Introduction
The source of funds for this Request for Proposals (RFP) is the Hawaii Tobacco Prevention and Control Trust Fund (Trust Fund). The Trust Fund was created by state law following a Master Settlement Agreement (MSA) between several US states and territories and the tobacco industry. The Hawai‘i Community Foundation (HCF) has held and managed the Trust Fund on behalf of the Hawai‘i Department of Health (DOH) since 2000 and consistent with the contract with the DOH, implements a community grants program.

Identification of the Issue to Be Addressed Through Community Grants/Cessation Program
Tobacco use continues to be a serious public health problem in Hawai‘i. Smoking harms nearly every organ in the body and half of all long-term smokers die prematurely from tobacco-related diseases. In Hawai‘i, roughly 1,100 deaths each year are attributable to smoking and 150 from second-hand smoke. Estimates of annual smoking-caused monetary costs in Hawai‘i include $336M in health care costs, $320M in lost productivity costs, and account for $117M of all Medicaid expenditures.

Hawai‘i’s current adult smoking prevalence rate is 14.5% (145,700 current adult smokers), a statistically significant decline since 2002. However, as stated by the American Legacy Foundation, tobacco is not an equal opportunity killer. Despite the overall decline in tobacco use, certain groups in Hawai‘i still have disproportionate rates of tobacco use as evidenced by the Hawai‘i Behavioral Risk Factor Surveillance System (BRFSS), the Adult Tobacco Survey, and other surveys, including those with low income, low educational levels, unemployment and certain ethnic groups. This data is consistent with statements shared by the National Networks for Tobacco Control and Prevention, the CDC, and other sources that:

- The greatest single predictor of tobacco use is low socioeconomic status (SES).
- Poverty is directly related to tobacco use.

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1 Hawai‘i Revised Statutes 328L-2 (2010).
5 2010 Hawaii Behavioral Risk Factor Surveillance System (BRFSS).
7 BRFSS accessible through the Hawaii Health Data Warehouse at http://www.hhdw.org/ under BRFSS Reports, Tobacco Use, Cessation.
9 Hawai‘i Health Data Warehouse - http://www.hhdw.org/.
11 Centers for Disease Control and Prevention and Gallup-Healthways Well being Index (2011).
• Low SES communities are less likely to have members who participate in cessation programs or receive cessation advice.
• Tobacco advertising is more prominent in low SES communities.
• Americans below the poverty line are 40% more likely to smoke than those at or above the poverty line.
• Low education levels (high school or less) are highly correlated with tobacco use.

Findings from Research and Evaluation
HCF’s community grants/cessation program is one component of an overall comprehensive cessation effort funded by the Trust Fund. The community grants/cessation program is intended to reach and serve priority populations, while the Hawaii Tobacco Quitline (HTQL) serves all Hawaii residents statewide. Beginning in 2009, evaluations of the community grants/cessation program and the HTQL were coordinated in order to:
• Obtain an overall picture of the effectiveness or impact of cessation efforts funded by the Trust Fund.
• Assess and compare quit attempts and quit rates.
• Determine optimal utilization of limited Trust Fund resources.
• Adjust and improve both programs (community grants for cessation and the Hawaii Tobacco Quitline).

Evaluation of 2009 Community Grant/Cessations Program: In 2009, HCF collaborated with the DOH on a comprehensive evaluation for all cessation efforts funded by the Trust Fund. Professional Data Analysts, Inc. (PDA), an external evaluator for the HTQL since 2005, was tasked to conduct a process and outcomes evaluation for the community grants/cessation program in order to integrate it with the HTQL evaluation. Preliminary results showed several successes including:

1) 2009 cessation grants program served large proportions of tobacco users from vulnerable populations (low SES, pregnant smokers, Native Hawaiians, homeless, low income, uninsured, those with chronic illness, and those with less than a high school degree) who need cessation services. Research suggests that these groups may be more likely to smoke, it may be harder for them to quit, and/or they may suffer disproportionately from the negative effects of using tobacco. These groups are not typically served in such large proportions at quitlines.
2) An estimated 3,495 interventions were provided in the first 18 months of the grant period.
3) The reach of the cessation grants program among all tobacco users was strong at 1.3% and is similar to the average reach for quitlines nationally (1 to 2% of tobacco users being reached). Multi-session interventions tended to be fairly intensive in nature, with a median of an hour and a half of counseling across two sessions. This is particularly important because higher program intensity is associated with higher quit rates.
4) Participants reported strong satisfaction with the services they received. A full 86% of survey respondents who received a multi-session intervention reported being very or mostly satisfied with the services they received at the time of a seven month follow-up survey. Further, nearly all (95%) reported that the program was a good fit for their culture.
5) Nearly nine in ten (87%) tobacco users who enrolled in a multi-session cessation intervention quit for at least 24 hours between enrollment and a seven month follow-up survey.
6) Nearly a quarter (24%) of tobacco users who enrolled in a multi-session cessation intervention were quit for the last 30 days at the time of a seven month follow-up survey. This quit rate is strong, given the vulnerable populations that

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cessation grants serve. Considering the margin of error, the quit rate for the cessation grants meet the 2015 goals for quitline success according to the North American Quitline Consortium.

In addition to these evaluation findings, extensive research has identified evidence-based programs and technologies that can help tobacco users quit. An array of resources and literature describe evidence based programs and/or best practices effective in helping tobacco users quit. Resources like the Centers for Disease Control and Prevention, National Institute for Health, the National Academy of Sciences, the American Legacy Foundation and others agree that cessation programs that include intensive interventions with counseling and medications or nicotine replacement therapies have been found to be useful and effective. National research shows that:

- The first step in becoming tobacco-free is making a quit attempt.
- Being ready to quit is a significant predictor of successful quitting.
- With the use of behavioral interventions (e.g. counseling) and pharmaceutical interventions (Nicotine replacement therapies and/or pharmacotherapies) tobacco users who can make a quit attempt, even if for a short period of time like 24-hours, have a higher probability of sustained abstinence (e.g. quitting tobacco in the long term).
- Intensive interventions for tobacco dependence have higher success at quit attempts than brief interventions.

In an effort to achieve the greatest impact with limited Trust Fund resources, HCF seeks to build on these findings and the research base in design of this Request for Proposals (RFP).

Purpose
To align with the state strategic plan goals (see Appendix 1) to reduce tobacco use prevalence and consumption, reduce tobacco related morbidity and mortality and decrease tobacco related disparities, the community grants program announces the availability of funds for cessation programs that:

- Reach and address priority populations in Hawai‘i as defined in this RFP.
- Provide intensive interventions (as defined in this RFP) to tobacco users ready to quit.
- Provide interventions based on available best practice or evidence based programming for tobacco cessation.

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13 Institute of Medicine for National Academies (2012), http://sites.nationalacademies.org/Tobacco/SmokingCessation/Tobacco_051286
16 Counseling may involve individual and group formats which are both effective in tobacco use treatment.
17 2011 PDA Cessation Grants Aggregate Evaluation Report
18 According to the Public Health Service Treating Tobacco Use and Dependence Clinical Practice Guidelines (2008) the more intense the intervention, the great the rate of abstinence. Interventions may be intensified by increasing the length of the individual intervention sessions and/or the number of intervention sessions.
Grant Expectations
If a grant is awarded, it will be finalized through a document entitled “Grant Terms and Agreement” or GTA. Grantees will be expected to:

1. Perform the scope of work as described in the proposal and/or negotiated at the time of the award consistent with the benchmarks listed in Appendix 2.
2. Fully implement the workplan included as part of the proposal.
3. Share performance information with HCF and, as appropriate, with other grantees.
4. Participate in HCF site visits, grantee gatherings, and trainings.
5. Coordinate with the statewide media campaign if programs have a media component.
6. Offer/refer clients to the Hawaii Tobacco Quitline, as appropriate.
7. Submit progress reports to HCF (update on the workplan, narrative and financial reports) consistent with the timeline developed by HCF to include a final report within thirty days of the grant end date.
8. Cooperate with and implement the evaluation designed for this RFP (see Appendix 2) by Professional Data Analysts (PDA). PDA has been retained to design an evaluation to assess the extent to which each funded program, and the community grants initiative as a whole, is meeting set benchmarks. All funded programs will be expected to implement the PDA evaluation design and components, utilize PDA evaluation tools and methods, and work with PDA’s local-based subcontractor SMS Research, to complete the evaluation. PDA has also been retained to evaluate the Hawaii Tobacco Quitline using the same kind of evaluation tools and methods. Specifically, the grantee will be expected to:
   a. Collect and submit data electronically on a quarterly basis using PDA’s protocols.
   b. Review PDA’s evaluation reports and other data as necessary to assess the program’s performance of activities and outcomes achieved.
   c. Attend evaluation training sessions and telephone calls to improve performance with the evaluation.
   d. Make appropriate adjustments and develop solutions to problems identified in the evaluation, as necessary.

The evaluation will consist of the following components:

- A Registration Form to be administered by funded programs to collect information at enrollment on each participant’s tobacco use, readiness to quit, and demographic and clinical characteristics when they enroll in the program. The form also asks participants if they would participate in a follow-up survey to better understand how to improve the program. The form may be completed by paper or pencil or by electronic interface on a tablet computer provided by PDA or on a grantee’s own computer with internet access.
- A Utilization Form administered by counselors of funded programs which tracks the number of participants served by session, the topics covered, and medications discussed or subsidized. The form may be completed by paper or pencil or by electronic interface on a tablet computer provided by PDA or on a grantee’s own computer with internet access.
- A 7 month follow-up telephone survey (approx. 5 minutes) administered by a Hawaii-based telephone survey company (not the funded program). The survey asks about the participant’s satisfaction with the program and their experience quitting.
- Additional evaluation strategies will be developed to remove barriers encountered by program participants (e.g. barriers confronted by sheltered and homeless tobacco, barriers related to language or literacy issues, etc.).

Each benchmark and the data source used in the evaluation are listed in Appendix 2, along with an example.
Key Definitions (for purposes of this RFP or the Evaluation Design)

- **Priority populations:** Direct service participants with a household income of less than $50,000 (size of 2 or more), OR education level less than high school, OR unemployed.
- **Intensive intervention:** Four or more sessions (individual or group), at least 10 minutes each, with someone formally trained in tobacco cessation accompanied by discussion about and/or use of applicable nicotine replacement therapy and/or pharmaceutical quit smoking aids.
- **Quit Attempt:** Abstinence from tobacco use for at least 24-hours.
- **Quit Rate:** Abstinence from tobacco use for thirty (30) days prior to being surveyed seven months after enrolling in the cessation program. The community grants evaluation design adopts the calculation for quit rates designed by the North American Quitline Consortium (NAQC) which suggests that only those participants who respond to a survey be used to calculate quit rates. In general, this produces higher quit rates than alternate calculation methods.
- **Best Practice:** Refers to methodologies, policies and procedures that provide guidance based on past experiences and evaluation, and are proven to be effective

Technical Assistance and Support to Grantees

As part of an awarded grant, grantees will receive technical assistance with respect to:

- Implementation of the PDA evaluation (i.e. assistance with the evaluation tools)
- Use of the PDA evaluation results (i.e. assistance with interpreting and using evaluation report findings)

HCF may arrange other technical assistance opportunities through grantee gatherings or other future events such as:

- Efforts to increase/improve treatment reach to the identified priority population
- Applying the best practices of tobacco cessation programming to grant activities

Funding Availability, Grant Term, Use of Funds

- Grants will be awarded for a three-year period with a maximum grant award of $75,000 per year (maximum of $225,000 over three years). The grant term is expected to begin in December, 2012 and run to December, 2015. Grant payments are contingent on the availability of funds from the Trust Fund.
- One million dollars ($1M) has been budgeted in calendar year CY 2012 and an additional $1M is expected to be budgeted in each of CY 2013 and CY 2014.
- Grant funds may not be used for capital improvements, to establish a statewide quitline, or to address third-party reimbursement.

Eligibility

To be eligible for funding under this RFP:

1. The applicant must be a non-profit organization with a 501(c)(3) tax-exempt status, a faith-based organization, or unit of government or submit a proposal using a fiscal sponsorship organization. The fiscal sponsor must have a 501(c)(3) status and be accountable for compliance with fiscal and programmatic requirements (see fillable Fiscal Sponsor Acknowledgement/Agreement template).
2. The applicant must have a good history of successful programmatic implementation and experienced personnel. Funding will not be provided for start-up organizations.
Timeline
In 2012, submission of proposals for the community grants/cessation program will be online. Anticipated RFP launch date is July 13, 2012. Your organization must first establish an online account with Hawaii Community Foundation to access the online application. Please go to: http://www.hawaiicommunityfoundation.org/grants/grants/grant/hawaii-tobacco-prevention-control-trust-fund-cessation to request an account or, if you already have an account, to access the online application. Note: If you are requesting an account, it may take a few days for you to receive the account information. It's highly recommended you request your account early to allow adequate time to complete the application by the submission deadline.

1. **Deadline:** submit your proposal online by 5:00pm HST on September 10, 2012.
2. Notification of awards will be sent by the end of December, 2012 with an initial notification by email.
3. First payment will be mailed upon the finalization of grant terms and agreement requirements.
4. Initial meetings with PDA to discuss evaluation design and data collection tools to occur within one month of grant award.

Proposal Review and Award Process
Proposals submitted as part of the 2012 grantmaking round will be reviewed by an internal review team comprised of HCF staff and an external review team comprised of a diverse group of individuals selected for their expertise, skills, and knowledge related to the focus of this RFP. The external review team will analyze the merits of each proposal and make recommendations to HCF. HCF will make the final decision on all grant awards. The strongest proposals will be those that address all the criteria listed below and provide supporting documentation (see Proposal Instructions). Any items missing from the on-line submission will delay review and may result in denial.

Criteria for Proposal Review
1. **Need**
   - The proposal identifies the specific priority population targeted by the intensive intervention and explains how that population will be identified and reached.
   - The applicant demonstrates knowledge of other programming to the specific priority population in their community or service area(s) and identifies gaps in cessation services that will be addressed by the proposed program.
   - The applicant demonstrates history and connection in providing services to the specific priority population.

2. **Program Activities/ Methodology**
   - The proposed program is well defined and reasonable.
   - The proposed intervention follows guidelines for intensive intervention as defined in this RFP.
   - The proposal commits to discussing the use of and/or facilitating access to medications, pharmacotherapies, and/or NRT in their intervention (unless there are contraindications).
   - The proposed program follows established best practices in the field of tobacco control

3. **Program Workplan; Program Performance; Outcomes Evaluation**
• A clear workplan is submitted that provides an overview of the program including anticipated activities, timeframe for those activities, who will be responsible monitoring performance, anticipated number of tobacco users to be reached and served and in what setting, etc. (see Workplan template).
• The proposal includes information on the organization’s experience using standardized evaluation protocols.
• The proposal confirms the applicant’s commitment to implement the evaluation designed for this RFP.

4. Strong Organization and Management
• The organization, its leadership and staff, have the experience, expertise, and commitment to implement the program and oversee the management of the grant. The proposal includes descriptions of personnel to serve on the program team and their qualifications relevant to the work to be performed. The organization has a Tobacco Treatment Specialist in place or outlines a plan to support that level of staff development and/or identifies other qualified cessation personnel.
• The proposal demonstrates the organization’s commitment and ability to hold itself accountable for program implementation and performance, including the outcomes evaluation.
• If applicable, the organization has a track record of effective partnerships and the proposal clearly defines specific roles and responsibilities of partners.
• If the proposal includes work by a contractor/consultant, a workplan developed by the contractor/consultant, with specific deliverables, is included as part of the proposal.

5. Realistic Budget
• The total program budget is detailed, justified, and reasonable in terms of scope and scale for the program and delivery of service to the specific priority population. Please disclose other funding sources supporting this program (if any) and whether those funds are secured or pending.
• The overall organizational operating budget is provided as part of the proposal.
• The Budget/Budget Narrative (see Budget template) is completed and submitted. The budget:
  o Includes a maximum 10% of the program budget for administrative/indirect costs (see budget template).
  o Dedicates 10% of the program budget to comply with the PDA evaluation (may be budgeted for an individual responsible for assuring implementation of the PDA evaluation design).
  o Excludes any other evaluation costs.

Proposal Instructions or Guidelines: The following headings will have fillable boxes in the online application and each box is allotted a maximum number of characters. The character counts in MS Word do not match the character counts in the application. You may cut and paste your work into the application but please be aware that you may need to edit your document so that it fits. You will need to be very clear and concise in order to fit the character limitations.

• **Executive Summary** (character count = 3,500)
  Provide a short description of the proposed program including the proposed activities and outcomes, the specific priority population to be served, and the applicant’s experience designing and/or delivering intensive cessation interventions and services. Include information about the applying organization and, if applicable, the fiscal sponsor as well as a description of the roles of any partners on the proposed program.
• **Program Narrative** (3 major pieces)

**Needs (maximum character count = 5,000)**
1. Describe the needs of a priority population (as defined in this RFP) and provide and identify tobacco use data or other specific documentation (assessments, current data, surveys etc.) regarding the need in that population. Explain any evidence supporting the proposed activities and relevance to the objectives of this RFP.

**Program and Activities/ Methodology (maximum character count = 7,000)**
2. Describe the proposed program and activities to be conducted, by whom, when, and where. Describe, if applicable, the role and work of proposed consultants/contractors. Do not integrate the consultant’s workplan and statement of qualifications in the Program Narrative but include it as a separate document. The program narrative should conform to the program workplan (see workplan template).
3. Outline your plan to monitor progress on implementation of the program. Who will be responsible?

**Organization and Management (maximum character count = 5,600)**
4. Describe how the program fits the mission of the organization, coordinates with other organizational activities (if any), and will be effectively managed. Identify and describe the qualifications of key program staff. Highlight the organization’s experience in design and/or delivery of intensive cessation interventions and/or work with members of the specific priority population.
5. Describe the capacity of the organization and its key partners to carry out and evaluate the work proposed. Give a clear definition of the specific roles and responsibilities for the collaborating entities and describe the applicant organization’s track record of effective partnership.

• **Program Workplan** (a fillable workplan template is provided in the online application process) Please complete the fillable worksheet with information for up to three years of your proposed program.

• **Program Budget and Budget Narrative** (a fillable budget template is provided in the online application process)
Detail how the applicant will use the requested funding by budget line item. In the Budget Narrative column, include a brief description of each budget line item, a description of any calculations to obtain the total by line item, and how that budgeted item relates to the overall program.

  ➢ A maximum of ten percent (10%) of total program costs may be allocated for administrative /indirect costs related to implementation of the program. Administrative or indirect costs are defined on Worksheet 2.
  ➢ Ten percent (10%) of total program costs must be budgeted to comply with the PDA evaluation (may be budgeted for an individual responsible for assuring implementation of the PDA evaluation design).

If the proposed program is part of a larger effort, include a description of the overall budget. Describe funding from all sources under the appropriate budget line item (e.g. other grants, fee for service etc.), dollar amounts, status (e.g. request pending, funding secured etc.) and the type (e.g. cash, in-kind, etc.) State what percentage of the organization’s operating budget will be funded by Trust Fund dollars.
If the budget proposes funds for a contractor/consultant, include the consultant workplan developed by the proposed contractor/consultant to include specific deliverables. **NOTE: Omission of this document will result in administrative denial.**

- **Supporting Documents** - required only for 501(c) (3) applicants. You will be asked to upload one copy of each item listed.
  - The organization’s Board approved operating budget for the current year.
  - The organization’s most recent audited financial statements or 990 tax return.
  - Income Statement (or Profit & Loss Statement) for the most recently completed fiscal year
  - Balance Sheet for the most recently completed fiscal year
  - The organization’s current Board list or leadership group list
  - Contractor/Consultant workplan

- If you are using a fiscal sponsor, please submit the following documents:
  - Fiscal Sponsor’s Acknowledgement/Agreement agreement
  - Fiscal Sponsor’s Board Resolution
  - Fiscal Sponsor’s Board of Directors list
  - Fiscal Sponsor’s Income Statement (or Profit & Loss Statement) for the most recently completed fiscal year
  - Fiscal Sponsor’s Balance Sheet for the most recently completed fiscal year
  - Fiscal Sponsor’s Annual Operating Budget for the current year

**DEADLINE:**

All materials must be submitted via the on-line system by 5:00 pm HST on:  

**September 10, 2012**  

(NOTE: HCF Neighbor Island Offices will not accept written proposals)

**Contact Information**

For questions about this RFP, please call Roella Foronda at (808)566-5536 (email: rforonda@hcf-Hawaii.org) or Jennifer Schember-Lang at (808)566-5572 (email: jschember-lang@hcf-Hawaii.org). Neighbor Islands may call our toll-free number at 1-888-731-3863.

For technical assistance with the online application process, please go online to [http://hawaiicommunityfoundation.org/ticket](http://hawaiicommunityfoundation.org/ticket).
Appendix 1
2012 Request for Proposals
Hawaii Tobacco Prevention and Control Trust Fund
Community Grants Program/Tobacco Cessation Services for Priority Population

Background
MSA funds flow into the State of Hawai‘i on an annual basis and into a Tobacco Settlement Special Fund administered by the DOH. These funds have been distributed according to state law to the Trust Fund, the Emergency and Budget Reserve Fund (Rainy Day Fund), the General Fund, the University of Hawaii John A. Burns School of Medicine (JABSOM), and to the DOH. The legislature has changed this distribution over time. As a result of legislative action in 2011, the Trust Fund will not receive any additional MSA allocation for fiscal years 2012 and 2013 (Act 124).

Over the past twelve years, the Trust Fund has provided significant support to implement Hawaii’s comprehensive tobacco control effort. A variety of tobacco prevention and control programs have received funding consistent with the Hawai‘i Statewide Strategic Plan for Tobacco Prevention and Control (Tobacco Strategic Plan) and the US Centers for Disease Control and Prevention Best Practices. This comprehensive tobacco control effort includes:

- State and community interventions (policy change activities, community grantmaking)
- Health communications interventions (media interventions to prevent tobacco use initiation, promote cessation, and shape social norms)
- Cessation Interventions (tobacco use treatment)
- Surveillance and evaluation
- Administration and Management

In 2010, the DOH and several community partners and stakeholders began work to update Hawaii’s tobacco control plan. This plan is intended to serve as an overall framework for programmatic direction and evaluation and set new five-year goals, whether funded by Trust Fund or other resources. The Tobacco Use Prevention & Control in Hawaii, A Strategic Plan for the State 2011-2016 (state strategic plan published in May, 2012, is available at: http://www.hawaiitobaccocontrol.org/uploads/tobacco-use-prevention-and-control-strategic-plan-state-2011-2016) builds on the principles originally adopted in 2006 including:

- Effective tobacco prevention and control will require a long-term sustained effort.
- Specific strategies will be identified for reducing tobacco-related disparities among priority groups and communities in Hawai‘i.
- Tobacco prevention and control activities will be evidence-based or follow a best practice. Strategies using innovative and promising practices are also encouraged with evaluation supporting those efforts.
Appendix 2

The performance measures below are standardized so that the same data is collected for each community grants program funded, as well as participants of the Hawaii Tobacco Quitline. In addition to these standard measures, PDA will provide each grant the opportunity to add up to two unique items to the Registration or Utilization Form, and two unique items to the 7 month follow-up survey. These items are designed to capture program characteristics, components, or outcomes that are unique to each program.

<table>
<thead>
<tr>
<th>Benchmark</th>
<th>Example</th>
<th>Data and Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>The number of participants served should result in a cost per enrollment equal to or less than $500 per enrollment. A cost per enrollment is defined as the grant dollar total divided by the number of people enrolled in a program.</td>
<td>A grant that receives $75,000 per year and serves 150 people has a cost of enrollment of $500 ($75,000 / 150 = $500). This meets the minimum benchmark of success for numbers served, because the cost per enrollment is $500 or less.</td>
<td>Number of enrollees collected by Registration Form.</td>
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<tr>
<td>The number of participants from priority populations served should be 80% of the total number served.</td>
<td>A grant that proposes to serve 150 people per year serves 120 from priority populations has met the minimum benchmark for success. This is because 80% of 150 is 120 (.80 * 150 = 120).</td>
<td>Number of enrollees and demographic data on participants served collected by a Registration Form.</td>
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<tr>
<td>Ninety percent (90%) of enrolled participants will be ready to quit.</td>
<td>A grant that serves 150 people per year, of whom 135 are ready to quit, will have met the minimum benchmark. This because 90% of 150 is 135 (.90 * 150 = 135).</td>
<td>Number of enrollees paired with participants’ readiness to quit as collected by a Registration Form.</td>
</tr>
<tr>
<td>Seventy-five percent (75%) of participants without contraindications for stop-smoking medications will use stop-smoking medications.</td>
<td>A total of 75 of 100 participants reached for a follow-up survey per year report using stop smoking medications. This meets minimum benchmarks because 75% of 100 is 75 (.75 * 100 = 75).</td>
<td>The proportion of participants who reported using stop-smoking medications, as collected on a 7-month follow-up telephone survey.</td>
</tr>
<tr>
<td>Eighty percent (80%) of tobacco users are very or</td>
<td>A total of 80 of 100 participants reached for a follow-up survey</td>
<td>The proportion of participants who reported being very or</td>
</tr>
<tr>
<td>Mostly satisfied with the services they received.</td>
<td>Per year report being very or mostly satisfied with services. This meets minimum benchmarks because 80% of 100 is 80 (.80 * 100 = 80)(^1).</td>
<td>Mostly satisfied with the services they received, as collected on a 7-month follow-up telephone survey.</td>
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<tr>
<td>Ninety percent of enrollees make a quit attempt of 24 hours or more.</td>
<td>A total of 90 of 100 participants reached for a follow-up survey per year report abstaining from tobacco for 24 hours or more since enrolling in the program. This meets minimum benchmarks because 90% of 100 is 90 (.90 * 100 = 90)(^1).</td>
<td>The proportion of participants reporting making a quit attempt of 24 hours or more, as collected on a 7-month follow-up telephone survey.</td>
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<tr>
<td>Thirty percent (30%) of enrollees achieve 30 day abstinence, as defined by the North American Quitline Consortium(^2).</td>
<td>A total of 30 of 100 participants reached for a follow-up survey per year report having not used any tobacco for the 30 days prior to being surveyed. This meets minimum benchmarks because 30% of 100 is 30 (.30 * 100 = 30)(^1).</td>
<td>The proportion of participants reporting 30 day abstinence, as collected on a 7-month follow-up telephone survey.</td>
</tr>
</tbody>
</table>

\(^1\) Please note that PDA takes responsibility for the number of participants reached by follow-up survey.