Tobacco Focused Community Profile Guidance Document

Version	Date	Rationale
V1	September 2018	Added guidance for minimally funded grantees (see highlighted sections)

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Introduction

The purpose of the tobacco-focused community profile (the profile) to make data-driven decisions and select the strategy(ies) that have the greatest prospect of reducing the burden of tobacco in your communities. The profile gives your team an opportunity to assess community and organizational needs, opportunities, and readiness. This process will help your team to make culturally sensitive, data-driven decisions to use local resources to reduce tobacco use and exposure in your community(ies). A coordinated approach will include primary data collection and secondary data analysis. The profile will inform the evidence-based interventions and strategies for year 2 and 3 of the FY19-21 grant funding cycle and serve as the basis of the implementation plan you will use to guide your work. For grantees receiving only the base funding amount (minimally funded grantees), the profile will help focus the foundational activities. Your community profiles should be completed by December 31st and your implementation plan should be done by April 30th.

Grantees who demonstrate completing a Community Health Assessment or other similar assessment within the last year, should include that data in the tobacco-focused community profile, as applicable. However, the community profile is very specific to your local tobacco issues, so be prepared to dive deeper into disparities, emerging issues or other tobacco-specific areas of concern. Grantees may also continue their current initiatives and projects while they conduct this profile process. Please discuss with your STEPP Point of Contact (POC).

All Core/LPHA grantees are required to create a tobacco-focused community profile. However, although the process is required for everyone, the order of the steps and the resources you use are flexible. If other resources will be utilized or developed, check in with your POC/TA provider first. This document is intended to be used for guidance. This guide will provide you with a number of resources to utilize throughout this process. Expected outputs of this profile process include:

- Tobacco Focused Community Profile
- Project Theory Diagram
- Project Flow (Logic Model)
- Implementation Plan

As you go through the assessment process, you may contact the Community Epidemiology & Program Evaluation Group (CEPEG) for evaluation questions, Colorado School of Public Health (CSPH) for key informant interview questions, and your STEPP POC for all other questions.

Minimally Funded Grantees

Minimally funded grantees are funded at $38,000 and are only required to conduct the foundational activities. In some cases, minimally funded grantees may be part of a regional collaboration with a lead agency. Lead agencies are expected to implement a coordinated set of activities within each of the following required components and may build on existing efforts already being conducted within the community(ies) they serve.

Foundational Activities:

- Tobacco Focused Community Profile
- Community education - provide education to build awareness around the importance of policies that influence tobacco use, such as price policies (Goal 4 strategy).
- Community engagement and building partnerships
- Cessation promotion and referral
- Healthy Kids Colorado Survey Participation/Support
- Agency staff build and maintain tobacco expertise
- Grant administration – progress reporting, participation in STEPP calls, implementation of evaluation plan

Minimally funded grantees will follow the same overall steps of the assessment process, scaling down the effort of each step. For example, interviewing fewer key informants, focusing only on one setting or town to assess or perhaps limiting the number or type (either tobacco retail or public smoking) of municipal policies to review. Additionally, these grantees are not required to complete a community readiness assessment. The implementation plan will consist of the foundational activities only. However, if the grantee determines they have the capacity to conduct evidence-based strategies in addition to the foundational activities, you **will** need to conduct a community readiness assessment and update the implementation plan with the strategy specific activities.

Acronyms

ACS	American Community Survey (U.S. Census)
BRFSS	Behavioral Risk Factor Surveillance System
CDE	Colorado Department of Education
CEPEG	Community Epidemiology & Program Evaluation Group
CHS	Child Health Survey
CSPH	Colorado School of Public Health
CTC	Communities That Care
HKCS	Healthy Kids Colorado Survey
LGBT	Lesbian, Gay, Bisexual, Transgender
LPHA	Local Public Health Agency
POC	STEPP Point of Contact
PRAMS	Pregnancy Risk Assessment Monitoring System
SES	Socio-Economic Status
STEPP	State Tobacco Education, Prevention and Cessation Partnership
TA	Technical Assistance
TRAC	Tobacco Retail Access Colorado

Moving the Mark on Tobacco Disparities

In the spring of 2014, STEPP enlisted the help of over 40 partners from across the state to participate in a two-day literature review, *Moving the Mark on Tobacco Disparities Boot Camp*, to rate and prioritize evidence-based strategies to address disparately-affected populations with disproportionate burden from tobacco in Colorado. The data showed that those who currently use tobacco are significantly more likely than those who do not use tobacco to have lower income, have less education, be a young adult, be a person of color, identify as LGBT, or have one or more behavioral health conditions. The knowledge review may be found here.

While the established and proven evidence-based strategies to reduce tobacco use are being implemented, in order to move the mark among the most disparately-affected residents, tobacco control interventions must be focused or adapted to better address the social determinants of health contributing to tobacco disparities. In the spring of 2017, STEPP convened 91 state and local public health and tobacco prevention partners for Moving the Mark on Tobacco 2.0: Checking in on Tobacco Control Learnings - Three Years Later (MTM 2.0) to discuss a statewide approach that addresses the populations comprising the remaining 15 percent of Colorado adults who are current smokers, while building upon what is working in order to maintain gains and prevent future use among the remaining 85 percent of adult Coloradans. Participants learned again about disparities in prevalence of adult current smoking and which populations have the highest numbers of current smokers in Colorado by several demographic factors. Data were presented both ways to show which populations could be targeted to impact health disparities and which could be targeted for largest reach.

Higher prevalence (%) of adult current smoking	**Higher population (#) of adult current smoking**
adults aged less than 65 years	adults aged 25-64 years
males	males
Native Americans, blacks, English-speaking Hispanics	whites, English-speaking Hispanics
LGB adults	heterosexual adults
those with less than college education	high school graduates and those with some college (no degree)
those living within 200 percent of federal poverty level	those living within 200 percent of federal poverty level
those on Medicaid or uninsured	those on private insurance or Medicaid
those who are unemployed/unable to work	those who are employed, and specifically those working in construction industry
those who rent their home	those who own their home

How to Know Which Municipality(ies) to Assess

Use Figure 1 to note the counties in which you are funded to work, and list potential priority cities/towns in each county based on population numbers, social determinants of health, and/or known tobacco-related burden. Social determinants of health could include any measures related to known tobacco-related disparities (e.g., percent of population living in poverty, without a high school education, or on Medicaid). Feel free to add rows as needed. STEPP does not expect grantees to assess every single town/city in their funded area. We ask that you are strategic and focus on what is feasible (e.g., 1-3 cities/towns per funded county). If you cover a more populated area, look at your burden data and focus on the high burden areas. If you cover more sparsely populated areas, focus on cities as a starting point. Some grantees may have more than one assessment or profile. Other things to consider when thinking about areas to assess are: cities or towns with highest percent living in poverty and/or highest tobacco burden, or high percent of minority population, percent of Medicaid clients, percent of individuals with a disability. A copy of Figure 1 can be found in the appendix.

Once you have listed out the communities available in your funding area for assessment, use Figure 2 to determine how many community(ies) to assess as part of the community profile process. The number of communities to assess and the number of strategies to be selected post assessment are directly tied to the tobacco funding your agency receives. Some grantees will only have one or two cities or towns to choose from for the assessment, while others might have multiple counties or large populated cities. Use the number of settings from Figure 1 as a guide to finalize selection of your prioritized communities for which you will complete an assessment. Please also note the requirement for foundational activities all grantees are expected to do.

Figure 1: Where You are Funded to Work

List each funded county	**List 1-3 towns or municipalities based on population numbers, social determinants of health, or known tobacco-related burden**	**Check if you plan to do a profile of this particular community**
Ex. Jefferson	*Lakewood* *Arvada* *Wheat Ridge*	*x* *x*

The Evidence-Based Tobacco Interventions

Evidence-based interventions are programs, policies, and/or practices that have been proven to work through implementation and research. FY19-21 program interventions continue the strategies from the FY16-18 grant cycle and are designed to further the advancement of the 2020 Strategic Plan goals. During the FY19-21 cycle, the interventions are arranged according to CDC tobacco control goal areas. It is also an expectation that all grantees, regardless of the funding amount, will conduct the foundational activities. For more information, see the LPHA Core Community Framework.

Goal 1: Prevent Initiation among Youth and Young Adults (Colorado Strategic Plan Goals 3, 5)

- 1.1 School - based tobacco-free policies and norms to reduce initiation, prevalence and intensity of smoking among youth
- 1.2 Community mobilization with additional interventions to restrict minors' access to tobacco products

Goal 2: Eliminate Exposure to Secondhand Smoke (Colorado Strategic Plan Goals 4, 6)

- 2.1 Community - Level Protections from Secondhand Smoke
- 2.2 Place - Based Tobacco Free Policies

Goal 3: Promote Quitting Among Adults and Youth (Colorado Strategic Plan Goals 1, 2)

- 3.1 Promote Integration of Tobacco Interventions within the Health Neighborhood

Goal 4: Identify and Eliminate Tobacco-Related Disparities among Population Groups (Colorado Strategic Plan Goals 1-7)

- 4.1 Community Mobilization with Education on Price Strategies

Data Collection

Community health assessments or profiles typically use both primary and secondary data to inform programmatic decisions. Data collection should be broad and cover topics related to each of the four goal areas. ***Secondary data*** refers to data that was collected by someone other than the user. Secondary data will be provided to all grantees by CDPHE. Common sources of secondary data for public health include U.S. Census data, surveillance data sources such as Behavioral Risk Factors Surveillance System (BRFSS), Healthy Kids Colorado Survey (HKCS), The Attitudes and Behaviors Survey on Health (TABS), hospital discharge datasets and data that were originally collected for research purposes. The CDC recommends using data and indicators for the smallest geographic locations possible (e.g., county-, city-, census block-, or zip code-level data), to enhance the identification of local assets and gaps.

You may have trouble finding geography-specific secondary data for smaller communities, and therefore, you may need to rely on data from a larger geography, such as county, health statistics region or even state level, that it is included within plus additional primary data collection.

Primary data are planned and collected first-hand through surveys, listening sessions or story circles, focus groups, key informant or key respondent interviews, and observations or environmental scans*. An advantage of using primary data is that you are collecting information for the specific purpose of your community profile. The questions you ask will be tailored to elicit the data that will help you with your work. For more information on story circles and key informant interviews, see Collecting Stories in Your Community: A Guide to Qualitative Data Collection.

*The purpose of an environmental scan is to understand context, collect information and identify resources, links and gaps to focus on understanding the internal and external environment of a particular topic and providing input into strategic thinking, decision making and planning.

The Tobacco-Focused Community Profile Process

These are the steps in the profile process. Please note this is not a linear process. The steps below will not necessarily be sequential and you may find yourself tackling the steps of the process in an order that is different from what is listed here. You may also refer to the example timeline with milestones to get a sense of targets and dates.

Step 1: Collect Data. Assess your organizational readiness, compile secondary data, and collect primary data (e.g., key informant interviews and environmental scans). This information will help to define the nature and extent of the local tobacco-related problems to be reflected in your project theory diagram. Given the sources of data and collection possibilities, this will be the most time-consuming part of the process. If you have completed a community health assessment within the last year, you should incorporate that data into your community profile. Because the community profile is tobacco focused, you will also need to dive deeper into tobacco specific areas of concern.

Step 2: Interpret Data and Create Profile. After data collection is completed, the information needs to be analyzed and interpreted. Consider the guiding questions to help interpret the data and prioritize needs. Create a summary list of key findings. Your POC will provide a template for the profile. Answering these questions will prepare you for the next three steps of the process, including the meeting with your STEPP point of contact (POC) and appropriate Technical Assistance (TA) provider(s) to share findings, discuss and finalize the problem, and identify evidence-based strategies that will be the basis for your implementation plan and will guide the work for the remainder of the grant cycle.

Step 3: Create Project Theory Diagram. After the community profile is complete, draft your Project Theory Diagram, which is the foundation of your implementation plan. Minimally funded grantees need to do this step only if they are selecting strategies in addition to the foundational activities. Visit the online evaluation module at http://evaluationco.org/ and review the first component which explains how to complete the Project Theory Diagram. Use the following link to see an example of a completed Project Theory Diagram. Review and determine appropriate evidence-based strategies and interventions that could be implemented to address the priority needs in the priority populations. Some resources include but are not limited to:

FY19-21 LHA Core Community Framework

https://www.cdc.gov/healthyschools/tobacco/strategies.htm

https://www.thecommunityguide.org/topic/tobacco

https://www.cdc.gov/tobacco/stateandcommunity/best_practices/index.htm

https://www.cdc.gov/tobacco/stateandcommunity/best-practices-health-equity/index.htm

Step 4: Strategy Selection Meeting. Meet with your STEPP POC and TA Provider(s) to identify appropriate strategies. During the meeting, you will discuss your project theory diagram and the tobacco control strategy(ies) you feel are most appropriate. The team will collaborate to further define and finalize the problem(s) your agency plans to tackle. Depending on your funding and capacity, your agency may address more than one strategy or work in more than one community. Minimally funded grantees will meet with their POCs to discuss the findings in their profile and identify areas in which to focus their foundational activities. These grantees will also discuss how they plan to educate and engage populations most burdened by tobacco in their community(ies). Your POC will share an implementation plan template.

Step 5: Draft Implementation Plan. The implementation plan is a document that outlines the steps necessary to meet the goals of the work (foundational and program interventions). Now that you know what problem(s) and strategy(ies) your team will work on, you will utilize the online evaluation module at http://evaluationco.org/ to clearly define your path by developing a Project Flow (logic model) for each strategy. Start populating the implementation plan template with the information from the Project Flow Diagram. The resulting implementation plan will be a draft, which you will come back to later (during Step 7) to modify and add more detail.

Step 6: Community Readiness Assessment. The community readiness assessment should be the first objective in your implementation plan. Before diving into your tobacco control work, it is important to assess how ready the community is to be a part of the work related to each of your identified strategies. The community you are assessing is specific to the problem and could be city-wide, neighborhood-wide, organization-wide or specific to a body of decision makers. This is an opportunity to further investigate potential supports (opportunities) and barriers, and to engage decision-makers and/or other partners. Minimally funded grantees need to do this step only if they are selecting strategies in addition to the foundational activities.

Step 7: Refine Implementation Plan. After you have the results of a community readiness assessment, you will further identify and refine the steps and your approach to the work in the implementation plan. You can expect the implementation plan to be a living document, updated at least annually, or as needed. Your STEPP POC and TA provider(s) will be referring to this document for the ongoing implementation of work for the remainder of the grant cycle.

Step 1. Collect Data

This section will provide you with resources and checklists and will guide you through the steps of gathering the data you will need for your community profile.

- **Your agency's organizational readiness and capacity** (**Table 1.1**). You may have an idea of what problems a community needs to address, but is your organization ready? Is the organization ready to commit resources? Does the agency believe the problems exist? Does the organization support the strategies you may implement? For minimally funded grantees, does the agency support the foundational activities you will implement?
    - The scoring of the Organizational Readiness Assessment can be found in **Table 1.1**

- **Secondary Data Collection** (**Table 1.2**). Common sources of secondary data for public health include U.S. Census data, surveillance data sources such as Behavioral Risk Factors Surveillance System (BRFSS), Health Kids Colorado Survey (HKCS), The Attitudes and Behaviors Survey on Health (TABS), hospital discharge datasets and data that was originally collected for other research purposes. In this table, you will assess overall estimates for indicators in the following topics. Data on disparities should also be added,

if available:

- General community demographics
- Tobacco-related health outcomes
- Current tobacco use prevalence (adults, pregnant women, & youth)
- Youth initiation, access, intentions, and perceived risks
- Local conditions such as the point of sale environment
- Health care provider advice
- Cessation
- Exposure to secondhand smoke and vapor

Secondary data will be provided to all grantees by CDPHE.

- **Primary Data Collection** (**Table 1.3**). This is data that are collected first-hand through surveys, listening sessions or story circles, key informant or key respondent interviews, and observations or environmental scans. These data are collected specifically for your community profile.
    - Environmental Scans, Observations, Etc.
    - Community norms around tobacco use and input on priority tobacco-related issues in the community collected via key informant interviews.

- **Brief Policy Review and Quick Gap Analysis** (**Table 1.4**).You will determine if the organization (e.g., school district, MUH organization or community-based organization) has tobacco-related policy language. For any cities or towns you are assessing, you will do a deeper policy gap analysis using the checklist in **Table 1.5** as your guide.

- **Key Informant Interviews** (**Step 1.6**). You will conduct a number of key informant interviews with community members in a variety of settings. "Settings" refers to where the work occurs, and can be a city, school district, multiunit housing property, etc. Key informant interviews consist of a series of open-ended questions that produce narrative answers. With their particular knowledge and understanding, these informants can provide insight into the nature of the tobacco problem and offer recommendations for solutions.

1.1 Organizational Readiness Assessment Checklist[1]

Use the checklist to identify and score your organization's readiness and support for the strategies you may implement. For minimally funded grantees, you will assess readiness and support for the foundational activities. Effective readiness assessment involves working with representatives from leadership and peers to collect data and information. Select 3-5 members (or 2-4 members for minimally funded grantees) of your organization to interview. In the table below, you will see questions to consider for your interview. Be sure to select team members from both leadership and program-level staff.

Organizational Readiness Score

Based on information from the interviews, you will determine the level of your organizational readiness to undertake tobacco control issues. Use the score tool to identify a high, medium, or low level of organizational readiness. Your organizational readiness score is a measurement of capacity and preparedness to conduct the work, the likelihood of whether the initiative will be successful,

and where you need to place your efforts as you begin. Low-medium scores indicate a need to begin with education and building awareness of the problem. Medium-high scores reflect the organization's ability to start actively working on the solutions.

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[1] Content within checklist adapted from Strategic Prevention Framework content on the Substance Abuse and Mental Health Services Administration's website, http://www.samhsa.gov/capt/applying-strategic-prevention-framework and "What Makes An Effective Advocacy Organization? A Framework for Determining Advocacy Capacity. 2009 The California Endowment, website tccgrp.com.

Table 1.1 Organizational Readiness Framework, Questions and Score

OUR AGENCY…	QUESTIONS TO CONSIDER DURING YOUR GROUP/KEY INFORMANT INTERVIEWS	BASED ON THE INTERVIEWS, HOW WOULD YOUR TEAM RATE YOUR ORGANIZATION'S READINESS? HIGH, MEDIUM, OR LOW (CHECK ONLY ONE).

● Has identified relevant data sources to use in the community profile analysis	● What community-level data sources exist?
	  ● How accessible are these data sources?
	● What state-level data sources exist?
	  ● How accessible are these data sources?
	● What data resources are available through our partners or coalitions?
		☐ High – we have great data and have identified all resources.
		☐ Medium – we have some data and are working to identify resources.
		☐ Low – we do not have strong data and are unable to identify resources.

● Understands what makes the community unique as well as what are some of its norms	● Is the population disproportionately young-or old? ● Are there many seasonal workers or minorities (college town or resort community)? ● Does the town/city have a reputation, for better or worse, regarding substance use? ● How has the community been affected by health disparities?	☐ High – understanding of our community culture is strong. ☐ Medium – we are developing an understanding of our community. ☐ Low – we do not have a clear understanding of our community.
● Believes our agency is ready to act	● To what extent does the agency understand the tobacco problem and believe it is a problem? ● Is the agency willing and able to implement a prevention effort? ● Is the agency willing and able to implement a tobacco related policy effort? Not applicable for min funded grantees. Instead, does the agency support the foundational activities you will implement?	☐ High - the agency believes that tobacco is a problem and is willing and able to implement a prevention effort. ☐ Medium – the agency understands the tobacco problem and is open to consider prevention efforts. ☐ Low – there are a lot of competing priorities around prevention efforts.
● Has strong leadership capacity for advocacy	● To what extent is leadership available and willing to do the necessary work? ● To what extent does leadership understand and clearly articulate our tobacco control goals? ● To what extent is [tobacco control/advocacy/ community policy change] important to achieving our goals and related to our strategies? Not applicable for min funded grantees.	☐ High – leadership is fully available and willing to do the necessary work for tobacco advocacy and policy change. ☐ Medium – leadership is available and willing and somewhat supportive of tobacco advocacy. ☐ Low – leadership is rarely available and not clear in their support of tobacco

● Has adaptive capacity for advocacy	● How effective are we at monitoring the external environment for tobacco control opportunities and our internal environment for capacity to respond?	☐ High - we regularly monitor the external environment for tobacco control opportunities and are poised to respond.
	● What strategic relationships do we currently have and what relationships do we need to cultivate in order to be successful? ● In what ways do local politics and policies help or hinder prevention efforts? ● What strategies can our agency implement to address these challenges?	also regularly cultivate strategic relationships. ☐ Medium - we strive to monitor the external environment for tobacco control opportunities and try to respond. We sometimes cultivate strategic relationships. ☐ Low - we do not monitor the external environment for tobacco control opportunities, as we should. We struggle to
● Has management capacity for advocacy	● How is information about tobacco control shared throughout our agency? ● How well do our teams function in order to capitalize on our tobacco control work and effectively utilize non-staff resources?	☐ High - our teams capitalize on our tobacco control work and effectively utilize staff and non- staff resources. ☐ Medium – we capitalize on some of our tobacco control work and utilize staff resources. ☐ Low – we do not capitalize on our tobacco control work very effectively and do not fully utilize staff resources.
● Has technical capacity for advocacy (not applicable for minimally funded grantees).	● What technical skills and resources do we have/need in order to implement our selected tobacco control strategies? ● Policy change knowledge and skills, tobacco control expertise, political knowledge and skills, advocacy skills, communications, outreach experience ● What specialized knowledge exists and to what extent can our agency leverage this knowledge? ● With which specific populations does our agency have experience working? ● To what extent does the problem relate to these specific populations? ● Do the affected communities have power in the decision making process?	☐ High – we have the technical skills and resources we need in order to implement our selected tobacco control strategies. ☐ Medium – we have most of the technical skills. ☐ Low – we have some of the technical skills. ☐ None – we have none of the technical skills.

1.2 Secondary Data Collection

In this step, you will review the data in the tables provided by CDPHE. Data for several indicators will be made available at the county, region, and state level. Indicator topic areas include demographics; tobacco-related health outcomes; current tobacco use prevalence (adults, pregnant women, & youth); youth initiation, access, intentions, and perceived risks; health care provider advice; cessation; and exposure to secondhand smoke and vapor. Depending on the size of a county, you may only have access to regional data. State data are provided as a comparison. County or regional estimates that are higher than the state estimate should be indicated as an "area of concern". Secondary Data sources include County Health Rankings, BRFSS, TABS, HKCS, CDPHE VISION.

Secondary Data

***Note: This table will be provided to all grantees by CDPHE in July 2018.**

If you have access to secondary data on the same indicators or additional indicators for your target population(s) that are more specific to that population than the county/regional data provided by CDPHE, you should create a copy of the table CDPHE provides in July and enter the data for your specific community, adding rows for any additional indicators.

1.3 Primary Data Collection

The data below will be collected primarily through observations, environmental scans, and interviews. Based on the data presented in the Secondary Data table, consider what other information might be needed. Some guiding questions to think about when considering your approach to primary data collection:

- What additional context can you provide to help understand the data presented?
- What additional questions come to mind as you view the findings presented?
- How do the findings confirm findings/trends emerging through your own analyses or other analysis you have seen?
- How do the findings differ from findings/trends emerging through your own analyses or other analysis you have seen? Complete the following table with your findings and information.

Minimally funded grantees may need to prioritize the type of data they are able to collect and should discuss the best approach with their POC. They may want to collect information in 1-2 areas, such as the retailer availability and Smoke Free policies. They may also collect information on the additional local conditions/factors after the profile is completed, as part of the ongoing work to gain a better understanding of the tobacco burden in their community.

Table 1.3 Primary Data Collection – Local conditions/factors

Type of data	Measure	Indicators	Data/findings	Data Source/describe how assessed	* Indicate if this is an area of concern
Name the area assessed (city/county/town)					
Retail availability	Overall, retail outlet numbers and environment.	● # Tobacco/vape retailers ● # of cigar bars ● # of vape shops or e-juice bars ● Compliance check results (past 3-5 years) (Rate of sales to minors over time) ● Where are areas where retailer density is disproportionally high? ● Proximity of retailers to youth-serving venues (schools, playgrounds, daycare) ● # of stores with outdoor advertising and their proximity to schools and playgrounds		Tobacco Retail Access Colorado (TRAC) (note, the system can't sort by store type) Environmental scans, store survey, observation, etc.	
Expanding Smoke-Free (SF) Protections	Community norms favorable toward tobacco use	● # of hotels/motels and % of those that are 100% smoke free ● # of construction companies ● # of community events that allow smoking ● # of outdoor dining areas ● # of city-owned parks ● List your large community pedestrian areas (river walks, town squares, shopping, etc.) ● Event sponsorship by tobacco			

SF Protections Summary	Overall, where SHS exposure is occurring and any specific settings that are considered high-risk?				
Multiunit Housing (MUH)		List the total number of the following Multiunit sing units: • # of households • # of households who rent • # of properties and # of units in properties • # of low-income and rent-assisted properties and # of units in your community		Census Data: https://www.census.gov/programs-surveys/ahs.html	
Tobacco Free Schools (TFS)		● # School Districts ● # Schools within district (# elementary, # MS, # HS, # alternative) ● % students eligible for free and reduced meal program ● # MS/HS implementing Second Chance (and which ones are not) ● # HS conducting NOT classes (and which ones are not) ● Evidence of tobacco use on district/school property/grounds ● CTC initiative within community that has a youth prevention and/or tobacco prevention focus		CDE website TRAC	
		● Signage checklist completed within past two years ● Evidence of updated TFS signage on district/school buildings – signage checklist completed within past two years ● CTC initiative within community that has a youth prevention and/or tobacco prevention focus			

Health neighborhood and place-based options (place based includes MUH)		A health neighborhood describes all the various community inputs that determine a person's unique health profile. Consider: ● Where they get their food ● Where they live and work ● The recreational opportunities ● Where they engage the medical and behavioral health communities including primary care doctors and specialists; dentists; pharmacists; substance abuse programs and support groups; and counseling. ● Consider contacts that only peripherally affect health—faith communities, school, job training, and exposure to the arts and humanities.		Briefly describe the quantity and quality of the most likely **key health neighborhood players** in the community you plan to focus on—be especially mindful of those partners with the ability to address the concerns of your community's health equity populations (e.g., hospitals, community behavioral health providers, justice-involved organizations, and low-income support agencies and charities, as well as major employers and others who may be engaged to support your endeavors through donations of resources).	

1.4 Brief Policy Review and Quick Municipal Policy Gap Analysis

You will determine if the organization (school district, multiunit housing organization, college campuses or community-based organization) has tobacco-related policy language and complete the table below. This information could be collected during your key informant interviews. A more detailed analysis of the policies themselves would be conducted at a later stage (not applicable to minimally funded grantees), depending on the selected strategy.

Table 1.4 Organizational Tobacco Policy Brief Review

Prevent initiation	Eliminate exposure to secondhand smoke	Promote quitting
Tobacco - Free Schools	Place-based	Health neighborhood integration
LPHA staff reviewed school district tobacco free school policies ❏ Yes, they have a policy ❏ No, they do not have a policy	LPHA staff met with Housing Authority to determine if there is language around tobacco use in their resident and employee policies. ❏ Yes, they have a policy ❏ No, they do not have a policy LPHA staff met with Housing Authority to determine if there is language around vaping and E cig use in their resident and employee policies. ❏ Yes, they have a policy ❏ No, they do not have a policy	LPHA staff met with community-based organization to determine if there is language around tobacco use in their employee handbook. ❏ Yes, they have a policy ❏ No, they do not have a policy LPHA staff met with community-based organization to determine if there is language around tobacco use for any visitors or guests. ❏ Yes, they have a policy ❏ No, they do not have a policy

Summary of Results for Table 1.4

For any cities or towns you are analyzing, you will do a deeper policy gap analysis with the checklist in **Table 1.5** as your guide. The purpose of a policy gap analysis is to help you gain familiarity with the current language around tobacco found in a particular municipal code. This is not an exercise to guide you in developing model policy language. To begin a policy gap analysis, go to the language you wish to analyze (often found online or through the city clerk). Once you find the tobacco-related language, review the policy using the checklist below.

Table 1.5 Checklist of Municipal Policy Indicators for Tobacco

This checklist can help you determine how many and what types of tobacco-related policies already exist in your municipal code so you can best decide where to extend your policy efforts. This is optional for the minimally funded grantees. You may choose to complete this task at a later time. However, if an evidence-based strategy is selected, you will have to complete this step for the policy effort you might be considering. Review the two primary sections of your municipal code: 1) that regulates the sale and use of tobacco products and 2) Smoking in Public Places (or something similar). See if your local code addresses any the provisions below. If they do, check yes, if not, check no. If you need assistance locating your municipal code, contact your city clerk. For questions related to completing this checklist, feel free to contact the Legal TA provider at Colorado School of Public Health. You may compare your indoor smoke-free policy to the Colorado Clean Indoor Air Act C.R.S. 25-14-204.

Provisions in Municipal Code?	Yes	No	Notes
Tobacco Sales & Furnishings			
Excise taxes on tobacco (local)			
Tobacco sales licensing system			
Place restrictions on tobacco advertising and promotion			
Regulate the number, location, and density of tobacco retail outlets			
Ban on vending machines			
Local compliance checks for minimum purchase age and administrative penalties for violations			
Minimum age of seller (must be legal age to purchase)			
Mandatory tobacco seller training			
Ban on self-service displays (all tobacco behind counter)			
Restrictions on sponsorship of special events			
Public Smoking			
Definition of smoking includes the use of electronic smoking devices such as E cigs			
Prohibition of smoking in all outdoor public places			
Prohibition of vaping in all outdoor public places			
Establishment of smoke-free outdoor settings such as patios, playgrounds and parks			
Removal of exemptions for certain indoor places (ex. hotels/motels 100% smoke free, no small business exemption, no long-term care facility exemption)			

Provide access to a referral system for tobacco cessation resources and services, such as the Colorado QuitLine			
Has your local clean indoor air act been updated? If so, when?			

1.6 Key Informant Interview Guide

Next, you will need to conduct key informant interviews to gain further details on the community (ies) you're assessing. This section will be one of the more time-consuming sections of the assessment as you will reach out to a variety of individuals in a number of areas. However, this information will be crucial to get a true community perspective on the problem of tobacco in a certain area (schools, stores, MUH, etc.). Typically, key informant interviews consist of a series of open-ended questions that produce narrative answers. This is the qualitative data that needs to be analyzed for key themes and illustrative quotes that represent a particular point of view or insight voiced by informants. The community experts (key informants), with their particular knowledge and understanding, can provide insight into the nature of a particular problem and give recommendations for solutions. Beyond helping gather deeper insight into tobacco problems and strategies, key informants can help you identify and gain access to key players and develop relationships with stakeholders and information sources.

You will need to analyze and report on quantitative survey data as well as qualitative comments that describe informants' perceptions, attitudes, concerns, and rationale.

Like any evaluation activity summary, your key informant interview write-up should include an explanation of data collection methods, results and implications. For information on how to conduct key informant interviews, see Collecting Stories in Your Community: A Guide to Qualitative Data Collection. You may also contact the Colorado School of Public Health for key informant interview related questions.

Minimally funded grantees: Consider scaling down your effort in this category. Prioritize 2-3 areas that make sense for your community and start there. Within those 2-3 areas, you may want to interview a smaller pool of people. If you want to explore problems in schools, select 1-2 school representatives to interview. If you want to connect with a community-based organization or service provider, perhaps you only interview the director or assistant director to ascertain their experience with tobacco problems. Technical Assistance at the Colorado School of Public Health is always available to help you strategize your approach for this step.

6a Who to Interview

Primary data collection method	Youth access	Community-level protections	Tobacco Free Schools	Place-based	Health neighborhood integration
Key informant interviews	Interview 2-3 city admin officials (city manager, council member, attorney, law enforcement etc.)	Interview 2-3 city admin officials (city manager, council member, attorney, etc.)	Interview 2-3 school officials (District-level staff, principal, counselor, school nurse, athletic director, SRO, etc.)	Interview 2-3 targets (Housing authority, HR manager, CEO, etc.)	Interview 3-6 (2-3 for minimally funded grantees) local service agency directors

6b Steps in the Key Informant Process

1. Gather and review the data you have collected thus far (HKCS, environmental scans, readiness assessments, etc.).
2. Determine what information is needed or missing (e.g. do you want to collect data on a specific tobacco-related problem, community concerns, community opinions, or existing services and service utilization?)
3. Determine target population and brainstorm about possible key informants
4. Choose key informants
    - Key informants must have first-hand knowledge about your community, its residents, and issues or problems you are trying to investigate.
    - Work with team, coalition members and stakeholders to identify most advantageous informants on the topic.
5. Refine and focus your interview tool. You will not ask all the questions below in the sample. It is broken out into topic areas. Feel free to modify any questions and create your own prompts to dive deeper.
6. Determine documentation method (note-taking and/or tape recording)
7. Select designated interviewer(s)
    - Determine who on your team, coalition, or partnership has the skills or background to conduct the interviews. Interviewers should be good listeners, have strong communication skills, be able to take detailed notes, be detail oriented, and comfortable meeting and talking to new people. For consistency, it is wise to only have one or two designated interviewers with a note taker.
8. Conduct key informant interviews
9. Compile and organize key informant interview data
10. See Colorado School of Public Health's (CSPH) resource, Collecting Stories in Your Community: A Guide to Qualitative Data Collection for information on analyzing the interviews.

6c Sample Key Informant Interview

Below is a sample interview guide/questionnaire related to tobacco prevention. This example contains an introductory question, general tobacco health and prevention questions. After that, there are sections with questions that get to more specific issues such as cessation and policy. You will select questions based upon whom you are interviewing. You may want to select a portion of these questions and/or create your own based on 1) with whom you are meeting and 2) your focused goal.

Introduction: Good morning/afternoon. My name is [**interviewer's name**]. I'm **(Introduce yourself)** Thank you for taking time out of your busy day to speak with me. I'll try to keep our time to 45 minutes, but we may find that we run over – up to 60 minutes total - once we get into the interview. (**Check to see if this is okay**)

The X County Health Department is gathering local data as part of developing a plan to impact tobacco-related disparities and improve health and quality of life in [focus area] or X County. Community input is essential to this process.

You have been selected for a key informant interview because of your knowledge, insight and familiarity with the community. The themes that emerge from these interviews may be summarized and made available to local decision makers; however, individual interviews will be kept strictly confidential.

To get us started, can you tell me briefly about the work that you and your organization do in the community?

Thank you. Next, I'll be asking you a series of questions about tobacco-related health and quality of life in [focus area] or X County. As you consider these questions, keep in the local perspectives you have from your current position and from experiences in this community.

General Health and Tobacco Issues

1. In general, how would you rate health and quality of life in [focus area] or X County?
2. In your opinion, has health and quality of life in [focus area] or X County improved, stayed the same, or declined over the past few years?
    a. Why has it [declined/improved/stayed the same]?
    b. What other factors have contributed to the [improvement, decline **or** to health and quality of life staying the same]?
3. What barriers, if any, exist to improving health and quality of life in [focus area] or X County?
4. Do you see tobacco as a problem in [focus area]? Why or why not?
5. Are there people or groups of people in [focus area] whose health or quality of life may not be as good as others?
    a. Who are these persons or groups (whose health or quality of life is not as good as others)?
    b. Why do you think their health/quality of life is not as good as others?

Tobacco Prevention

6. Who are the people in [focus area] that need to be involved to make changes around the tobacco problem in [focus area]?
7. What organizations in the community are actively involved in tobacco prevention efforts?

    a. What organizations need to be involved to make changes around the tobacco problem in [the/specific] community?

8. What do you think the community's attitude is about supporting tobacco prevention efforts? Would they spend money, time, offer space for meetings, or donate staff time for these efforts? Are the leaders in the community involved in prevention efforts?
9. What strengths or assets does the community have to support tobacco prevention and control? What weaknesses, barriers, or obstacles does the community have that make tobacco prevention and control difficult?
10. What types of tobacco prevention and control activities already exist in the community? What suggestions do you have that would help us provide tobacco prevention and control in your community?

Tobacco Free Schools

11. What issues and/or challenges does your district/school face regarding creating and maintaining a tobacco free environment?
12. How do you think schools and community partners can support youth tobacco prevention / education within schools?
13. How would you like support from local public health and other community partners to create and maintain tobacco free environments at your school?
14. Do you have tobacco policy violations on your school campus? If so, who generally violates the policy? Students, staff, families and/or visitors?
15. Would you be interested in our help to communicate tobacco policy so there are fewer violations?
16. Would you be interested in our help to implement an online, self-paced tobacco education program for students who have violated policy or are experimenting with tobacco? (Second Chance)
17. Would you be interested in our help to provide a tobacco cessation class for students who are using tobacco and interested in quitting?
18. Would you be interested in tobacco cessation resources for staff and families?

Tobacco Cessation/Tobacco Health Neighborhood

19. What factors in your community contribute to current tobacco use habits of vulnerable or low-income individuals?
20. What is your organization or agency doing to address the tobacco use habits of low income individuals?
    a. Probe: Do you have a tobacco use policy for clients and employees?
21. What are the [5] most important organizations in your community serving low income individuals to meet their needs (e.g. health, housing, food, medical care, etc.)?
22. Thinking of low-income members of your community, what services or organizations are available to meet social or recreational needs?
23. If someone in the [community/agency/organization] wants to quit using tobacco where would they go for help?
24. In your opinion, what else needs to be done around cessation in your community?
25. In addition to [local public health] and our local medical community which organizations do you know are already addressing tobacco?

26. In your opinion what organizations would make for good strategic partnerships in our tobacco control work? Why? (*Looking for reach, relationships to vulnerable communities, access to resources including political leverage and funding*).

Smoke Free Multiunit Housing

27. Do you believe tobacco/secondhand smoke exposure is a problem in your community?
    a. If yes, how does this issue seem apparent in your community?
28. Would management of your housing community support smoke-free policy implementation?
    a. If no, why do you think they would not be willing to support policy change?
29. Would members of your community be willing to work with your community's policy makers and a local agency to choose and implement the environmental or policy changes? Why do you think that is?
30. Would your housing management company be willing to devote funds to help support such policy changes?
    a. If yes, how would they support these changes with funds?
31. What do you believe would be the barriers and challenges of implementing a smoke-free policy within your community?
32. On a scale of 1 to 10 (with 10 being the highest), what is your level of interest in taking part in a policy change such as this?
33. Do you believe a smoke-free policy would be financially beneficial to management, if so, how?
34. Do you think your community would benefit from portfolio-wide implementation or property specific policy implementation?

Tobacco Policy (specific to a city/town administrator or decision maker)
Optional for minimally funded grantees.

35. What types of tobacco rules and regulations currently exist in [your organization, county, city/town]? Are the people in the [focus area] aware of any or all of these efforts?
    a. What are your thoughts or ideas about how to make the [specific] policy more successful? Probe: education, signage, training
    b. Do you feel the policy is being adequately enforced? If no, why?
36. Is there someone (who) you would recommend as a "key informant" for this assessment?

Close: Thanks so much for sharing your concerns and perspectives on these issues. The information you have provided will contribute to develop a better understanding about factors impacting health and quality of life in [focus area].

Before we conclude the interview, is there anything you would like to add?

As a reminder, summary results will be made available by the X County Health Department and used to develop a tobacco-focused health improvement plan. For minimally funded grantees: As a reminder, summary results will be used to build an education and engagement plan. Should you have any questions, please feel free to contact X at the health department. Here is their contact information [**provide postcard**]. Thanks once more for your time. It's been a pleasure to meet you!

Step 2: Interpret Profile Data to Identify Problem(s): Guiding Questions. Create Profile.

After Step 1 of the assessment is complete, the information needs to be interpreted and summarized. Consider the guiding questions below to help interpret the data, prioritize needs and consider the conceptual and practical fit of possible strategy solutions. First, create a bulleted list summarizing key findings and responses to the guiding questions below. Using the profile template, create a draft tobacco-focused community profile.

Based on your profile data...

1. What are the community's most pressing problems and related behaviors?
2. How do the community rates compare to state rates?
3. Are there specific indicators that stand out?
4. How have the rates changed over time?
5. How often are the problems occurring?
6. In what settings are they occurring?
7. Which populations experience the problems the most? Are sub-populations experiencing different problems or consequences?
8. Are there particular places, times, or sub-populations that seem to be "driving the data"?
9. What are the associated issues? What might explain the data?
10. How is the problem currently being addressed, if at all?
11. Do we need more information?

Strategy – Practical Fit[2]

Practical fit is defined as "your current ability to effectively implement a tobacco control strategy, given your community's readiness, population and general local circumstances".

1. What resources (e.g., cost, staffing, and access to target population) are necessary to impact the problem(s)?
2. What resources are available?
3. What is the community's attitude toward the problem? Is there buy-in of key decision-makers?
4. How do tobacco control strategies fit with existing prevention or reduction efforts in the community?
5. What opportunities or supports exist to address the problem? What are the barriers?
6. How likely is tobacco control work to be sustained? Is there community ownership? Are there community champions to help sustain this work?
7. What happens if we do nothing?

[2] Adapted from The MOAPC Guidance Document 9.12.16 prepared by MassTAPP (http://masstapp.edc.org/massachusetts-opioid-abuse-prevention-collaborative-guidance-document).

Step 3. Create Project Theory Diagram (Evaluation Module)

This step is optional for the minimally funded grantees. Minimally funded grantees need to do this step only if they are selecting strategies in addition to the foundational activities. In preparation for the meeting with your POC and other key TA providers, complete this Project Theory Diagram. It will particularly be helpful in the beginning to develop your problem statement (which includes describing the core problem, community needs and influential factors). You should complete one Project Theory Diagram for each community assessed. The Project Theory Diagram is the first component in the Evaluation Module (http://evaluationco.org/) that you will complete later. Bring this to your meeting with the STEPP POC and TA provider(s). You may contact CEPEG for evaluation related questions. Use the following link to see an example of a completed Project Theory Diagram.

Table 3.1 Project Theory Diagram

Core Problem ***(Describe what is wrong and why it matters)***	**Evidence-based Intervention Strategies** ***(what you plan to do about it)***	**Desired Results/Outcomes**
		Short-term **(3-12 Months)**
Community Needs ***(List community data, at least 3 data sources)***		**Intermediate** **(12-24 Months)**
Influential Factors ***(Describe potential supports/opportunities and barriers)***		**Long-term** **(24 Months+)**
		• Reduce tobacco prevalence and initiation among youth and young adults, with emphasis on low SES population by 50% by 2020. • Reduce exposure to SHS and vapor, with emphasis on low SES populations by 50% by 2020. • Decrease cessation success gap affecting low SES youth and adult smokers by 50%. Tobacco dependence is treated as a chronic condition by all health systems

Step 4: Meet with your Point of Contact and TA Provider(s)

Meet with your STEPP POC and all appropriate TA provider(s) to identify appropriate strategies. Minimally funded grantees will meet with their POCs to discuss the findings in their profile and identify areas in which to focus the foundational activities. These grantees will also discuss the strategies for educating and engaging populations most burdened by tobacco in your community(ies). During the meeting you will discuss your project theory diagram and the tobacco control strategy(ies) you feel are most feasible given funding. The team will collaborate to further define and finalize the problem(s) your agency plans to tackle. Depending on your funding and capacity, your agency may address more than one strategy and in more than one community. Please refer to the funding-strategy matrix below to review the expected level of efforts based on allocated funding. Figure 2 below shows the number of communities and strategies you're expected to assess and work in based on your funding. Please note the requirement for foundational activities all grantees are expected to do.

Figure 2: Funding and Strategy Matrix

Funding Amount	Foundational Activities (including Goal 4)	Expected # of Evidence-Based Strategies (in Goal 1,2,3)*	# of settings** in which at least 1 strategy must be implemented***
$50,000 or less	X	0	0
$50,001 – $100,000	X	1	1
$100,001- $200,000	X	1	2
$200,001- $300,000	X	2	3
$300,001 – $399,000	X	2	4
$400,001 – $800,000	X	3	5
$800,001 – 1 million +	X	4	6+

*CDC Goal 4 strategy: Identifying and eliminating tobacco-related health disparities is required to be implemented by all grantees (see foundational activities below).

** "Setting" refers to a specific place or site where the work occurs, and can include retail outlets, school districts, multiunit housing properties, etc.

***Regional collaborations may increase the number of communities in which the strategies are implemented based on collaboration approach.

Step 5: Draft Implementation Plan (see POC for template)

The implementation plan is a document that outlines the steps necessary to meet your goals. Your STEPP POC will share the implementation plan template. Now that you know what problem(s) and strategy(ies) your team will work on, utilize the online evaluation module (http://evaluationco.org/) to *clearly* define your path by developing a Project Flow (logic model) for each strategy. Minimally funded grantees need to do this step only if they are selecting strategies in addition to the foundational activities. Information from the online evaluation module should be incorporated into your implementation plan. Remember to make your community readiness assessment (Step 6) the first objective in your Implementation Plan.

Table 5.1 Project Flow Diagram (Logic Model)

INPUTS	**OUTPUTS**		**OUTCOMES**		
Resources	**Activities**	**Participants**	**Short-term Outcomes (3-12months)**	**Intermediate Outcomes (12-24months)**	**Long-term Outcomes (24months +)**
					• Reduce tobacco prevalence and initiation among youth and young adults, with emphasis on low SES population by 50% by 2020. • Reduce exposure to SHS and vapor, with emphasis on low SES populations by 50% by 2020. • Decrease cessation success gap affecting low SES youth and adult smokers by 50%. Tobacco dependence is treated as a chronic condition by all health systems.
Evidence-based strategies			**Influential Factors**		

Step 6: The Community Readiness Assessment[3]

Minimally funded grantees are not required to do a community readiness assessment if no strategies in addition to the foundational activities are selected.
Now that you've identified the strategy(ies) and community(ies) in which you will focus the work, conduct a more in-depth community readiness assessment to better identify the steps of the implementation plan. Readiness assessment is the first objective in the implementation plan. This should be the first SMART objective in your Implementation Plan (e.g. By X date, assess the readiness of X community to work on X tobacco control strategy).

According to Tri Ethnic center, community can be defined in a number of ways. The most common is a geographic area, such as a town, a neighborhood, or a school district. But a community might also be an organization. For example, we might be interested in measuring the readiness level of a state's Department of Public Health to begin working on increasing the physical activity of that state's senior population. In this case, the community is the Department of Public Health while the issue is increasing the physical activity of the state's senior population.

Step 1: Identifying the problem.

Identify the problem that your group will be assessing for readiness, remembering to be specific.

Step 2: Identify and clearly define and delineate your community.

Identify the community whose readiness you are assessing. As noted above, examples of communities include:

- Geographic community – a city, a county, an area enclosed by certain boundaries, etc.
- Subgroup of a geographical community defined by ethnicity, age, etc.
- Occupation group such as law enforcement, medical community, environmentalists.
- Systems such as mental health or children's development.
- Organizations or departments of organizations (e.g. a university, a school district).

Step 3: Prepare your interview questions.

Step 4: Choose your key respondents.

Some community surveys rely on a random sample of the community's population, and they ask each individual about their personal attitudes toward the issue. The Community Readiness Model, instead, uses **key respondents** to answer the interview questions and provide information about how the community views the issue. Additionally, these interviews can serve as a baseline measurement of a partner organization or a municipality's readiness towards making community change.

How many interviews should be done?

Conduct at least 6 key respondent interviews in your community. Some communities may require more interviews in order to get a more complete picture of the community. 6-12 interviews are

[3] Colorado State University. (2011). Tri-Ethnic Center for Prevention Research. Community Readiness for Community Change Handbook, 2nd Ed. Fort Collins. http://triethniccenter.colostate.edu/docs/CR_Handbook_8-3-15.pdf

often sufficient. When the community is very small or very homogenous, even 4 interviews may be sufficient.

Step 5: Conduct and then discuss each interview with your team.

Step 6: Score the interviews

Each interview is scored to provide a readiness level for each dimension - knowledge of efforts, leadership, community climate, knowledge of the issue, resources.

Step 7: Refine the Implementation Plan

Minimally funded grantees need to do this step only if they are selecting strategies in addition to the foundational activities. After the results of the community readiness assessment, you're able to further identify and refine the steps and your approach to implementing the identified strategies. Update your implementation plan and share with your POC and TA provider(s) for further refinement and agreement on expected steps and activities. Check your STEPP Scope of Work (SOW) for due dates for this deliverable.

The implementation plan is where you write down clear, attainable activities that you and your team will conduct to achieve your objectives. The implementation plan explains how you are going to work to 'solve' the tobacco problem uncovered during your community profile.

You can expect the implementation plan to be a living document, updated at least annually, or as needed. Your STEPP POC and TA provider(s) will be referring to this document for the ongoing implementation of work for the remainder of the grant cycle.

During the assessment process, you will also have some current initiatives you will need and want to continue. Your POC will share a template with you for a "bridge implementation plan". This will assist you, your POC and your TA providers, to all be on the same page about what existing work will continue during those first 6-9 months of your contract.

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Figure 1: Where you are funded to Work

List each funded county	List the top 1-3 most populous towns or municipalities in those counties	Check if you plan to do a profile of this particular community
Ex. Jefferson	*Lakewood* *Arvada* *Wheat Ridge*	*X* *X*

Table 1.1 Organizational Readiness Framework, Questions and Score

OUR AGENCY…	QUESTIONS TO CONSIDER DURING YOUR GROUP/KEY INFORMANT INTERVIEWS	BASED ON THE INTERVIEWS, HOW WOULD YOUR TEAM RATE YOUR ORGANIZATION'S READINESS? HIGH, MEDIUM, OR LOW

• Has identified relevant data sources to use in the community profile analysis	• What community-level data sources exist?
	  • How accessible are these data sources?
	• What state-level data sources exist?
	  • How accessible are these data sources?
	• What data resources are available through our partners or coalitions?
		□ High – we have great data and have identified all resources.
		□ Medium – we have some data and are working to identify resources.
		□ Low – we do not have strong data and are unable to identify resources.

• Understands what makes the community unique as well as what are some of its norms	• Is the population disproportionately young-or old? • Are there many seasonal workers or minorities (college town or resort community)? • Does the town/city have a reputation, for better or worse, regarding substance use? • How has the community been affected by health disparities?	□ High – understanding of our community culture is strong. □ Medium – we are developing an understanding of our community. □ Low – we do not have a clear understanding of our community.
• Believes our agency is ready to act	• To what extent does the agency understand the tobacco problem and believe it is a problem? • Is the agency willing and able to implement a prevention effort? • Is the agency willing and able to implement a tobacco related policy effort? Not applicable for min funded grantees. Instead, does the agency support the foundational activities you will implement?	□ High - the agency believes that tobacco is a problem and is willing and able to implement a prevention effort. □ Medium – the agency understands the tobacco problem and is open to consider prevention efforts. □ Low – there are a lot of competing priorities around prevention efforts.
• Has strong leadership capacity for advocacy	• To what extent is leadership available and willing to do the necessary work? • To what extent does leadership understand and clearly articulate our tobacco control goals? • To what extent is [tobacco control/advocacy/ community policy change] important to achieving our goals and related to our strategies? Not applicable for min funded grantees.	□ High -Leadership is fully available and willing to do the necessary work for tobacco advocacy and policy change. □ Medium – Leadership is available and willing and somewhat supportive of tobacco advocacy. □ Low – Leadership is rarely available and not clear in their support of tobacco advocacy.
• Has adaptive capacity for advocacy	• How effective are we at monitoring the external environment for tobacco control opportunities and our internal environment for capacity to respond? • What strategic relationships do we currently have and what relationships do we need to cultivate in order to be successful? • In what ways do local politics and policies help or hinder prevention efforts? • What strategies can our agency implement to address these challenges?	□ High - we regularly monitor the external environment for tobacco control opportunities and are poised to respond. We also regularly cultivate strategic relationships. □ Medium - we strive to monitor the external environment for tobacco control opportunities and try to respond. We sometimes cultivate strategic relationships. □ Low - we do not monitor the external environment for tobacco control opportunities, as we should.

		We struggle to cultivate strategic relationships.
• Has management capacity for advocacy	• How is information about tobacco control shared throughout our agency? • How well do our teams function in order to capitalize on our tobacco control work and effectively utilize non- staff resources?	□ High - our teams capitalize on our tobacco control work and effectively utilize staff and non-staff resources. □ Medium – we capitalize on some of our tobacco control work and utilize staff resources. □ Low – we do not capitalize on our tobacco control work very effectively and do not fully utilize staff resources.
• Has technical capacity for advocacy (not applicable for minimally funded grantees)	• What technical skills and resources do we have/need in order to implement our selected tobacco control strategies? • Policy change knowledge and skills, tobacco control expertise, political knowledge and skills, advocacy skills, communications, outreach experience • What specialized knowledge exists and to what extent can our agency leverage this knowledge? • With which specific populations does our agency have experience working? • To what extent does the problem relate to these specific populations? • Do the affected communities have power in the decision making process?	□ High – we have the technical skills and resources we need in order to implement our selected tobacco control strategies. □ Medium – we have most of the technical skills. □ Low – we have some of the technical skills. □ None – we have none of the technical skills.

Table 1.2 Secondary Data Resources

***Note: Secondary Data table will be provided to all grantees by CDPHE in July 2018.**

Description of key tobacco-related secondary data sources (population-based surveys)

For more information see: https://www.colorado.gov/cdphe/data-source-fact-sheets

	Population Represented	Sub-State Granularity	Frequency	Years Administered*
BRFSS	Adults aged 18+ years	Region*, county*, and census tract†	Annual	1990-2010, 2011-2016
TABS	Adults aged 18+ years	Region, metro-area counties	Every 3 years (depending on funding)	2001, 2005, 2008, 2012, 2015
HKCS	High school students‡	Region	Every 2 years	2013, 2015, 2017
CHS	Children aged 1-14 years	Region*, county*	Annual	2004-2010, 2011-2016
PRAMS	Women with a recent live birth	Region*, county*	Annual	1997-2015
ACS	All residents	County, city, zip code, census tract, block group, school district, etc.	Annual	Annually with datasets for 2006-2010 (combined) to 2012-2016 (combined)

* Data are typically presented as 3-year combined estimates; single year estimates might be available for regions/counties with larger populations.

† BRFSS census tract-level estimates are based on statistical models that also utilize ACS data.

‡ HKCS also provides limited data on middle school students, and data are only available at the state level.

BRFSS: Behavioral Risk Factor Surveillance System

TABS: The Attitudes and Behaviors Survey on Health

HKCS: Healthy Kids Colorado Survey

CHS: Child Health Survey

PRAMS: Pregnancy Risk Assessment Monitoring System

ACS: American Community Survey (U.S. Census)

Table 1.3 Primary Data Collection – Local conditions/factors

Type of data	Measure	Indicators	Data/findings	Data Source/describe how assessed	* Indicate if this is an area of concern
Name the area assessed (city/county/town)					
Retail availability	Overall, retail outlet numbers and environment	• # Tobacco/vape retailers • # of cigar bars • # of vape shops or e-juice bars • Compliance check results (past 3-5 years) (Rate of sales to minors over time) • Where are areas where retailer density is disproportionally high? • Proximity of retailers to youth-serving venues (schools, playgrounds, daycare) • # of stores with outdoor advertising and their proximity to schools and playgrounds		Tobacco Retail Access Colorado (TRAC) (note, the system can't sort by store type) Environmental scans, store survey, observation, etc.	
Expanding Smoke-Free (SF) Protections	Community norms favorable toward tobacco use	• # of hotels/motels and % of those that are 100% smoke free • # of construction companies • # of community events that allow smoking • # of outdoor dining areas • # of city-owned parks • List your large community pedestrian areas (river walks, town squares, shopping, etc.) • Event sponsorship by tobacco			
SF Protections Summary	Overall, where SHS exposure is occurring and any specific				

	settings that are considered high-risk?				
Multiunit Housing (MUH)		List the total number of the following Multiunit sing units: • # of households • # of households who rent • # of properties and # of units in properties • # of low-income and rent-assisted properties and # of units in your community		Census Data: https://www.census.gov/programs-surveys/ahs.html	
Tobacco Free Schools (TFS)		● # School Districts ● # Schools within district (# elementary, # MS, # HS, # alternative) ● % students eligible for free and reduced meal program ● # MS/HS implementing Second Chance (and which ones are not) ● # HS conducting NOT classes (and which ones are not) ● Evidence of tobacco use on district/school property/grounds ● Signage checklist completed within past two years ● Evidence of updated TFS signage on district/school buildings – signage checklist completed within past two years ● CTC initiative within community that has a youth prevention and/or tobacco prevention focus		CDE website TRAC	
Health neighborhood and place-based options		A health neighborhood describes all the various community inputs that determine a person's unique health profile. Consider: ● Where they get their food ● Where they live and work ● The recreational opportunities		Briefly describe the quantity and quality of the most likely **key health neighborhood players** in the community you plan to focus on—be especially mindful of those partners with the ability to address the	

(place based includes MUH)		• Where they engage the medical and behavioral health communities including primary care doctors and specialists; dentists; pharmacists; substance abuse programs and support groups; and counseling. • Consider contacts that only peripherally affect health—faith communities, school, job training, and exposure to the arts and humanities.		concerns of your community's health equity populations (e.g., hospitals, community behavioral health providers, justice-involved organizations, and low-income support agencies and charities, as well as major employers and others who may be engaged to support your endeavors through donations of resources).	

Table 1.4 Organizational Tobacco Policy Brief Review

Not applicable to minimally funded grantees

Preventing initiation	Eliminate exposure to secondhand smoke	Promote quitting
Tobacco Free Schools	Place-based	Health neighborhood integration
LPHA staff reviewed school district tobacco free school policies ❏ Yes, they have a policy ❏ No, they do not have a policy	LPHA staff met with Housing Authority to determine if there is language around tobacco use in their resident and employee policies. ❏ Yes, they have a policy ❏ No, they do not have a policy LPHA staff met with Housing Authority to determine if there is language around vaping and E cig use in their resident and employee policies. ❏ Yes, they have a policy ❏ No, they do not have a policy	LPHA staff met with community-based organization to determine if there is language around tobacco use in their employee handbook. ❏ Yes, they have a policy ❏ No, they do not have a policy LPHA staff met with community-based organization to determine if there is language around tobacco use for any visitors or guests. ❏ Yes, they have a policy ❏ No, they do not have a policy

Table 1.5 Checklist of Municipal Policy Indicators for Tobacco

This is optional for the minimally funded grantees.

Provisions in Municipal Code?	Yes	No	Notes
Tobacco Sales & Furnishings			
Excise taxes on tobacco (local)			
Tobacco sales licensing system			
Place restrictions on tobacco advertising and promotion			
Regulate the number, location, and density of tobacco retail outlets			
Ban on vending machines			
Local compliance checks for minimum purchase age and administrative penalties for violations			
Minimum age of seller (must be legal age to purchase)			
Mandatory tobacco seller training			
Ban on self-service displays (all tobacco behind counter)			
Restrictions on sponsorship of special events			
Public Smoking			

Definition of smoking includes the use of electronic smoking devices such as E cigs			
Prohibition of smoking in all outdoor public places			
Prohibition of vaping in all outdoor public places			
Establishment of smoke-free outdoor settings such as patios, playgrounds and parks			
Removal of exemptions for certain indoor places (ex. hotels/motels 100% smoke free, no small business exemption, no long-term care facility exemption)			
Provide access to a referral system for tobacco cessation resources and services, such as the Colorado QuitLine			

Table 3.1 Project Theory Diagram

This step is optional for the minimally funded grantees. Minimally funded grantees need to do this step only if they are selecting strategies in addition to the foundational activities

<table>
<tr><th>Core Problem
(Describe what is wrong, why it matters and what you plan to do about it)</th><th>Evidence-based Intervention Strategies</th><th>Desired Results/Outcomes</th></tr>
<tr><td rowspan="2"></td><td rowspan="6"></td><td>Short-term
(3-12 Months)</td></tr>
<tr><td></td></tr>
<tr><td>Community Needs
(List community data, at least 3 data sources)</td><td>Intermediate
(12-24 Months)</td></tr>
<tr><td></td><td></td></tr>
<tr><td>Influential Factors
(Describe potential supports/opportunities and barriers)</td><td>Long-term
(24 Months+)</td></tr>
<tr><td></td><td>Reduce tobacco prevalence and initiation among youth and young adults, with emphasis on low SES population by 50% by 2020.
Reduce exposure to SHS and vapor, with emphasis on low SES populations by 50% by 2020.
Decrease cessation success gap affecting low SES youth and adult smokers by 50% Tobacco dependence is treated as a chronic condition by all health systems.</td></tr>
</table>

Table 5.1 Project Flow Diagram (Logic Model)

Minimally funded grantees need to do this step only if they are selecting strategies in addition to the foundational activities.

INPUTS	OUTPUTS		OUTCOMES		
Resources	**Activities**	**Participants**	**Short-term Outcomes (3-12 months)**	**Intermediate Outcomes (12-24 months)**	**Long-term Outcomes (24months +)**
					• Reduce tobacco prevalence and initiation among youth and young adults, with emphasis on low SES population by 50% by 2020. • Reduce exposure to SHS and vapor, with emphasis on low SES populations by 50% by 2020. • Decrease cessation success gap affecting low SES youth and adult smokers by 50% Tobacco dependence is treated as a chronic condition by all health systems.
Evidence-based strategies			**Influential Factors**		