Communities of Excellence
in Tobacco Control

A Communities of Excellence Needs Assessment Guide

California Department of Public Health
California Tobacco Control Program

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Communities of Excellence in Tobacco Control: A Framework for Assessing Community Tobacco Control Needs

Introduction

This manual provides information about the California Tobacco Control Program's (CTCP) social norm change strategy and how the Communities of Excellence (CX) needs assessment framework supports this strategy. It describes the historical context for developing CX, its evolution, and updated tools and instructions for exploring your community's tobacco control-related needs.

The term "tobacco" used in this manual refers to commercial tobacco products. CTCP does not seek to impinge upon the sacred use of traditional or ceremonial tobacco in American Indian communities.

Social Norm Change

The ultimate goal of tobacco control work is to end the tobacco epidemic once and for all, especially among young people and communities disproportionately burdened by commercial tobacco. Through leadership, experience, and research, CTCP empowers community and statewide grantees and local health agencies to promote health and quality of life by creating social norms that keep tobacco products out of the hands of youth, help tobacco users quit, and ensure that all Californians can live, work, play and learn in tobacco-free environments.

California's approach to protecting the public's health and preventing tobacco-related diseases and illnesses, such as cancer,[1] cardiovascular disease,[2] premature births, sudden infant death syndrome, emphysema, and asthma, is accomplished through a social norm change strategy. It emphasizes changing norms in the larger physical and social environment, rather than changing the behavior of individuals. It seeks to impact the diverse and complex social, cultural, economic, and political factors which foster and support continued tobacco use.

California's social norm change strategy[3] is a cost-effective and efficient approach because the strategy involves creating population-level changes, such as the adoption of policies, that lead to reduced tobacco use rates;[4] decreased exposure to secondhand smoke, thirdhand smoke and tobacco marketing; and promote tobacco cessation.[5] The social norm change strategy works on the premise that as new people or businesses move into the community, they inherit and adopt the established norms about tobacco use (e.g., no smoking on restaurant patios) and promotion and sale of tobacco (e.g., not being able to sell tobacco products without a license).

Overall, California's social norm change strategy seeks to create an environment where tobacco use becomes less desirable, less acceptable, and less accessible. Through community interventions, the provision of statewide training and technical assistance, and mass media campaigns, CTCP works to achieve social norm changes that add up to a significant decrease in tobacco use at the population level. Community interventions that focus on policy, environmental, and system-level change are the building blocks of social norm change and play a vital role in changing and sustaining social norms.

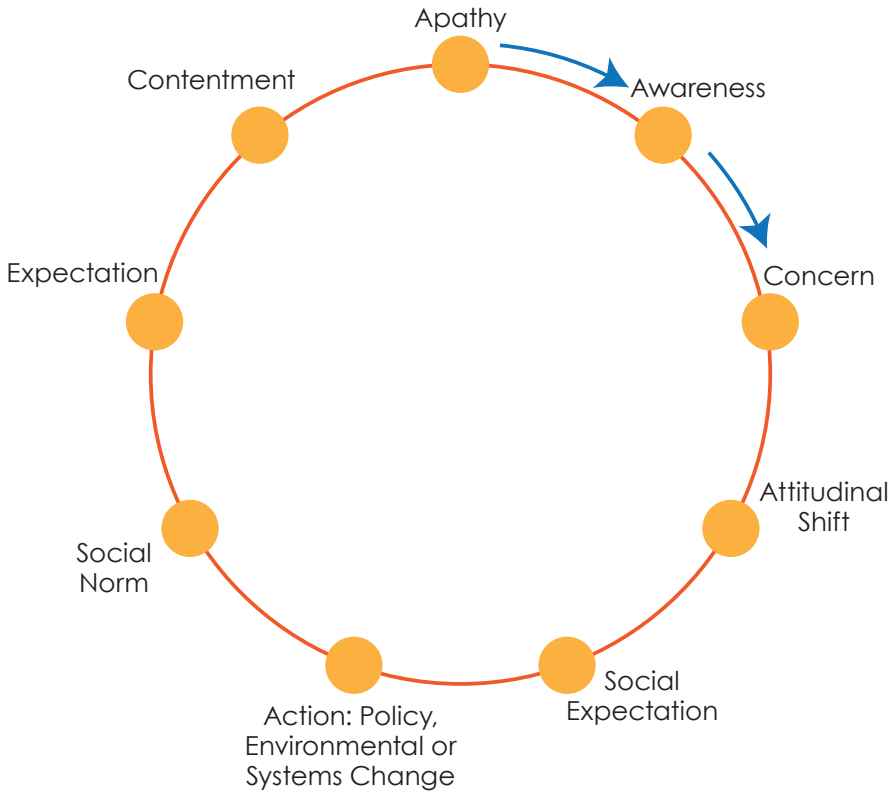
California's social norm change strategy relies on a comprehensive and cross-cutting population approach. It seeks to create changes that impact every member of the community and social structure to achieve health equity. The social norm change strategy recognizes that people do not live in silos and that community-wide changes impact all the groups in that community, provided that the policies and system changes adopted do not allow for exemptions, which can create inequities.

California's social norm change strategy also recognizes that adults are an important audience for education and awareness-raising efforts, as adults exert considerable influence and control over a community's tobacco use norms. It is adults who make decisions to:

- Raise taxes on tobacco products and designate a portion of that revenue for tobacco use prevention and cessation;
- Enact laws to protect the public and workers from exposure to secondhand and thirdhand smoke;
- Dedicate funding for smoking cessation services and other tobacco control efforts;
- Prioritize enforcement of tobacco laws;
- Advocate and vote for policies which protect children from tobacco exposure, protect communities from inequities in tobacco marketing practices, and limit the influence of the tobacco industry;
- Model a tobacco-free lifestyle and social norms to youth and young adults.

The social norm change strategy, illustrated by the Social Issue Cycle (Figure 1), works by moving a community or organization along a cyclical continuum that may begin with **apathy** for an issue. Through education and outreach, **awareness** is raised which results in **concern** for an issue and a **shift in attitudes**. These attitudinal changes create a **social expectation** that **action** will be taken to resolve the issue. In turn, the social expectation for action provides the political will necessary to support policy, environment or system-level changes, which result in a new social norm. As the new **social norm** is broadly adopted, there is an **expectation** that people, communities, and organizations will conform to the new social norm resulting in **contentment**.

Figure 1: Social Issue Cycle



The Social Issue Cycle is not static. It is constantly evolving. One example of the Social Issue Cycle in action in California concerns secondhand smoke exposure. When CTCP was launched in 1989, smoking was permissible on airplanes, in hospitals, and in most workplaces. Through statewide media and community interventions, communities became aware and concerned about secondhand smoke exposure in enclosed spaces. This concern led to changes in attitudes about the acceptance of exposure to secondhand smoke, which

created support for policies restricting smoking on airplanes, at worksites and in bars. As local and statewide clean indoor air policies were adopted, the social norm changed and people began to expect smokefree environments. While initially controversial, today there is a wide-spread contentment with clean indoor air policies. In California, the expectation for protection from secondhand smoke exposure has moved to a similar expectation in outdoor settings. This expectation has also launched additional clean air laws in California, including making state-owned beaches and parks smokefree.[6] In addition, numerous sport venues, amusement parks, community trails, fairs and festivals, and even downtown streets now restrict smoking.

Development of CX

What are the requirements for needs assessments and local planning?

In November 1988, California voters approved the Tobacco Tax and Health Promotion Act of 1988 (Proposition 99) which raised the tobacco tax in California by 25 cents and earmarked that 20 percent of the funds collected be allocated to a comprehensive tobacco control program jointly administered by the California Department of Public Health (CDPH) and the California Department of Education.[7] The enabling legislation that established California's comprehensive tobacco control program designated the 61 health departments that serve 58 counties and three cities as Local Lead Agencies (LLAs).[8,9]

Almost three decades after Proposition 99's passage, in November 2016, the voters of California overwhelmingly passed Proposition 56, the California Healthcare, Research and Prevention Tobacco Tax Act of 2016.[10] Proposition 56 increased the state cigarette tax from $0.87 to $2.87 per pack, taking California's ranking from 37th to 9th in the nation for highest cigarette tax. The initiative also increased the tax on other tobacco products, including electronic cigarettes, by an equivalent amount for the first time. With 64.4 percent voting in favor of Proposition 56, Californians sent a strong message of their support to end the tobacco epidemic.[11]

The enabling legislation also requires LLAs to periodically submit a comprehensive tobacco control plan to CDPH and to obtain the involvement of local community organizations in the development of that plan.[9,10] The legislation requires that the plan provide demographic information; local data on smoking and tobacco use; a description of program goals and objectives, target populations, activities, evaluation, and budget cost estimates for program activities; and budget information including staffing configurations

and computer hardware and software needs. Additionally, local health departments are required to use a uniform data and information management system, which permits comparisons of workload, unit costs, and outcome measurements on a statewide basis.

Why did CTCP develop the CX needs assessment process?

Development of the CX framework was stimulated by several factors. After a decade of funding local tobacco control programs, CTCP believed it was important for local health departments to take a critical look at their communities to determine what had been accomplished and what remained to be done. At this time, two major events occurred; the 1998 Master Settlement Agreement (MSA)[12] and enactment of the 1998 California Children and Families (CCF) Act (Proposition 10)[13] which raised the cigarette excise tax by 50 cents per pack beginning in January 1999. These events had the potential to dramatically alter California's tobacco control landscape with additional funding and new tobacco control partners that may not have previously been involved in tobacco control activities.

Collaboration in the Development of CX

It was within this context of the enactment of the MSA and CCF Act in the late 1990's that CTCP formed a workgroup to design a uniform needs assessment process. The workgroup included representatives from local health departments, networks representing priority populations, regional community linkage projects, community-based organizations, and voluntary health organizations.

The workgroup's efforts were informed by several local, regional, and national activities. Individually, multiple organizations had identified specific tobacco control benchmarks and were using ratings to compare and contrast progress on each. Similarly, the U.S. Centers for Disease Control and Prevention and others were developing community cardiovascular disease prevention indicators.[14]

Simultaneous to CTCP's steps to standardize local tobacco control assessment practices, the American Cancer Society (ACS) embarked on its Communities of Excellence Initiative.[15] This initiative involved development of a comprehensive tobacco control training tool to guide communities through mobilizing a coalition to develop a local tobacco control strategy. Because of the similarities in the work being done by ACS and CTCP, the two efforts were merged. ACS implemented CX in more than 40 states to promote strong comprehensive tobacco control program planning and development. Evaluation of the CX process in both California and across the nation has shown that local programs using the CX process develop better workplans, have a larger

impact, and more effectively engage local participants in their tobacco control work.[16] CTCP has continued to update, revise, and utilize the CX process to assess and to measure needs, opportunities, and successes across the evolving tobacco control movement in California.[17-22]

CTCP combined the concepts of community engagement, community indicators, and rating systems to develop the CTCP CX needs assessment framework.

The Standardized Framework

Prior to the adoption of the CX framework for needs assessments, each agency that was planning tobacco control work would conduct its needs assessments independently of each other and the state. There was a lack of consistency from one agency to the next in the types of data collected or the way in which the data were coalesced and shared. Thus, the workgroup sought to design a needs assessment which was uniform yet flexible enough for use in diverse communities. This model needed to be accessible and feasible for communities that vary greatly in terms of needs, size, barriers, and capacity.

Goals

The goals for developing the CX needs assessment framework were to:

- Broaden the involvement of the community in local tobacco control planning;
- Standardize the assessment of community needs and assets across all 61 local health departments;
- Ground the development of the comprehensive tobacco control plan in the needs assessment findings and focus the resulting plans on community norm change versus individual behavior change; and
- Strengthen and improve local program evaluation efforts as a result of using a uniform nomenclature and standardized evaluation requirements.

CX Framework: The Four-legged Stool

The resulting CX needs assessment framework consists of a four-legged stool which supports CTCP's overarching social norm change strategy:

1. Community engagement in assessing needs, prioritizing, and planning;
2. Rating community capacity to address social disparities;

3. Standardized tobacco control indicators and assets; and,
4. Uniform needs assessment tools.

Community Engagement in Assessing Needs, Prioritizing, and Planning

CTCP is motivated by the guiding principle that identifying tobacco problems and their solutions should be a community-led process. When communities participate in identifying the problems, then invest in the solutions during the CX needs assessment process, that ownership will lead to effective implementation and enforcement to the change they choose to create. When people who are impacted by tobacco use and disease are asked to define the problem, CTCP projects provide the expertise to define possible solutions and support the community's ability to reach a solution by providing education, training, collaboration, evaluation, and media resources. That solution is the basis for policy, system, and environmental change issue campaigns. Table 1. *Problems, Solutions, and Issues* provides examples of how problems and their solutions can define the issues communities work on.

Table 1. Problems, Solutions, and Issues

Problem	Solution	Issue
Too many youth can buy tobacco products directly from local retailers	Put a mechanism in place to ensure retailers comply with age-of-sale laws	Tobacco Retail Licensing
Many apartment dwellers report secondhand smoke (SHS) drifting into their homes through walls and windows	Eliminate smoking within a multi-unit housing dwelling and within so many feet of any external doors and windows	Smokefree Multi-unit Housing
Smoking is visible and SHS is encountered in outdoor public spaces, including sidewalks, outdoor dining, parks, and recreational areas	Prohibit smoking in outdoor spaces designated as public places	Comprehensive Secondhand Smoke

When identifying issues, they must be widely felt (many people feel that the issue is important and agree with the solution), deeply felt (people feel strongly enough to do something about the issue), and easy to understand (a good issue does not require lengthy and difficult explanations). The CX process is at the core of measuring how widely your community feels about an issue

and how deeply they feel the need to pursue that issue, with the community represented at the decision-making table. [23]

CX seeks to engage community members to assess tobacco-related problems using readily available data and identify the solutions that are a best fit for the community at the time of assessment. Community members are necessary at all stages of the CX and plan-writing process, including setting priorities, developing a work plan, and helping to mobilize the community to activate the plan. Engagement of the community is an essential element of the CX framework as it brings together a variety of expertise, influence, and connections. It gives credibility to program efforts since community members were involved in identifying priorities and developing the plan of action. Additionally, community engagement amplifies the program's messages by multiplying the channels through which messages are promoted, increasing the likelihood that target audiences will come into contact with the messages. Through involvement of the community and its leaders, the community is mobilized to address tobacco-related problems as they are experienced at the community level.

At the heart of CX is the idea that communities can achieve excellence in tobacco control by engaging a motivated and diverse group of people to assess where their community is now in terms of tobacco control, determine where it needs to go, and how it will get there.

Local agencies who are leading the CX needs assessment are highly encouraged to develop relationships with and involve groups who are disproportionately affected by tobacco use, exposure to secondhand/thirdhand smoke, and/or who represent the diverse populations and sectors of the community being assessed. These sectors include, but are not limited to health care providers/systems, education, law enforcement, business, housing, tourism, human services, religion, community planning, community activist and volunteer groups, service/fraternal organizations, culture, and the environment. CX is an opportunity to engage individuals and organizations that are impacted by tobacco, but have not previously participated in the efforts of the tobacco control program.

The CX process should provide a variety of ways to engage numerous community members in a process that is both inclusive and equitable. This may include providing opportunities to participate in meetings virtually, providing in-language or translation options, and hosting meetings outside of normal

working hours. See Table 2. *How to be More Inclusive and Equitable in Community Engagement Efforts* for specific examples of ensuring your community engagement efforts are inclusive and equitable.

Table 2. How to be More Inclusive and Equitable in Community Engagement Efforts

Engagement: How to be…	…More Inclusive	…More Equitable
Provide space for introductions and ice breakers, both in-person and in virtual environments	• Require everyone to speak up early in the gathering through introductions/ice breakers to build investment in the session and CX process and get more comfortable with each other in discussion mode	• Create a "level-set" by ensuring everyone has an opportunity to introduce themselves and identify what experiences or knowledge they bring to the table and can contribute to the assessment process
Host CX partially or entirely online using conference software (e.g. Zoom, Teams, Meet)	• Ensure the length of the meeting suits community member needs and the technology is easy to use, without any added expense to the participants • Overcome geography, location, and/or travel costs that may prevent participation by offering online engagement	• Ensure there are phone-in or in-person options for those without adequate internet connections • Mail materials to those who may not have the ability to print or join online so they can also offer feedback
Use Digital Engagement Tools to Create an Interactive Experience	• Using online tools like Kahoot or Mentimeter to poll your participants on their thoughts and conduct online priority setting • Use Google Docs or digital workspaces like Slack to organize your data packets, notes, and resources for participants to access	• Ensure digital tools are available in multiple languages (if needed); and are accessible by cell phone, if internet access is an issue • Ensure documents, infographics, and reports are ADA compliant for use by people in-person or online

Shared responsibilities with diverse partners to conduct CX assessment tasks and responsibilities	• Build time into your CX process to provide train-the-trainer trainings, to engage additional partners who can facilitate parts of the conversation and assessment process, so that facilitation is shared	• To ensure issues proposed are assessed equitably, partners representing and/ or connected to populations most impacted by the problem should be at the table and helping to lead the discussion
Provide CX assessment sessions in languages beyond English as needed in your community, with translators and/or sign-language interpreters, when appropriate	• When trying to address health disparities in specific priority populations, conducting the assessments in multiple languages may be necessary	• To ensure issues proposed are assessed equitably, partners representing and/ or connected to populations most impacted by the problem should be at the table and helping to lead the discussion

Rating Community Capacity to Address Social Disparities

CX recognizes that certain populations use tobacco products at a higher rate, experience greater secondhand smoke exposure at work and at home, are disproportionately targeted by the tobacco industry, and/or have higher rates of tobacco-related disease compared to the general population. These populations in California include, but are not limited to:[24]

- African Americans, American Indian and Alaska Natives, Native Hawaiians and Pacific Islanders, Asian American men, Latinx
- People of low socioeconomic status;
- People with limited education, including high school non-completers;
- Sexual and gender minorities, including lesbian, gay, bisexual, transgender, and queer (LGBTQ) people;
- Rural residents;
- Current members of the military and veterans;
- Individuals employed in jobs or occupations not covered by smokefree workplace laws;

- People with substance use disorders or behavioral health issues;
- People with disabilities; and
- School-age youth.

This leg of the CX stool assesses the use of tobacco-related disparity data in planning and conducting tobacco control interventions; developing a specific plan of action for reducing tobacco-related disparities; collaborating with community efforts that address social determinants of health; multicultural media engagement; and using evaluation tools to capture, understand and communicate social and tobacco-related inequities. To understand and communicate these social and tobacco-related inequities, here is a list of terms and definitions.

Glossary[25]

Term	Definition
Disparity	A disparity is a difference in outcome between population groups. Disparities are not always due to inequities, but can be. An inequity is a difference in outcomes that is unfair and unjust.
Equality	Equality describes circumstances in which each individual or group is given the same or equal treatment, including the same resources, opportunities, and support. However, because different individuals or groups have different histories, needs, and circumstances, they do not have equal positions in society or starting points. Providing the same resources, supports, or treatment does not guarantee that everyone will have fair or equal outcomes.
Equity	Equity recognizes that because different individuals or groups have different histories and circumstances, they have different needs and unequal starting points. Using an equity approach, individuals and groups receive different resources, opportunities, support, or treatment based on their specific needs. By providing what each individual or group needs, they can have equal or fair outcomes.
Health disparity	A health disparity is a difference in physical or mental health status or outcomes between groups. A health equity analysis can help determine whether a health disparity—such as a difference in disease burden—is also a health inequity.

Inequity	An Inequity is a difference in outcome between population groups that is unfair or unjust. This term is separate from, but related to, the term disparity in that inequities are generally disparities—differences between groups—that are avoidable or warrant moral criticism and condemnation.

Standardized Tobacco Control Indicators and Assets

Indicators

Community indicators represent environmental or community-level measures which ask to what extent a certain condition exists in the community. Indicators are focused at the community, organization, or agency level and are observational in nature. They focus on aspects related to tobacco marketing, promotion and distribution; economic factors, secondhand smoke exposure, the environmental impact of tobacco waste, accessibility of tobacco products, and availability of cessation support.

Example:

Indicator 2.2.13	**Smokefree Multi-Unit Housing**: The number of jurisdictions with a policy prohibiting smoking in the individual units of multi-unit housing including balconies and patios.

Assets

Community assets represent factors that promote and sustain tobacco control efforts in the community by facilitating tobacco control work. They address such things as funding for tobacco control activities, community engagement and inclusivity, capacity building, and cultural competence.

Example:

Asset 2.4	**Youth Engagement in Tobacco Control**: The degree our program has participatory collaborative partnerships with diverse youth and youth serving organizations, and engages them to support tobacco control related activities that focus on policy, systems, and environmental changes.

Uniform Needs Assessment Tools

The CX needs assessment involves a focused inquiry facilitated by a local agency who engages coalition members, advisory group members and others in rating indicators and assets. The process uses existing local, regional, state,

and national data, discusses the meaning of that data, and then rates how well the community is doing with respect to an indicator or asset. Quantitative data, qualitative data, and the expertise of community members are taken into consideration and a rubric is used to guide selection of the rating. A consensus rating is recorded on standardized forms along with comments to substantiate the rating. Based on the needs assessment, priorities are identified and a workplan with specific objectives, activities, timelines, responsible parties and evaluation measures is developed.

Evolution of CX

Since CX was introduced in 2001, the indicators and assets are periodically revised to reflect changes in tobacco control priorities and solutions, with new indicators added and existing indicators modified if needed. Indicators that no longer serve community needs are retired. California's tobacco control community participates in this process in the months prior to the release of an updated CX manual. This current manual, published in 2020, serves as an update to the 2016 CX manual.

With the availability of additional funding for tobacco control in California through community grants, CX also provides a useful framework for local health jurisdictions to help plan and guide the work being done in order to ensure it meets community needs and priorities. LLAs are encouraged to share CX results with community members and organizations who may apply for new funding opportunities, in order to ensure that all communities and populations are reached, and that there is not a duplication of work.

Conclusion

Since the inception of the CX needs assessment framework in the late 1990s, CTCP has sought to keep the process relevant by regularly updating the CX indicators and assets. CTCP believes that the resulting revisions provide a needs assessment framework that is highly relevant to today's environment and that these tools will help make major progress in reducing tobacco-related disparities.

2020 Communities of Excellence Indicators and Assets List

Communities of Excellence Indicators

The term "tobacco" used in this list refers to commercial tobacco products. CTCP does not seek to impinge upon the sacred use of traditional or ceremonial tobacco in American Indian communities.

Priority Area: Limit Tobacco Promoting Influences (1) Tobacco Marketing and Deglamorization Indicators (.1)	
Definition: These indicators address: 1) advertising and marketing tactics used to promote the use of tobacco products including electronic smoking devices (ESD), 2) the glamorization of tobacco (including ESD) through entertainment and social media venues, 3) the public image of tobacco (including ESD) companies, and 4) other environmental factors and industry influences that promote or decrease tobacco product use (including ESD). ESD includes heated tobacco products. Outcome objectives based on these indicators may address the continuum of policy change and compliance including voluntary or legislated policy change, resolutions, policy implementation, or promotion of enforcement/ compliance, as appropriate to the indicator (e.g., for some indicators a voluntary policy may be the only legally viable option).	
1.1.1	**Store Interior Marketing**: The number of jurisdictions with a policy restricting or eliminating time, place, and manner, in-store tobacco product advertising, promotions, or product displays (e.g., "power walls") consistent with the First Amendment and federal law.
1.1.2	**Content Neutral Signage Restriction**: The number of jurisdictions with a policy restricting or eliminating outdoor window signage or other exterior signage such as hanging signs, wall signs attached to the outside of the building, or sidewalk signs consistent with the First Amendment and federal law.
1.1.3	**Media Outlet Advertising Policies**: The proportion of print and digital media outlets (e.g., magazines, newspapers, social media) that have adopted a voluntary policy to refuse tobacco product advertising.

Priority Area: Limit Tobacco Promoting Influences (1) Tobacco Marketing and Deglamorization Indicators (.1)	
1.1.4	Retired
1.1.5	**Enforcement of the Master Settlement Agreement (MSA)/Smokeless Tobacco Master Settlement Agreement (STMSA)/Federal Tobacco Marketing Restrictions**: The number and type of violations by tobacco manufacturers or retailers for advertising, sponsorship, promotional, or other marketing requirements identified in the MSA, STMSA, or federal law.
1.1.6	**Sponsorship**: The number of jurisdictions with a policy restricting or eliminating time, place, and manner of tobacco company sponsorship and marketing at public, entertainment, and sporting venues (e.g., county fair, rodeo, motor sports, sporting events, parade, concert, museum, dance, festival, business forum) consistent with the First Amendment and federal law.
1.1.7	**Adult-Only Facility Marketing**: The number of jurisdictions with a policy restricting or eliminating time, place, and manner of tobacco product marketing and sponsorship at adult-only facilities (e.g., bars and night clubs) consistent with the First Amendment and federal law.
1.1.8	**College/Trade School Marketing**: The number of colleges, universities, trade/technical schools with a policy restricting or eliminating tobacco company product marketing and sponsorship consistent with the First Amendment and federal law.
1.1.9	**Corporate Giving**: The number of professional groups, community groups, and institutions (e.g., education, research, public health, women's, cultural, entertainment, fraternity/sorority groups, social service) with a voluntary policy that prohibits partnering with and acceptance of funds from both tobacco and ESD companies for any purpose.
1.1.10	**Political Contributions**: The number of elected officials or political caucuses that have signed a voluntary pledge to refuse tobacco and ESD company contributions.
1.1.11	**Smoking in the Movies**: The number of elected officials, parent organizations, health groups, entertainment entities or other groups that have adopted resolutions and voluntary policies that support: 1) an "R" rating for movies that depict smoking, 2) certifying no payments for depicting tobacco use, 3) an end to the depiction of tobacco brands, 4) requiring the placement of strong anti-smoking ads prior to airing any film with any tobacco presence, and 5) limiting government supported movie subsidies to tobacco-free movies.

Priority Area: Limit Tobacco Promoting Influences (1) Tobacco Marketing and Deglamorization Indicators (.1)	
1.1.12	**Candy Tobacco Look-Alike Products**: The number of jurisdictions with a policy eliminating the sale of edible products packaged to resemble tobacco products (e.g., candy cigarettes, bubble gum cigars, chewing gum).
1.1.13	**Anti-Industry Media Coverage**: The number and quality of news media stories, blogs, or social media efforts highlighting the harmful impact of tobacco and ESD industry practices and/or political lobbying on health and/or the environment.
1.1.14	Retired
1.1.15	Retired
1.1.16	Retired
1.1.17	**Anti-tobacco Advertising Placement**: The number of jurisdictions covered by a public policy that mandates a 1:1 or 3:1 placement of anti-tobacco advertising in prime retail locations to counter pro-tobacco and ESD advertisements, buydowns or other promotional offers consistent with the First Amendment and federal law.
1.1.18	Retired
1.1.19	**Point-of-Sale Graphic Health Warning Signs About Tobacco Use**: The number of jurisdictions with a policy requiring tobacco retailers to display graphic health warning signs that raise awareness about risks of tobacco use consistent with the First Amendment and federal law.
1.1.20	**Search Engine Promotion of Smokefree and Tobacco-free Environments**: The number of online publications and online databases with search engines that include smokefree and/ or tobacco-free categories among search selections/features for businesses to select and promote to the organization's target audience.

Priority Area: Limit Tobacco Promoting Influences (1) Economic Indicators (.2)	
Definition: These indicators address financial incentives and disincentives to reduce tobacco and/or ESD industry influences, and promote non-tobacco use norms. ESD includes heated tobacco products. Outcome objectives based on these indicators may address the continuum of policy change and compliance including voluntary or legislated policy change, resolutions, policy implementation, or promotion of enforcement/ compliance, as appropriate to the indicator (e.g., for some indicators a voluntary policy may be the only legally viable option).	
1.2.1	**Divestment of Stocks**: The number of public (e.g., county, city or tribal government, public university) and private institutions (e.g., union, private university) with a policy divesting and prohibiting reinvestment in tobacco or ESD stock.
1.2.2	**Health Insurance Discounts for Non-tobacco Users**: The number of public and private employers that offer discounted health insurance premiums to non-tobacco users.
1.2.3	Retired
1.2.4	**Tobacco Product Hazardous Waste**: The number of jurisdictions with a policy establishing hazardous waste (including household hazardous waste) or hazardous materials (Hazmat) standards on tobacco products, retailers, distributors, or manufacturers that may include, but are not limited to point-of-sale warning sign requirements, application of Hazmat business plan requirements to e-cigarette businesses consistent with Health and Safety Code Chapter 6.95, or policies for schools and other government entities on the management of hazardous waste tobacco products, in a manner consistent with the California Constitution and California law.
1.2.5	**Conflict of Interest**: The number of public (e.g., county, city or tribal government, public university) or privately funded agencies with a voluntary policy or contract language prohibiting awardees from accepting funding from tobacco, ESD, and cannabis companies during the grant/contract period.
1.2.6	Retired
1.2.7	Retired

Priority Area: Limit Tobacco Promoting Influences (1) Economic Indicators (.2)	
1.2.8	**Healthy Community Incentives**: The number of jurisdictions offering incentives in the form of financial aid, tax credits, a lower local tobacco retail license fee, technical assistance (e.g., business planning) or other tangible goods and services in exchange for adopting meaningful and sustainable health promoting practices (e.g., healthy retail programs, building smokefree multi-unit housing) that support tobacco free living and non-nicotine dependence.
1.2.9	**American Indian Commercial Tobacco Excise Tax**: The number of American Indian tribal governments with a tribal excise tax on commercial tobacco products designating a portion of the revenue for a comprehensive tobacco control program to prevent and reduce commercial tobacco use. Note: This indicator is tribal government specific as tribal governments are sovereign nations and have authority to enact tobacco taxes or enter into agreements with the State to collect state tobacco taxes.
1.2.10	**Minimum Retail Price/Package/Volume Size**: The number of jurisdictions with a policy setting a minimum retail sale price for tobacco products in conjunction with minimum package/volume size to reduce sales of low-cost tobacco and nicotine products.

Priority Area: Limit Tobacco Promoting Influences (1) School and Community-based Prevention Indicators (.3)	
Definition: These indicators address the availability and provision of tobacco use prevention education that impacts youths in school and youth-serving programs, such as the Scouts or 4-H.	
1.3.1	Retired
1.3.2	Retired
1.3.3	Retired
1.3.4	Retired

Priority Area: Limit Tobacco Promoting Influences (1) Physical Environment Indicators (.4)	
Definition: These indicators address the integration of tobacco-free living elements into community planning, economic development, and redevelopment. See Tobacco Control Planning Assets (4).	
1.4.1	Retired
1.4.2	Retired
1.4.3	Retired

Priority Area: Limit Tobacco Promoting Influences (1) Global Movement Indicators (.5)	
Definition: These indicators address countering the national and international promotion and distribution of tobacco and ESD products, including in other states and countries. ESD includes heated tobacco products. Outcome objectives based on these indicators may address the continuum of policy change and compliance including voluntary or legislated policy change, resolutions, policy implementation, or promotion of enforcement/ compliance as appropriate for the indicator (e.g., for some indicators a voluntary policy may be the only legally viable option).	
1.5.1	**International Marketing Accountability**: The number of local resolutions in support of policies to hold U.S. tobacco companies accountable for consistent marketing and product distribution standards across their U.S. and international business operations.
1.5.2	Retired
1.5.3	Retired
1.5.4	Retired
1.5.5	**Global Governance for Tobacco Control**: The extent to which global governance mechanisms on tobacco, health, racial discrimination, human rights, economics and social justice are strategically used to promote a culture of health and decrease the marketing, availability, and use of tobacco products, especially among populations where tobacco use prevalence remains high.

Priority Area: Reduce Exposure to Secondhand Smoke, Tobacco Smoke Residue, Tobacco Waste, and Other Tobacco Products (2) Policy Indicators (.2)	
Definition: These indicators address the impact of tobacco, ESD, and cannabis use on people, other living organisms, and the physical environment resulting from exposure to: 1) secondhand smoke emissions from combustibles and aerosols, 2) tobacco smoke residue, 3) tobacco waste, and 4) tobacco products. ESD includes heated tobacco products. Outcome objectives based on these indicators may address the continuum of policy change and compliance including voluntary or legislated policy change, resolutions, policy implementation, or promotion of enforcement/ compliance as appropriate for the indicator (e.g., for some indicators a voluntary policy may be the only legally viable option).	
2.2.1	**Household Smoking**: The proportion of households with a voluntary policy that does not allow smoking in the home (e.g., single dwelling house, mobile home, apartment, condominium, boat).
2.2.2	Retired
2.2.3	**American Indian Smokefree Worksites (Non-Gaming Worksites)**: The number of American Indian tribal governments with a policy eliminating smoking of commercial tobacco products within indoor worksites on tribal lands, not including casino/leisure complexes. Note: This indicator is not intended to apply to ceremonial, religious or sacred use of tobacco products.
2.2.4	**Labor Code Section 6404.5 Exemptions**: The number of jurisdictions with a policy eliminating indoor worksite smoking in those areas that are exempted by the state smokefree workplace law (e.g., tobacco shops and private smokers' lounges, 20 percent of hotel guest rooms, cabs of motor trucks or tractor trucks, theatrical production sites, and long-term health care facilities).
2.2.5	Retired
2.2.6	**Smokefree Outdoor Dining/Bars/Service Areas**: The number of jurisdictions with a policy designating the outdoor dining, beverage, and service areas of restaurants, bars, nightclubs, and mobile catering businesses as smokefree.

Priority Area: Reduce Exposure to Secondhand Smoke, Tobacco Smoke Residue, Tobacco Waste, and Other Tobacco Products (2) Policy Indicators (.2)	
2.2.7	**Smokefree Outdoor Worksites**: The number of jurisdictions with a policy designating outdoor worksite premises as smokefree (e.g., agricultural worksites, construction sites, logging operations, fishing operations). Note: Do not use this indicator for the following types of worksites: outdoor dining areas (2.2.6), non-recreational outdoor public areas (2.2.9), health care campuses (2.2.10), outdoor recreational areas (2.2.16), K-12 schools (2.2.17), and faith community campuses (2.2.20).
2.2.8	**Smokefree Entryways**: The number of jurisdictions with a policy eliminating smoking within 20 feet or more of all entryways, windows, vents, and openings of public and private worksites.
2.2.9	**Smokefree Outdoor Non-recreational Public Areas**: The number of jurisdictions with a policy eliminating smoking on the premises of outdoor non-recreational public areas (e.g., walkways, streets, plazas, college/trade school campuses, shopping centers, transit stops, farmers' markets, swap meets). Note: Do not use this indicator, if the outdoor non-recreational public area is one of the following areas: health care campus (2.2.10), K-12 school (2.2.17), and faith community campus (2.2.20).
2.2.10	**Smokefree Health Care Campuses**: The number of jurisdictions with a policy eliminating smoking indoors and outdoors, at all times, on the premises of licensed health care and/or assisted living facilities at all times, (e.g., local health departments, hospitals, other acute health care facilities, drug and rehab facilities, mental health facilities, adult day care or residential facilities, social rehabilitation facilities, adult group homes, assisted living facilities, skilled nursing facilities, doctors' offices).
2.2.11	Retired
2.2.12	Retired
2.2.13	**Smokefree Multi-Unit Housing**: The number of jurisdictions with a policy prohibiting smoking in the individual units of multi-unit housing including balconies and patios.
2.2.14	Retired

Priority Area: Reduce Exposure to Secondhand Smoke, Tobacco Smoke Residue, Tobacco Waste, and Other Tobacco Products (2) Policy Indicators (.2)	
2.2.15	Retired
2.2.16	**Smokefree Outdoor Recreational Areas**: The number of jurisdictions with a policy eliminating smoking on the premises of outdoor recreational facilities and venues including their parking lots, (e.g., amusement parks, beaches, fairgrounds, parks, parades, piers, playgrounds, sporting venues, tot lots, zoos).
2.2.17	**Tobacco-free Schools**: The number of public and private kindergarten, elementary, middle, high schools, including charter schools that designate their campuses and school-sponsored events on or off school property as tobacco-free inside and outside at all times.
2.2.18	**Smokefree Licensed Home Childcare and Foster Homes**: The number of jurisdictions with a policy eliminating smoking on the premises of licensed home childcare and foster homes, inside and outside, at all times.
2.2.19	Retired
2.2.20	**Smokefree Faith Community Campuses**: The number of faith community organizations (e.g., churches, synagogues, mosques, temples) with a voluntary policy designating outdoor areas as smokefree except when tobacco is used for ceremonial or religious purposes.
2.2.21	Retired
2.2.22	Retired
2.2.23	Retired
2.2.24	**Secondhand Smoke Designated as a Nuisance**: The number of jurisdictions with a policy declaring exposure to secondhand smoke as a nuisance.
2.2.25	**American Indian Smokefree Gaming**: The number of American Indian/tribal owned casino/leisure complexes with a policy eliminating smoking of commercial tobacco products within all indoor areas of casino/leisure complexes. Note: This indicator is not intended to apply to ceremonial, religious or sacred use of tobacco products.
2.2.26	Retired

Priority Area: Reduce Exposure to Secondhand Smoke, Tobacco Smoke Residue, Tobacco Waste, and Other Tobacco Products (2) Policy Indicators (.2)	
2.2.27	Retired
2.2.28	Retired
2.2.29	**Eliminate Tobacco Product Sales to Address Tobacco Waste**: The number of jurisdictions with a policy that eliminates the sale and distribution of classes of tobacco products, or product packaging, that demonstrably contribute to tobacco product pollution, create single-use plastic waste, or create e-waste, including but not limited to: cigarette filters, cigarette pack waste, plastic cigar tips, cigar packaging sleeves, chew canisters, single use electronic cigarettes, and single use nicotine cartridges.
2.2.30	Retired
2.2.31	Retired
2.2.32	**Smokefree Multi-Unit Housing Incentives**: The number of jurisdictions that implement a program offering incentives to encourage private adoption of smokefree multi-unit housing through such means as tax incentives (e.g., income tax credit, property tax credit), technical assistance/signage assistance/free advertising) that includes a formal application review and monitoring process.
2.2.33	**Smoking and Tobacco Products Definition**: The number of jurisdictions with a policy defining "smoking" to include the burning or heating of tobacco products, other plant products, other natural or synthetic products and defining "tobacco products" to include cigarettes, smokeless tobacco, cigars, pipe tobacco, hookah tobacco, and any product containing nicotine or any product used to introduce nicotine into the body, including but not limited to such things as dissolvable tobacco products and any ESD, whether or not it delivers nicotine, but excluding products specifically approved by the FDA for use in treating nicotine or tobacco dependence. ESDs do not include any battery or battery charger when sold separately.
2.2.34	**Tobacco Product Waste Designated as a Nuisance**: The number of jurisdictions with a policy declaring exposure to or accumulation of tobacco waste as a nuisance for which tobacco businesses or property owners bear responsibility.

Priority Area: Reduce Exposure to Secondhand Smoke, Tobacco Smoke Residue, Tobacco Waste, and Other Tobacco Products (2) Policy Indicators (.2)	
2.2.35	**Smokefree Outdoor Public Places**: The number of jurisdictions with a comprehensive policy eliminating smoking in outdoor recreational and non-recreational public places (including beaches, parks, sidewalks, dining, entryways, worksites, event sites, bike lanes/paths, alleys, and parking structures) without designated smoking areas or distances.

Priority Area: Reduce the Availability of Tobacco (3) Policy Indicators (.2)	
Definition: These indicators address the sale, distribution, sampling, or furnishing of tobacco products and ESD. ESD includes heated tobacco products. Outcome objectives based on these indicators may address the continuum of policy change and compliance including voluntary or legislated policy change, resolutions, policy implementation, or promotion of enforcement/ compliance as appropriate for the indicator (e.g., for some indicators a voluntary policy may be the only legally viable option).	
3.2.1	**Tobacco Retail Licensing**: The number of jurisdictions with a policy requiring retailers that sell, give, or furnish tobacco products to be licensed, designate a portion of the license fee for enforcement, prohibit police harassment of persons who purchase, use or possess tobacco, and exclude any provision that criminalizes a person for the purchase, use, or possession of tobacco products.
3.2.2	**Tobacco Retailer Density/Zoning**: The number of jurisdictions with a policy restricting the number, location, and/or density of tobacco retail outlets through use of any of the following means: conditional use permits, zoning, tobacco retail permits or licenses, or direct regulation.
3.2.3	**Self Service Displays**: The number of jurisdictions with a policy prohibiting the sale of tobacco products through self-service displays and requiring them to be in a locked or covered case.

Priority Area: Reduce the Availability of Tobacco (3) Policy Indicators (.2)	
3.2.4	**Tobacco Industry Sampling, Coupons/Discounts/Gifts**: The number of jurisdictions with a policy restricting the redemption of coupons, coupon offers, gift certificates, gift card rebate offers, loyalty and discount programs, buy-downs, multi-pack offers, and retail-value added promotions for free, low-cost, or reduced-cost tobacco products or other similar offers for tobacco and ESD products consistent with the First Amendment and federal law.
3.2.5	Retired
3.2.6	Retired
3.2.7	**Tobacco-free Pharmacies and Health Care Providers**: The number of jurisdictions with a policy eliminating the sale and distribution of tobacco products from places where pharmacy and/or other health care services are provided by a licensed health care professional (e.g., hospital, vision screening, blood pressure screening).
3.2.8	Retired
3.2.9	**Menthol and Other Flavored Tobacco Products**: The number of jurisdictions with a policy eliminating or restricting the sale and/or distribution of any mentholated cigarettes and other flavored tobacco products, and paraphernalia (e.g., smokeless tobacco products, dissolvable tobacco products, flavored premium cigars such as little cigars, cigarillos, hookah tobacco, e-cigarettes, e-hookah, wrappers).
3.2.10	Retired
3.2.11	Retired
3.2.12	Retired
3.2.13	Retired
3.2.14	**Healthy Retail Standards**: The number of jurisdictions with healthy retail standards to decrease the availability of tobacco marketing and products and increase the availability and marketing of products that promote and protect health including healthy foods and beverages, condoms, and vaccines.
3.2.15	Retired

Priority Area: Reduce the Availability of Tobacco (3) Policy Indicators (.2)	
3.2.16	**American Indian Tobacco 21**: The number of American Indian tribal governments implementing a policy for the legal minimum age of commercial tobacco sales on tribal lands to be 21 years of age. (Note: this indicator is implementation only due to Federal age of tobacco sale and is tribal government specific as tribal governments are sovereign nations and have authority to implement and enforce age of tobacco sale laws.)
3.2.17	**No Sale of Tobacco Products**: The number of jurisdictions with a policy prohibiting the sale and distribution of any tobacco products or emerging nicotine products not approved by the Food and Drug Administration (FDA) for cessation purposes
3.2.18	**Tobacco Only Store Sales**: The number of jurisdictions with a policy restricting the sale of all tobacco products to tobacco-only stores.
3.2.19	**Adult Only Venue Tobacco Sales**: The number of jurisdictions with a policy restricting the sale of tobacco products to adult-only venues not accessible to persons under 21 years of age.
3.2.20	**Removing Exemption(s) Clause(s)**: The number of jurisdictions with a policy eliminating the sale and distribution of any tobacco product currently exempt from existing policy language (e.g. smokeless tobacco products, menthol products, hookah, etc.).

Priority Area: Reduce the Availability of Tobacco (3) Behavior Indicators (.3)	
Definition: These indicators address the sale, distribution, sampling, or furnishing of tobacco products and other nicotine containing products that are not specifically approved by the FDA as a treatment for nicotine or tobacco dependence (e.g., social sources of tobacco, shoulder tapping).	
3.3.1	Retired

Priority Area: Promote Tobacco Cessation (4) Cessation Service Indicators (.1)	
Definition: These indicators address the direct provision of culturally, linguistically, and age appropriate cessation services and cessation pharmacotherapy access.	
4.1.1	**Cessation Services**: The extent to which evidence-based, culturally, linguistically, and age appropriate behavior modification-based tobacco cessation services are available in the community.
4.1.2	Retired
4.1.3	**Cessation Pharmacotherapy**: The extent to which people who use tobacco have barrier-free access to all evidence-based smoking cessation medications, including monotherapy and combination therapies.
4.1.4	Retired

Priority Area: Promote Tobacco Cessation (4) Policy Indicators (.2)	
Definition: These indicators address the availability of behavior modification and cessation pharmacotherapy services provided through health care plans, the health care system, and employers.	
4.2.1	**Health Insurance Coverage for Cessation Benefits**: The number of health plans providing comprehensive coverage of nicotine dependence treatment with no barriers to behavioral health counseling and cessation pharmacotherapy, consistent with the U.S. Public Health Service Clinical Practice Guidelines, Treating Tobacco Use and Dependence (2015 Update).
4.2.2	Retired
4.2.3	Retired
4.2.4	Retired
4.2.5	Retired
4.2.6	Retired
4.2.7	**Bi-Directional Electronic Medical Referral to the Quitline**: The number of health care practices and systems that have implemented bi-directional tobacco use treatment referral to the California Smokers' Helpline.

Priority Area: Promote Tobacco Cessation (4) Policy Indicators (.2)	
4.2.8	**Nicotine Addiction Treatment Incorporated into Health Care Professional Curricula**: The number of medical, nursing, dental, pharmacy, and other allied health professional schools or local societies that provide curricula on tobacco cessation and policy issues, such as: assessment and treatment for nicotine or tobacco dependence, the history of the tobacco epidemic, and/or the role of the tobacco industry as a social determinant of health.
4.2.9	**Tobacco Use Assessment and Cessation Referral Systems**: The extent to which health care, behavioral health, social service, housing, education, and other agencies systematically capture the screening rates, number of identified smokers, and number of smokers referred to quit supports regardless of system, medical record, and referral type.

Tobacco Control Funding Assets (1)	
Definition: These assets address the availability of funding to support tobacco control efforts.	
1.1	**Tobacco Control Funding**: The local jurisdiction's annual per capita funding dedicated to tobacco control for both community and school programs, from various sources, including tobacco taxes (e.g., Propositions 99, 10, 56), Master Settlement Agreement, and other public or private sources is $6.54 to $9.15, consistent with the Centers for Disease Control and Prevention Best Practices, 2014 recommendations for California.
1.2	**MSA Funding**: The amount of MSA funds that are appropriated for the purpose of tobacco control activities.
1.3	**Proposition 10 Funding**: The amount of local Proposition 10 funds that are appropriated for cessation and secondhand smoke education targeting pregnant women and families with young children.
1.4	Retired

Social Capital Assets (2)	
Definition: These assets address the extent to which people and organizations work collaboratively in an atmosphere of trust to accomplish goals of mutual interest.	
2.1	**Training and Skill Building**: The extent our program provides technical assistance and support to diverse community groups to enable them to effectively engage in tobacco control activities and activities to reduce tobacco-related social determinants of health.
2.2	**Coalition/Advisory Committee Satisfaction**: The degree coalition/ advisory committee members are satisfied with group functioning, ability to recruit and engage diverse partners, and member involvement in intervention activities that focus on policy, system, and environmental change.
2.3	**Key Opinion Leader Support**: The extent of support among local key opinion leaders for tobacco related community norm change strategies.
2.4	**Youth Engagement in Tobacco Control**: The degree our program has participatory collaborative partnerships with diverse youth and youth-serving organizations, and engages them to support tobacco control-related activities that focus on policy, systems, and environmental changes.
2.5	**Community Engagement in Tobacco Control**: The degree our program has collaborative partnerships with diverse organizations and individuals in addition to CTCP and TUPE-funded organizations, to engage them to support tobacco control-related activities that focus on policy, system, and environmental change such as community assessments, data collection, education of community members and decision makers, and media events.
2.6	Retired
2.7	Retired

Cultural Diversity and Cultural Competency (3)	
Definition: These assets address behaviors, attitudes, and policies that enable effective work in cross-cultural situations within the work environment and community. Culture refers to patterns of human behavior that include the languages, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, sexual orientation and gender identity, or social groups. Competency refers to having the capacity to function effectively as an individual or organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and the community.	
3.1	**Coalition/Advisory Committee Diversity**: The degree our program engages a coalition or advisory committee in designing and implementing tobacco control activities that includes diversity across race/ethnicity, culture, sexual orientation and gender identity, geography, and non-traditional partners (e.g., housing, employee development, law enforcement, parks and recreation, environmental groups).
3.2	Retired
3.3	**Cultural Competence Assessment**: The degree our program conducts organizational cultural competence assessments
3.4	**Tailored Educational and Outreach Materials**: The degree our program makes culturally appropriate educational, outreach and media materials easily available and appropriate for the languages and literacy levels of commonly encountered groups in the service area.
3.5	Retired
3.6	**Equity in Funding**: The degree to which culturally and ethnically diverse organizations are funded to implement community norm change-focused tobacco control efforts in the community, in proportion to community demographics.
3.7	Retired

Tobacco Control Planning Assets (4)	
Definition: These assets address participating in or leading community planning processes to integrate tobacco use prevention and reduction strategies and/or development of a focused time-limited strategic plan to address an evolving or emerging tobacco-related issue.	
4.1	**Tobacco-Related Recommendations in Community Plans**: The extent our program participates in local planning to integrate tobacco-related interventions recommendations into local and regional general plans, community health/health equity frameworks, Adverse Childhood Experience protocols, health department accreditation, and/or other similar evidence-informed, community planning processes.
4.2	**Affordable Care Act Community Health Needs Assessment Participation**: The number of local tobacco control advocates who actively participate in the Community Health Needs Assessment, which is required to be conducted by non-profit hospitals every three years pursuant to the Affordable Care Act*, for the purpose of promoting the inclusion of indicators and interventions that support tobacco-free living (e.g., physical environment and housing improvements, economic development, community support, leadership development, coalition development, community health improvement and advocacy, workforce development, other community development activities to build health and safety). *SEC. 9097: Additional Requirements for Charitable Hospitals and as defined in Internal Revenue Service, Schedule H instructions (Form 990), 2011.

Social Disparities Capacity Assessment Instructions

Background

CTCP has successfully reduced the smoking prevalence of Californians across all demographic groups. However, large differences in smoking prevalence persist among population groups by race/ethnicity, sexual orientation and gender identity, socioeconomic status, educational attainment, occupation, geography, and behavioral health conditions. People in these groups represent, "priority populations" who have higher rates of tobacco use than the general population, experience greater secondhand smoke exposure at work and at home, are more targeted by the tobacco industry, and/or have higher rates of tobacco-related disease compared to the general population. As a result, they suffer disproportionately from tobacco-related death and disease also known as tobacco-related disparities. CTCP is committed to accelerating the rate of change in priority population groups disproportionately impacted by tobacco use and secondhand smoke exposure, and to eliminating tobacco-related disparities.

The CX planning framework helps agencies to systematically assess their communities and then to design tobacco control plans that focus on substantive, long-lasting social norm change in order to reduce tobacco use and exposure to secondhand smoke. To reduce tobacco-related disparities, it is vitally important that tobacco control interventions reach the populations most impacted by tobacco use. Current social norms in California which exacerbate tobacco-related health disparities include: a lack of tobacco-free policies in alternative settings such as hospitals, skilled nursing facilities, and behavioral health facilities; permissive smoking policies within tribal gaming facilities and worksites; a lack of full health insurance coverage for tobacco cessation counseling and pharmaceutical support; tobacco pricing policies that support ready access to low-cost cigarettes and other tobacco products; aggressive marketing of flavored tobacco products, including menthol; and saturation of environments with tobacco marketing, particularly in low-income and African American neighborhoods.

Addressing these and other social norms which promote tobacco use requires that we engage priority population communities in a manner that is effective and relevant. Doing so requires becoming familiar with these communities, including their specific cultural, linguistic, and social characteristics. It

also requires developing an understanding of strategies for addressing the interconnectedness between tobacco use and other social and environmental issues. The Social Disparities Capacity Assessment is designed to help agencies: 1) review how tobacco use impacts priority populations in their community, 2) identify program strengths which can be leveraged, and 3) identify weaknesses that can be improved through the addition of scope of work activities that reach out to and engage priority population groups in an effective and culturally relevant manner.

Cover Page

1. **Community Area(s) Assessed**: Identify the community name(s) that best reflects the geographical area assessed. In general, county health departments should use a countywide perspective and city health departments should use a citywide perspective. However, there may be times when it is appropriate to use a different frame of reference for the assessment.

   OTIS: In OTIS there are four types of drop-down menus for communities: 1) countywide, 2) incorporated cities, 3) unincorporated communities, and 4) American Indian tribal lands.

2. **Completion Date**: Identify the month, day, and year your agency completed the Social Disparities Capacity Assessment.

   OTIS: A calendar is provided in OTIS to select the date.

3. **Data Sources, References, and Citations**: Use local, regional, state, and/or national data to assess the item. List the title and year of data sources used in the assessment. Qualitative data sources, such as key informant interviews, focus group findings, and completer discussions are acceptable data sources.

   OTIS: A drop-down menu of common data sources is in OTIS, but you are encouraged to identify additional local data or other references and citations.

4. **Who completed the assessment?** List the coalition name, organization names, and/or the names of individuals who reviewed data, discussed, and completed the Social Disparities Capacity Assessment.

   Record Keeping: For audit and record keeping purposes, it is recommended that you maintain a file with the data documents used to complete the Social Disparities Capacity Assessment along with the completed worksheet. Do not submit these documents to CTCP.

Social Disparities Capacity Rating - Worksheet A

Purpose: The Social Disparities Capacity Assessment should be used to: 1) inform how you are reaching priority populations in your tobacco control work, 2) identify strengths you can leverage in scope of work activities to address tobacco-related disparities, and 3) identify weaknesses that can be improved through the addition of scope of work activities that reach out to and engage priority population groups in an effective and culturally relevant manner.

1. **Assessment and Rating Process**: The Social Disparities Capacity Assessment should be based on your completers' knowledge of Social Disparities within your community and a discussion of relevant quantitative and qualitative data reviewed. Refer to the Social Disparities Capacity Rating Rubric to help guide the discussion. In addition to completing the rating for each item on the worksheet, you will write a brief narrative summary (limited to 500 words) which describes the program's overall strengths and weaknesses in relation to the five items that make up the Social Disparities Capacity Assessment.

2. **Social Disparities Capacity Assessment Measure**: The Social Disparities Capacity Measure is composed of five areas: 1) Tobacco-related Data Profile, 2) Tobacco Disparity Strategic Plan, 3) Social Determinants of Health Considerations, 4) Media Engagement, and 5) Evaluation Inclusion.

3. **Rating Scale**: Each item is rated on a six-point (0 to 5) Likert scale of *Strongly Disagree, Somewhat Disagree, Neither Agree nor Disagree, Somewhat Agree, Agree, and Strongly Agree*. Check the most appropriate rating in response to each item.

4. **Rating Rubric**: The Social Disparities Capacity Rating Rubric provides a general description for each item on the Likert scale. Refer to it to help you select the most appropriate rating for each of the 5 items on the Social Disparities Capacity Rating Worksheet.

5. **Capacity to Address Social Disparities Score**: To facilitate comparisons, the ratings given to each item on the Social Disparities Capacity Assessment will be converted into a "score."

   OTIS: OTIS will automatically calculate the Social Disparities Capacity Assessment score once the data are entered and saved.

   If not using OTIS: To manually calculate the Social Disparities Capacity Assessment Score use the formula provided at the bottom of the Worksheet

A, Box A-1.

- Sum the individual ratings.
- Multiply the results by 100 and divide the sum by the total possible score (25)
- Display the score as a percentage.

Example: If the rating for the Social Disparities items totaled 20, the score would be
20 × (100/25) = 80 percent.

6. **Narrative Summary**: Complete the Social Disparities Capacity Assessment Narrative Summary (limited to 500 words) to describe the program's strengths and weaknesses in relation to the five items assessed above. Make sure that the description helps to substantiate the rating given to each of the five items.

7. **CX Needs Assessment Overview Report-Worksheet I**: Transfer the individual ratings and score from the Social Disparities Capacity Assessment to Worksheet I to manually create a report that summarizes your assessment conclusions.

   OTIS: This report will be created automatically in OTIS once data from the Social Disparities Capacity Rating Worksheet are entered and saved in OTIS.

Social Disparities Capacity Assessment Cover Page

Social Disparities Capacity Assessment Cover Page

Community Area(s) Assessed:

Social Disparities Capacity Assessment Completion Date:

Which quantitative and qualitative data sources, references, and citations were used to complete the Social Disparities Capacity Assessment ratings? (Title and Year)

Who was engaged in discussing and completing the Social Disparities Capacity Assessment rating? (List the coalition name, organizational names, and/or the names of individuals.)

Social Disparities Capacity Assessment Rating-Worksheet A

Instructions: Please indicate your level of agreement with each of the 5 items below.

Social Disparities Question	Strongly Disagree (0)	Somewhat Disagree (1)	Neither Agree nor Disagree (2)	Somewhat Agree (3)	Agree (4)	Strongly Agree (5)
1. **Tobacco-related Data Profile**. Our tobacco control program maintains a current demographic and epidemiological profile of the community to prioritize, plan, and implement activities to reduce tobacco-related health disparities in a culturally and linguistically appropriate manner.	☐	☐	☐	☐	☐	☐
2. **Tobacco Disparity Strategic Plan**. Our tobacco control program has a written strategic plan that outlines a vision, clear objectives and strategies to reduce tobacco-related disparities in a culturally and linguistically appropriate manner within the service area.	☐	☐	☐	☐	☐	☐

Social Disparities Question	Strongly Disagree (0)	Somewhat Disagree (1)	Neither Agree nor Disagree (2)	Somewhat Agree (3)	Agree (4)	Strongly Agree (5)
3. Social Determinants of Health Considerations (SDOH). Our tobacco control program collaborates with community programs that address the following SDOH factors that may contribute to tobacco-related health disparities: • Availability of quality housing • Community safety and violence prevention • Recreation opportunities, parks and open space • Land use and community planning • Quality public education • Community economic development (e.g., job creation, business development) • Racial/social injustice • Arts and culture • Transportation planning and availability • Environmental justice • Food security • Early childhood development and education • Youth development and leadership	☐	☐	☐	☐	☐	☐

Social Disparities Question	Strongly Disagree (0)	Somewhat Disagree (1)	Neither Agree nor Disagree (2)	Somewhat Agree (3)	Agree (4)	Strongly Agree (5)
4. Media Engagement.* Our tobacco control program regularly works with multicultural media through traditional and social media channels to raise awareness about the impact of tobacco use on diverse populations in our service area. *Media Engagement includes both paid and earned media.	☐	☐	☐	☐	☐	☐
5. Evaluation Inclusion. Our tobacco control program routinely collects data that can be used to communicate and understand social inequities in health including using methods such as Photovoice, digital storytelling, key informant interviews, focus groups, listening sessions, and demographics analysis.	☐	☐	☐	☐	☐	☐

Box A- 1

Social Disparities Capacity Assessment Score:	Add lines 1 through 5		x	$\frac{100}{25}$	=	%

Social Disparities Capacity Assessment Narrative Summary: Overall, describe the program's strengths and weaknesses in relation to the 5 items assessed (limited to 500 words).

Social Disparities Capacity Assessment Rating Rubric

Worksheet A

Social Disparities Question	Strongly Disagree 0	Somewhat Disagree 1	Neither Agree nor Disagree 2	Somewhat Agree 3	Agree 4	Strongly Agree 5
1. **Tobacco-related Data Profile**. Our tobacco control program maintains a current demographic and epidemiological profile of the community to prioritize, plan, and implement activities to reduce tobacco-related health disparities in a culturally and linguistically appropriate manner.	Our tobacco control program **never reviews or uses** demographic and epidemiological data for priority setting, planning, and implementation activities.	Our tobacco control program **rarely reviews and uses** demographic and epidemiological data for priority setting, planning, and implementation activities.	Our tobacco control program occasionally reviews and incorporates demographic and epidemiological data into priority setting, planning, and implementation activities.	Our tobacco control program **frequently reviews** demographic and epidemiological data and **incorporates** these data into priority setting, planning, and implementation activities.	Our tobacco control program **regularly seeks out** demographic and epidemiological data and **usually incorporates** these data into priority setting, planning, and implementation activities.	Our tobacco control program **actively collects, maintains, and tracks** a core data set that comprises a Tobacco-related Data Profile for our service area and **always incorporates** these data into priority setting, planning, and implementation activities.

Social Disparities Question	Strongly Disagree 0	Somewhat Disagree 1	Neither Agree nor Disagree 2	Somewhat Agree 3	Agree 4	Strongly Agree 5
2. **Tobacco Disparity Strategic Plan**. Our tobacco control program has a written strategic plan that outlines a vision, clear objectives and strategies to reduce tobacco-related disparities in a culturally and linguistically appropriate manner within the service area. *Strategies addressed by the plan include: 1. Improve data collection and analyses to identify disparities and drive interventions. 2. Increase awareness among disparately impacted populations regarding the impact of tobacco use and secondhand smoke exposure. 3. Integrate representatives of disparate populations in key decision-making bodies and processes. 4. Reduce the impact of tobacco industry targeting of diverse populations through policy, environmental, and system changes.	Our tobacco control program **does not have** a tobacco-specific disparity plan -or- a chronic disease disparity strategic plan.	Our tobacco control program **does not have** a tobacco-specific disparity strategic plan, -but- our agency has a **non-tobacco specific** chronic disease disparity strategic plan.	Our tobacco control program **has** a tobacco-specific disparity strategic plan that is **more than three years old.**	Our tobacco control program **has** a tobacco-specific disparity strategic plan that was **prepared within the last 3 years,** -but- it **does not address each of the four strategies*.**	Our tobacco control program **has** a tobacco-specific dispaity strategic plan that was **prepared within the last three years,** that **addresses each of the four strategies*,** -but- it **has been minimally implmented.**	Our tobacco control program **has** a tobacco-specific dispaity strategic plan that was **prepared within the last 3 years,** that **addresses each of the four strategies*** -and- it is **actively being implemented and evaluated** across all elements.

Social Disparities Question	Strongly Disagree 0	Somewhat Disagree 1	Neither Agree nor Disagree 2	Somewhat Agree 3	Agree 4	Strongly Agree 5
3. **Social Determinants of Health Considerations[1, 2].** Our tobacco control program collaborates with community programs that address the following SDOH factors that may contribute to tobacco-related health disparities: • Availability of quality housing • Community safety and violence prevention • Recreation opportunities, parks and open space • Land use planning • Quality public education • Community economic development (e.g., job creation, business development) • Racial/social injustice • Arts and culture • Transportation planning and availability • Environmental justice • Food security • Early childhood development and education • Youth development and leadership.	In the past three years, our tobacco control program has collaborated with community programs that address **3 or fewer** SDOH factors that may contribute to tobacco-related health disparities.	In the past three years, our tobacco control program has collaborated with community programs that address **at least 4** SDOH factors that may contribute to tobaco-related health disparities.	In the past three years, our tobacco control program has collaborated with community programs that address **at least 6** SDOH factors that may contribute to tobaco-related health disparities.	In the past three years, our tobacco control program has collaborated with community programs that address **at least 8** SDOH factors that may contribute to tobaco-related health disparities.	In the past three years, our tobacco control program has collaborated with community programs that address **at least 10** SDOH factors that may contribute to tobaco-related health disparities.	In the past three years, our tobacco control program has collaborated with community programs that address **more than 10** SDOH factors that may contribute to tobaco-related health disparities.

Social Disparities Question	Strongly Disagree 0	Somewhat Disagree 1	Neither Agree nor Disagree 2	Somewhat Agree 3	Agree 4	Strongly Agree 5
4. **Media Engagement*.** Our tobacco control program regularly works with multi-cultural media through traditional and social media channels to raise awareness about the impact of tobacco use on diverse populations in our service area. *Media Engagement includes both paid and earned media.	Our tobacco control program **never** engages multi-cultural media through traditional or social media channels to raise awareness about the impact of tobacco use on diverse populations in our service area.	**At least one time per year**, our tobacco control program engages multi-cultural media through traditional and social media channels to raise awareness about the impact of tobacco use on diverse populations in our service area.	**At least two times per year**, our tobacco control program engages multi-cultural media through traditional and social media channels to raise awareness about the impact of tobacco use on diverse populations in our service area.	**At least four times per year**, our tobacco control program engages multi-cultural media through traditional and social media channels to raise awareness about the impact of tobacco use on diverse populations in our service area.	**At least six times per year**, our tobacco control program engages multi-cultural media through traditional and social media channels to raise awareness about the impact of tobacco use on diverse populations in our service area.	**At least eight times per year**, our tobacco control program engages multi-cultural media through traditional and social media channels to raise awareness about the impact of tobacco use on diverse populations in our service area.

Social Disparities Question	Strongly Disagree 0	Somewhat Disagree 1	Neither Agree nor Disagree 2	Somewhat Agree 3	Agree 4	Strongly Agree 5
5. **Evaluation Inclusion.** Our tobacco control program routinely collects data that can be used to communicate and understand social inequities in health including using methods such as Photovoice, digital storytelling, key informant interviews, focus groups, listening sessions, and demographics analysis.	Our tobacco control program **never** collects data that can be used to communicate and understand **social inequities** in health including using methods such as: Photovoice, digital storytelling, key informant interviews, focus groups, listening sessions, and demographics analysis.	**At least one time per year**, our tobacco control program collects and discusses data that can be used to communicate and understand **social inequities** in health including using **one** of the following methods: Photovoice, digital storytelling, key informant interviews, focus groups, listening sessions, and demographics analysis.	**At least two times per year,** our tobacco control program collects and discusses data that can be used to communicate and understand **social inequities** in health including using **two** of the following methods: Photovoice, digital storytelling, key informant interviews, focus groups, listening sessions, and demographics analysis.	**At least two times per year,** our tobacco control program collects and discusses data that can be used to communicate and understand **social inequities** in health including using **three** of the following methods: Photovoice, digital storytelling, key informant interviews, focus groups, listening sessions, and demographics analysis.	**At least two times per year,** our tobacco control program collects and discusses data that can be used to communicate and understand **social inequities** in health including using **four** of the following methods: Photovoice, digital storytelling, key informant interviews, focus groups, listening sessions, and demographics analysis.	**At least two times per year,** our tobacco control program collects and discuses data that can be used to communicate and understand **social inequities** in health including using **five or more** of the following methods: Photovoice, digital storytelling, key informant interviews, focus groups, listening sessions, and demographics analysis.

1. Social determinants of health are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Conditions (e.g., social, economic, and physical) in these various environments and settings (e.g., school, church, workplace, and neighborhood) have been referred to as "place." In addition to the more material attributes of "place," the patterns of social engagement and sense of security and well-being are also affected by where people live. Resources that enhance quality of life can have a significant influence on population health outcomes. Healthy People 2020. Office of Disease Prevention and Health Promotion. Social Determinants of Health. https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health, 2020

2. Question is adapted from Bay Area Regional Health Inequities Initiative. Local health department organizational self-assessment for addressing health inequities. Oakland, CA, 2010

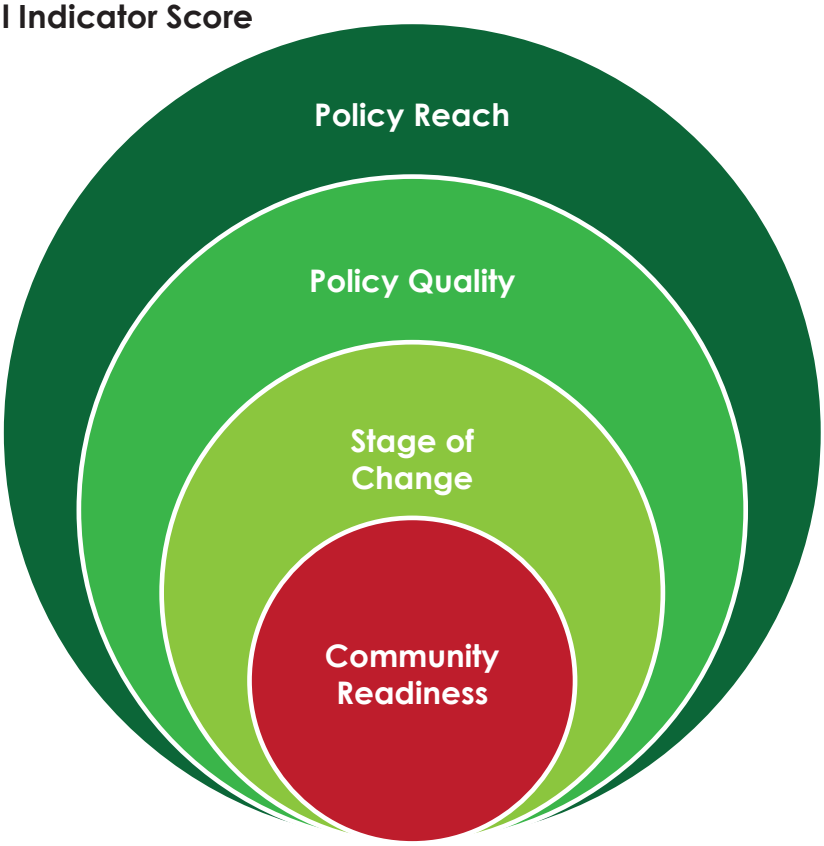
Indicator Assessment Instructions

Background

The Indicator Assessment consists of two parts: 1) rating Community Readiness (Worksheet B); and 2) rating Policy/System Status (Worksheets C, D, and E). Each indicator will be reviewed and rated based on these two assessments.

To facilitate comparisons of the ratings, the ratings will be converted into "scores" and a Total Indicator Score (Worksheet F) will be generated for each indicator. As demonstrated in Figure 2. Total Indicator Score, the assessment of policy reach, policy quality, stage of change, and community readiness will comprise the Total Indicator Score.

Figure 2. Total Indicator Score



In addition to completing the rating worksheets, you will write the Narrative Summary (Worksheet G). The Narrative Summary provides information to support the indicator assessment ratings and the resulting Total Indicator Score.

Table 3, *Summary of Indicator Worksheets*, provides a brief description of the worksheets you will use to rate each indicator, manually calculate the overall Indicator Score, and manually record key information from the indicator assessment onto an overview report.

Table 3. Summary of Indicator Worksheets

Summary of Indicator Worksheets		
Worksheet	**Title**	**Description**
Worksheet B	Community Readiness	This worksheet is used to assess the community's readiness to work on a policy or system change in terms of a) adopting a change, b) implementing a change, or c) facilitating acceptance and compliance with a change.
Worksheet C	Stage of Change	This worksheet is used to assess the stage of change that a community is at along the six-stage change continuum.
Worksheet D	Policy Quality	This worksheet is used to assess the quality of legislated policies against a pre-defined public health quality standard.
Worksheet E	Policy Reach	This worksheet is used to assess the proportion of the population within the local health jurisdiction that is protected by a specific legislated policy.
Worksheet F	Total Indicator Score	This worksheet is used to manually calculate preliminary indicator scores prior to entering assessment findings into OTIS. Once data are entered and saved into OTIS, these scores will be automatically generated in OTIS.
Worksheet G	Indicator Narrative Summary	This worksheet is used to summarize quantitative and qualitative information which explains and supports the Community Readiness and Policy/ System Status scores.
Worksheet I	Needs Assessment Overview Report	This worksheet is used to organize all of the ratings, scores, and narrative explanations from your CX needs assessment from the Social Disparities Capacity Assessment, Indicator Assessment (Community Readiness, Stage of Change, Policy Quality, Policy Reach), and the Asset Assessment prior to entering the assessment information into OTIS. Once all of the assessment data is entered and saved into OTIS, this report will be automatically created by OTIS.

Community Readiness-Worksheet B

This worksheet is used to assess the community's readiness to work on a policy or system change in terms of a) adopting a change, b) implementing a change, or c) facilitating acceptance and compliance with a change. The Community Readiness assessment consists of the five items listed below. Each of these items is rated on a six-point (0 to 5) Likert scale of None, Poor, Fair, Good, Very Good, and Excellent.

1. Scope of the Problem
2. Community Awareness
3. Community Support
4. Decision Maker Support
5. Earned Media

Policy/System Status

This assessment describes the status of tobacco-related policy and systems within the community. It consists of three measures: 1) Stage of Change, 2) Policy Quality, and 3) Policy Reach.

1. Stage of Change-Worksheet C

This worksheet is used to assess the stage of change that a community is at along a six stage change continuum: *No Formal Activities, Planning/ Advocating, Policy/System Change Proposed, Policy/System Change Adopted, Policy Implemented, and Compliance/ Enforcement.*

2. Policy Quality-Worksheet D

This worksheet is used to assess the quality of **legislated policies** against a pre-defined public health quality standard.[1] This standard was established for legislated policies adopted by a county board of supervisors or city council for the following types of policies:

- Content Neutral Signage
- Minimum Retail Price/Package/Volume Size
- Outdoor Dining SHS
- Outdoor SHS

1 The standard was created by the California Tobacco Control Program, California Department of Public Health (CTCP,CDPH) as a result of reviewing the literature, and working with Public Health Law Center, American Nonsmokers' Rights Foundation, and local, state and national public health practitioners.

- Multi-Unit Housing (MUH)
- Tobacco Product Sales to Address Tobacco Waste
- Smokefree Outdoor Public Places
- Tobacco Retail Licensing (TRL)
- Tobacco Retailer Density/Zoning
- Tobacco Industry Sampling, Coupons/Discounts/Gifts
- Tobacco-Free Pharmacies
- Menthol and Other Flavored Tobacco Products
- No Sale of Tobacco Products

The Quality Rating will be calculated for the entire local health jurisdiction by CTCP for indicators listed in Table 4. *Summary of Indicator Rating Data*.

- The Quality Rating is a composite rating for the entire health jurisdiction. It is computed by calculating the quality rating for each ordinance adopted within the local health jurisdiction, summing the individual quality ratings for "like" types of ordinances and then dividing the sum by the total possible points for the local health jurisdiction.
- A zero will be assigned for indicators that have no CTCP-assigned quality rating (e.g., legislated policies not rated by CTCP, voluntary policies, resolutions, and systems changes).
- Significant updates to the policy quality rating formula were made between the 2016 and 2020 CX Processes. Results may not be comparable between these years.

3. Policy Reach - Worksheet E

This worksheet is used to assess the proportion of the population within the local health jurisdiction that is protected by a specific legislated policy. A local health jurisdiction-wide Reach Rating will be calculated by CTCP for indicators listed in Table 4. *Summary of Indicator Rating Data*.

- The Reach Rating is calculated by summing the populations of the jurisdictions where a legislated policy has been enacted and then dividing the sum by the total population of the local health jurisdiction (i.e., county population or city population for Berkeley, Long Beach, and Pasadena).
- A zero will be assigned for indicators that have no CTCP-assigned reach rating (e.g., legislated policies not rated by CTCP, voluntary policies, resolutions, and systems changes).
- Significant updates to the policy reach formula were made between the 2016 and 2020 CX Processes. Results may not be comparable between these years.

Table 4. *Summary of Indicator Rating Data*, summarizes the source of the rating information for different types of policy and system changes.

Table 4. Summary of Indicator Rating Data

		Policy/System Status			
Indicator	**Type of Policy/System Change**	**Community Readiness**	**Stage of Change**	**Policy Quality**	**Policy Reach**
1.2.10	**Minimum Retail Price/ Package/ Volume Size**	Coalition Rates	Coalition Rates	CTCP Provides Composite Rating	CTCP Provides Composite Rating
2.2.6	**Smokefree Outdoor Dining/ Bars/ Service Areas**	Coalition Rates	Coalition Rates	CTCP Provides Composite Rating	CTCP Provides Composite Rating
2.2.9	**Smokefree Outdoor Non-recreational Public Areas**	Coalition Rates	Coalition Rates	CTCP Provides Composite Rating	CTCP Provides Composite Rating
2.2.13	**Smokefree Multi-Unit Housing**	Coalition Rates	Coalition Rates	CTCP Provides Composite Rating	CTCP Provides Composite Rating
2.2.29	**Eliminate Tobacco Product Sales to Address Tobacco Waste**	Coalition Rates	Coalition Rates	CTCP Provides Composite Rating	CTCP Provides Composite Rating
2.2.35	**Smokefree Outdoor Public Places**	Coalition Rates	Coalition Rates	CTCP Provides Composite Rating	CTCP Provides Composite Rating
3.2.1	**Tobacco Retail License Ordinance**	Coalition Rates	Coalition Rates	CTCP Provides Composite Rating	CTCP Provides Composite Rating

3.2.2	**Tobacco Retailer Density/ Zoning Ordinance**	Coalition Rates	Coalition Rates	CTCP Provides Composite Rating	CTCP Provides Composite Rating
3.2.4	**Tobacco Industry Sampling, Coupons/ Discounts/ Gifts**	Coalition Rates	Coalition Rates	CTCP Provides Composite Rating	CTCP Provides Composite Rating
3.2.7	**Tobacco-Free Pharmacies and Healthcare Providers Ordinance**	Coalition Rates	Coalition Rates	CTCP Provides Composite Rating	CTCP Provides Composite Rating
3.2.9	**Menthol and Other Flavored Tobacco Products Ordinance**	Coalition Rates	Coalition Rates	CTCP Provides Composite Rating	CTCP Provides Composite Rating
3.2.17	**No Sale of Tobacco Products**	Coalition Rates	Coalition Rates	CTCP Provides Composite Rating	CTCP Provides Composite Rating
	Other Ordinances	Coalition Rates	Coalition Rates	0	0
	Voluntary Policy	Coalition Rates	Coalition Rates	0	0
	Resolution	Coalition Rates	Coalition Rates	0	0
	System Change	Coalition Rates	Coalition Rates	0	0

Cover Page

1. **Indicator Number and Title**: List the indicator number and brief title.

   OTIS: A drop-down menu is provided in the Online Tobacco Information System (OTIS).

2. **Core Indicator**: A "core" indicator is one that every agency must assess. Refer to the funding guidelines for a list of the core indicators. Indicate "yes" if the indicator is listed as a core indicator. Indicate "no" if it is not listed as a "core" indicator in the funding guidelines.

   OTIS: In OTIS, this field will be pre-populated.

3. **Community Area(s) Assessed**: Identify the community name(s) that best reflects the geographical area assessed. In general, county health departments should use a countywide perspective and city health departments should use a citywide perspective. However, there may be times when it is appropriate to use a different frame of reference for the assessment.

   OTIS: In OTIS there are drop-down menus for four types of communities: 1) countywide, 2) incorporated cities, 3) unincorporated communities, and 4) American Indian tribal lands.

4. **Completion Date**: Identify the month, day, and year your agency completed the Indicator Assessment.

   OTIS: A calendar is provided in OTIS to select the date.

5. **Data Sources, References, and Citations**: Use local, regional, state, and/or national data to assess the indicator. List the title and year of data sources used in the assessment. In addition to quantitative data, qualitative data sources, such as key informant interviews, focus group findings, and coalition discussions are acceptable data sources.

   OTIS: A drop-down menu of common data sources is in OTIS, but you are encouraged to identify additional local data or other references and citations used in your assessment.

6. **Who completed the assessment?** List the coalition name, organization names, and/or names of the individuals who reviewed, discussed, and rated the indicator.

7. **Record Keeping**: For audit and record keeping purposes it is recommended that you maintain a file with the data documents used to rate each indicator along with a copy of the completed worksheet. Do not submit these documents to CTCP.

Community Readiness - Worksheet B

Purpose: This worksheet is used to assess the community's readiness to work on a policy or system change relevant to the indicator in terms of 1) adopting a change, 2) implementing a change, or 3) facilitating acceptance and compliance with a change.

1. **Community Readiness Measure**: Community Readiness is composed of five items: 1) Scope of the Problem, 2) Community Awareness, 3) Community Support, 4) Decision Maker Support, and 5) Earned Media. Table 5, *Community Readiness Assessment*, describes the assessment question for each item and the rating scale.

2. **Rating Rubric**: The *Community Readiness Rating Rubric* provides a general description for each item on the Likert scale. Refer to it to help you select the most appropriate rating for each of the five items on the Community Readiness Worksheet.

Table 5. Community Readiness Assessment

Community Readiness Assessment		
Item	**Assessment Question**	**Rating Scale See Rating Rubric**
Scope of the Problem	To what extent do local, regional, state or national data demonstrate the existence of a public health problem?	0-5 None to Excellent
Community Awareness	How much awareness is there among community members that a public health problem exists?	0-5 None to Excellent
Community Support	To what extent have community members demonstrated support for action?	0-5 None to Excellent
Decision Maker Support	To what extent have decision makers and community leaders demonstrated support for action (political will)?	0-5 None to Excellent
Earned Media	To what extent has there been unpaid neutral or positive media coverage in the past year relevant to this indicator?	0-5 None to Excellent

3. **Assessment and Rating Process**: For each indicator, tobacco control project staff, coalition members, and additional community participants are to review and discuss quantitative and qualitative data relevant to that indicator. Based on this review and discussion of data, consult the rating rubric and assign a rating for each of the five Community Readiness items.

4. **Community Readiness Score**: To facilitate comparisons, the rating from each assessment form is being converted into a "score."

   OTIS: OTIS will automatically calculate the Community Readiness Score once the data are entered and saved

   If not using OTIS: To manually calculate the Community Readiness Score use the formula provided on the bottom of Worksheet B, Box B-1.

   - Sum the individual ratings.
   - Multiply the results by 100 and divide the sum by the total possible score (25).
   - Display the score as a percentage.

   Example: If the rating for an indicator totaled 15, the score would be 15 x (100/25) =60 percent.

5. **Total Indicator Score-Worksheet F**: Transfer information from Worksheet B to Worksheet F (Total Indicator Score) in order to manually calculate the Total Indicator Score.

   OTIS: These calculations will be automatically performed in OTIS once data from individual worksheets are entered and saved.

6. **Complete Narrative Summary-Worksheet G**: See Worksheet G Instructions.

7. **Complete CX Needs Assessment Overview Report-Worksheet I**: Use Worksheet I to manually create a report that summarizes the Community Readiness Score and narrative justification.

Policy/System Status

Purpose: This assessment describes the status of tobacco-related policy and systems within the community. It consists of three measures: 1) Stage of Change, 2) Policy Quality, and 3) Policy Reach. Each of these measures is rated on a six item continuum.

1. Stage of Change is a measure that describes where a community is at along the continuum of policy/system change.
2. Quality is a measure of the strength—or the extent of public health protection provided by the policy.
3. Reach describes the proportion of the population covered by legislated policies enacted to date.

Policy/System Status Stage of Change-Worksheet C

Purpose: This assessment describes the stage of change that a community is at along a six stage change continuum: No Formal Activities, Planning/ Advocating, Policy/System Change Proposed, Policy/System Change Adopted, Policy Implemented, and Compliance/Enforcement.

1. **Assessment and Rating Process**: The Stage of Change assessment and rating should be based on your completers' knowledge and their discussion of quantitative and qualitative data relevant to the indicator in consultation with the definitions in Table 6, *Policy/System Change Stages*. The rating assigned should reflect the highest level of Stage of Change achieved within the community area assessed. See Table 7, *Rating Tips*, for guidance on handling mixed policy situations.

2. **Stage of Change Measure**: The Stage of Change measure consists of six discrete stages along a continuum of change: *1) No Formal Activities, 2) Planning/Advocating, 3) Policy/ System Change Proposed, 4) Policy/System Change Adopted, 5) Policy Implemented, and 6) Compliance/ Enforcement*. See Table 6, *Policy/System Change Stages*, for the definition of each stage.

3. **Rating Scale**: Each Stage of Change is assigned a rating of 0 to 5. Select one stage to represent the stage of change for the **entire** community assessed. See Table 6, *Policy/System Change Stages*, for a definition of each Stage of Change and the corresponding rating for each stage.

Table 6. Policy/System Change Stages

Policy/System Change Stages		
No Formal Activities	In this stage, general information gathering and fact finding are underway, but no formal activities specific to the indicator have been completed.	0
Planning/ Advocating	In this stage, partnership development, strategy development (e.g., Midwest Academy Strategy Chart completed), specific data collection, and/ or the provision of information and education to key opinion leaders are underway.	1
Policy/System Change Proposed	In this stage, a policy or system change has been drafted or proposed; a resolution may have been enacted; education and media activities are underway; and recruitment of partners beyond core supporters is underway.	2
Policy/System Change Adopted	In this stage: A. A voluntary policy or system change has been adopted and may be implemented **OR** B. A legislated policy has been adopted but not yet implemented. A ***legislated policy*** is one adopted by a government or a board authorized to set formal rules (e.g., county, city, tribe, housing authority, school board, transit board, fair board, hospital board, parks and recreation board, planning commission).	3
Policy Implemented	In this stage, a legislated policy(s) has been enacted and implementation is underway which may include: provision of training, communication to stakeholders notifying them of the policy and expectations, posting signage, collecting fees, and conducting compliance checks.	4
Compliance/ Enforcement	In this stage, a high degree of compliance has been achieved with a legislated policy(s). Progressive action is taken to address non-compliance and cessation support initiatives are in place.	5

4. **Rating Tips**: See Table 7, *Rating Tips*, for an explanation on how to handle situations where you have a mixture of systems level, resolutions, voluntary policies, and legislated policies.

Table 7. Rating Tips

Rating Tips	
Situation	**How to Rate**
Mixed stages of change	• If the area assessed is comprised of multiple jurisdictions (e.g., cities, tribes) or multiple organizational entities (e.g., hospitals, college campuses) which are at different stages of policy or system change, give yourself "credit" for the highest level of policy or system change achieved within the community area assessed. • For example, if one legislated smokefree multi-unit housing policy has been adopted and implemented in the county and ten voluntary smokefree policies have been adopted, then rate the stage as "Policy Implemented." • On the Indicator Narrative Summary (Worksheet G) you will describe the mix of stages and approximate the number of voluntary and legislated policies adopted within the assessment area.
A resolution has been adopted, but no voluntary or system changes have been adopted	If the strongest policy/system change adopted to-date is one or more resolutions, then the highest rating possible is a two (2) rating.
Voluntary policies or administrative system changes have been adopted	If only voluntary policies or administrative system changes (e.g., adoption of EMR to assess smoking status) then the highest rating possible is a three (3) rating.

5. **Stage of Change Rating**: Circle the rating for the Stage of Change which best fits the community area assessed.

6. **Stage of Change Score**: To facilitate comparisons, the rating from each assessment form is being converted into a "score."

OTIS: OTIS will automatically calculate the Stage of Change Score once the data are entered and saved.

If not using OTIS: To manually calculate the Change of Stage Score use the formula provided on the bottom of Worksheet C, Box C-1.

- Multiply your Stage of Change rating by 100.
- Divide the results by five.
- Display the score as a percentage.

Example: If the Stage of Change rating was 3, the score would be 3 × (100/5) = 60 percent.

7. **Total Indicator Score-Worksheet F**: Transfer information from Worksheet C to Worksheet F (Total Indicator Score) in order to manually calculate the Total Indicator Score.

   OTIS: These calculations will be automatically performed in OTIS once data from individual worksheets are entered and saved.

8. **Complete Narrative Summary-Worksheet G**: See Worksheet G Instructions.

9. **Complete CX Needs Assessment Overview Report-Worksheet I**: Use Worksheet I to manually create a report that summarizes the Stage of Change rating, score, and narrative justification.

   OTIS: This report will be created automatically in OTIS once data from individual worksheets are entered and saved.

Policy/System Status Policy Quality-Worksheet D

Purpose: Quality is a measure of the strength—or the extent of public health protection provided by the policy. This worksheet is used to record the quality of legislated policies adopted against a pre-defined public health standard. A standard has been established for TRL, MUH, Outdoor SHS, Tobacco Retailer Density/Zoning, Minimum Package/Volume Size, Outdoor Dining (SHS), Tobacco Free Pharmacies, and Menthol and Other Flavored Tobacco Products polices adopted by a county board of supervisors or city council.

1. **Assessment and Rating Process**: CTCP collects and rates TRL, MUH, Outdoor SHS, Tobacco Retailer Density/Zoning, Minimum Package/Volume Size, Outdoor Dining (SHS), Tobacco Free Pharmacies, and Menthol and Other Flavored Tobacco Products adopted by county boards of supervisors and city councils according to a pre-determined standard.

    - For the CX Needs Assessment, CTCP will calculate a composite local health jurisdiction-wide Policy Quality rating for the indicators listed in Table 4. Summary of Indicator Rating Data using information in the Policy Evaluation Tracking System (PETS).
    - The composite rating is computed by calculating the quality rating for each ordinance adopted within the local health jurisdiction, summing the individual quality ratings for "like" types of ordinances and then dividing the sum by the total number of jurisdictions in the local health jurisdiction.
    - Agencies will be able to modify the quality rating calculated by CTCP, but must provide an explanation on the Narrative Summary (Worksheet G) if they do so. For example, if one or more strong policies have been enacted that have not yet been rated by CTCP, the agency may raise the rating, but would need to provide an explanation.
    - When no Policy Quality rating is available, the rating given will be zero.

2. **Rating Scale**: The quality scale is composed of a six item continuum, rated on a scale of 0 to 5. See Table 8, Policy Quality Rating Scale, for a definition of each item and the corresponding rating.

Table 8. Policy Quality Rating Scale

Policy Quality Rating Scale		
Items	**Definition**	**Rating Scale**
None	No policies relevant to the indicator have been adopted in the community area assessed.	0
Poor	On average, the legislated policies in the community area assessed meet 1% to 20% of the established standard.	1
Fair	On average, the legislated policies in the community area assessed meet 21% to 40% of the established standard.	2
Good	On average, the legislated policies in the community area assessed meet 41% to 60% of the established standard.	3
Very Good	On average, the legislated policies in the community area assessed meet 61% to 80% of the established standard.	4
Excellent	On average, the legislated policies in the community area assessed meet 81% to 100% of the established standard.	5

3. **Policy Quality Rating**: Circle the score for the Policy Quality which best fits the community area assessed.

4. **Policy Quality Score**: To facilitate comparisons, the rating from each assessment form is being converted into a "score."

   OTIS: OTIS will automatically calculate the Policy Quality score once the data are entered and saved.

   If not using OTIS: To manually calculate the Policy Quality Score use the formula provided on the bottom of Worksheet D, Box D-1.

   - Multiply your Policy Quality rating by 100.
   - Divide the results by five.
   - Display the score as a percentage.

   Example: If the Policy Quality rating was 3, the score would be 3 × (100/5) = 60 percent.

5. **Total Indicator Score-Worksheet F**: Transfer information from Worksheet D to Worksheet F (Total Indicator Score) in order to manually calculate the Total Indicator Score.

   OTIS: These calculations will be automatically performed in OTIS once data from individual worksheets are entered and saved.

6. **Complete Narrative Summary-Worksheet G**: See Worksheet G Instructions.

7. **Complete CX Needs Assessment Overview Report-Worksheet I**: Use Worksheet I to manually create a report that summarizes the Policy Quality rating, score, and narrative justification.

   OTIS: This report will be created automatically in OTIS once data from individual worksheets are entered and saved.

Policy/System Status Policy Reach-Worksheet E

Purpose: This worksheet is used to record the reach of **legislated policies** adopted by describing the proportion of the population within the local health jurisdiction that is protected by a specific policy change.

1. **Assessment and Rating Process**: CTCP will calculate the reach rating for indicators listed in Table 4. *Summary of Indicator Rating Data*.

   - The rating is based on information in the PETS and population data. It is calculated by summing the populations of the jurisdictions where a specific policy has been enacted and dividing that sum by the total population of the community area assessed.

   - Agencies will be able to modify the rating provided by CTCP, but must provide a narrative explanation if they do so. For example, if one or more policies have been enacted after CTCP provided the Policy Reach rating; an agency may raise the rating, but would need to provide an explanation.

   - When no Policy Reach rating is available, the rating given will be zero.

2. **Rating Scale**: The reach scale is composed of a six item continuum, rated on a scale of 0 to 5. See Table 9. *Policy Reach Rating Scale* for a definition of each item and the corresponding rating.

Table 9. Policy Reach Rating Scale

Policy Reach Rating Scale		
Items	**Definition**	**Rating Scale**
None	No legislated policies have been adopted in the community area assessed.	0
Poor	1% to 20% of the population is protected by the policy change(s).	1
Fair	21% to 40% of the population is protected by the policy change(s).	2
Good	41% to 60% of the population is protected by the policy change(s).	3
Very Good	61% to 80% of the population is protected by the policy change(s).	4
Excellent	81% to 100% of the population is protected by the policy change(s).	5

3. **Policy Reach Rating**: Circle the rating for Policy Reach which best fits the community area assessed.

4. **Policy Reach Score**: To facilitate comparisons, the rating from each assessment form is being converted into a "score."

   OTIS: OTIS will automatically calculate the Policy Reach score once the data are entered and saved.

   If not using OTIS: To manually calculate the Policy Reach Score use the formula provided on the bottom of Worksheet E, Box E-1.

   - Multiply your Policy Reach rating by 100.
   - Divide the results by five.
   - Display the score as a percentage.

   Example: If the Policy Reach rating was 3, the score would be 3 × (100/5) = 60 percent.

5. **Total Indicator Score-Worksheet F**: Transfer information from Worksheet E to Worksheet F (Total Indicator Score) in order to manually calculate the Total Indicator Score.

OTIS: These calculations will be automatically performed in OTIS, once data from individual worksheets are entered and saved.

6. **Complete Narrative Summary-Worksheet G**: See Worksheet G Instructions.

7. **CX Needs Assessment Overview Report-Worksheet I**: Use Worksheet I to manually create a report that summarizes the Policy Reach rating, score, and narrative justification.

   OTIS: This report will be created automatically in OTIS, once data from individual worksheets are entered and saved.

Total Indicator Score Calculation Instructions-Worksheet F

Purpose: The purpose of the Total Indicator Score Worksheet is to help you manually calculate preliminary indicator scores prior to entering assessment findings into OTIS. The Total Indicator Score is based on the rating of Community Readiness and Policy Status (Stage of Change + Quality + Reach). Once data is submitted and saved into OTIS, this data will be calculated for you.

Instructions: Prior to entering your ratings into OTIS, it is likely that you will want to calculate the Total Indicator Score manually in order to give your completers instant feedback.

1. Record the indicator number and brief title.

2. Record the Community Readiness Rating and Score from Box B-1 of the Community Readiness: Worksheet B.

3. Record the Stage of Change Rating from Box C-1 of the Stage of Change: Worksheet C.

4. Record the Quality Rating from Box D-1 of the Policy Quality: Worksheet D.

5. Record the Reach Rating from Box E-1 of the Policy Reach: Worksheet E.

6. Add lines 2a, 2b, and 2c and record the number. Divide that number by 15. This is your **Total Policy/System Status Score**.

7. Add the lines 1 and 3 and record the number. Divide that number by 40. This is your **Total Indicator Score**.

Indicator Narrative Summary Instructions-Worksheet G

Purpose: The purpose of the narrative is to summarize quantitative and qualitative information which explains and supports the Community Readiness and Policy/System Status scores.

Instructions: In a narrative format provide a descriptive summary response to each of the questions listed on Worksheet G.

1. **Community Readiness Status–Scope of the Problem and Support**: Summarize key quantitative and qualitative data from the discussion about the Scope of the Problem, Community Awareness, and Community/Decision Maker Support (limited to 300 words). Include the following information in the summary:

    - Awareness of the problem and support/opposition for addressing this indicator
    - Highlight any subpopulations or geographical communities for which there are unique factors related to community readiness for policy/system change

2. **Community Readiness Status–Outreach**: Summarize and record the history of intervention activities related to the indicator (limited to 300 words). Include the following information in the summary:

    - Partnership development activities
    - Educational outreach to community decision makers
    - Media activities
    - Policy and system change activities
    - Enforcement and compliance activities

3. **Voluntary Policy Status**: Estimate the approximate number of voluntary policies or resolutions that have been adopted related to the indicator or check "Don't Know" (limited to 100 words).

4. **Legislated Policy Status**: Estimate the approximate number of legislated policies that have been adopted which are relevant to the indicator (limited to 100 words).

5. **Modification of Policy Quality or Reach Scores**: If the Policy Quality or Policy Reach scores were modified from that provided by CTCP, provide an explanation that supports the change (limited to 300 words).

Indicator Assessment Cover Page

Indicator #:	Indicator Title:

Core Indicator? (Circle one) Yes No

Community Area(s) Assessed:

Indicator Assessment Completion Date:

Which quantitative and qualitative data sources, references, and citations were used to complete the Indicator rating? (Title and Year)

Who was engaged in discussing and completing the Indicator rating? (List the coalition name, organizational names, or names of individuals.)

Community Readiness - Worksheet B

Instructions: What is the community's readiness for working on policy/system change adoption, implementation, or compliance and enforcement relevant to this indicator? Check a single box for each item.

	None (0)	Poor (1)	Fair (2)	Good (3)	Very Good (4)	Excellent (5)
1. **Scope of the Problem.** To what extent do local, regional, state, or national data demonstrate the existence of a public health problem?	☐	☐	☐	☐	☐	☐
2. **Community Awareness.** How much awareness is there among community members that a public health problem exists?	☐	☐	☐	☐	☐	☐
3. **Community Support.** To what extent have community members demonstrated support for action?	☐	☐	☐	☐	☐	☐
4. **Decision Maker Support.** To what extent have decision makers and community leaders demonstrated support for action (political will)?	☐	☐	☐	☐	☐	☐
5. **Earned Media.** To what extent has there been unpaid neutral or positive media coverage in the past year relevant to this indicator?	☐	☐	☐	☐	☐	☐

Box B-1

Community Readiness Score: Add lines 1 through 5 ☐ x $\frac{100}{25}$ = ☐ %

Policy/System Status Stage of Change - Worksheet C

Instructions: For this indicator, what is the overall stage of policy/system change adoption in the community area assessed? Circle the most applicable rating.

Policy/System Change Stage: Refers to the policy adoption stage of the assessed area.	**Rating**
No Formal Activities. In this stage, general information gathering and fact finding are underway, but no formal activities specific to the indicator have been completed.	0
Planning/Advocating. In this stage, partnership development, strategy development (e.g., Midwest Academy Strategy Chart completed), specific data collection, and/or the provision of information and education to key opinion leaders are underway.	1
Policy/System Change Proposed. In this stage, a policy or system change has been drafted or proposed; a resolution may have been enacted; education and media activities are underway; and recruitment of partners beyond core supporters is underway.	2
Policy/System Change Adopted. In this stage: A. A voluntary policy or system change has been adopted and may be implemented **OR** B. A legislated policy has been adopted but not yet implemented. A ***legislated policy*** is one adopted by a government or a board authorized to set formal rules (e.g., county, city, tribe, housing authority, school board, transit board, fair board, hospital board, parks and recreation board, or planning commission).	3
Policy Implemented. In this stage, a ***legislated policy(s)*** has been enacted and implementation is underway which may include: provision of training, communication to stakeholders notifying them of the policy and expectations, posting signage, collecting fees, and conducting compliance checks.	4
Compliance/Enforcement. In this stage, a high degree of compliance has been achieved with a ***legislated policy(s)***. Progressive action is taken to address non-compliance.	5

Box C-1 **Policy/System Change Stage Score:** Insert rating from above [ ] x $\frac{100}{5}$ = [ ] %

Policy/System Status Policy Quality - Worksheet D

Instructions: For this indicator, what is the overall quality of the policies adopted in the community area assessed? CTCP will provide an established standard using PETS. Circle the most applicable rating.

Quality Rating: Refers to how well the requirements in a legislated policy meet an established standard.	**Rating**
None. No policies relevant to the indicator have been adopted in the community area assessed.	0
Poor. On average, the legislated policies in the community area assessed meet 1% to 20% of the established standard. A ***legislated policy*** is one adopted by a government or a board authorized to set formal rules (e.g., county, city, tribe, housing authority, school board, transit board, fair board, hospital board, parks and recreation board, planning commission).	1
Fair. On average, the legislated policies in the community area assessed meet 21% to 40% of the established standard.	2
Good. On average, the legislated policies in the community area assessed meet 41% to 60% of the established standard.	3
Very Good. On average, the legislated policies in the community area assessed meet 61% to 80% of the established standard.	4
Excellent. On average, the legislated policies in the community area assessed meet 81% to 100% of the established standard.	5

Box D-1

Policy Quality Score: Insert rating from above [ ] x $\frac{100}{5}$ = [ ] %

Policy/System Status Policy Reach - Worksheet E

Instructions: For this indicator, what is the overall population reach of the policies adopted in the community area assessed? Circle the most applicable rating.

Reach: Refers to the percentage of the population in the area assessed (e.g. county, city) that is covered by a legislated county or city policy.	**Rating**
None. No legislated policies have been adopted in the community area assessed.	0
Poor. 1% to 20% of the population is protected by the policy change(s).	1
Fair. 21% to 40% of the population is protected by the policy change(s).	2
Good. 41% to 60% of the population is protected by the policy change(s).	3
Very Good. 61% to 80% of the population is protected by the policy change(s).	4
Excellent. 81% to 100% of the population is protected by the policy change(s).	5

Box E-1

Policy Reach Score: Insert rating from above [ ] x $\frac{100}{5}$ = [ ] %

Total Indicator Score - Worksheet F

Instructions: OTIS will calculate a Total Score for each indicator based on your Community Readiness and Policy Status. The OTIS Communities of Excellence in Tobacco Control Overview Report (OTIS CX Overview Report) will compile the Total Score, sub scores, and narrative comments for each indicator.

To manually calculate the total score for an indicator, use this form:

Indicator #	Indicator Title:	Rating	Score
		#	%
Community Readiness	**1. Transfer the rating sum and score from Worksheet B, Box B-1**	_____	_____
Policy System Status	**2a. Stage of Change** Transfer the rating and score from Worksheet C, Box C-1	_____	_____
	2b. Policy Quality Transfer the rating and score from Worksheet D, Box D-1	_____	_____
	2c. Policy Reach Transfer the rating and score from Worksheet E, Box E-1	_____	_____
	3. Total Policy/System Status Add lines 2a+2b+2c. Record that number. Divide the sum of (2a+2b+2c) by 15 to get the percentage	**(2a+2b+2c)=** _____ **Total**	**(Line 3 Total) ÷ 15** _____
Total Indicator Score	**4. Total Indicator Score** Add lines 1 and 3. Record that number. Divide the sum of lines (1 + 3) by 40 to get the percentage.	**(1 + 3)=** _____ **Total**	**(Line 4 Total) ÷ 40** [ ]

Indicator Narrative Summary-Worksheet G

Purpose: The purpose of the narrative is to provide information which explains and supports the Community Readiness and Policy/System Status scores.

Instructions: In a narrative format provide a descriptive summary which includes the following information:

1. Summarize key data and findings related to the status of the indicator, including awareness of the problem and support/opposition for addressing this indicator. Highlight any subpopulations or geographical communities for which there are unique factors related to community readiness for policy/system change related to the indicator (limited to 300 words).

2. Summarize partnership development activities, educational outreach to community decision makers, media activities, policy/system change implementation activities, enforcement activities, and/or compliance activities conducted by your agency or other agencies in the local health jurisdiction related to the indicator (limited to 300 words).

3. Estimate the approximate number of voluntary policies or resolutions that have been adopted related to the indicator or check "Don't Know" (limited to 100 words).

   ☐ Don't Know

4. Estimate the approximate number of legislated policies related to the indicator that have been adopted (limited to 100 words).

5. If the Policy Quality or Policy Reach scores were modified from that provided by CTCP, provide an explanation that supports the change (limited to 300 words).

Community Readiness Rating Rubric

Worksheet B

Community Readiness Question	None 0	Poor 1	Fair 2	Good 3	Very Good 4	Excellent 5
1. **Scope of the Problem:** To what extent do local, regional, state or national data demonstrate the existence of a public health problem relevant to this indicator?	**No** national, state, regional, or local data exists relevant to the indicator.	**National, state, regional, or local** data relevant to the indicator are available. Data are **more than 5** years old.	**Only state OR national** data relevant to the indicator are available. Data were collected **within the last 5** years	**State AND regional** data relevant to the indicator are available. Data were collected **within the last 5** years. Together these data describe who is impacted by the problem and the health or social impact of the problem.	**Local** data relevant to the indicator are available. Data were collected **within the last 3** years. The local data describe who is impacted by the problem, the health or social impact of the problem, and **community awareness about the problem**.	**Robust local** data relevant to the indicator are available. Data were collected **within the last 3** years. The data describe who is impacted by the problem, the health or social impact of the problem, community awareness about the problem, **community support for addressing the problem, and decision-maker support for addressing the problem**

	Community Readiness Question	None 0	Poor 1	Fair 2	Good 3	Very Good 4	Excellent 5
2.	**Community Awareness:** How much awareness is there among community members that a public health problem exists relevant to this indicator?	The community is generally **not** aware that a problem exists.	There is **vague** awareness that a problem exists.	There is **general** awareness that a problem may exist, but it is not perceived as a local problem.	There is **clear** awareness that a **local** problem exists; **50% or less** of the population is aware of the problem. Awareness **may be lower in many** geographic areas or among specific racial/cultural groups.	There is **high** awareness that a **local** problem exists; **Greater than 50% but less than 75%** of the population is aware of the problem. Awareness **may be lower in a few** geographic areas or among specific racial/cultural groups.	There is **extremely high** awareness that a **local** problem exists; **75% or more** of the population is aware of the problem. Awareness is **generally good across all** geographic areas and racial/cultural groups.

Community Readiness Question	None 0	Poor 1	Fair 2	Good 3	Very Good 4	Excellent 5
3. **Community Support:** To what extent have community members demonstrated support for action relevant to this indicator?	There is **no** community support for action relevant to the issue. In fact, **strong opposition** may have been expressed.	In general, the community is **indifferent** to the issue.	There is **passive** support for the issue. In general, **few** community members or organizations have **considered** taking action such as forming a committee, collecting local data, conducting awareness raising and education programs, or seeking funding.	There is **active** community support for the issue. Planning and preparation activities have been **initiated** such as forming a committee, collecting local data, conducting awareness raising and education programs, strategic planning, or applying for funding to address the issue. State or local attitudes, beliefs, opinion polls, and intercept surveys demonstrate that **50% or less** of the population supports various intervention strategies to support the issue.	**Active** community support for the issue has moved from planning and preparation activities among core supporters to **engaging** additional people through conducting educational and media outreach. State or local attitudes, beliefs, opinion polls, and intercept surveys demonstrate that **greater than 50% but less than 75%** of the population supports various intervention strategies to support the issue.	Informal and formal community leaders have demonstrated their support by **offering** tangible assistance with policy or system change or compliance/ enforcement efforts. State or local attitudes, beliefs, opinion polls, and intercept surveys demonstrate that **75% or more** of the population supports various intervention strategies to support the issue.

	Community Readiness Question	None 0	Poor 1	Fair 2	Good 3	Very Good 4	Excellent 5
4.	**Decision Maker Support:** To what extent have decision makers and community leaders demonstrated support for action (political will) relevant to this indicator?	There is **no** decision maker support for action relevant to the issue. In fact, **strong opposition** may have been expressed.	In general, the decision makers are **indifferent** to the issue.	There is **passive support** for the issue among decision makers. Decision makers have not been motivated to take any action beyond fact finding to address the problem.	There is **active support** for the issue expressed by **one or more** influential decision makers. **Exploration** of various solutions is **underway**.	**One or more** decision makers have publicly identified themselves as a **champion** for the issue.	A **majority** of decision makers who have the authority to take action on a policy or system change or compliance/ enforcement effort have **publically voiced support** for specific action relevant to the issue.

Community Readiness Question	None 0	Poor 1	Fair 2	Good 3	Very Good 4	Excellent 5
5. **Earned Media**: To what extent has there been unpaid neutral or positive media coverage in the past year relevant to this indicator? The focus of this assessment is on the amount of earned media related to the indicator, rather than on who generated the earned media. The earned media may have been generated as a result of local, regional, state, or national efforts. Earned media refers to unpaid publicity and press coverage through either mainstream outlets like television, radio, print, talk shows, editorials, or letters to the editor, traditional web publishers, or social media outlets like blogs, community forums, and podcasts. Earned media does not include paid marketing such as advertising and sponsorships.	In the past three years, **no** earned media items relevant to the indicator have appeared in the community from local, regional, state, or national sources.	**At least 1 unpaid earned media item per year** relevant to the indicator has appeared in the community from local, regional, state, or national sources, in the past three years.	**At least 2 unpaid earned media items per year** relevant to the indicator have appeared in the community from local, regional, state, or national sources, in the past three years.	**At least 3 unpaid earned media items per year** relevant to the indicator have appeared in the community from local, regional, state, or national sources, in the past three years.	**At least 4 unpaid earned media items per year** relevant to the indicator have appeared in the community from local, regional, state, or national sources, in the past three years.	**At least 5 unpaid earned media items per year** relevant to the indicator have appeared in the community from local, regional, state, or national sources, in the past three years. Additionally, earned media is **routinely used to increase** awareness about this issue and to set an agenda.

Asset Assessment Instructions

Purpose: The Asset Worksheet findings will be used to help identify factors that promote and sustain tobacco control efforts in the community by facilitating tobacco control work. You will be able to determine "how much" or "to what extent" an issue is being addressed in your community.

Assessment and Rating Process: The assessment and rating of Assets should be based on your completers' knowledge of the assets and a discussion of all relevant quantitative and qualitative data collected and reviewed. Refer to the Assets Rating Rubric to help guide the discussion. In addition to rating the assets, you will write a brief narrative summary (limited to 500 words) which explains and supports the rating given to each asset.

Cover Page

1. **Asset Numbers and Titles**: List the number and brief title for each asset rated.

   OTIS: A drop-down menu is provided in OTIS.

2. **Core Asset**: A "core" asset is one that every agency must assess. Refer to the funding guidelines/procurement for a list of the core assets. List the number for each core asset rated.

   OTIS: In OTIS, this field will be pre-populated.

3. **Community Area(s) Assessed**: Identify the community name(s) that best reflects the geographical area assessed. In general, county health departments should use a countywide perspective and city health departments should use a citywide perspective. However, there may be times when it is appropriate to use a different frame of reference for the assessment.

   OTIS: In OTIS there are drop-down menus for four types of communities: 1) countywide, 2) incorporated cities, 3) unincorporated communities, and 4) Indian tribal lands.

4. **Completion Date**: Identify the month, day, and year your agency completed the Asset Assessment.

OTIS: A calendar is provided in OTIS to select the date.

5. **Data Sources, References and Citations**: Use local, regional, state and/or national data to assess the assets. List the title and year of data sources used in the assessment. Qualitative data sources, such as key informant interviews, focus group findings, and coalition discussions are acceptable data sources.

   OTIS: A drop-down menu of common data sources is in OTIS, but you are encouraged to identify additional local data or other references and citations.

6. **Who completed the assessment**? List the coalition name, organization names, and/or the names of individuals who reviewed data and rated the assets.

7. **Record Keeping**: For audit and record keeping purposes, it is recommended that you maintain a file with the data documents used to rate each asset along with a copy of the completed worksheet. Do not submit these documents to CTCP.

Asset Rating-Worksheet H

1. **Rating Scale**: Each asset is rated on a six point (0 to 5) Likert scale of *None, Poor, Fair, Good, Very Good, and Excellent*. You are not required to rate every asset. A "Not Rated" (NR) response is provided for those assets you do not rate.

   OTIS: In OTIS, a drop-down menu is provided.

2. **Rating Rubric**: Refer to the *Asset Rating Rubric* to help you with the assessment. The rubric provides a general definition or meaning for each measure on the Likert scale and will help guide your rating of each asset.

3. **Core Assets**: You are required to complete any Asset which is identified as a "Core" Asset in the funding document (e.g., Local Lead Agency Guidelines, Request for Application, or Request for Proposal).

   OTIS: In OTIS, this field will be pre-populated.

4. **Non-Core Assets**: Completion of non-core assets is optional. However, in order to include an objective and activities related to a specific asset, you must have assessed the asset.

5. **Rating Assets**: Assign a rating of None to Excellent for each asset rated. For assets that are not rated, circle "NR" for not rated.

6. **Comments**: A "Comments" field is provided following each asset. Completion of this field is mandatory (limited to 500 words.) Use this field to record information that justifies and supports the rating. It is important that your comments substantiate and/or explain the rating given in order to provide context and background to the reviewers of your funding application.

7. **Complete CX Needs Assessment Overview Report Worksheet I**: Transfer the individual assets ratings to Worksheet I to manually create a report that summarizes your assessment conclusions.

   OTIS: This report will be created automatically in OTIS once data from the Asset Rating Worksheet is entered and saved in OTIS.

Asset Assessment Cover Page

Asset #:	Asset Title(s):

Which were Core Assets? (Provide Asset Numbers)

Community Area(s) Assessed:

Asset Assessment Completion Date:

Which quantitative and qualitative data sources, references, and citations were used to complete the Asset ratings? (Title and Year)

Who was engaged in discussing and completing the Asset ratings? (List the coalition name, organizational names or the names of individuals.)

Asset Rating - Worksheet H

Instructions: Based on your review and discussion of data, circle the most appropriate rating. Circle "NR" (not rated) for those assets which you are not rating.

	Community Asset	None	Poor	Fair	Good	Very Good	Excellent	
1.1	**Tobacco Control Funding:** The local jurisdiction's annual per capita funding dedicated to tobacco control for both community and school programs, from various sources, including tobacco taxes (e.g., Propositions 99, 10, 56), Master Settlement Agreement, and other public or private sources is $6.54 to $9.15, consistent with the Centers for Disease Control and Prevention Best Practices, 2014 recommendations for California.	0	1	2	3	4	5	NR
	Comments:							
1.2	**Master Settlement Agreement (MSA) Funding:** The amount of MSA funds that are appropriated for the purpose of tobacco control activities.	0	1	2	3	4	5	NR
	Comments:							

	Community Asset	None	Poor	Fair	Good	Very Good	Excellent	
1.3	**Proposition 10 Funding:** The amount of local Proposition 10 funds that are appropriated for cessation and secondhand smoke education targeting pregnant women and families with young children.	**0**	**1**	**2**	**3**	**4**	**5**	**NR**
	Comments:							
2.1	**Training and Skill Building**: The extent our program provides technical assistance and support to diverse community groups to enable them to effectively engage in tobacco control activities and activities to reduce tobacco-related social determinants of health.	**0**	**1**	**2**	**3**	**4**	**5**	**NR**
	Comments:							

	Community Asset	None	Poor	Fair	Good	Very Good	Excellent	
2.2	**Coalition/Advisory Committee Satisfaction**: The degree coalition/ advisory committee members are satisfied with group functioning, ability to recruit and engage diverse partners, and member involvement in intervention activities that focus on policy, system, and environmental change.	**0**	**1**	**2**	**3**	**4**	**5**	**NR**
	Comments:							
2.3	**Key Opinion Leader Support**: The extent of support among local key opinion leaders for tobacco related community norm change strategies.	**0**	**1**	**2**	**3**	**4**	**5**	**NR**
	Comments:							

	Community Asset	None	Poor	Fair	Good	Very Good	Excellent	
2.4	**Youth Engagement in Tobacco Control:** The degree our program has participatory collaborative partnerships with diverse youth and youth-serving organizations, and engages them to support tobacco control-related activities that focus on policy, systems, and environmental changes.	0	1	2	3	4	5	NR
	Comments:							
2.5	**Community Engagement in Tobacco Control**: The degree our program has collaborative partnerships with diverse organizations and individuals in addition to CTCP and TUPE-funded organizations, to engage them to support tobacco control-related activities that focus on policy, system, and environmental change such as community assessments, data collection, education of community members and decision makers, and media events.	0	1	2	3	4	5	NR
	Comments:							

	Community Asset	None	Poor	Fair	Good	Very Good	Excellent	
3.1	**Coalition/Advisory Committee Diversity**: The degree our program engages a coalition or advisory committee in designing and implementing tobacco control activities that includes diversity across race/ethnicity, culture, sexual orientation and gender identity, geography, and non-traditional partners (e.g., housing, employee development, law enforcement, parks and recreation, environmental groups).	0	1	2	3	4	5	NR
	Comments:							
3.3	**Cultural Competence Assessment**: The degree our program conducts organizational cultural competence assessments.	0	1	2	3	4	5	NR
	Comments:							

	Community Asset	None	Poor	Fair	Good	Very Good	Excellent	
3.4	**Tailored Educational and Outreach Materials:** The degree our program makes culturally appropriate educational, outreach and media materials easily available and appropriate for the languages and literacy levels of commonly encountered groups in the service area.	0	1	2	3	4	5	NR
	Comments:							
3.6	**Equity in Funding:** The degree to which culturally and ethnically diverse organizations are funded to implement community norm change-focused tobacco control efforts in the community, in proportion to community demographics.	0	1	2	3	4	5	NR
	Comments:							

	Community Asset	None	Poor	Fair	Good	Very Good	Excellent	
4.1	**Tobacco-Related Recommendations in Community Plans**: The extent our program participates in local planning to integrate tobacco-related interventions recommendations into local and regional general plans, community health/health equity frameworks, Adverse Childhood Experience protocols, health department accreditation, and/or other similar evidence-informed, community planning processes.	**0**	**1**	**2**	**3**	**4**	**5**	**NR**
	Comments:							

	Community Asset	None	Poor	Fair	Good	Very Good	Excellent	
4.2	**Affordable Care Act Community Health Needs Assessment Participation**: The number of local tobacco control advocates who actively participate in the Community Health Needs Assessment, which is required to be conducted by non-profit hospitals every three years pursuant to the Affordable Care Act*, for the purpose of promoting the inclusion of indicators and interventions that support tobacco-free living (e.g., physical environment and housing improvements, economic development, community support, leadership development, coalition development, community health improvement and advocacy, workforce development, other community development activities to build health and safety). *SEC. 9097: Additional Requirements for Charitable Hospitals and as defined in Internal Revenue Service, Schedule H instructions (Form 990), 2011.	0	1	2	3	4	5	NR

Comments:

Assets Rating Rubric

Worksheet H

	Tobacco Control Funding Assets	None 0	Poor 1	Fair 2	Good 3	Very Good 4	Excellent 5
1.1	**Tobacco Control Funding:** The local jurisdiction's annual per capita funding dedicated to tobacco control for both community and school programs, from various sources, including tobacco taxes (e.g., Propositions 99, 10, 56), Master Settlement Agreement, and other public or private sources is $6.54 to $9.15, consistent with the Centers for Disease Control and Prevention Best Practices, 2014 recommendations for California.	**No** local funding, including Propositions 99, 56, and 10, is appropriated for tobacco control. Proposition 99, is appropriated for tobacco control.	Per capita appropriation for tobacco control in the community area assessed from all sources, including, but not limited to, monies from Propositions 99, 56, and 10 (including TUPE and Department of Justice); MSA; federal funds, foundations, and lawsuits is: **Less than $3**	Per capita appropriation for tobacco control in the community area assessed from all sources, including, but not limited to, monies from Propositions 99, 56, and 10 (including TUPE and Department of Justice); MSA; federal funds, foundations, and lawsuits is: **At least $4.50**	Per capita appropriation for tobacco control in the community area assessed from all sources, including, but not limited to, monies from Propositions 99, 56, and 10 (including TUPE and Department of Justice); MSA; federal funds, foundations, and lawsuits is: **At least $6.54**	Per capita appropriation for tobacco control in the community area assessed from all sources, including, but not limited to, monies from Propositions 99, 56, and 10 (including TUPE and Department of Justice); MSA; federal funds, foundations, and lawsuits is: **About $7.50**	Per capita appropriation for tobacco control in the community area assessed from all sources, including, but not limited to, monies from Propositions 99, 56, and 10 (including TUPE and Department of Justice); MSA; federal funds, foundations, and lawsuits is: **About $9 Or more**

Tobacco Control Funding Assets	None 0	Poor 1	Fair 2	Good 3	Very Good 4	Excellent 5
1.2 **Master Settlement Agreement (MSA) Funding:** The amount of MSA funds that are appropriated for the purpose of tobacco control activities.	**No** city or county MSA funds are appropriated for the purpose of tobacco control activities.	Annual MSA appropriation is **>0% but ≤ 25%** of the health department's annual Propositions 99 and 56 LLA allocation.	Annual MSA appropriation is **>25% but ≤ 50%** of the health department's annual Propositions 99 and 56 LLA allocation.	Annual MSA appropriation is **>50%, but ≤75%** of the health department's annual Propositions 99 and 56 LLA allocation.	Annual MSA appropriation is **>75%, but ≤ 100%** of the health department's annual Propositions 99 and 56 LLA allocation.	Annual MSA appropriation is **greater** than the health department's annual Propositions 99 and 56 LLA allocation.

Tobacco Control Funding Assets	None 0	Poor 1	Fair 2	Good 3	Very Good 4	Excellent 5
1.3 **Proposition 10 Funding**: The amount of local Proposition 10 funds that are appropriated for cessation and second-hand smoke education targeting pregnant women and families with young children.	The local Proposition 10 Commission Plan **does not** address cessation and second-hand smoke education targeting pregnant women and families with young children.	The local Proposition 10 Commission Plan **includes** goals and objectives addressing cessation and secondhand smoke education targeting pregnant women and families with young children, -but- **no** specific projects or activities are identified.	The local Proposition 10 Commission Plan **includes** goals and objectives addressing cessation and secondhand smoke education targeting pregnant women and families with young children -but- **less than 1%** of the health jurisdiction's Proposition 10 allocation is for these activities.	The local Proposition 10 Commission Plan **includes** goals and objectives addressing cessation and secondhand smoke education targeting pregnant women and families with young children -and- appropriates **1%** of the health jurisdiction's Proposition 10 allocation for these activities.	The local Proposition 10 Commission Plan **includes** goals and objectives addressing cessation and secondhand smoke education targeting pregnant women and families with young children -and- appropriates **greater than 1% and less than 5%** of the health jurisdiction's Proposition 10 allocation for these activities.	The local Proposition 10 Commission Plan **includes** goals and objectives addressing cessation and secondhand smoke education targeting pregnant women and families with young children -and- **appropriates 5% or more** of the health jurisdiction's Proposition 10 allocation for these activities.

Social Capital Assets	None 0	Poor 1	Fair 2	Good 3	Very Good 4	Excellent 5
2.1 **Training and Skill Building**: The extent our program provides technical assistance and support to diverse community groups to enable them to effectively engage in tobacco control activities and activities to reduce tobacco-related social determinants of health.	**No** tobacco control training and skill building activities were provided by our project to diverse community groups in the **past 12 months** to enable them to effectively engage in tobacco control activities and activities to reduce tobacco-related social determinants of health.	**One** tobacco control advocacy training or skill building activity was provided to diverse community groups in the **past 12 months** to enable them to effectively engage in tobacco control activities and activities to reduce tobacco-related social determinants of health.	**Two** tobacco control advocacy training or skill building activities were provided to diverse community groups in the **past 12 months** to enable them to effectively engage in tobacco control activities and activities to reduce tobacco-related social determinants of health.	**Three** tobacco control advocacy training or skill building activities were provided to diverse community groups in the **past 12 months** to enable them to effectively engage in tobacco control activities and activities to reduce tobacco-related social determinants of health.	**Four** tobacco control advocacy training or skill building activities were provided to diverse community groups in the **past 12 months** to enable them to effectively engage in tobacco control activities and activities to reduce tobacco-related social determinants of health.	**Five or more** tobacco control advocacy or skill building activities were provided to diverse community groups in the **past 12 months** to enable them to effectively engage in tobacco control activities and activities to reduce tobacco-related social determinants of health.

Social Capital Assets	None 0	Poor 1	Fair 2	Good 3	Very Good 4	Excellent 5
2.2 **Coalition/ Advisory Committee Satisfaction**: The degree coalition/ advisory committee members are satisfied with group functioning, ability to recruit and engage diverse partners, and member involvement in intervention activities that focus on policy, system, and environmental change.	**No** satisfaction survey was disseminated in the last 12 months to assess satisfaction with program planning, involvement of the community, implementation activities, quality of services, or progress made.	A satisfaction survey was disseminated in the last 12 months. **No to very low satisfaction** was expressed by members on **3 or more** of the following measures: program planning, involvement of the community, implementation of activities, quality of services, or progress made.	A satisfaction survey was disseminated in the last 12 months. Members expressed **fairly low** satisfaction on **2** of the following measures, but others were rated somewhat satisfied to very satisfied: program planning, involvement of the community, implementation of activities, quality of services, and progress made.	A satisfaction survey was disseminated in the last 12 months. Members were **somewhat satisfied** with regard to: program planning, involvement of the community, implementation of activities, quality of services, and progress made.	A satisfaction survey was disseminated in the last 12 months. Members expressed **satisfaction** with regard to: program planning, involvement of the community, implementation of activities, quality of services, and progress made.	A satisfaction survey was disseminated in the last 12 months. Members expressed **high to very high satisfaction** with regard to: program planning, involvement of the community, implementation of activities, quality of services, and progress made.

Social Capital Assets	None 0	Poor 1	Fair 2	Good 3	Very Good 4	Excellent 5
2.3 **Key Opinion Leader Support**: The extent of support among local key opinion leaders for tobacco related commu-nity norm change strategies.	There is **no** support for tobacco-related community norm change strategies among local key opinion leaders as evidenced by surveys, key informant interviews, policy votes, statements in the media, etc. Statements are made by policy makers to not accept Prop 99 or 56 funding.	There is **minimal** support for tobacco-related community norm change strategies among local key opinion leaders as evidenced by surveys, key informant interviews, policy votes, statements in the media, etc. Support is generally tied to youth-only initiatives.	There is **some** support for tobacco-related community norm change strategies among local key opinion leaders as evidenced by surveys, key informant interviews, policy votes, statements in the media, etc. Support is generally tied to youth-only initiatives	There is **consistent** support for tobacco-related community norm change strategies among local key opinion leaders as evidenced by surveys, key informant interviews, policy votes, statements in the media, etc. There is support for initiatives that go beyond a youth focus.	There is **progressive** support for tobacco-related community norm change strategies among local key opinion leaders as evidenced by surveys, key informant interviews, policy votes, statements in the media, etc. Local key opinion leaders initiate community norm change strategies.	There is **consistent** and **progressive** support for tobacco-related community norm change strategies among local key opinion leaders as evidenced by surveys, key informant interviews, policy votes, statements in the media, etc. Local key opinion leaders initiate community norm change strategies.

Social Capital Assets	None 0	Poor 1	Fair 2	Good 3	Very Good 4	Excellent 5
2.4 **Youth Engagement in Tobacco Control**: The degree our program has participatory collaborative partnerships with diverse youth and youth-serving organizations, and engages them to support tobacco control-related activities that focus on policy, systems, and environmental changes.	Our tobacco control program **does not have** participatory collaborative partnerships with diverse youth and youth-serving organizations.	Our tobacco control program has participatory collaborative partnerships with diverse youth and youth-serving organizations. **At least 1 time** per year, we engage them to support tobacco control-related activities that focus on policy, system, and environmental change; mobilize their involvement in community assessments; and participate in activities that address tobacco-related determinants of health.	Our tobacco control program has participatory collaborative partnerships with diverse youth and youth-serving organizations. **At least 2 times per year**, we engage them to support tobacco control-related activities that focus on policy, system, and environmental change; mobilize their involvement in community assessments; and participate in activities that address tobacco-related determinants of health.	Our tobacco control program has participatory collaborative partnerships with diverse youth and youth-serving organizations. **At least 3 times per year**, we engage them to support tobacco control-related activities that focus on policy, system, and environmental change; mobilize their involvement in community assessments; and participate in activities that address tobacco-related determinants of health.	Our tobacco control program has participatory collaborative partnerships with diverse youth and youth-serving organizations. **At least 4 times per year**, we engage them to support tobacco control-related activities that focus on policy, system, and environmental change; mobilize their involvement in community assessments ; and participate in activities that address tobacco-related determinants of health.	Our tobacco control program has participatory collaborative partnerships with diverse youth and youth-serving organizations. **At least 5 times per year**, we engage them to support tobacco control-related activities that focus on policy, system, and environmental change; mobilize their involvement in community assessments; and participate in activities that address tobacco-related determinants of health.

Social Capital Assets	None 0	Poor 1	Fair 2	Good 3	Very Good 4	Excellent 5
2.5 **Community Engagement in Tobacco Control**: The degree our program has collaborative partnerships with diverse organizations and individuals in addition to CTCP and TUPE-funded organizations, to engage them to support tobacco control-related activities that focus on policy, system, and environmental change such as community assessments, data collection, education of community members and decision	Our tobacco control program **never** has collaborative partnerships with diverse organizations and individuals (not including CTCP and TUPE), to engage them to support tobacco control-related activities that focus on policy, system, and environmental changes such as community assessments, data collection, education of community	Our tobacco control program has participatory collaborative partnerships with diverse organizations and individuals. **At least 1 time per year**, our tobacco control program has collaborative partnerships with diverse organizations and individuals (not including CTCP and TUPE), to engage them to support tobacco control- related activities that focus on policy, system, and	Our tobacco control program has participatory collaborative partnerships with diverse organizations and individuals. **At least 2 times per year**, our tobacco control program has collaborative partnerships with diverse organizations and individuals (not including CTCP and TUPE), to engage them to support tobacco control-related activities that focus	Our tobacco control program has participatory collaborative partnerships with diverse organizations and individuals. **At least 3 times per year**, our tobacco control program has collaborative partnerships with diverse organizations and individuals (not including CTCP and TUPE), to engage them to support tobacco control-related activities that focus	Our tobacco control program has participatory collaborative partnerships with diverse organizations and individuals. **At least 4 times per year**, our tobacco control program, has collaborative partnerships with diverse organizations and individuals (not including CTCP and TUPE), to engage them to support tobacco control-related activities that focus	Our tobacco control program has participatory collaborative partnerships with diverse organizations and individuals. **At least 5 times per year**, our tobacco control program has collaborative partnerships with diverse organizations and individuals (not including CTCP and TUPE), to engage them to support tobacco control-related activities that focus on

2.5	makers, and media events.	members and decision makers, and media events.	environmental changes such as community assessments, data collection, education of community members and decision makers, and media events.	on policy, system, and environmental changes such as community assessments, data collection, education of community members and decision makers, and media events.	on policy, system, and environmental changes such as community assessments, data collection, education of community members and decision makers, and media events.	on policy, system, and environmental changes such as community assessments, data collection, education of community members and decision makers, and media events.	policy, system, and environmental changes such as community assessments, data collection, education of community members and decision makers, and media events.

Cultural Diversity and Cultural Competence Assets	None 0	Poor 1	Fair 2	Good 3	Very Good 4	Excellent 5
3.1 **Coalition/Advisory Committee Diversity**: The degree our program engages a coalition or advisory committee in designing and implementing tobacco control activities that includes diversity across race/ethnicity, culture, sexual orientation and gender identity, geography, and non-traditional partners (e.g., housing,	Our tobacco control program has **not built and engaged** a diverse coalition or advisory committee in designing and implementing tobacco control activities.	Our tobacco control program **has built and engaged** a coalition or advisory committee in which **a few** of the groups from our demographic profile or non-traditional partners are represented among the membership and the executive leadership of the group.	Our tobacco control program has **built and engaged** a coalition or advisory committee in which **some** of the groups from our demographic profile or non-traditional partners are represented among the membership and are engaged in the executive leadership of the group.	Our tobacco control program has **built and engaged** a diverse coalition or advisory committee in which **most** of the groups from our demographic profile or non-traditional partners are represented among the membership and are engaged in the executive leadership of the group.	Our tobacco control program has **built and engaged** a diverse coalition or advisory committee in which **almost all** groups from our demographic profile or non-traditional partners are represented among the membership and are engaged in the executive leadership of the group.	Our tobacco control program has **built and engaged** a highly diverse coalition or advisory committee in which **all** groups from our demographic profile or non-traditional partners are represented among the membership and engaged in the executive leadership of the group.

3.1 employee development, law enforcement, parks and recreation, environmental groups).	Members are **rarely involved** in designing and implementing tobacco control activities.	Members are **sometimes involved** in designing and implementing tobacco control activities.	Our tobacco Members are **usually involved** in designing and implementing tobacco control activities.	Members are **almost always involved** in designing and implementing tobacco control activities.	Members are **always highly involved** in designing and implementing tobacco control activities.

Cultural Diversity and Cultural Competence Assets	None 0	Poor 1	Fair 2	Good 3	Very Good 4	Excellent 5
3.3 **Cultural Competence Assessment**: The degree our program conducts organizational cultural competence assessments.	Our tobacco control program **has no current plans to perform** a self-assessment of cultural competence.	Our tobacco control program **has discussed or planned** self-assessments of cultural competence -but- has not completed one.	Our tobacco control program **performed** self-assessments of cultural competence in the past -but- has not done so in more than 4 years.	Our tobacco control program **performed** self-assessments of cultural competence within the past 3 years -but- has done so on an **as needed basis or inconsistently over time**.	Our tobacco control program **follows** a cultural competency model but **has not** used the results to make project improvements.	Our tobacco control program **follows** the competency model and **uses** the results to make project improvements.

Cultural Diversity and Cultural Competence Assets	None 0	Poor 1	Fair 2	Good 3	Very Good 4	Excellent 5
3.4 **Tailored Educa-tional and Outreach Materials**: The degree our program makes culturally appropriate educational, outreach and media materials easily avail-able and appropriate for the languages and literacy levels of commonly encoun-tered groups in the service area.	Educa-tional and media materials used by our tobacco control program **do not reflect** the major cultural, ethnic, and language needs of the com-munities served, relative to the demo-graphics of the com-munity.	Educational and media materials used by our tobacco control program **currently do not reflect** the major cultural, ethnic, and language needs of the communities served, relative to the demo-graphics of the community. However, there are materials that are **being developed and/or being revised** to work toward meeting this gap.	Educational and media materials used by our tobacco control program **reflect a few** of the major cultural, ethnic, and language needs of the communi-ties served, relative to the demo-graphics of the community, -but- there are **major gaps** in terms of the popula-tions and/or breadth of subject matter.	Educational and media materials used by our tobacco control program **reflect several** of the major cultural, ethnic, and language needs of the communi-ties served, relative to the demographics of the comunity, -but- there are **some gaps** in terms of the popula-tions and/or breadth of subject matter.	Educational and media materials used by our tobacco control program **reflect most** of the major cultural, ethnic, and language needs of the communi-ties served, relative to the demographics of the com-munity, -but- there are **minor gaps** in terms of the popula-tions and/or breadth of subject matter.	Educational and media materials used by our tobacco control program **reflect all** of the major cul-tural, ethnic, and language needs of the commun-ities served, relative to the demograpics of the community. There are **no gaps** in terms of the popula-tions and/ or breadth of subject matter.

Cultural Diversity and Cultural Competence Assets	None 0	Poor 1	Fair 2	Good 3	Very Good 4	Excellent 5
3.6 **Equity in Funding**: The degree to which culturally and ethnically diverse organizations are funded to implement community norm change-focused tobacco control efforts in the community, in proportion to community demographics.	**No** culturally and ethnically diverse organizations are funded to implement community norm change-focused tobacco control efforts in the community.	**No** culturally and ethnically diverse organizations are funded to implement community norm change-focused tobacco control efforts in the community. **However, at least one** mainstream organization such as the local health department or voluntary health organization is funding a specific community norm change-focused tobacco control effort within a culturally or ethnically diverse community.	**One** culturally or ethnically diverse organization, in proportion to the demographics of the community, is funded to implement community norm change-focused tobacco control efforts.	**Two or three** culturally or ethnically diverse organizations, in proportion to the demographics of the community, are funded to implement community norm change-focused tobacco control efforts.	**Four or five** culturally or ethnically diverse organizations, in proportion to the demographics of the community, are funded to implement community norm change-focused tobacco control efforts.	**More than five** culturally or ethnically diverse organizations, in proportion to the demographics of the community, are funded to implement community norm change-focused tobacco control efforts.

Tobacco Control Planning Assets	None 0	Poor 1	Fair 2	Good 3	Very Good 4	Excellent 5
4.1 **Tobacco-Related Recommendations in Community Plans**: The extent our program participates in local planning to integrate tobacco-related interventions recommendations into local and regional general plans, community health/health equity frameworks, Adverse Childhood	In the **past three years**, our tobacco control program **has not participated** in any planning process to integrate tobacco-related interventions into local and regional general plans, community health/ health equity frameworks, Adverse Childhood Experience protocols,	In the **past three years**, our tobacco control program **has participated** in **at least one planning process** where we have provided tobacco-related intervention contributions for local and regional general plans, community health/ health equity frameworks, Adverse Childhood Experience protocols,	In the **past three years**, our tobacco control program **has participated** in **two (2) planning processes** where we have provided tobacco-related intervention contributions for local and regional general plans, community health/health equity frameworks, Adverse Childhood Experience	In the **past three years**, our tobacco control program **has participated** in **three (3) planning processes** where we have provided tobacco-related intervention contributions for local and regional general plans, community health/ health equity frameworks, Adverse Childhood Experience protocols,	In the **past three years**, our tobacco control program **has participated** in **four (4) planning processes** where we have provided tobacco-related intervention contributions for local and regional general plans, community health/ health equity frameworks, Adverse Childhood Experience protocols,	In the **past three years**, our tobacco control program **has participated** in **five (5) or more planning processes** where we have provided tobacco-related intervention contributions for local and regional general plans, community health/health equity frameworks, Adverse Childhood Experience protocols, health department accreditations,

4.1	Experience protocols, health department accredita-tions, and/or other similar evidence-informed, commu-nity planning processes.	health department accredita-tions, and/or other similar evidence-informed, commu-nity planning processes.	health department accreditations, and/or other similar evidence-informed, community planning processes.	protocols, health department accredita-tions, and/or other similar evidence-informed, commu-nity planning processes.	health department accredita-tions, and/or other similar evidence-informed, commu-nity planning processes.	health department accredita-tions, and/or other similar evidence-informed, commu-nity planning processes.	and/or other similar evidence-informed, community planning pro-cesses.

Tobacco Control Planning Assets	None 0	Poor 1	Fair 2	Good 3	Very Good 4	Excellent 5
4.2 **Affordable Care Act Community Health Needs Assessment (CHNA) Participation**: The number of local tobacco control advocates who actively participate in the Community Health Needs Assessment, which is required to be conducted by non-profit hospitals every three years pursuant to the Affordable Care Act*, for the purpose of promoting the inclusion of indicators and interventions that support tobacco-free living (e.g., physical environment and housing improvements, economic development, community support, leadership development, coalition development, community health improvement	Tobacco control advocates **have not approached local hospitals** about participating in the CHNA **-and- none participated** in the development of the most recent CHNA.	Tobacco control advocates **have approached local hospitals** about participating in the CHNA, **-but- none were active participants** in the most recent CHNA.	**At least 1** tobacco control advocate **participated in the most recent CHNA, -but- the needs assessment plan did not address interventions** that support tobacco free living. *	**At least 1** tobacco control advocate **participated in the most recent CHNA -and- the plan explicitly addressed interventions** that support tobacco free living. *	**More than 1** tobacco control advocates **actively participated in the most recent CHNA -and- the resulting plan includes at least 1** explicit tobacco control indicator **-and- at least 2** measures that support tobacco free living. *	Tobacco control advocates **actively participated in the most recent CHNA -and- the resulting plan includes more than 1** explicit tobacco control indicator **–and- at least 3 measures** that support tobacco free living.*

4.2	and advocacy, work-force development, other community development activities to build health and safety). *SEC. 9097: Additional Requirements for Charitable Hospitals and as defined in Internal Revenue Service, Schedule H instructions (Form 990), 2011.

Needs Assessment Overview Report Instructions

Purpose: The purpose of the Needs Assessment Overview Report Worksheet I is to display and organize on one worksheet all of the scores and narratives for your CX needs assessment, prior to viewing this information in OTIS. This report will be created automatically in OTIS, once data from individual worksheets are entered and saved.

Instructions: Once individual worksheet data are entered and saved in OTIS, this information will automatically populate the Needs Assessment Overview Report. However, if you are completing worksheets on paper and want to give your completers instant feedback, you will need to transfer the information from the individual worksheets onto the Needs Assessment Overview Report Worksheet.

1. **Cover Page Information**

   Write down your agency name, community area(s) assessed, and date the CX assessment was completed.

2. **Record the Social Disparities Score**

   - Transfer the ratings from the Social Disparities Capacity Rating- Worksheet A (Items 1 through 5) to Worksheet I
   - Transfer the score from Box A-1 of the Social Disparities Capacity Rating- Worksheet A to Worksheet I
   - Record important facts from the Social Disparities Capacity Narrative Summary on Worksheet I

3. **Record the Indicator Ratings and Score**

   - Record the indicator number and brief title on Worksheet I, column 1.
   - Transfer the score from Box B-1 of the Community Readiness- Worksheet B to Worksheet I, column 2.

- Transfer the score from Box C-1 of the Stage of Change- Worksheet C to Worksheet I, column 3.

- Transfer the score from Box D-1 of the Policy Quality- Worksheet D to Worksheet I, column 4.

- Transfer the score from Box E-1 of the Policy Reach - Worksheet E to Worksheet I, column 5.

- Transfer the score from Line 3 of the Total Indicator Score- Worksheet F to Worksheet I, column 6.

- Transfer the score from Line 4 of the Total Indicator Score- Worksheet F to Worksheet I, column 7.

- Transfer important facts from the Narrative Summary- Worksheet G to Worksheet I, column 8.

4. **Record the Asset Score**

- Record the asset number and brief title on Worksheet I, column 1.

- Transfer the rating circled for each of the assets rated in the Asset Rating- Worksheet H to Worksheet I, column 2.

- Transfer important comments for each of the assets rated in the Asset Rating - Worksheet H to Worksheet I, column 3.

Needs Assessment Overview Report

Needs Assessment Overview Report - Worksheet I

Agency Name:

Community Area(s) Assessed:

Date CX Assessment Completed:

Social Disparities Capacity Assessment Overview - Worksheet I

Item	Rating	**Social Disparities Narrative Summary**: Overall, describe the program's strengths and weaknesses in relation to the 5 items assessed.
1. Tobacco-related Data Profile		
2. Tobacco Disparity Stategic Plan		
3. Social Determinants of Health Considerations		
4. Media Engagement		
5. Evaluation Inclusion		
RATING SUM		
Social Disparities Score (Rating Sum x 100/25)	**(%)**	

Indicator Assessment Overview - Worksheet I

1 Indicator (# and Brief Title)	2 Community Readiness Score %	3 Stage of Change Score %	4 Policy Quality Score %	5 Policy Reach Score %	6 Total Policy/ System Status Score %	7 Total Indicator Score %	8 Indicator Narrative Summary: Items 1-5 (Worksheet G)

Asset Assessment Overview - Worksheet I

1 Asset (# and Brief Title)	2 Rating	3 Comments

Priority Setting Following a CX Needs Assessment

Creating a Balanced Workplan

A priority setting process will help determine which of the assessed indicators and assets will lead to the greatest community impact and should ultimately become workplan objectives. Prioritizing the indicators and assets involves narrowing the list to those that are most important to work on during the workplan period. Once the priority indicators and assets have been determined, the LLA will create a workplan that reflects those priorities. CTCP recommends that community members and tobacco control partners be involved in identifying priorities while LLA staff and the local program evaluator take responsibility for writing the objectives. The prioritization decisions can also help non-LLA tobacco control partners identify other work that may be needed in the jurisdiction.

There are many models available to assist with priority setting, and each agency has the flexibility to choose their preferred method. This section contains examples of priority setting methods; how to utilize the results of priority setting to create a LLA workplan; and why you should share the prioritization results with other community partners.

Priority Setting: An Overview

Priority setting involves consideration of a variety of factors, from funding limitations to the political climate. Keep in mind that the CX Needs Assessment scores are a starting point for the discussion on priority setting and should not form the sole basis of your prioritization decisions. In general, the lower overall score an indicator or rating an asset receives, the greater the need to work on that indicator or asset. Indicators are scored using a scale of 1 to 100. A score of 85 percent or above would be considered high, a score of between 70 percent and 85 percent would be fair, and a score below 70 percent would be low. Thus, a score of 69 percent or lower would indicate a high need to work on a particular indicator. Assets are rated on a zero to five Likert scale, with zero

The lower overall score or rating an indicator or asset receives, the greater the need to work on that indicator or asset.

indicating a low score and five indicating a high score. Similar to indicators, the lower the score, the greater the need to work on a particular asset.

Creating a balanced workplan in terms of comprehensiveness, effort, community participation and engagement, and meaningful community norm change for tobacco control is the overall goal. Factors besides the overall scores or ratings should be considered when selecting priorities for the greatest impact in a community. For example, consider the following questions when prioritizing indicators and assets:

- Will this issue align with CTCP requirements?
- Does the issue advance health equity in my community?
- Will addressing the issue result in long-term, sustainable community change?
- Is there political will among decision-makers to address the issue? Can political will be obtained?
- Do community members feel enthusiastic about the issue? Is there community momentum around the issue? Can community momentum be created?
- Do agency staff, coalition members, and/or community partners have the resources needed to work on the issue? If not, can the resources be acquired?
- Will this issue address emerging needs and challenges facing the community?

This is not an exhaustive list, but rather, examples of factors to consider when selecting indicators and assets as priorities. The degree of importance assigned to each of these and other questions depends on the unique needs of each agency and/or community.

Many different voices and perspectives should be at the decision-making table. Involving key stakeholders in the priority setting process supports community buy-in, which is important to achieving success and may also give you political justification if a controversial area is selected as a priority for your workplan. Determine who should be part of the priority setting process early, invite participants, and ensure you have a committed group that represents your community.

Decide how much input the participants will have in terms of final decisions. Will community participants votes count toward a final decision, or will their identified priorities be recommendations for consideration by the LLA? Setting expectations for participation at the beginning, and reaffirming roles throughout will help the priority setting process be collaborative and constructive. Following the priority setting process, maintain engagement by

periodically updating participants on progress toward finalizing the workplan and starting to work on the new objectives.

Priority Setting Processes

There are four main steps in the priority setting process. The four steps are outlined below and examples of how you might complete the priority setting process are included for reference.

Step 1: Choose a Process for Priority Setting
There is no correct or incorrect process, but it is important that the method be clear and easy to understand for everyone participating. The examples in this manual have been successful in the past, and can be adapted for in person or virtual meetings.

Step 2: Choose Criteria for Priority Setting
Select criteria that will help you compare each indicator and asset. The criteria must be fair and consistent across each indicator or asset. In general, three to five criteria is recommended. Consider criteria that will assist in measuring the impact of an indicator or asset, or that have particular importance for your community. You can choose from the list below, Options for Prioritization Criteria, or develop your own.

Options for Prioritization Criteria

1. **Coalition Enthusiasm/Engagement**: The issue would be fun, enjoyable, and exciting to address. There is community momentum around the issue. If this criteria is utilized, it is important that the coalition represents broad community diversity (e.g., age, race/ethnicity, education level, organizational and community sector representation, and/or personal interest) within your LLA jurisdiction.

2. **Cost Benefit**: Working on the issue will result in an outcome that is greater than the human and financial resources needed to achieve the change (i.e., an assessment of how much "bang for the buck" you will receive).

3. **Data-driven**: There is research or evaluation data that indicate addressing the issue is effective at achieving the desired outcome. Different issues and communities may need different approaches based on the diversity within the community.

4. **Area of Need**: The overall CX rating indicates a low score, there is an under-served population with tobacco-related disparities, or a geographic area that has a high need related to the indicator or asset.

5. **Long-Term**: Addressing the issue will result in a policy, system, or environmental change or social norm change that is sustained and becomes a community norm.

6. **Meaningful**: Addressing the issue will make a real impact in terms of the problem addressed. The amount of change that can be created may be different for various communities, especially populations with tobacco-related disparities, and this should be accounted for.

7. **Political Will**: There is political will or enough community support to create political will among decision-makers to address the issue.

8. **Practical**: The community has the expertise, time, and resources to address the issue. Partners can support the case for practicality.

9. **Public Support**: Support by the public and/or influential community leaders for the issue is fair to excellent.

10. **Reach**: A large segment of the community with tobacco-related health disparities will be reached or impacted by the issue/intervention or an especially vulnerable population will be reached or impacted.

11. **Stretch**: The issue reflects new ground for the group and may involve tapping into new skills and partnerships that involve building the capacity of the group, including organizations that serve vulnerable populations or local leaders or champions.

12. **Winnable**: It is likely that the group will succeed in achieving the action.

13. **Equitable**: The issue allows a community to advance equity or address an inequity in the community.

14. **Upstream approach**: The issue is tackling the structure or system, such as social and political injustices, that is enabling inequities related to race, class, gender, or economic status, or contributes to tobacco-related health disparities.

15. **Power**: This issue allows us work with new partners and sectors, including communities experiencing inequities, to innovate solutions and intentionally share power and decision making, which can help promote community ownership of the issue.

16. **Mobilizing**: This issue allows us to investigate, collect, and share data that promotes awareness about root causes of inequities to improve health outcomes for priority populations.

Step 3: Rate, Score, or Rank Indicators and Assets

Rating, scoring, or ranking the indicators and assets can be a challenging endeavor so it is important to have a clear process laid out. You can use one of the examples highlighted in this manual or a different process, but it must be clear and equitable. Example 1 shows how to use a priority setting chart, and Example 2 shows how to use a score chart comparison. Use scores and narrative information from completed indicator and asset worksheets to populate the charts.

Group charts by focus areas for indicators (i.e., Area 1: Limit Tobacco Promoting Influences, Area 2: Reduce Exposure to Secondhand Smoke, Tobacco Waste, and Other Tobacco Products, Area 3: Reduce the Availability of Tobacco, Area 4: Promote Tobacco Cessation). Also, group assets together when organizing rating charts. This will assist you in understanding what indicators and assets you can utilize to meet CTCP requirements for workplan development.

Depending on the number of indicators and assets to be rated, and the number of people working on priority setting, you may decide to break into smaller groups for this step, then reconvene to discuss, or you could decide to complete the process with the full group.

Step 4: Vote for Priorities

After rating, scoring, and ranking indicators, select a method for voting to help determine which assets and indicators to prioritize for the workplan. Example 1 shows a dot voting method, and Example 2 demonstrates a multi-voting method. You can use one of the voting methods highlighted in this manual or a different method.

Virtual Voting:

Sometimes an in-person meeting is not possible, or may not be the best way to involve all of the people you want to contribute to your CX priority setting process. The rating and voting processes can also be

completed virtually. Use a virtual meeting platform such as WebEx or Zoom to conduct priority setting meetings. These platforms often have collaborative features such as whiteboards and instant polling that you can use to facilitate priority setting decisions. You can also gather input from different groups or individuals separately and incorporate all the feedback into the process.

Priority Setting Process Example 1:
Indicator/Asset Priority Setting Chart and Dot Voting Method

Step 1: Choose a Process for Priority Setting

Example 1 demonstrates how to use an overall chart of indicators and assets for priority setting. This chart begins with the first three columns filled in with results from the indicator and asset worksheets, and the last two columns open for additional feedback to solicit during the priority setting meeting. Table 10. *Sample Indicator/Asset Priority Setting Chart* shows the indicator or asset name (column 1), overall score/rating (column 2), and key findings/needs (column 3).

Use scores and narrative information from the indicator and asset overview forms (Worksheet I) to populate the chart.

Table 10. Sample Indicator/Asset Priority Setting Chart

Indicator/ Asset	Overall Score/ Rating	Key Findings/ Needs	Prioritization Criteria/ Rating	Intervention Goal
2.2.13 Smokefree Multi-Unit Housing	50%	Policies have been adopted and imple-mented, but only 30% of the population is protected by the policies		

Step 2: Choose Criteria for Priority Setting

In this example, Coalition Enthusiasm/Engagement, Area of Need, Public Support, and Winnable were selected as prioritization criteria.

Step 3: Rate, Score, or Rank Indicators and Assets

Through discussion and consensus, rate each criteria on a scale of zero to five with zero being lowest, and five being highest. Note what the intervention goal would be if it was ultimately selected as a priority and became an objective. Indicators can have intervention goals such as voluntary policy, legislated policy, or resolutions. Assets may address attitudes, beliefs, or process measures such as training or the amount of participation in local advocacy activities.

Write the consensus score for each criteria in the Prioritization Criteria/ Rating section (column 4). Determine an overall score for each indicator by calculating an average and rounding. Note the intervention goal (column 5) for each indicator. Scores and intervention goals for this example are included in Table 11. *Complete Indicator/Asset Priority Setting Chart*.

Table 11. Complete Indicator/Asset Priority Setting Chart

Indicator	Overall Score/ Rating	Key Findings/ Unique Factors	Prioritization Criteria/Rating	Intervention Goal
3.1 Coalition/ Advisory Committee Diversity	2	Several ethnic groups are underrep-resented in relation to their proportion in the community.	Coalition Ratings: Enthusiasm: 5 Area of Need: 4 Public Support: 4 Winnable: 2 Overall: 4	Organi-zational Policy (Voluntary)
2.2.13 Smokefree Multi-Unit Housing	50%	Policies have been adopted and implement-ed, but only 30% of the popula-tion is protected by the policies.	Coalition Ratings: Enthusiasm: 2 Area of Need: 4 Public Support: 0 Winnable: 2 Overall: 2	Legislated Policy
4.1.1 Cessation Services	75%	Cessation services are available, but not in Spanish.	Coalition Ratings: Enthusiasm: 3 Area of Need: 2 Public Support: 3 Winnable: 5 Overall: 3	Voluntary Policy

Step 4: Vote for Priorities

Now that the indicators and assets have been rated, it is time for the group to vote for which will be priorities for the workplan. This example demonstrates a dot voting method.

Give participants dot stickers or utilize electronic symbols and ask them to vote for their top priorities based on their individual impression of the information on the chart. Each member places dot stickers next to their choices. To determine the number of dots per person, use the "1/4 rule"—if 20 indicators and assets were rated and are being considered, give each member 1/4 of 20, or five dots. Stickers may not be torn in half, and multiple stickers may not be placed on the same indicator or asset. Table 12. *Dot Voting Method* shows what a dot voting chart would look like. In this example, Indicator 2.2.13, Smokefree Multi Unit Housing received the most votes, and is considered a priority.

Table 12. Dot Voting Method

Indicator	Overall Score/ Rating	Key Findings/ Unique Factors	Prioritization Criteria/Rating	Intervention Goal	Votes
3.1 Coalition/ Advisory Committee Diversity	2	Several ethnic groups are underrepresented in relation to their proportion in the community.	Coalition Enthusiasm: 5 Area of Need: 4 Public Support: 4 Winnable: 2 Overall: 4	Organizational Policy (Voluntary)	● ● ●
2.2.13 Smokefree Multi-Unit Housing	50%	Policies have been adopted and implemented, but only 30% of the population is protected by the policies.	Coalition Enthusiasm: 2 Area of Need: 4 Public Support: 0 Winnable: 2 Overall: 2	Legislated Policy	● ● ● ●
4.1.1 Cessation Services	75%	Cessation services are available, but not in Spanish.	Coalition Enthusiasm: 3 Area of Need: 2 Public Support: 3 Winnable: 5 Overall: 3	Voluntary Policy	●

Priority Setting Process Example 2: Score Chart Comparison and Multi-Voting Method

Step 1: Choose a Process for Priority Setting

Example 2 demonstrates how to use a score chart comparison method to compare indicators and assets for priority setting. This method uses scores and narrative information from the indicator and asset overview forms (Worksheets B and H) to populate the charts. Table 13. *Sample Indicator Score Data* shows fictional indicator scores that will be used throughout this example.

Table 13. Sample Indicator Score Data

Indicator 1-(3.2.1) Tobacco Retail Licensing (TRL)	
Community Readiness	76%
Scope of the Problem-Very Good	
Community Awareness-Excellent	
Community Support-Good	
Decision Maker Support-Good	
Earned Media-Very Good	
Policy Status	
Stage	60%
Quality	40% - Fair
Reach	60% - Good
Total Policy Status Score	53%
Total Indicator Score	**68%**

Indicator 2-(2.2.13) MUH	
Community Readiness	76%
Scope of the Problem-Excellent	
Community Awareness-Very Good	
Community Support-Good	
Decision Maker Support-Poor	
Earned Media-Fair	
Policy Status	
Stage	80%
Quality	80% - Very Good
Reach	80% - Very Good
Total Policy Status Score	80%
Total Indicator Score	**68%**

Using the sample indicator score data as a basis for the score chart comparison discussions, populate only the first column with the indicator to be rated, and blank columns for the group to add findings (column 2), examination of findings (column 3) and the intervention goal (column 4) during the priority setting meeting.

Table 14. *Sample Score Chart Comparison Table* shows how to organize the chart. It's a good idea to group indicators by each priority area and assets all together. This will assist you in understanding what indicators and assets you can utilize to meet CTCP requirements for workplan development.

While the sample shows indicators, this chart can also be used for priority setting with assets.

Table 14. Sample Score Chart Comparison Table

Indicator/Asset	Findings	Examination of Findings	Intervention Goal
1.1.2: Content Neutral Signage Requirements			
2.2.13: Smokefree Multi-Unit Housing			
3.2.1: Tobacco Retail Licensing			
3.2.9: Menthol and Other Flavored Tobacco Products			
4.1.1: Tobacco Cessation Services			

Step 2: Choose Criteria for Priority Setting

In this example, Community Readiness and Policy Status scores (e.g., Scope of the Problem, Community Support, Decision Maker Support, and Policy Reach and Quality) are criteria for discussion.

Step 3: Rate, Score, or Rank Indicators and Assets

Column 2, Findings

Discuss the scores that were established for each indicator and record key findings related to the criteria in column 2, Findings. Note areas of strength and weakness related to the selected criteria, and state current policy status. In this example, three tobacco retail license policies have passed in the LLA, but none have been implemented, and two multi-unit housing policies exist in the county, but only one is a legislated policy and it has been adopted and implemented. These factors are noted in Table 15. *Completed Score Chart Comparison Table*, column 2 for the indicators discussed in this example.

When examining the indicators in Table 13. *Sample Indicator Score Data*, note that there are differences in the criteria ratings, but the overall score for both indicators is 68 percent. Recall that an overall indicator score of 69 percent or below indicates a high need to work on a particular indicator. In this example, a more in-depth examination of the indicator findings is needed to select the priority.

Column 3, Examination of Findings

The CX priority setting group uses "insider knowledge," past experience, and quantitative or qualitative data to take a closer look at the rating criteria. After more closely examining the findings, record key observations in column 3, Examination of Findings. Consider these nuanced factors from the fictional example, and see how the information was included in Table 15. *Completed Score Chart Comparison Table*.

Even though Indicator #2, MUH scored fairly high on the Total Policy Status score (80 percent), the Decision Maker support was rated as poor and thus, Community Readiness was rated at only 60 percent. This outcome is possible, because the CX Needs Assessment addresses an entire community, rather than just one jurisdiction in the county. It is possible that there may be several jurisdictions in which the political will for an issue may be low, while also having a very strong policy passed on that issue in another jurisdiction.
In comparing the two indicators, Indicator #1, TRL may be more feasible and

practical to work on, given that Community Readiness scored higher for that indicator. Conversely, you may feel that although Community Readiness scored lower for MUH, that this is an area you can and want to address in your workplan. Perhaps you have knowledge and confidence that although political will may not be present right now, it can be obtained for this issue.

Column 4, Intervention Goal

Note what the intervention goal would be if it was ultimately selected as an objective. Indicators can have intervention goals such as voluntary policy, legislated policy, or resolutions. Assets may address attitudes, beliefs, or process measures such as training or the amount of participation in local advocacy activities.

Table 15. *Completed Score Chart Comparison Table* shows an example of intervention goals for this example.

Table 15. Completed Score Chart Comparison Table

Indicator/Asset	Findings	Examination of Findings	Intervention Goal
1.1.2: Content Neutral Signage Requirements			
2.2.13: Smokefree Multi-Unit Housing	Two policies, only one policy is legislated (adopted and implemented).	Very strong political will for MUH policy in City X	Go for adoption and implementation in City X
3.2.1: Tobacco Retail Licensing	Three policies, none implemented.	Need to focus on policy implementation, especially in City Y.	Go for countywide adoption and implementation, or do implementation only in City Y.
3.2.9: Menthol and Other Flavored Tobacco Products			
4.1.1: Tobacco Cessation Services			

Step 4: Vote for Priorities

Now that the indicators and assets have been rated, it is time for the group to vote and narrow down priorities. This example demonstrates a multi-voting method.

In this method, multiple votes are taken consecutively. People can do this by marking their vote on a chart, by written ballots, or an electronic platform. Generally the more items on a list, the more votes each voting member should be allotted; five to ten votes is common, but the number of votes and how options are eliminated may vary. Reduce the number of votes each person has as the list narrows. With each round, eliminate lower-scoring options until the list is narrowed to the desired number of priorities.

Table 16. *Multi Voting Method* shows a scenario with results of the votes in this example. At any point if the decision is clear and you have arrived at the desired number of priorities, stop the voting process. If the list needs to be narrowed down more, hold additional rounds of voting. Keep in mind that for a comprehensive tobacco control plan, you will need to meet requirements outlined in the procurement with respect to the number of objectives, the number of policy objectives, the number and type of priority areas to be addressed, and any special campaign requirements. Be sure to identify at least one priority in each priority area and for assets to ensure flexibility when creating a workplan that meets community identified needs and CTCP requirements.

Round 1

In this example, ten participants each vote for their three priorities. Votes from this round are tallied, and items receiving the most votes continue, while others drop off. In this vote, 1.1.2: Content Neutral Signage Requirements and 4.1.1: Tobacco Cessation Services received the lowest number of votes and are dropped from the list.

Round 2

Each participant votes for their top two priorities from the condensed list of indicators or assets. In this round, 3.2.9: Menthol and Other Flavored Tobacco Products was dropped from the list.

Round 3

In the final round of voting, participants are allotted one vote each for their top priority from the condensed list of indicators or assets. 3.2.1: Tobacco Retail Licensing is identified as the priority.

Table 16. Multi-Voting Method

Indicator/ Asset	Findings	Examination of Findings	Intervention Goal	Vote 1	Vote 2	Vote 3
1.1.2: Content Neutral Signage Require-ments				**3 votes**	**n/a**	**n/a**
2.2.13: Smokefree Multi-Unit Housing	Only one policy passed in the entire county.	Very strong political will for MUH policy in City X.	Go for adoption and imple-mentation in City X.	**6 votes**	**7 votes**	**3 votes**
3.2.1: Tobacco Retail Licensing	No implment-ed policies in the county.	Need to focus on policy imple-mentation, especially in City Y.	Go for countywide adoption and imple-mentation, or do imple-mentation only in City Y.	**10 votes**	**9 votes**	**6 votes**
3.2.9: Menthol and Other Flavored Tobacco Products				**7 votes**	**4 votes**	**n/a**
4.1.1: Tobacco Cessation Services				**4 votes**	**n/a**	**n/a**

Making Final Decisions for the Workplan

Once the priority setting process has been completed, you are ready to consider what goes into the workplan. In prioritizing for the workplan, you should consider not just the overall score, but the Community Readiness and Policy/System Status scores, as well as the jurisdiction(s) in which it makes the most sense to focus the effort. The prioritization process guides the final decisions for your workplan and creates a foundation for non-LLA partners to understand local tobacco control priorities.

An important consideration to factor into final decision-making is the creation of a balanced and comprehensive workplan. A balanced workplan meets the needs of the community, involves coalition members and community partners, is comprehensive, staggers efforts over the entire plan period, has objectives of varying intensity of effort, and addresses CTCP priorities as defined in the funding opportunity.

The number of objectives that go into a scope of work depends on CTCP's procurement requirements, the complexity of the issues, community readiness, community partnerships, the human resources available to complete the activities (both by staff and coalition/advisory committee members), and the budget available to finance various program, media, and evaluation activities. Your priority setting has helped you to determine some of these factors for the indicators and assets you selected for your CX Needs Assessment.

Creating a balanced workplan may mean that some indicators and/or assets that were identified as high priorities may need to be put off for future efforts. Working on the implementation of a previously passed policy to ensure that it becomes a community norm (e.g., a multi-unit housing indicator that scored in the mid-range) might be paired with a more intensive effort designed to raise community awareness and involvement in a new arena (e.g., a retail environment indicator that scored as a high priority). It is also advantageous to consider how the new workplan builds upon existing efforts, previous work, and work currently being done by other community partners.

There are several ways decisions around objectives can be made. Community members can narrow the indicators and assets down to a specified number. Project staff can then create objectives around those indicators and assets and bring them back to the community for a further consideration and final vote. This can be done in person, through an online meeting platform, or via e-mail. Another option is for the community members to narrow down the indicators

and assets to the exact number of objectives to be in the workplan by coming to a consensus during the priority setting meeting. Project staff can later create the objectives and share them with the community.

Whatever decision-making process is used, it is important to communicate the final workplan objectives to all of those that participated in the CX Needs Assessment process so that everyone knows the final outcome. It's also a great opportunity to invite CX participants to become actively engaged in the new workplan activities and help move the objectives forward.

Using the CX Needs Assessment Findings to Write Meaningful Workplan Objectives and Activities

1. **Social Disparities Capacity Assessment**: Use the findings from the Social Disparities Capacity assessment to inform how you do your work and to identify strengths that you can leverage and weaknesses that can be strengthened through activities written into your scope of work. For example: if your program has a tobacco disparity strategic plan, but it does not address any of the four strategies listed in the Social Disparities Capacity Rubric, you may want to revise your disparity plan to incorporate those strategies.

2. **Community Readiness Assessment**: Use the findings from the Community Readiness assessment to identify activities to include in the scope of work. For example:

    a. If there is a lack of quantitative evidence, then data collection activities should be planned.

    b. If awareness is low, then media and educational outreach activities should be developed to raise awareness about the issue, that a problem exists in the community, and that the community can do something to address the problem.

3. **Stage of Change Assessment**: Use the findings from the Stage of Change assessment to inform whether you should work on voluntary or legislated policy/system change approaches and to identify activities to include in the scope of work. For example:

    a. If the community is in the Planning/Advocating stage, then activities should include concrete action steps such as recruiting supporters, media activities, and developing model policy language in order to move into the next stage.

    b. If the community is in the Policy Implemented stage, then activities need to focus on short-term interventions that increase the

institutionalization of business practices and education for enforcement to ensure compliance (but do not directly support enforcement efforts).

4. **Policy Quality and Reach Assessments**: Use the findings from the Policy Quality and Reach assessments to guide the development of objectives and whether objectives should focus on strengthening the quality of existing policies and/or extending the proportion of the population protected by legislated policies. For example: if on average, the legislated policies in the community area assessed meet only 50 percent of the established standard, you will want to strengthen the quality of those policies.

5. **Priority Setting**: Use information from the Social Disparities Capacity, Community Readiness, and Policy/System Status assessments to set priorities and develop objectives for the workplan. Typically, the top three to five priorities will be developed into objectives. The number of objectives to be developed will depend on funding guidelines, resources, and the complexity or difficulty of the objectives.

Coalition Guide to Communities of Excellence

What is CX?

- The goal of CX is to provide a "snapshot" of where the community is at in terms of tobacco control progress and determining which direction to go next.

- The CX process requires local community members and organizations coming together to define tobacco-related problem(s), to define the solutions, and then enter into a dialogue with tobacco control programs about how to achieve those solutions by developing a plan of action.

Why do we conduct a CX Needs Assessment?

- To ensure diverse sectors of our community have a voice in our work

- To identify meaningful tobacco control plans that emphasize community norms (e.g. values, beliefs, attitudes, and behaviors shared by most people in a "group") and develop change strategies that will have community buy-in.

- To strengthen local programs abilities to evaluate their work.

- To obtain funding from the CTCP and allow the state to identify the factors that contribute to excellence and achievement in tobacco control work.

What is being analyzed during the CX Needs Assessment?

- CX uses a specific list of measures for assessing needs and strengths in a community. These measures are called "indicators" and "assets."

    - Indicators focus on what is happening locally at the community level around tobacco control issues and needs. The Indicator assessment is based on two measures: "Community Readiness" to support tobacco control work, and "Policy/System Change Status" to tackle specific policy recommendations and best practices.

  - Assets look at community factors or resources that will help promote, support, and sustain local tobacco control efforts with additional support or resources provided by the funded agencies.

- In addition to analyzing indicators and assets, each county will conduct a Social Disparities Capacity assessment. This assessment looks at how tobacco use impacts specific populations most impacted by tobacco use and illness in a community, including those populations identified in California's Tobacco Education and Research Oversight Committee's (TEROC) Master Plan, entitled New Challenges, New Promises for All 2018-2020. This assessment is also designed to identify program strengths which can be leveraged and identify weaknesses that can be improved through the addition of scope of work activities that reach out to and engage priority population groups in an effective and culturally relevant manner.

- CTCP will provide instructions, worksheets, and data to help with completion of the needs assessment.

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