funding to CDC and the Missouri Foundation for Health (MFH), a relatively new health philanthropy based in St. Louis. MFH has committed $4 million over the next three years, and already has funded a variety of tobacco-related programs at the local, regional and statewide level, recently completing a county level tobacco survey with a sample of over 50,000 Missourians. The Center for Tobacco Policy and Research is funded by MFH and is located at St. Louis University. Faculty at SLU are providing evaluation technical assistance and training to locals along with conducting evaluation studies themselves of MFH's priority programs.

Nebraska: In 2000, Nebraska allocated $7 million a year to tobacco prevention. The state developed a comprehensive plan that included a counter-marketing media campaign, statewide quite line, a surveillance system and youth-based program (No Limits). Funds have bulged and shrunk based on state budget needs for other health services. In an assessment of systemic gaps, the diversity of funding sources, lack of evidence-based prevention programs and no comprehensive evaluation plan were noted as deficiencies. Despite cuts to a level of just $3 million a year, program roll-outs and activities have continued, albeit without a comprehensive evaluation plan in place. Rather, each activity has been monitored separately and then brought together in a snapshot progress report

presented by the two principal collaborating organizations, Tobacco Free Nebraska and the Nebraska Health and Human Services System[4].

Colorado: As has been the pattern in so many states, the original intention of funding Colorado's tobacco prevention programs with tobacco settlement money in 2000 was abandoned in light of state budget shortfalls. However, in 2005, a cigarette tax increase was used to fund a $27 million a year fund to put comprehensive tobacco prevention and cessation programs at CDC recommended levels in place. The original 2000 statewide plan included evaluation at 10 percent of the total budget. To accomplish this work, the Colorado Tobacco Research Program started at the University of Colorado but had to suspend its work by 2003 because of funding. The Statewide Tobacco Education and Prevention Partnership run by the Colorado Department of Public Health and Environment provides grants to non profits working in tobacco control. It is unclear whether this funding requires grantees to include evaluation in their programs. The state describes its evaluation plan as "more of an outline showing outcome objectives and instruments/sources."[5] The state currently has a group developing a more comprehensive evaluation plan, and it was not yet available for review.

Oklahoma: Voters in Oklahoma established the Tobacco Settlement Endowment Trust Fund, whereby only interest accrued on the tobacco settlement funds can be spent on certain broadly specified programs, including tobacco prevention. The Trust Fund's board decides how to allocate the resources and to date, they have maintained fidelity to funding tobacco control programs. This consistency of funding has permitted longer-term planning, although disbursement delays have had negative impact. The University of Oklahoma Health Sciences Center provides contract support for evaluation of select programs. A statewide evaluation plan was not available for review and was described as "more of an outline showing our outcome objectives and instruments/sources".[6]

[4] Tobacco Free Nebraska and Nebraska Health and Human Services System. Reducing Tobacco Use in Nebraska. May, 2006. Nebraska Health and Human Services System, Lincoln, Nebraska.

[5] Email communication with Mr. Carsten Baumann, Evaluation Director, CDPHE-Prevention Services Division, June 11, 2007.

[6] Email communication with Dr. Joyce Morris, State Assessment Coordinator, Tobacco Use Prevention Service, June 11, 2007.

SECONDARY ENVIRONMENTAL SCAN OBJECTIVES

Two additional activities were included in this environmental scan. The first activity was to assess possible venues to collect school level and district level tobacco policies, and the second activity was to look into whether the school wellness guidelines might serve as an opportunity to collect routine information to monitor school-related tobacco policies and progress.

Federal Options:

The organization that successfully reports on school level issues, recently conducting a national nutrition and physical activity profile of elementary school policies and practices is the National Center for Education Statistics at the U.S. Department of Education. Generally in partnership with a national survey firm (i.e., Westat, Inc.), the NCES deploys rapid turnaround survey capability on important policy issues. There are no plans to collect tobacco policy information at this time and because the data are reported at a state level, additional work would be required to access local information through public use files.

The School Health Index developed by the CDC encourages schools to collect and track data regarding tobacco (along with many other health indicators). Although it is designed as a self-assessment and planning guide (and not an evaluation tool), the SHI could capture school-level policies regarding tobacco, but only among those schools that voluntarily collect the data and who would be willing to share. Schools in Kansas have not participated fully enough to have sufficient representation to warrant a CDC-generated statewide report, so compliance is a challenge.

State Options:

The state of Kansas requires schools to submit information that is reported in the "Building, District and State Report Card." Completed and published each fall, this report includes school-level profile information. The data focus on a variety of issues including demographics of students, disciplinary actions taken during the school year, and certification level of teachers, but this data collection activity could be considered as a potential venue to collect building-level policies for tobacco. It is assumed that revising the data collection process to include tobacco policy and practices would encounter resistance and prove more difficult in practice than in theory, but perhaps it is worth investigating.

Required by the Child Nutrition and WIC Reauthorization Act of 2004, every school district that participates in a federal meals program had to enact a wellness policy by July, 2006. In Kansas, the Kansas State Department of Education took the lead in providing guidelines for districts and their wellness policy committees and task forces to consider as they worked towards meeting the new requirement. The Wellness Policy Guidelines were provided along with an online Wellness Policy Builder tool that was designed to assist in assessment and tracking performance. Congress provided no funds to facilitate the creation or adoption of

wellness policies and imposed no financial penalties for school districts that fail to adopt or enforce them. This means that community and individual involvement are crucial[7].

Even though the federal law requires that wellness policies include goals for nutrition education, physical activity and *other school-based activities designed to promote student wellness* in a manner that the local education agency (LEA) determines appropriate, tobacco policies are not included in the Kansas wellness profile.

Kansas passed SB154 in 2005 that supports the federal requirement by directing KSDE to pay "particular attention…to providing healthful foods and beverages, physical activities and wellness education with the goals of preventing and reducing childhood obesity[8]. This represents two problems. First, schools are encouraged but not required to implement the guidelines; state law does require that each school board consider the guidelines when developing local wellness policies. Second, the inclusion of tobacco policies and practices *per se* is not required and is considered a burden on both the LEA and KSDE beyond the parameters set by federal and state law. Finally, even were tobacco policies to be included as a wellness policy guideline, LEAs provide information on the wellness policy performance of their school or schools in a single, summary report. None of the wellness policy adoption or compliance is designed to be or is currently being tracked on a school-by-school basis in Kansas, but rather is designed to provide a district level view on these issues.

An attempt to quantify the magnitude of difficulty in collecting district-specific tobacco policies was completed. Web-based information for individual districts was searched, and a telephone call request for copies of the district's tobacco use policy was made if unavailable. Far from robust, the review does provide a window into the level of effort it would take to independently collect tobacco policy information from approximately 300 public school districts. The results of the investigation are included in Table 2 below. Based on these unscientifically collected data, the effort required would cost relatively little and would provide a summary data set that could be analyzed by principal counties represented by attending students and by region. Further linkages could be made that could match school tobacco policy with each district's socioeconomic profile, academic/annual yearly performance status, legislative district and other variables of interest. Collecting specific data from individual public schools would be significantly more costly as there are over 1,400 elementary, middle/junior high and high schools across the state that would have to be reviewed for available online policy and/or contacted individually.

[7] School Wellness Policies. http://www.healthystates.csg.org/NR/rdonlyres/C87EB28D-B2F6-4399-B1BD-BC5617940019/0/SchoolWellnessPoliciesFINAL.pdf Retrieved 6/12/2007.

[8] Kansas School Wellness Policy Model Guidelines. http://www.kn-eat.org/SNP/SNPDocs/Wellness/Wellness_Policy_Guidelines_Booklet_Final.pdf Retrieved 5/1/2007.

SCHOOL DISTRICT TOBACCO POLICY	STUDENTS
Tobacco-free building	**enrollment**
USD 226 Meade	500
USD 245 Leroy-Gridley	280
USD 246 Northeast	613
USD 251 North Lyon	568
USD 256 Marmaton	363
USD 258 Humboldt	534
total enrollment	2,858
Tobacco-free grounds for students,	**enrollment**
no mention of staff/visitor policy	
USD 225 Fowler	192
USD 231 Gardner-Edgerton	3,865
USD 250 Pittsburg	2,680
total enrollment	6,737
Tobacco-free grounds for students,	**enrollment**
tobacco-free buildings for staff	
USD 103 Cheylin	147
USD 202 Turner-Kansas City	3,959
USD 208 Wakeeney	414
USD 213 West Solomon Valley	61
USD 223 Barnes	470
USD 230 Spring Hill	1,713
USD 249 Frontenac	788
total enrollment	7,552
Tobacco-free grounds for students,	**enrollment**
staff, and visitors	
USD 104 White Rock	100
USD 203 Piper-Kansas City	1,456
USD 205 Bluestem	735
USD 206 Remington-Whitewater	555
USD 207 Ft. Leavenworth	1,644
USD 210 Hugoton	1,068
USD 211 Norton Community Schools	696
USD 212 Northern Valley	189
USD 214 Ulysses	1,783
USD 215 Lakin	665
USD 219 Minneola	257
USD 224 Clifton-Clyde	322
USD 227 Jetmore	312
USD 233 Olathe	24,499
USD 234 Fort Scott	1,970
USD 237 Smith Center	441
USD 240 Twin Valley	665

SCHOOL DISTRICT TOBACCO POLICY	STUDENTS
USD 248 Girard	1,104
USD 252 Southern Lyon County	611
USD 253 Emporia	4,910
USD 254 Barber County	626
USD 257 Iola	1,478
USD 258 Wichita	48,451
USD 260 Derby	6,597
Total enrollment	101,134
Total number of districts sampled	40
Districts with no response, no website	16
Total students represented in sample	118,281

Table 2. Unscientific sample of school tobacco policies in Kansas.