California Department of Public Health
California Tobacco Control Program
CDC NOFO 20-2001
Evaluation Plan

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Overview of Evaluation

In 1989, California voters approved Proposition 99, which increased the tobacco excise tax on cigarettes and other tobacco products and funded the creation of the California Tobacco Control Program (CTCP), a branch of the California Department of Public Health. CTCP's program uses a denormalization strategy[1-2] to change tobacco norms at a community, institutional, and policy level through prevention, cessation, and policy activities. These assorted activities include policy initiatives with local lead agencies* (LLAs); media campaigns; the California Smokers Helpline (CSH); competitively-awarded community-, regional-, and tribal-based organizations targeting various priority populations; and behavioral health service providers. In addition, CTCP maintains an active portfolio of surveillance and evaluation projects to understand the tobacco control landscape and related policies.

Through the combined efforts of CTCP, LLAs, CSH, and other CTCP-funded partners, California has achieved policy changes with positive environmental, behavioral, and health outcomes. These changes have led to positive impacts for CTCP's priority populations, defined as groups that are disproportionately targeted by the tobacco industry or have higher rates of tobacco use, exposure to secondhand smoke, and tobacco-related diseases compared to the general population. Racial/ethnic priority populations include, but not limited to, African Americans, American Indian and Alaska Natives, Native Hawaiians and Asian and Pacific Islanders, and Latinos. People of lower socioeconomic status and people with limited education, including high school non-completers are also priority populations. Sexual and gender minority priority populations include lesbian, gay, bisexual and transgender people. Additional priority population groups include rural residents, current members of the military and veterans, people with substance use disorders or behavioral health issues, people with disabilities, and school-age youth.[3]

CTCP's evaluation of efforts related to CDC 15-1509 and 14-1410 found 157 communities across the state passed smokefree multiunit housing policies covering nearly 31 percent of state residents in 2020, including 42 percent of Asians, Native Hawaiians, and Pacific Islanders, 23.6 percent of Latinos, and 27.8 percent of African Americans. Tobacco retailer density decreased from 92 per 100,000 residents in 2014 to 78 per 100,000 in 2020.[4] While quitline usage declined, reflecting the national trend,[5] there were increases in the proportion of CSH users from specific priority populations in FY2019, specifically Asians (10.0 percent), Hispanic/Latinos (19.3 percent), Medi-Cal beneficiaries (70.9 percent), and people experiencing mental health and/or substance use challenges (48.9 percent).[4] Overall, the adult cigarette smoking rate in California fell from 11.8 percent in 2014 to 6.9 percent in 2019, while the rate of cigarette smoking among high school students fell from 10.5 percent in 2012 to 2.0 percent in 2018.[6]

Although CTCP's program is successful in reducing overall tobacco use, disparities in smoking rates remain, reflected in data from the 2019 California Health Interview Survey. While the overall California smoking rate in 2019 was 6.9 percent, populations such as African Americans and American Indian/Alaska Natives reported higher rates of smoking (12.2 percent and 8.6 percent, respectively). Similarly, higher rates of smoking were reported among Californian sexual minorities, with 8.9 percent of people that identify as gay or lesbian and 10.1 percent of people that identify as bisexual, reporting current smoking compared to their heterosexual counterparts (6.6 percent) in 2019. Over ten percent of those who likely had serious psychological distress in the past month reported smoking compared to 6.6 percent of those who were not likely to have experienced similar distress. Among those who sought behavioral health or substance use treatment in 2019, 9.4 percent

*Local Lead Agencies are legislatively designated as the 61 county and city health departments, or a governmental or private non-profit agency when the local health department is unable to fulfill the mandates of the local lead agency.

of current smokers versus 6.5 percent of those who did not seek treatment. While 44.1 percent of all Californians reported being exposed to secondhand smoke (SHS) or e-cigarette vapor in 2019, higher proportions of Latinos (45.8 percent), African Americans (48.4 percent), American-Indian/Alaska Native (71.2 percent), and Native Hawaiian/Pacific Islanders (54.0 percent) reported exposure to SHS or e-cigarette vapor.[7]

The CDC 20-2001 grant provides an opportunity for CTCP to continue to expand its work to increase health equity and reduce tobacco-related disparities in specific and targeted ways. CTCP's Component 1 activities encompass tobacco use prevention, SHS exposure prevention, cessation strategies targeting specific priority populations such as the Hispanic/Latino community in San Bernardino County and people living with behavioral health or substance use problems who access treatment centers, and specific targeted policy work (SHS policies in multiunit housing (MUH). Component 2 strategies include continued support of CSH and further work to expand both referrals to CSH and reimbursement routes for cessation counseling and nicotine replacement therapy/pharmacotherapies. CTCP plans to leverage its state-funded efforts to advance work in these areas, specifically its award-winning media campaigns, capacity-building with LLAs, and other funded-projects targeting diverse populations throughout the state.

This report provides a plan for evaluating some of these efforts. First, CTCP will evaluate work related to the statewide requirement (Component 1, Focus Area 1) with behavioral health facilities to create tobacco-free campuses, increase tobacco use screenings, and increase the provision of cessation aids such as nicotine replacement therapy and pharmacotherapies. Second, CTCP outlines policy evaluation (Component 1, Focus Area 3) work to increase the number of MUH developments with comprehensive smokefree policies, which CTCP defines to include tobacco, vape products, and marijuana. Third, CTCP discusses planned quitline evaluation activities (Component 2, Focus Area 4), which will examine increased referrals to the CSH, diversification of CSH support modalities (e.g., phone, online chat, self-paced video), overall CSH usage, and attempted and sustained quits overtime. For the community-based requirement (Component 1, Focus Area 2), CTCP plans to work with the San Bernardino County LLA in its efforts to address tobacco access with the Hispanic/Latino population in the county. Work related specifically to this will be discussed in a future evaluation plan.

Over the next five years, CTCP plans to capture both qualitative and quantitative data to understand the barriers and facilitators for policy changes at the organizational, local government, and regional government levels while leveraging robust surveillance systems to examine changes in tobacco use behaviors and outcomes over time. This evaluation plan provides a strong basis to make claims regarding program effectiveness and environmental, behavioral, and health outcomes, including tobacco-related disparities. Specifically, this plan will reveal how CTCP's efforts can yield equitable health outcomes for California's diverse populations. The evaluation results will be used to make programmatic adjustments throughout the grant period, highlight successes, and provide valuable information for other tobacco control programs across the nation.

Component 1

Evaluation Focus Areas

The focus areas for the Component 1 evaluation plan are the Statewide (Focus Area 1) and Policy or Health Systems Change Requirements (Focus Area 3). CTCP will include information on the Community-Based Requirement (Focus Area 2) describing work with the San Bernardino County LLA in a future evaluation plan based on future CDC guidance.

For the Statewide Requirement, CTCP will continue its work to create tobacco-free behavioral health treatment campuses and expand the capacity of behavioral health providers to screen, refer,

and treat patients with tobacco use disorder. CDC 20-2001 will continue to build on the work started through CTCP's California Behavioral Health and Wellness Initiative (CABHWI) and evaluation from the University of California San Francisco (UCSF). The Initiative aims to reduce tobacco use and promote wellness among clients receiving residential behavioral health treatment in California, including implementation of tobacco-free campus policies and implementing tobacco use screening and treatment. From 2018 to 2020, CTCP awarded 12 behavioral health facilities grants to adopt and implement tobacco-free campus policies and support tobacco screening and cessation via nicotine replacement therapy. CTCP plans to leverage the results of these evaluation efforts to inform future programmatic changes and adjustments. Evaluation results, concentrating on tobacco use behavior and cessation outcomes, will be leveraged by CTCP to inform its work as part of CDC 20-2001.

The CDC 20-2001 evaluation focuses on the behavioral health strategy "Promote health systems changes in behavioral health care facilities to encourage and support screening and treatment of tobacco use and dependence." Under this strategy, CTCP plans to engage county behavioral health and substance use treatment administrators to fully integrate tobacco use screening and treatment in behavioral health and substance use facilities, provide model tobacco-free behavioral health campus policies and training to institute those policies, and fund a formative assessment on advancing tobacco-free policies, tobacco use screenings, and cessation treatment. The evaluation will report on process outcomes from these activities and include findings from the CABHWI evaluation to provide context for barriers and facilitators to instituting these policies. Together, these activities will yield an increased number of facilities with smokefree policies, increased screening for tobacco use disorder and increased cessation attempts, ultimately leading to decreased tobacco use rates among those in residential behavioral health treatment facilities (see the Behavioral Health Logic Model, Figure 1).

Under the Policy or Health Systems Change (PHSC) requirement, CTCP plans to further expand its work to reduce SHS exposure in MUH through strengthening existing or implementing new comprehensive smokefree policies. While the Year 1 workplan indicates Strategy 2, "Increase and enhance comprehensive smokefree polices, including workplaces, bars, and restaurants" as the only strategy under SHS, activities in Year 1 also fall under Strategy 3: "Increase policies for smoke-free housing, including federally-assisted, multi-family properties and Section 8, coupled with promotion of evidence-based cessation treatment and resources." The PHSC portion of the Component 1 evaluation will examine activities related to Strategy 3, which will be selected in future workplans. Planned and in-process activities related to comprehensive smokefree policies include participation in housing conferences, monthly technical assistance calls with CTCP-funded projects to implement comprehensive smokefree housing policies, and hosting educational webinars for policymakers, housing and planning associations. These activities will promote comprehensive smokefree policies in MUH and educate on effective enforcement. The expected outcome of these activities is an increase in the number of jurisdictions that adopt smokefree MUH policies, which will in turn increase the proportion of the population protected from SHS. Additionally, CTCP expects to find a decrease in reports of SHS exposure from cigarettes, electronic tobacco devices, and marijuana. The number of cigarette and other tobacco users reporting quit attempts or who have quit in the past year should also increase (see Secondhand Smoke Multiunit Housing Logic Model, Figure 2).

For the behavioral health and SHS evaluations, CTCP plans to collect qualitative and quantitative data over the course of the grant to demonstrate progress on the above strategies and outcomes from these efforts. Evaluation plans are in Tables A1 and A3. Evaluation questions and indicators are in Tables B1 and B3. These data will enable CTCP to answer the overarching CDC-required evaluation questions on program effectiveness and outcomes for Focus Area 1 and policy-related outcomes and unintended consequences for Focus Area 3.

Program Logic Models – Component 1

Figure 1: Component 1, Focus Area 1 Logic Model: State-Based with focus on Behavioral Health

Inputs: CDC funding; Proposition 56-funded California Behavioral Health and Wellness Initiative (12 CTCP-funded behavioral health/substance use sites and evaluation)

Key program strategy: Promote health systems changes in behavioral health care facilities to encourage and support screening and treatment of tobacco use and dependence

CDC Y1 Activities	Outputs	Short-term Outcomes	Intermediate Outcomes	Long-term Outcomes
• Release solicitation for substance use/behavioral health facilities to create tobacco-free campuses, increase tobacco use dependence screening, and treatment assistance to clients. • Engage county behavioral health administrators/providers • Update model tobacco-free campus policy language and train behavioral health facilities on tobacco-free campus policies, including assessment and treatment of tobacco use dependence • Promote integration of tobacco use dependence treatment interventions and tobacco-free campus policies in behavioral health treatment settings • Assess policy strength and implementation at behavioral health and substance use facilities	• Updated model policy developed • Policy makers and behavioral health facility administrators educated on integration of tobacco use assessment/treatment in policies • Policy makers and behavioral health facility administrators engaged in creating tobacco-free campus policies and assessment/treatment protocols • Substance use/behavioral health treatment facilities funded to adopt policies for tobacco-free campuses and implement tobacco use dependence assessment and treatment	• Increased number of counties that require tobacco-free campus policies adoption • Increased awareness of tobacco-related disparities among those providing behavioral health services • Increased support for tobacco use dependence screening/treatment in behavioral health and substance use treatment facilitates • Increased capacity to deliver tobacco use treatment in behavioral health and treatment facility settings • Increased understanding of organizational barriers to receiving substance use treatment for priority populations.	• Increased number of behavioral health and substance use treatment facilities offering tobacco use screening and treatment • Increased number of behavioral health/substance use treatment facilities adopting tobacco-free campus policies • Increased number of tobacco use dependence screening at facilities with tobacco-free campus policies • Increased number of quit attempts among behavioral health and substance use treatment facility patients • Increased NRT compliance among facility clients	• Increased proportion of behavioral health and/or substance use treatment facility patients who quit tobacco use • Decreased tobacco use prevalence among adults with behavioral health and/or substance use challenges

Environmental contexts: High rates of tobacco use among behavioral health population, health risks among individuals in behavioral health/substance use treatment facilities in CA, competing treatment priorities, need for policy development to promote tobacco cessation, state tobacco control funding, varied tobacco cessation insurance coverage landscape, existing attitudes and norms related to tobacco use among those seeking or providing treatment at behavioral health/substance use treatment facilities

Note: “Tobacco use” includes combustible and non-combustible tobacco products, including e-cigarettes, vapes, vape pens, smokeless tobacco, cigars, and cigarillos. “Tobacco use” excludes traditional and ceremonial use of tobacco.

Figure 2: Component 1, Focus Area 3 Logic Model: Comprehensive Smokefree Policies in Multiunit Housing

Inputs: CDC funds, Local Lead Agencies (LLAs)

Key program strategy: Strategy MUH (insert strategy from CDC workplan)

CDC Y1 Activities	Outputs	Short-term Outcomes	Intermediate Outcomes	Long-term Outcomes
• Network at conferences with housing industry and local governments to educate them on multiunit housing policies • Host monthly calls with CTCP-funded projects to develop policies to restrict tobacco use in multiunit housing • Develop comprehensive smokefree model policy (including tobacco, cannabis, and e-cigarette) • Develop toolkit related to indoor cannabis and e-cigarette use • Conduct webinars for city attorneys and policymakers related to secondhand smoke (SHS) laws	• Partnerships with local government and housing developers on comprehensive smokefree multiunit housing policies • Capacity-building opportunities and trainings related to comprehensive smokefree policies in multiunit housing identified for CTCP-funded projects and their partners • Comprehensive smokefree multiunit housing model policy created • Toolkit created on indoor cannabis and e-cigarette use • Policymakers and city attorneys trained on SHS laws related to tobacco, cannabis, and vaping	• Increased capacity for SHS policy enforcement in multiunit housing • Increased number of jurisdictions interested in creating comprehensive smokefree multiunit housing policies • Increased partnerships with multiunit housing developers interested in creating comprehensive smokefree policies • Increased readiness of CTCP-funded projects to create policies to restrict smoking in multiunit housing	• Increased number of jurisdictions that adopt comprehensive smokefree policies for multiunit housing that include tobacco, marijuana, and vaping definitions • Increased prevalence of smokefree homes among those who live in MUH • Increased proportion of California population covered by comprehensive multiunit housing policies • Increased proportion of California priority populations covered by comprehensive multiunit housing policies	• Decreased prevalence of tobacco SHS exposure in the home in the last two weeks • Decreased prevalence of secondhand e-cigarette vapor exposure in the home in the last two weeks • Decreased prevalence of secondhand cannabis smoke exposure in the home in the last two weeks

Environmental contexts: State excise tax, state tobacco control funding, tobacco industry spending, secondhand smoke/vapor media campaigns, tobacco retailer laws, existing multiunit housing policies regarding tobacco use at the local level or as private housing policy

Note: “Tobacco use” includes combustible and non-combustible tobacco products, including e-cigarettes, vapes, vape pens, smokeless tobacco, cigars, and cigarillos. “Tobacco use” excludes traditional and ceremonial use of tobacco. “Comprehensive smokefree policies” include tobacco, cannabis, and electronic smoking devices.

Table A1: Evaluation Plan Overview – Component 1, Focus Area 1

OMB Control Number: 0920-1132
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1. Federal Agency, Center, and Division to Which Report is Submitted:	2. Federal NOFO or Other Identifying Number Assigned by Federal Agency:	3. Name of Submitting Organization	4. Reporting Period
Centers for Disease Control and Prevention (CDC), Office on Smoking and Health (OSH)	CDC NOFO 20-2001	California Department of Public Health, Center for Healthy Communities, California Tobacco Control Program	Years 1-5

A. Evaluation Plan Overview

1. Strategies to Evaluate*:* Select strategies from your work plan that you would like to evaluate during the funding period.

☒Promote health systems changes in behavioral health care facilities to encourage and support screening and treatment of tobacco use and dependence

2. Overall Evaluation Approach and Context: Describe the general approach that you will undertake to evaluate these strategies. Provide information on relevant contextual factors for your program, such as how the program is situated in your state and how it connects to other programs or initiatives.

Evaluation Approach: CTCP will use a mixed methods approach, combining qualitative and quantitative methods. CTCP will primarily use program data and reports to monitor progress. Outcome data will use a combination of report data and population-level data drawn from probability-based samples that reflect the population of California. Evaluation questions and approaches to answer those questions are explained in Table B, below. The proposed questions and methods also align with CDC's Framework for Evaluation and utilize a health equity approach by being mindful populations facing tobacco use disparities; in this case, those seeking behavioral health and substance use treatment.

Evaluation and Programmatic Contexts: CTCP recently celebrated its 30th year of working toward ending tobacco commercial use in the state. Recently, the program has shifted toward a strategy to end commercial tobacco in the state by 2035. To move this strategy forward, CTCP specifically works toward health equity through targeted tobacco efforts with multiple priority populations, as defined in the introduction. Toward that end, CTCP's NOFO 20-2001 workplan works specifically with behavioral health and substance use treatment facilities to address tobacco use and cessation. In 2019, the California Health Interview Survey estimated that among those who likely had serious psychological distress in the last 30 days, 10.4 percent were current smokers compared to 6.6 percent who did not have a serious psychological issue. Among those who sought help for a behavioral health or substance use

issue, 9.2 percent were current smokers.[7] California behavioral health facilities only screen for tobacco use 37.6 percent of the time compared to the national average of 48.9 percent, and only 41.2 percent of behavioral health facilities in California are smokefree versus 48.6 percent of facilities nationally. Among substance use treatment facilities, those in California screen for tobacco only 51.5 percent of the time, below the national average of 64.0 percent. Similarly, only 22.4 percent of California substance use facilities are tobacco-free compared to 34.5 percent nationally.[8] Tobacco use is often not addressed in behavioral health settings often due to lack of training in smoking cessation, beliefs that clients are not interested in quitting smoking, and the concern that stopping smoking may interfere with addiction treatment.[9] Further, given the low priority placed on smoking cessation, the limited avenues for reimbursement of tobacco services, and the elevated smoking prevalence among staff in recovery from drug use, only 29 percent of substance use disorder treatment programs nationally offer any smoking cessation services to clients.[10]

CTCP plans to engage behavioral health and substance use programs to integrate tobacco use screening, referral, and treatment over the next five program years. In the first program year, CTCP plans to develop model policy language for tobacco-free behavioral health and substance use treatment campuses/facilities. CTCP will release one request for applications from behavioral health/substance use facilities to support the creation of up to 15 tobacco-free campuses and to increase tobacco-use screening and provide tobacco use treatment services for clients. Furthermore, CTCP will engage behavioral health administrators at the county level to identify and prioritize approaches to creating tobacco-free behavioral health treatment campuses and to integrate tobacco use screening and treatment into those sites' workflows.

The planned behavioral health activities fit into the overall context of creating a commercial tobacco-free California by 2035 in multiple ways. First, it targets those with behavioral health and substance use issues, a high tobacco-use priority group, by promoting screening of tobacco use and cessation opportunities, while other parts of CTCP's programmatic efforts address other priority populations simultaneously. Second, this work helps to meet CTCP's goal to address health equity through decreasing tobacco use among those seeking assistance with behavioral health and/or substance use issues. Additional contextual factors include the 12 quality improvement projects at behavioral health/substance use facilities funded by CTCP to create tobacco-free campuses and increase screening and treatment opportunities, plus other work underway with CTCP-funded initiatives. The CDC NOFO 20-2001 helps to augment the work of these funded facilities.

3. Evaluation Stakeholders and Primary Intended Users of the Evaluation: Describe individuals or groups who have a stake in the evaluation and who will use the evaluation results. Include a brief description of how you have (or plan to) engaged these evaluation stakeholders.

Intended Users include internal CTCP staff, Behavioral Health County Administrators, Behavioral Health and Substance Use treatment facility staff, and the California Department of Health Care Services which administers the state's substance use disorder

treatment system. Potential additional users include patient advocacy organizations (e.g., Mental Health America of California) and other behavioral health/substance use patient groups.

Engagement: Internal CTCP program staff and evaluators hold monthly meetings on programmatic progress to provide input and feedback for the evaluation. Each funded local behavioral health/substance use treatment facility is also responsible for individually managing local-level evaluation questions. Some of this data will be used to inform the state-level evaluation as part of the reporting for CDC NOFO 20-2001. Additional external evaluation stakeholders (e.g., CTCP's Evaluation Task Force) will assist in the interpretation of evaluation findings and help chart next steps related to programmatic improvement.

4. Communication/Dissemination: Describe your broad plans for communicating/sharing your findings and provide examples of products that you will develop. Describe how your evaluation results or findings will be published on a publicly available website.

CTCP evaluators will share evaluation findings annually with internal and external CTCP stakeholders and interim results/findings as appropriate. Potential products include presentations, infographics, and factsheets for use on social media channels and websites. As appropriate, peer-reviewed manuscripts will be developed. If required, CTCP will develop health impact statements as part of the CDC reporting. Additionally, findings will be disseminated via Tobacco Education and Research Oversight Committee meetings.

5. Use of Evaluation Findings: Describe how your evaluation findings will be used to ensure continuous quality and programmatic improvement.

To assure continuous quality and programmatic improvement, CTCP evaluation staff meet with program staff regularly to discuss and interpret evaluation findings related to its behavioral health and substance use work. Internal monthly calls are held with program staff to discuss programmatic improvement efforts and findings from the evaluation. External stakeholders, such as the CTCP Evaluation Task Force, will help to interpret findings to assist with developing programmatic improvement. This is discussed further below under the "Use of evaluation findings" table at the end of the Component 1 section.

6. Health Impact*:* Describe here what you want to be able to say about the contribution of your program to changes in health, behavior, or environment in a defined community, population, organization, or system by the end of the cooperative agreement. Consider what types of evaluation you will need to conduct in years 4, 3, 2, 1 if you want to be able to report health impact at the end of the cooperative agreement in year 5.

CTCP expects to find changes in tobacco use and behaviors and environmental changes throughout the grant period. In Years 1-3, CTCP expects to see environmental impacts related to behavioral health and substance use treatment facilities through the increase in the number of sites creating tobacco-free campuses and increased provision of tobacco use screening and treatment (nicotine replacement therapy and/or pharmacotherapies). CTCP expects to find changes in self-reported tobacco use behaviors among those who engage in behavioral health and substance use treatment, primarily engagement in cessation services and number of those in service to have quit smoking while in treatment. In the long-term, CTCP hopes to demonstrate a change in the past 30-day tobacco

use prevalence among those reporting behavioral health challenges and substance use, therefore working toward decreased tobacco use disparities among those living with behavioral health and/or substance use issues.

Table B1: Evaluation Design and Data Collection Matrix – Component 1, Focus Area 1

1. Strategy-Specific Evaluation Approach and Context: For the behavioral health evaluation, CTCP will employ a mixed methods approach. CTCP will collect qualitative data on barriers, facilitators, and promising practices at different time points during the grant period to understand the challenges and opportunities to expand tobacco cessation options for those in behavioral health settings as well as the creation of tobacco-free campuses. CTCP will initially collect data related to program processes to show programmatic growth or change over time, then measure the reach and success of capacity-building activities through the number of policies adopted, the reach of those policies, and whether those policies affected tobacco use among those who accessed behavioral health and/or substance use facilities.

2. Strategy: Promote health systems changes in behavioral health care facilities to encourage and support screening and treatment of tobacco use and dependence

3. Activity(s): Collect and analyze data from a variety of sources to understand reach and impact of the programs work, detailed below.

4. Evaluation Questions	**5. Indicator(s)**	**6. Data Source**	**7. Data Collection Method**	**8a. Data Collection Start**	**8b. Data Collection End**	**9. Data Analysis**	**10. Person(s) Responsible**
What you want to know. NOTE: Bolded questions refer to CDC's required effectiveness and outcomes questions.	*A specific, observable, and measurable characteristic or change that shows progress toward achieving a specified objective or outcome.* NOTE: Bolded indicators are CDC-provided	*Where you will collect the data (i.e. program records, surveys, etc.).* *List a source for each indicator.*	*How you will collect the data (i.e. abstraction from spreadsheet, database, etc.).*	*When will you start data collection?*	*When you will end data collection.*	*What type of analysis will you apply to the data (i.e. descriptive statistics, thematic analysis)?*	*Who is responsible for collecting the data for this indicator?*
PROCESS INDICATORS							
How many behavioral health/substance use (BH/SU) treatment facilities were sent the tobacco-free campus model policy?	Number of BH/SU facilities sent the model policy	Smoking Cessation Leadership Center program reports	Count abstracted from reports	2021	2023	Descriptive statistics (counts)	CTCP Evaluation Unit (EU); CTCP Community & Statewide Initiatives Section (CSI); Smoking Cessation Leadership Center (SCLC; Contractor)

What were barriers and facilitators to implementing tobacco-free campus policies, tobacco use screening, and tobacco cessation treatment at BH/SU facilities?	Barrier and facilitator themes	Behavioral Health Initiative Evaluation reports	Abstracted from evaluation findings	2021	2022	Thematic analysis	EU; University of California San Francisco (UCSF; (Contractor)
How many technical assistance requests were received regarding BH/SU tobacco-free campus policies?	Number of requests initiated	Smoking Cessation Leadership Center program reports	Count abstracted from reports	2021	2023	Count	EU; CSI; SCLC
How has the number of behavioral health and substance use treatment facilities providing tobacco treatment changed over time statewide?	Percentage of facilities with tobacco screening and/or cessation services over time	SAMSHA N-SSATS & N-MHSS Databases (secondary datasets)	Survey Public Use Files	2020	2025	Descriptive statistics (percentages)	EU; CTCP Surveillance Unit (SU)
How many people utilizing BH/SU facilities did tobacco-free policies reach?	Sum of clients at all facilities	Behavioral Health Initiative Evaluation; SAMHSA N-SSATS and N-MHSS Databases (secondary datasets)	Evaluation report; Survey Public Use Files	2020	2025	Descriptive statistics (count)	EU; SU; UCSF (Contractor)
EFFECTIVENESS QUESTIONS							
Which evidence-based strategies, promising practices, and/or culturally tailored interventions were effective (or not effective) at reaching and improving positive tobacco-related outcomes among those accessing BH/SU facilities?	County behavioral health administrator and BH/SU administrator survey responses	Survey	Survey database	2022	2025	Descriptive statistics and qualitative thematic analysis	EU; Contractor (TBD)

OUTCOME QUESTIONS							
To what extent did recipient efforts increase use of evidence-based cessation treatment at behavioral health and substance use facilities?	Number of behavioral health and substance use organizations that received capacity building assistance from CTCP/contractor that includes pharmacotherapy or nicotine replacement therapy	CTCP program data; SAMHSA Behavioral Health Treatment Services Locator	Spreadsheet abstracted from CTCP program data and SAMHSA database	2023	2025	Descriptive statistics	EU
To what extent did recipient efforts increase quit attempts and sustained quits (7-month) among those accessing behavioral health and substance use facilities?	Proportion of those accessing BH/SU services who report a quit attempt and a successful quit at 7-month follow-up	Patient survey and follow-up survey	Survey database	2023	2025	Descriptive statistics	EU; Contractor (TBD)
To what extent did recipient efforts reduce tobacco use and dependence among those experiencing mental health and/or substance use problems?	**Proportion of adults aged 18 years or older who experienced psychological distress in the past 30 days who have smoked at least 100 cigarettes in their lifetime and who now report smoking cigarettes every day or some days***	CHIS (secondary dataset)	CHIS Dataset	2020	2025	Descriptive statistics/Trend analysis	EU; SU

Table A3: Evaluation Plan Overview – Component 1, Focus Area 3

OMB Control Number: 0920-1132
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1. Federal Agency, Center, and Division to Which Report is Submitted:	2. Federal NOFO or Other Identifying Number Assigned by Federal Agency:	3. Name of Submitting Organization	4. Reporting Period
Centers for Disease Control and Prevention (CDC), Office on Smoking and Health (OSH)	CDC NOFO 20-2001	California Department of Public Health, Center for Healthy Communities, California Tobacco Control Program	Years 1-5

A. Evaluation Plan Overview

1. Strategies to Evaluate*:* Select strategies from your work plan that you would like to evaluate during the funding period.

☐Increase and enhance comprehensive smoke-free policies, including in workplaces, bars, and restaurants

☒Increase policies for smoke-free housing, including federally- assisted, multi-family properties and Section 8, coupled with promotion of evidence-based cessation treatment and resources

2. Overall Evaluation Approach and Context: Describe the general approach that you will undertake to evaluate these strategies. Provide information on relevant contextual factors for your program, such as how the program is situated in your state and how it connects to other programs or initiatives.

Evaluation Approach: CTCP will rely on quantitative methods to examine process and outcomes from its comprehensive smokefree multiunit housing (MUH) policy work drawing on a combination of internal CTCP data and population-level data drawn from probability-based samples that reflect the population of California. Evaluation questions and approaches to answer those questions are explained in Table B, below. The proposed questions and methods align with CDC's Framework for Evaluation and utilize a health equity approach by being mindful of populations facing tobacco use disparities; in this case, among priority populations covered by comprehensive smokefree MUH policies. An estimated 26.8 percent of Californians live in MUH buildings with three or more units per building, however, larger proportions of Latinos (28.2 percent), African Americans (40.9 percent), American Indian/Alaska Natives (36.1 percent), Asians (29.0 percent), and Native Hawaiians/Pacific Islanders (39.8 percent) live in such dwellings. Nearly half of gay/lesbian (46 percent) and bisexual (44.6 percent) also live in MUH.[4]

Evaluation and Programmatic Contexts: CTCP recently celebrated its 30th year of working toward ending tobacco use in the state. Recently, the program has shifted toward a strategy to end commercial tobacco in the state by 2035. As part of shifting its strategy,

CTCP will expand its work to prevent secondhand smoke (SHS) exposure. Specific to CDC NOFO 20-2001, CTCP plans to increase comprehensive smokefree (MUH) policy adoption during the grant period that address smoke from tobacco and cannabis, as well as vapor from electronic smoking devices. Data from the 2019 California Health Interview Survey (CHIS), a large population-based survey, shows 44.1 percent of California adults had been exposed to SHS in the past year. Exposure to SHS also differed by race/ethnicity, with 54.0 percent of Native Hawaiians and other Pacific Islanders, 60.9 percent of multiracial people, 71.2 percent of American Indian/Alaska Natives, 45.8 percent of Latinos, and 48.4 percent of African Americans reporting exposure. Over 60 percent (60.5 percent) of gay and lesbian people and 62.6 percent of bisexual identified people reported SHS exposure in the same time period compared to 43.1 percent of their heterosexual/straight counterparts.

While CTCP's Year 1 workplan states the strategy selected for its SHS policy work will be primarily related to worksites, work is underway and will continue through the end of CDC 20-2001 on increasing comprehensive smokefree MUH policies (Strategy 3: Increase policies for smokefree housing, including federally assisted, multi-family properties and Section 8, coupled with promotion of evidence-based cessation services and resources.) Subsequent workplans will identify Strategy 3 moving forward. In Year 1, CTCP plans to participate in housing conferences to discuss comprehensive smokefree MUH policies with housing developers/industry representatives and policymakers. The program also hosts monthly calls with approximately 10-20 funded organizations to identify needs related to developing, disseminating, implementing, and enforcing comprehensive smokefree MUH policies. To ensure policies are comprehensive, CTCP will develop and disseminate a model policy and a toolkit which address indoor cannabis and vaping. CTCP plans to increase enforcement capacity by training policy makers and city attorneys on existing laws related to indoor tobacco, cannabis, and vape use.

Within the context of the End Commercial Tobacco Campaign, CTCP's policy activities will help decrease exposure to SHS of all types. In concert with cessation activities targeting a variety of populations with tobacco use disparities (i.e., racial/ethnic groups and youth; see Component 2), work related to comprehensive smokefree MUH policies can further reduce SHS exposure among populations who are exposed at a higher rate than average by reducing the number of locations where that exposure can occur.

3. Evaluation Stakeholders and Primary Intended Users of the Evaluation: Describe individuals or groups who have a stake in the evaluation and who will use the evaluation results. Include a brief description of how you have (or plan to) engaged these evaluation stakeholders.

Intended Users include Internal CTCP staff, local lead agency staff, housing developers and management companies, policymakers, and city attorneys. Additional potential users include MUH residents and community groups.

Engagement: Internal CTCP program staff and evaluators hold monthly meetings on programmatic progress and program staff are able to provide input and feedback for the evaluation. Additional external stakeholders (e.g., CTCP's Evaluation Task Force) will assist in the interpretation of evaluation findings and help chart next steps related to programmatic improvement.

4. Communication/Dissemination: Describe your broad plans for communicating/sharing your findings and provide examples of products that you will develop. Describe how your evaluation results or findings will be published on a publicly available website.

CTCP evaluators will share evaluation findings annually with internal CTCP stakeholders and external stakeholders as needed. Potential products include presentations, infographics, and factsheets for use on social media channels and websites Impact statements will also be used as part of CTCP's reporting to CDC. Additionally, findings will be disseminated via Tobacco Education and Research Oversight Committee meetings.

5. Use of Evaluation Findings: Describe how your evaluation findings will be used to ensure continuous quality and programmatic improvement.

To assure continuous quality and programmatic improvement, CTCP program staff will meet to discuss and interpret evaluation findings related to its comprehensive smokefree MUH policy work. Internal monthly calls are held with all CTCP-related program staff and evaluators to discuss programmatic improvement efforts and findings from the evaluation. External stakeholders, such as the CTCP Evaluation Task Force, will help to interpret findings to assist with developing programmatic improvement. This is discussed further below under the "Use of evaluation findings" table at the end of the Component 1 section.

6. Health Impact*:* Describe here what you want to be able to say about the contribution of your program to changes in health, behavior, or environment in a defined community, population, organization, or system by the end of the cooperative agreement. Consider what types of evaluation you will need to conduct in years 4, 3, 2, 1 if you want to be able to report health impact at the end of the cooperative agreement in year 5.

CTCP aims to see a decrease in SHS exposure throughout the grant period. In the first few years, CTCP expects the primary impact will be increases in comprehensive smokefree MUH policies adopted by local jurisdictions, which will impact the number of MUH residents covered by such policies. Subsequently, CTCP expects to find an increase in the number of households that have rules about smoking and vaping indoors among those who live in apartment complexes; decreased SHS exposure overall among California adults who live in smokefree MUH; and, decreased SHS exposure disparities among adults who live in smokefree MUH facilities. Further, priority populations living in MUH would report lower exposure to SHS and/or decreases in smoking rates.

Table B3: Evaluation Design and Data Collection Matrix – Component 1, Focus Area 3

1. Strategy-Specific Evaluation Approach and Context: CTCP will employ a mixed methods approach to understand the successes and unintended consequences resulting from comprehensive smokefree MUH policies passed. Comprehensive smokefree policies include tobacco, cannabis, and e-cigarettes, such as vape pens. Policies will be qualitatively assessed to understand their content, then quantified to understand the number of policies and types adopted during the grant period using CTCP's internal tracking system. CTCP will also quantify the number and reach of comprehensive smokefree MUH policies by jurisdiction. To examine intended outcomes, CTCP will monitor SHS exposure using state-funded surveillance systems. To understand both intended and unintended consequences, CTCP will monitor SHS exposure by selected populations (i.e., racial/ethnic groups) to ensure SHS exposure disparities are not further exacerbated at the state-level, county, or jurisdictional level (depending on quality and availability of data) using state-funded surveillance systems.

2. Strategy: Increase policies for smoke-free housing, including federally- assisted, multi-family properties and Section 8, coupled with promotion of evidence-based cessation treatment and resources

3. Activity(s): We plan to collect and analyze data from a variety of sources to understand reach and impact of the programs work, detailed below.

4. Evaluation Questions	5. Indicator(s)	6. Data Source	7. Data Collection Method	8a. Data Collection Start	8b. Data Collection End	9. Data Analysis	10. Person(s) Responsible
What you want to know. NOTE: Bolded questions refer to CDC's required outcomes and intended/unintended consequences questions.	*A specific, observable, and measurable characteristic or change that shows progress toward achieving a specified objective or outcome.* Note: Bolded indicators are CDC recommended	*Where you will collect the data (i.e. program records, surveys, etc.).* *List a source for each indicator.*	*How you will collect the data (i.e. abstraction from spreadsheet, database, etc.).*	*When will you start data collection?*	*When you will end data collection.*	*What type of analysis will you apply to the data (i.e. descriptive statistics, thematic analysis)?*	*Who is responsible for collecting the data for this indicator?*
PROCESS INDICATORS							
How many Communities of Practice calls were held annually?	Count of calls	CTCP staff report	Email; spreadsheet	2020	2025	Descriptive statistics (counts)	EU; CSI
How many webinars were conducted on comprehensive smokefree multiunit housing related to tobacco, cannabis, and electronic smoking devices?	Count of webinars conducted	CTCP staff report	Email; spreadsheet	2020	2025	Descriptive statistics (counts)	EU; CSI
OUTCOMES QUESTIONS							

4. Evaluation Questions	5. Indicator(s)	6. Data Source	7. Data Collection Method	8a. Data Collection Start	8b. Data Collection End	9. Data Analysis	10. Person(s) Responsible
What impact did the policy change have on Increasing protection from secondhand smoke? For which priority populations?	**Number and proportion of Californians (and by priority population) covered by comprehensive smokefree MUH policies**	Policy Evaluation Tracking System (PETS) Database	Database extraction	2021	2025	Descriptive statistics (counts and percentages)	EU
How many and what types of jurisdictions adopted comprehensive smokefree multiunit housing policies?	Count and proportion of jurisdictions by type (e.g., unincorporated county, city) with comprehensive smokefree MUH policies	PETS Database	Database extraction	2021	2025	Descriptive statistics (counts)	EU
What impact did the policy change have on reducing exposure to secondhand smoke?	Number and proportion of Californians reporting secondhand smoke (tobacco, e-cigarette vapor, and marijuana) exposure	California Adult Tobacco Survey (CATS)	Database extraction	2020	2025	Descriptive statistics (count/ percentages) and inferential statistics (trend analysis)	EU; CTCP Surveillance Unit
INTENDED/UNINTENDED CONSEQUENCE QUESTIONS							
What effect did the policy change have overall, and as appropriate among racial/ethnic groups experiencing tobacco-related disparities?	Number and proportion of Californians reporting secondhand smoke (tobacco, e-cigarette vapor, and marijuana) exposure by race/ethnicity	CATS	Database extraction	2020	2025	Descriptive statistics (counts/ percentages); inferential statistics (chi-square tests; trend analyses)	EU; CTCP Surveillance Unit
To what extent were there unintended consequences (e.g., exacerbating disparities or disproportionately benefiting population groups)?	Policy coverage and strength by priority population	PETS	Database extraction	2023	2025	Descriptive statistics	EU; Cal-EIS Fellow

Use of Evaluation Findings

Below, we provide a table that lists key stakeholders and the process we plan to implement to assure continuous use of findings:

Key Stakeholder	**Processes for Use of Findings**
CTCP Evaluation Task Force (ETF)	Distribute key evaluation findings and lessons learned via CDC reports and other evaluation products. ETF can provide guidance on current trends in tobacco research and evaluation methods. CTCP Evaluation and Surveillance Section meets with ETF at least annually where updates on evaluation proposals, projects, and findings are presented and feedback is provided.
Tobacco Education and Research Oversight Committee (TEROC)	Distribute key evaluation findings via TEROC reports to help inform future programmatic and evaluation efforts. TEROC is convened quarterly and is kept apprised of all programmatic and evaluation efforts on an ongoing basis.
Internal CTCP 20-2001 program staff	CTCP evaluation staff hold monthly meetings with other CTCP staff working on CDC deliverables and provide updates on evaluation project status and preliminary evaluation findings. CTCP evaluation staff will distribute key evaluation findings and consult with other CTCP staff on programmatic questions germane to the evaluation plan, including, but not limited to, needed changes in the approach to the evaluation and suggestions for programmatic modifications.
CTCP-funded and partnering agencies, including behavioral health facilities, SHS policymakers, policy implementers, and patient advocacy groups (e.g., Mental Health America of California)	Distribute key evaluation findings and lessons learned via CTCP staff to demonstrate progress on key indicators and areas for programmatic improvement, including, but not limited to, information on tobacco-free behavioral health facilities, availability of cessation services at behavioral health facilities, and reduction in SHS exposure across priority populations.

Component 2
Evaluation Focus Area

CTCP proposed activities under multiple strategy areas in its workplan, four of which are eligible for evaluation under the Quitline Evaluation Requirement (Component 2, Focus Area 4). Of the four strategies, CTCP evaluators selected coupled strategies to evaluate over the course of CDC 20-2001: “Increase public-private partnerships to reimburse and/or pay for evidence-based cessation treatment and support quitline sustainability” and “Implement culturally appropriate, evidence-based strategies to reduce tobacco-related disparities and increase utilization of quit support services.” The reason for selecting these two strategies are twofold. First, increased referral and reimbursement of California Smokers’ Helpline (CSH) services, especially the provision of nicotine replacement therapy and/or pharmacotherapies, can provide an incentive for current tobacco users with a low-cost/no-cost solution to aid in their quit attempt. Second, utilizing culturally competent based outreach strategies can lead to increased utilization of CSH services by various populations, which can lead to an overall decrease in tobacco use and exposure to SHS.

For the first strategy, CTCP plans to collect qualitative and quantitative process data that seeks to understand how CTCP’s efforts impact the expansion of health care plans offering reimbursement for CSH services and whether health systems implemented tobacco use disorder screening, referral, and treatment. For the second strategy, CTCP will collect quantitative and qualitative process data to examine the promotion of CSH services to different priority populations (e.g., those accessing Medi-Cal, California’s Medicaid program; youth who vape). CTCP plans to provide training to organizations and health systems providing services to priority populations (e.g., federally-qualified health centers; those working with youth; community- and tribal-based clinics) on increasing screening for tobacco use and referral to CSH. Outcomes expected from these activities include, but are not limited to, increased awareness of cessation resources, increased cessation referral, and increased availability of cessation tools, ultimately leading to increased cessation attempts and successful quits. See the Logic Model (Figure 3, below) outlining the programmatic logic for these strategies and activities.

To assess outcomes, CTCP will rely on quantitative methods using program data and population-based surveys to assess quit attempts and quit successes over time. While not directly collecting data as part of this evaluation project on diversification of cessation modalities (e.g., text; online support), CTCP will work with CSH to report this data as part of the Performance Measures in the annual evaluation report. The evaluation plan is further discussed in Table A4 and a list of the progress and outcome indicators, data sources, and methods are provided in Table B4, both of which are below.

Program Logic Model – Component 2

Figure 3: Component 2, Focus Area 4 Logic Model: California Smokers' Helpline

Inputs: CDC funding; California Proposition 56 funds

Key program strategies: Increase public-private partnerships to reimburse and/or pay for evidence-based cessation treatment and support quitline sustainability; Implement culturally appropriate, evidence-based strategies to reduce tobacco-related disparities and increase utilization of quit support services

CDC Y1 Activities	Outputs	Short-term Outcomes	Intermediate Outcomes	Long-term Outcomes
• Partner with health systems to promote screening, referrals, and NRT • Develop and disseminate materials on motivational interviewing and referral to the California Smokers Helpline (CSH) Quit Vaping resources and services for adults working with youth. • Provide educational outreach to community health providers on culturally-appropriate cessation services • Increase proactive outreach to low-income populations through the 211 systems to provide CSH referrals	• Providers trained to make referrals via the e-referral system • Health care systems implementing screenings for tobacco use and referral protocols • Disseminated materials on CSH services to priority populations • Disseminated materials to adults who work with youth to refer to CSH • Trained providers and community health professionals on culturally-appropriate cessation resources, including CSH • Funded 211 systems to refer to CSH	• Increased awareness of CSH and CSH cessation resources among providers • Increased awareness of CSH and CSH cessation resources among tobacco users and priority populations • Increased number of health with NRT cost-sharing agreements • Increased number of health systems implementing tobacco screening and referral protocols • Increased CSH referrals from health systems serving priority populations • Increased CSH referrals from 211 systems • Increased number of priority population callers to CSH	• Increased diversification of referral sources to CSH services • Increased CSH intake among priority populations • Increased diversification of CSH modalities used • Increased intent to quit tobacco use among priority populations • Increased quit attempts among tobacco users from priority populations	• Increased cessation among current tobacco users • Increased number of CSH users who report quit success at 7-month follow-up • Decreased tobacco use prevalence among adults and youth • Decreased tobacco use disparities among priority populations

Environmental contexts: State excise tax rates, rates of tobacco use and intent to quit, state tobacco control funding, tobacco cessation reimbursement/coverage, tobacco industry spending, cessation media campaigns, seasonality (New Year's), CSH modalities

Note: "Tobacco use" includes combustible and non-combustible tobacco products, including e-cigarettes, vapes, vape pens, etc. "Tobacco use" excludes traditional and ceremonial use of tobacco.

Table A4: Evaluation Plan Overview – Component 2, Focus Area 4

OMB Control Number: 0920-1132
Expiration Date: XX/XX/XXXX

1. Federal Agency, Center, and Division to Which Report is Submitted:	2. Federal NOFO or Other Identifying Number Assigned by Federal Agency:	3. Name of Submitting Organization	4. Reporting Period
Centers for Disease Control and Prevention (CDC), Office on Smoking and Health (OSH)	CDC NOFO 20-2001	California Department of Public Health, Center for Healthy Communities, California Tobacco Control Program	Years 1-5

A. Evaluation Plan Overview

1. Strategies to Evaluate*:* Select strategies from your work plan that you would like to evaluate during the funding period.

- ☐Implement and expand delivery of tobacco use and dependence treatment services, including quitline and digital-based technologies, such as text and/or web services
- ☒Increase public-private partnerships to reimburse and/or pay for evidence-based cessation treatment and support quitline sustainability
- ☒Implement culturally appropriate, evidence-based strategies to reduce tobacco-related disparities and increase utilization of quit support services
- ☐Implement tailored and/or culturally appropriate evidence-based mass-reach health communications strategies, including paid and/or earned media, to increase cessation and/or promote the quitline among populations experiencing tobacco-related disparities

2. Overall Evaluation Approach and Context: Describe the general approach that you will undertake to evaluate these strategies. Provide information on relevant contextual factors for your program, such as how the program is situated in your state and how it connects to other programs or initiatives.

Evaluation Approach: CTCP will use a mixed methods approach to examine how efforts related to expanding partnerships with health plans to increase cost-sharing for California Smokers Helpline (CSH) activities, combined with coverage of nicotine replacement therapy/pharmacotherapies and increased outreach and training to reach priority populations, can yield increased sustained quits. CTCP will use qualitative and quantitative methods to answer evaluation questions, including CDC-required evaluation questions on service effectiveness and modalities, quit attempts and sustained quits, including changes in quit attempts and sustained quits overall and among the priority populations. CTCP will draw upon program data and reports to monitor progress and outcomes data. Additionally, CTCP will use population-level data drawn from probability-based samples that reflect priority

populations. Evaluation questions and approaches to answer those questions are more fully explained in Table B, below. The proposed questions and methods also align with CDC's Framework for Evaluation and utilize a health equity approach by being mindful of the populations experiencing tobacco use disparities.

Evaluation and Programmatic Contexts: CTCP was a driver for the creation of the California Smokers' Helpline (CSH) in 1992 in English and Spanish, and then expanded to four Asian language dialects in 1994.[1] Since that time, CSH has diversified the modalities and services to include digital cessation services (e.g., online chat) and electronic provider referrals. Quitline call volume has decreased both in California and nationally.[11] However, CTCP's quitline evaluation (CDC DP 14-1410) findings showed that the proportion of callers from priority populations increased, including among Hispanic/Latinos, Asians, and those who are living with a mental health condition. Results also indicated an increase in electronic referrals from providers to CSH. In addition, a significant increase was found in the proportion of callers who access Medi-Cal between FY2014 (61.1 percent) to FY2019 (70.9 percent).[4]
In order to evaluate efforts to decrease tobacco use disparities, CTCP will evaluate two coupled quitline strategies. Work commencing on the first strategy, "Increase public-private partnerships to reimburse and/or pay for evidence-based cessation treatment and support quitline sustainability", will aim to increase call volume and provide instrumental support to current tobacco users/vapers through reimbursement for nicotine replacement therapies, while also maintaining outreach to Medi-Cal members. Work in the second strategy, "Implement culturally appropriate, evidence-based strategies to reduce tobacco-related disparities and increase utilization of quit support services", will expand outreach and referral for youth and other priority populations through the development of educational materials, trainings on culturally competent/appropriate cessation methods, and further referral services via county 2-1-1 call center providers. Additional quitline strategies not examined as part of this evaluation are related to expanded digital modalities (e.g., online videos, social media referrals) and mass-media communications (e.g., expanded multi-language campaigns). However, CTCP will report the different modalities accessed by CSH users in order to answer CDC-required evaluation questions.

Within the context of the California's End Commercial Tobacco Campaign efforts, CTCP's quitline activities will help decrease tobacco use disparities. These efforts work congruently with other CDC NOFO 20-2001 efforts, especially policies related to reducing secondhand smoke exposure and targeted efforts to offer cessation opportunities and treatment to those accessing treatment at behavioral health facilities.

3. Evaluation Stakeholders and Primary Intended Users of the Evaluation: Describe individuals or groups who have a stake in the evaluation and who will use the evaluation results. Include a brief description of how you have (or plan to) engaged these evaluation stakeholders.

Intended Users: CTCP staff, CSH staff, state and local workgroups, Department of Health Care Services (the Medi-Cal administrator), priority population serving organizations, tribal groups/agencies, smokers, 2-1-1 call center staff and administrators.

Engagement: Internal CTCP program staff and evaluators hold monthly meetings on programmatic progress to provide input and feedback on the evaluation. Evaluators also attend calls between CTCP and California Smokers' Helpline staff. Some of this data will be used to inform the state-level evaluation as part of the reporting for CDC NOFO 20-2001. Additional external stakeholders (e.g., CTCP's Evaluation Task Force) will assist in the interpretation of evaluation findings and help chart next steps related to programmatic improvement.

4. Communication/Dissemination: Describe your broad plans for communicating/sharing your findings and provide examples of products that you will develop. Describe how your evaluation results or findings will be published on a publicly available website.

CTCP Evaluators will share evaluation findings annually with internal CTCP stakeholders and external stakeholders as needed. Potential products include presentations, infographics and factsheets for use on social media channels and websites. Impact statements will also be used as part of reporting to CDC. Additionally, findings will be disseminated via Tobacco Education and Research Oversight Committee meetings.

5. Use of Evaluation Findings: Describe how your evaluation findings will be used to ensure continuous quality and programmatic improvement.

To assure continuous quality and programmatic improvement, CTCP program staff will meet to discuss and interpret evaluation findings related to its quitline work. Additionally, CTCP staff will review performance measures on an annual basis as a means of tracking trends over time. Internal monthly calls are held with all CDC-related program staff and evaluators to discuss programmatic improvement efforts and findings from the evaluation. External stakeholders, such as the Evaluation Task Force, will help to interpret findings from this and other CTCP evaluations to assist with developing programmatic improvement. This is discussed further below under the "Use of evaluation findings" table at the end of the Component 2 section.

6. Health Impact*:* Describe here what you want to be able to say about the contribution of your program to changes in health, behavior, or environment in a defined community, population, organization, or system by the end of the cooperative agreement. Consider what types of evaluation you will need to conduct in years 4, 3, 2, 1 if you want to be able to report health impact at the end of the cooperative agreement in year 5.

CTCP expects to find its efforts and those of its partners will increase the proportion of CSH callers from priority populations and sustained quits. Between Years 1-4, CTCP will collect and report on process indicators related to activities to increase to increase of screening, referral and cessation cost-sharing, reach of efforts to educate providers and referrers on quitline services, and understand referrals from 2-1-1 referral systems. These efforts should yield higher levels of quit intent, access of CSH services, and higher levels of quit attempts and success. At the end of the grant, CTCP will report on the impacts of these efforts through a health equity lens by examining differences by priority population to demonstrate lowered health disparities.

Table B4: Evaluation Design and Data Collection Matrix – Component 2, Focus Area 4

1. Strategy-Specific Evaluation Approach and Context: CTCP will employ a mixed methods approach using quantitative and qualitative methods to evaluate how programmatic efforts lead to sustained quits throughout the grant period. CTCP aims to understand what barriers and facilitators exist to increasing the number of health plans referring to and reimbursing CSH services and nicotine replacement therapy and pharamacotherapies. CTCP will quantify the number of resources distributed to aiding youth referrals to tobacco and vaping cessation services. CTCP will collect and report on data related to culturally competent cessation service trainings by quantifying the number of attendees and the communities and sectors those attendees represent. Leveraging existing contracts with 2-1-1 Call Centers across the state, CTCP will report 2-1-1 Call Center referrals to the CSH. Lastly, working with CSH, CTCP plans to analyze program data to examine which cessation counseling modalities were used during the grant period, which led to successful and sustained quits, and which priority populations benefitted from these services.

2. Strategy: Increase public-private partnerships to reimburse and/or pay for evidence-based cessation treatment and support quitline sustainability; Implement culturally appropriate, evidence-based strategies to reduce tobacco-related disparities and increase utilization of quit support services

3. Activity(s): We plan to collect and analyze data from a variety of sources to understand reach and impact of the programs work, detailed below.

4. Evaluation Questions	5. Indicator(s)	6. Data Source	7. Data Collection Method	8a. Data Collection Start	8b. Data Collection End	9. Data Analysis	10. Person(s) Responsible
What you want to know. NOTE: Bolded questions refer to CDC's required outcomes and intended/unintended consequences questions.	*A specific, observable, and measurable characteristic or change that shows progress toward achieving a specified objective or outcome.* *BOLD Refers to CDC recommended indicator*	*Where you will collect the data (i.e. program records, surveys, etc.). List a source for each indicator.*	*How you will collect the data (i.e. abstraction from spreadsheet, database, etc.).*	*When will you start data collection?*	*When you will end data collection.*	*What type of analysis will you apply to the data (i.e. descriptive statistics, thematic analysis)?*	*Who is responsible for collecting the data for this indicator?*
PROCESS INDICATORS							
How many and what types health systems adopted screening, referral, and/or cessation reimbursements?	Number and type of health systems	CA Quits Progress Reports	Spreadsheet	2020	2022	Descriptive statistics (counts)	CTCP Evaluation Unit (EU)
How many webinars were conducted on culturally competent/appropriate cessation services?	Number of webinars	Webinar conducted	Emails	2020	2022	Descriptive statistics (counts)	EU

4. Evaluation Questions	5. Indicator(s)	6. Data Source	7. Data Collection Method	8a. Data Collection Start	8b. Data Collection End	9. Data Analysis	10. Person(s) Responsible
How many callers were referred to CSH services from 2-1-1 call centers?	Number and demographics of 2-1-1 callers referred to CSH / follow through	2-1-1 Call Center records and/or CSH intake records	Spreadsheet	2021	2025	Descriptive statistics (counts)	EU
Which modalities were accessed by CSH service utilizers? By priority population group?	Number and proportion of CSH clients per modality	CSH records; Performance Measure 10	Spreadsheet	2020	2025	Descriptive statistics (counts)	EU
How many CSH clients accessed pharmacotherapies or nicotine replace therapy via CSH and which types?	**Number and proportion of CSH clients per NRT/ pharmacotherapy type**	CSH records; Performance Measure 10	Spreadsheet	2020	2025	Descriptive statistics (counts)	EU
How many people accessed CSH services and from which priority population groups?	**Number and proportion of CSH clients by demographic group**	CSH records; Performance Measure 11	Spreadsheet	2020	2025	Descriptive statistics (counts)	EU
EFFECTIVENESS QUESTIONS							
What services and modalities and/or combination of services resulted in increased quit attempts and sustained quits at 7-month follow-up?	Odds of 7-month sustained quit by modality	CSH	Program database	2023	2025	Inferential statistics (logistic regression)	EU; CTCP Surveillance Unit (SU)
What services and modalities and/or combination of services resulted in increased quit attempts and sustained quits at 7-month follow-up by priority population group?	Odds of 7-month sustained quit by modality and priority population group	CSH	Program database	2023	2025	Inferential statistics (logistic regression)	EU; SU
OUTCOMES QUESTIONS							

4. Evaluation Questions	5. Indicator(s)	6. Data Source	7. Data Collection Method	8a. Data Collection Start	8b. Data Collection End	9. Data Analysis	10. Person(s) Responsible
To what extent did recipient efforts contribute to a measurable change in quit attempts and sustained quits at 7-month follow-up?	Difference in quit attempts and sustained quits over time	California Adult Tobacco Survey (CATS)	Survey database	2023	2025	Inferential statistics (trend analysis)	EU; SU
To what extent did recipient efforts contribute to a measurable change in quit attempts and sustained quits overall and among populations experiencing tobacco-related disparities?	Tobacco use quit attempts and sustained quits overall and by priority population	CATS	Survey database	2023	2025	Inferential statistics (trend analysis)	EU; SU

Use of Evaluation Findings

Below, we provide a table that lists key stakeholders and the process we plan to implement to assure continuous use of findings:

Key Stakeholder	**Processes for Finding Use**
Evaluation Task Force (ETF)	Distribute key evaluation findings via CDC reports and solicit guidance on current trends in tobacco research and evaluation methods. CTCP Evaluation and Surveillance Section meets with the ETF at least annually.
Tobacco Education and Research Oversight Committee (TEROC)	Distribute key evaluation findings via TEROC reports to help inform future programmatic and evaluation efforts. TEROC is convened quarterly and is kept apprised of all programmatic and evaluation efforts on an ongoing basis.
Internal CTCP 20-2001 program staff	Consult with program staff on interpretation of evaluation findings. Distribute key evaluation findings and consult with staff on programmatic questions germane to the evaluation plan, including, but not limited to, needed changes in approach to the evaluation and suggestions for programmatic modifications.
California Smokers Helpline staff	Consult with staff on interpretation of evaluation findings. Distribute key findings (report) to assist with adjustments to program over time.
CTCP-funded and partnering agencies	Distribute key evaluation findings via CTCP's Partners website to inform agencies about progress/expansion of California Smokers Helpline reach and available services.

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