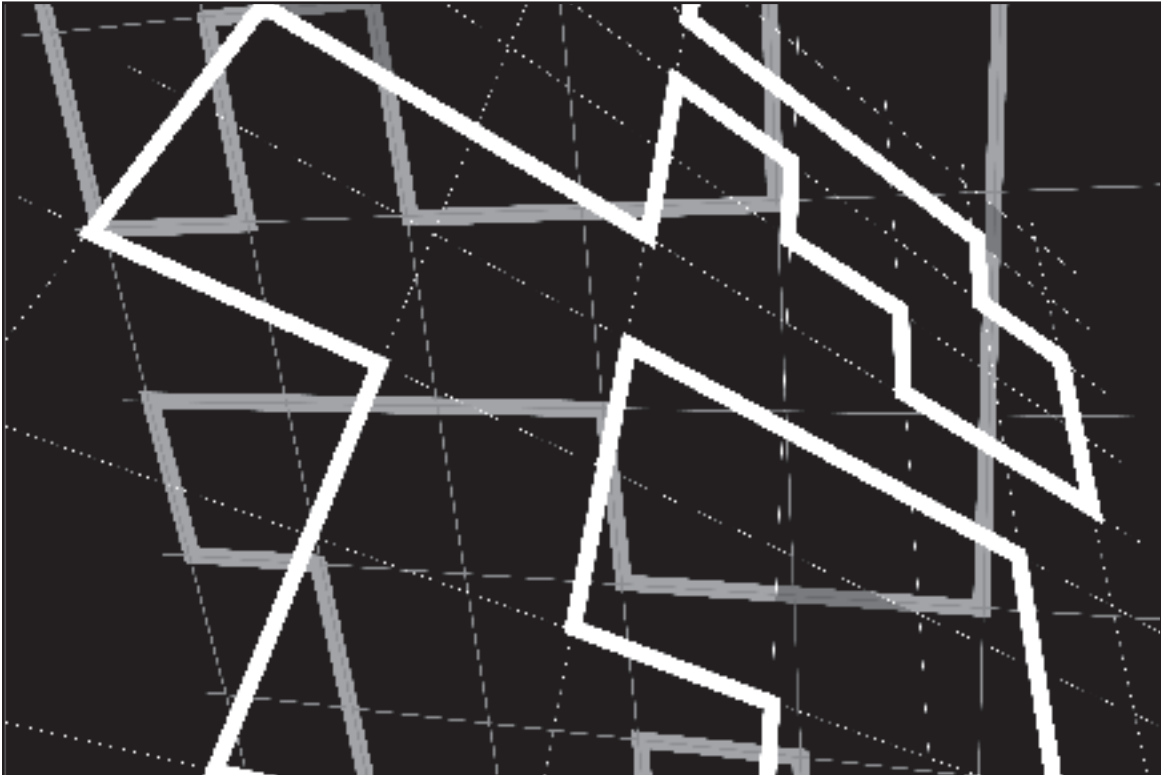

Appendices and Glossary



National Tobacco Control Program

An Overview

The Centers for Disease Control and Prevention (CDC) is the lead federal agency for comprehensive tobacco prevention and control. CDC develops, conducts, and supports strategic activities to protect the public's health from the harmful effects of tobacco use.

To carry out its mission, CDC:

- ▶ Expands the science base for effective tobacco control.
- ▶ Builds sustainable capacity and infrastructure for comprehensive tobacco control programs and policies.
- ▶ Communicates information about tobacco issues to policy makers, health professionals, and the public.
- ▶ Provides technical assistance on developing, implementing, and evaluating tobacco control policies, strategies, and initiatives.
- ▶ Builds strategic partnerships with national and international organizations.

Through its Office on Smoking and Health, CDC manages the National Tobacco Control Program (NTCP), which funds comprehensive tobacco control programs in state health departments and territories. NTCP-funded programs work to implement the strategies described in the following publications:

- ▶ *Best Practices for Comprehensive Tobacco Control Programs*¹
- ▶ *Reducing Tobacco Use: A Report of the Surgeon General*²
- ▶ *The Guide to Community Preventive Services: Tobacco Use Prevention and Control*³
- ▶ *Treating Tobacco Use and Dependence: Clinical Practice Guideline*⁴
- ▶ *The Health Consequences of Smoking: A Report of the Surgeon General*⁵
- ▶ *Preventing Tobacco Use Among Young People: A Report of the Surgeon General*⁶
- ▶ *Women and Smoking: A Report of the Surgeon General*⁷
- ▶ *Tobacco Use Among U.S. Racial/Ethnic Minority Groups—African Americans, American Indians and Alaska Natives, Asian Americans and Pacific Islanders, and Hispanics: A Report of the Surgeon General*⁸

CDC created NTCP to encourage coordinated, nationwide activities to reduce tobacco-related disease and death. NTCP provides funds and technical support to all 50 states, the District of Columbia, seven U.S. territories, and eight national networks of Indian tribes, Alaskan Natives, and other minority ethnic groups.

NTCP's Goals

The overall goal of NTCP's comprehensive tobacco control programs is to reduce tobacco-related disease, disability, and death. This goal is subdivided into four goal areas:

- ▶ Preventing initiation of tobacco use among young people.
- ▶ Eliminating nonsmokers' exposure to secondhand smoke.
- ▶ Promoting quitting among adults and young people.
- ▶ Identifying and eliminating tobacco-related disparities.

The Four Strategies of the NTCP □

- ▶ Population-based community interventions.□
- ▶ Countermarketing.□
- ▶ Public policies and regulations to reduce tobacco use.□
- ▶ Surveillance and evaluation.□

For more information on the NTCP go to <http://www.cdc.gov/tobacco>.

References

1. □Centers for Disease Control and Prevention. *Best practices for comprehensive tobacco control programs*. Atlanta, GA: Centers for Disease Control and Prevention; 1999.
2. □U.S. Department of Health and Human Services. *Reducing tobacco use: a report of the Surgeon General*. Atlanta, GA: Centers for Disease Control and Prevention; 2000.
3. □Task Force on Community Preventive Services. The guide to community preventive services: tobacco use prevention and control. *American Journal of Preventive Medicine*. 2001;20(Suppl 2):1–88.
4. □Fiore MC, Bailey WC, Cohen SJ, Dorfman SF, Goldstein MG, Gritz EG, Heyman RB, Jaén CR, Kottke TE, Lando HA, Mecklenburg RE, Mullen PD, Nett LM, Robinson L, Stitzer ML, Tommasello AC, Villejo L, Wewers ME. *Treating tobacco use and dependence: clinical practice guideline*. Rockville, MD: U.S. Department of Health and Human Services. Public Health Service; 2000.
5. □U.S. Department of Health and Human Services. *The health consequences of smoking: a report of the Surgeon General*. Atlanta, GA: Centers for Disease Control and Prevention; 2004.
6. □U.S. Department of Health and Human Services. *Preventing tobacco use among young people: a report of the Surgeon General*. Atlanta, GA: Centers for Disease Control and Prevention; 1994.
7. □U.S. Department of Health and Human Services. *Women and smoking: a report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, Office of the Surgeon General; 2001.

8. U.S. Department of Health and Human Services. *Tobacco Use Among U.S. Racial/Ethnic Minority Groups—African Americans, American Indians and Alaska Natives, Asian Americans and Pacific Islanders, and Hispanics: a report of the Surgeon General*. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health; 1998.

Selecting and Rating the Indicators

The Centers for Disease Control and Prevention (CDC) began producing this publication by appraising the logic models for three of the four goal areas of the National Tobacco Control Program (NTCP):

- ▶ Preventing initiation of tobacco use among young people.
- ▶ Eliminating nonsmokers' exposure to secondhand smoke.
- ▶ Promoting quitting among adults and young people.

As a result of the appraisal, our previously published logic models were updated, and the new versions are published here.¹

Selecting the Indicators and Data Sources

After an extensive review of published and fugitive literature, we selected candidate indicators for the outcome components of each NTCP goal area's logic model. Then we reviewed the scientific evidence for an association between the candidate indicators and the outcome components in the NTCP logic models. For example, we looked for evidence that an increase in levels of support for policies, and enforcement of policies, to decrease young people's access to tobacco (indicator 1.6.4) is associated with a reduction in the percentage of teenagers who experiment with tobacco (outcome 10 in goal area 1).

Next, we selected example data sources and survey questions for each indicator. One important criterion used to select example data sources was their easy availability to state tobacco control programs. Such data sources include the Behavioral Risk Factor Surveillance System; Adult Tobacco Survey: CDC-Recommended Questions; Youth Tobacco Survey: CDC-Recommended Questions; Current Population Survey: Tobacco Use Supplement; CDC Pregnancy Risk Assessment Monitoring System; and the CDC Youth Risk Behavior Surveillance System.

The selected survey questions come primarily from these survey or surveillance systems. However, if these sources had no appropriate questions to measure the indicator, we developed example questions or chose questions from national or state surveys and evaluation protocols (e.g., Legacy Media Tracking Survey) that are not widely used by state tobacco control programs, although they are available to them.

Rating the Indicators

We assembled a panel of experts (whose names are listed in Appendix C) to rate the final set of candidate indicators. The principal reason for having experts rate the indicators was to have them advise CDC on which indicators were key for evaluation of comprehensive state tobacco control programs. The experts also assessed the indicators on the basis of several criteria and advised us about which data sources are most

useful for tracking these indicators. In developing the rating process, we first did a pilot test. As a result of that test, we refined the indicator rating process, instructions to raters, and supportive materials (see page 284).

The panelists were asked to rate each of the 136 candidate indicators separately according to the following criteria:

- ▶ **Strength of the evaluation evidence.** The extent to which the literature supports use of the indicator for the evaluation of comprehensive, statewide tobacco control programs, as characterized by the logic models.

Reference citations on each indicator rating form were intended to provide guidance for reviewer ratings.

- ▶ **Resources needed for data collection and analysis.** The amount of funds, time, and effort needed to collect reliable and precise data on the indicator and to analyze primary or secondary data.

In making their judgments, reviewers were instructed to consider the availability of existing data (e.g., archival records or other secondary data) and the difficulties related to sampling and data collection methods. We reminded reviewers that many state health departments do not have extensive data collection systems for use in comprehensive evaluations of their tobacco control programs. However, all states have access to data on adults from the Behavioral Risk Factor Surveillance System, as well as periodic data on attitudes and policies through the Tobacco Use Supplements of the Current Population Survey. In addition, CDC synthesizes behavioral and policy data on the State Tobacco Activities Tracking and Evaluation (STATE) system. The resources needed for data collection and analysis are less when data are already available than when new data must be collected and analyzed.

- ▶ **Utility.** The extent to which the indicator would help to answer key evaluation questions for a state comprehensive tobacco control program.

Although many indicators are also appropriate and useful for evaluating local tobacco control programs, reviewers were asked to consider the utility of each indicator for evaluating state tobacco control programs.

- ▶ **Face validity.** The extent to which judgments about and measurements of the indicator would appear valid and relevant to policy makers and other decision makers who use the results of an evaluation to justify their continued support.
- ▶ **Uniqueness.** Whether the indicator contributes distinctive information for the evaluation of tobacco control efforts.

Reviewers who believed that an indicator was not unique were instructed to identify the redundant indicator.

- ▶ **Conformity with accepted practice.** The degree to which use of the indicator as a measure of a tobacco control program's progress is consistent with accepted, real-world tobacco control practice.
- ▶ **Overall quality.** A global rating that reflects the reviewer's opinion of the overall quality of the indicator.

- ▶ **Summary rating.** The reviewer’s opinion of how essential a particular indicator is for the evaluation of comprehensive, statewide tobacco control programs.

After the rating process, 31 indicators were merged, 4 eliminated, and 7 added, leaving a total of 120 indicators for which we provide information in this publication.

In addition, we asked the expert raters to:

- ▶ Comment on the data sources and survey questions that CDC had selected for each proposed indicator.
- ▶ Suggest alternative data sources and questions.
- ▶ Suggest additional indicators that would be useful for evaluation of comprehensive state tobacco control programs.

Each expert used a separate rating form for each indicator (see end of this appendix for a reprint of the rating form and rater instructions).

The form has three sections:

- ▶ A summary of information on CDC’s proposed indicator and logic model component to which it relates, suggested data sources and survey questions, and (when available) a reference to the scientific evidence supporting the use of the indicator.
- ▶ A rating scale for each criterion.
- ▶ Space for reviewer comments.

We also encouraged the experts to write notes on the rating forms and to provide additional information, references, or other documentation.

Analysis and Synthesis of Data from the Expert Reviews

After CDC received the completed rating forms from the experts, all data (including written comments) were entered into an electronic file. We adjusted for multiple responses, skipped items, and coding errors. If, for example, a rater circled more than one response for a criterion, we averaged the responses unless the rater had noted a preference for one response over another. Skipped items and “don’t know” responses were combined into a “no answer” category. All data were analyzed using the Statistical Analysis System (SAS v.8.02).²

For each type of rating, numerical data were analyzed in various ways. Frequency distributions of numerical data were analyzed to help us understand the raters’ perceptions about the indicators. Narrative comments included on the raters’ rating sheets were also reviewed to help us understand why raters gave an indicator a particularly high or low rating. To limit the effect of outliers, we used the median scores for each indicator.

After reviewing the experts’ ratings, we decided to combine indicators that were originally divided by population group (e.g., young people, adults). The experts’

numeric ratings for the 31 merged indicators are not provided in this publication but are noted with NR. In addition, after reviewing the rating data and comments carefully, we eliminated four indicators that were rated “not essential” by most panel members.

CDC also reviewed the expert panelists’ “resources needed” scores (their estimate of the intensity of resources required to collect and analyze data on each indicator). CDC substituted scores for six indicators that were rated by the experts. For example, the experts rated the “resources needed” criterion for indicator 1.9.12 (amount of tobacco industry campaign contributions to local and state politicians) as 2.5 out of 4. We know, however, that data about this indicator are readily available from archival sources, so we lowered the score to 1 out of 4.

The indicator rating tables include seven indicators that were not rated by the experts. Most of those were suggested by the experts themselves, and CDC used its best judgment to select which expert-proposed indicators to include. These indicators are not rated (and noted by an NR), but some information about them is provided in the indicator profiles.

Two criteria used by expert panelists were not included in the final rating tables: “uniqueness” and the “summary rating.” “Uniqueness” was only used to determine redundant indicators, and we found that the “summary rating” was highly correlated with “quality.”

After extensive analysis and consideration, we also decided not to use the expert panelists’ assessment for the “strength of evaluation evidence” criterion because, among other reasons, several panelists were concerned that their knowledge of the scientific literature on certain areas of tobacco control was limited. Instead, ratings for this criterion are based on the findings from an independent literature review conducted by the Battelle Centers for Public Health Research and Evaluation under contract to CDC. Battelle staff reviewed 847 articles to assess the evidence supporting the use of each indicator to measure a downstream outcome of a tobacco control program.

We evaluated and scored each relevant article or report on the following factors:

Type of Article

One designation per article as follows:

- ▶ **Research article.** Article with new data, generally from a single study.
- ▶ **Review article.** Article with summaries of multiple published studies and no original data.
- ▶ **Background article.** Article with information relevant to the indicator but no evidence of a relationship between the indicator and outcomes.

Score:

Research article = 0.5

Review article = 1.0

Background article = 0.0

Linkage

The extent of evidence provided in the article for a link between the indicator and the expected downstream outcomes in the NTCP goal area logic models.

Score:

Article shows *any* evidence of link between the indicator and an expected outcome = 1.0

Article shows only evidence *against* a link between the indicator and expected outcome = -1.0

Relevance

The degree to which the article specifically focuses on the indicator.

Score:

Article focuses directly on the indicator = 1.0

Article does not focus directly on the indicator = 0.0

Study Strength

How well the study was designed and how well it showed a link between the indicator and outcomes in the NTCP goal area logic models.

Score:

Article shows *strong* links between the indicator and an expected outcome = 1.0

Article shows a *weak* link = 0.5*

These data were used to calculate the Strength of Evaluation Evidence (SEE) criterion, as follows:

$$SEE = \sum(T*L*R*S)$$

where, for each article,

T = article type

L = linkage

R = relevance

S = study strength

The product of T*L*R*S for each article was summed across all articles for each indicator. The result was translated into the relative score in the indicator rating tables, symbolized as follows:

- ▶ No data (⊗): Indicators for which no studies tested an association between the indicator and a downstream outcome in one of NTCP's goal area logic models.
- ▶ No support (○): Indicators for which most studies that tested an association between the indicator and outcomes in the logic models found that the association was not significant (SEE score = -0.5-0.0).

* An article that showed a weak link was given a value of 0.5 rather than 0 (zero) because a weak link is stronger than no link.

- ▶ Minimal support (○): Indicators for which roughly an equal amount of research showed a significant association as showed no association between the indicator and downstream logic model outcomes. This category also includes indicators for which studies with weak designs supported an association between the indicator and an outcome (SEE score: 0.01–0.5).
- ▶ Moderate support (◐): Indicators for which more research showed a significant association between the indicator and a logic model outcome than research showing a non-significant association. This category also includes indicators for which studies supported an association between the indicator and a downstream outcome in the logic models, but the study designs were not strong (SEE score = 0.51–2.5).
- ▶ Strong support (◑): Indicators for which research showed a strong relationship between the indicator and a logic model outcome. Included in this category are all long-term indicators because the research supporting these indicators as predictive of beneficial health effects is well established (SEE score > 2.5).

We also footnoted indicators that had low reviewer response, low agreement among reviewers, or a modified “resources needed” criterion with the following symbols:

- ▶ An asterisk (*) indicates low reviewer response: if less than 75% of experts rated the indicator or if more than 75% of experts gave a certain criterion an invalid rating (e.g., “don’t know”), we considered the indicator to have low reviewer response. A low response suggests a high degree of uncertainty among raters. An example of such an indicator is 2.3.2: Level of receptivity to media messages about secondhand smoke.
- ▶ A dagger (†) indicates a low level of agreement among reviewers: if less than 75% of the valid ratings were within one point of each other, we considered the rating to have a low level of agreement. An example of an indicator with a low level of agreement is 1.6.3: Proportion of students who would ever wear or use something with a tobacco company name or picture. This low level of agreement represents a relatively high degree of variability in the raters’ responses for the criterion.
- ▶ A diamond (◊) indicates that the “resources needed” rating for this indicator was modified by CDC after the experts provided their ratings for this criterion. An example of such an indicator is 1.9.1: Extent and type of retail tobacco advertising and promotions.

Review of this Publication

This publication was peer reviewed internally at CDC and externally by program managers of state tobacco control programs and by other experts in the field of tobacco control.

CDC/OSH Key Indicators Report: Instructions for Expert Panel Reviewers

Purpose

CDC's Office on Smoking and Health (OSH) is developing a report intended to assist state and territorial tobacco control program evaluation efforts under the National Tobacco Control Program (NTCP). State Program Managers, State Evaluators, OSH staff, and national partners will be the primary audiences for the report. The report will aim to accomplish the following functions:

- ▶ Serve as a companion to OSH's Best Practices for *Comprehensive Tobacco Control Programs* and *Introduction to Program Evaluation for Comprehensive Tobacco Control Programs*.
- ▶ Describe key outcome indicators for evaluation of statewide, comprehensive tobacco control programs, and suggest appropriate data sources and measures for these indicators.
- ▶ Encourage states to use consistent evaluation measures and comparable data sources.
- ▶ Help OSH determine evaluation criteria for the NTCP, assess Best Practices recommendations, and provide consistent surveillance and evaluation technical assistance to states.

Methods

Report development began with a critical appraisal of OSH logic models for three of the four NTCP goal areas: (1) preventing initiation of tobacco use among youth; (2) eliminating nonsmokers' exposure to secondhand smoke; and (3) promoting quitting among youth and adults. The logic models (figures 1, 2, and 3) graphically display the links among input, activity, output, and short, intermediate, and long-term outcome components.

The fourth NTCP goal area—identify and eliminate disparities among population groups—will be incorporated through guidance on population-specific data collection methods and measures.

Almost every identified outcome indicator may be tracked for various population groups, including groups with high tobacco use prevalence rates or excess tobacco-related disease morbidity and mortality. In addition, OSH is currently developing a logic model specific to this disparities goal. The primary focus is currently on identifying appropriate program activities and process measures.

The indicators are organized by CDC/OSH goal area and logic model component. Extensive review of published and fugitive literature identified candidate indicators for the outcome components of each logic model. Selection decisions were guided by a need to highlight key indicators for evaluation of statewide, comprehensive tobacco control programs. Linkages connecting antecedent and consequent indicators were reviewed for evidence of association; for example, what is the evidence that implementation of tobacco-free policies in schools is associated with "downstream" outcomes? Each goal indicator list (tables 1, 2, and 3) shows the proposed indicators and references to supportive evaluation research. However, the references provided are not intended to be a comprehensive bibliography.

Next, optimal data sources and measures were selected for each indicator. The primary criterion used to select measures was whether the data sources are readily available to state tobacco control programs. These include the Behavioral Risk Factor Surveillance System (BRFSS), CDC Adult and Youth Tobacco Surveys, and other similar surveys and surveillance data sources. Where necessary, measures were drawn from other national and state-specific surveys and evaluation protocols that are not widely used at present but are accessible to state tobacco control programs.

Finally, a pilot study was conducted to test the rating process. Refinements in the instructions, rating forms, and supportive materials were made in response to feedback from pilot study participants.

Rating Process

The principal purpose of this expert review process is to advise CDC/OSH on which of the proposed indicators are considered key for the evaluation of comprehensive state tobacco control programs, and what data sources and measures would be most useful for tracking these indicators. Reviewers are asked to do the following:

- ▶ Rate each indicator on a set of criteria. □
- ▶ Comment on the data sources and measures that have been identified for each proposed indicator. □
- ▶ Suggest alternative data sources and measures. □
- ▶ Offer additional indicators that may be useful for state tobacco control program evaluation. □

Rating Form

Each indicator is presented on a separate rating form in the same order as the indicators are listed in tables 1, 2, and 3. The rating forms have three sections:

- ▶ Summary information on the proposed indicator, including the goal area, logic model component, suggested data sources and measures, other relevant information, and a reference regarding the evidence supporting use of the indicator, where available. □
- ▶ Eight rating criteria scales for reviewer response. □
- ▶ Space for open-ended reviewer comments on the proposed indicator and data sources/measures. □

In the summary information section on the rating forms, the data sources/measures suggested are intended only to help operationalize the indicators and do not represent a comprehensive list of all possible measures for the indicators. In several instances where existing data sources or measures have not been identified, they have been labeled generically (e.g., “State Adult Tobacco Survey”) and the measure noted as “No question identified.” This suggests that a measure could be added to a state-specific survey. For measures involving data collection at levels other than for an individual respondent, only the data source is identified (e.g., “Environmental scan of tobacco advertising and promotional practices in retail outlets” or “Local

level policy tracking system”). Finally, to conserve space, response options for the suggested measures have been abbreviated.

Rating Criteria

The following criteria are to be used to rate each indicator:

1. **Strength of the evaluation evidence**—extent to which you believe that the literature supports use of the indicator for the evaluation of comprehensive, statewide tobacco control programs, as characterized by the logic models. The reference citations included in tables 1, 2, and 3 and on each indicator rating form are intended to provide guidance in your ratings on this criterion, but your knowledge about other citations should also be used.
2. **Data collection and analysis resource needs**—your rating of the intensity of resource use (cost, time, and effort) required to collect reliable and precise measures, and to analyze appropriately primary or secondary data on the indicator. In making your judgments, please consider availability of existing data (e.g., archival records or other secondary data) and methodology and sampling frame issues. Please recognize that, with few exceptions (e.g., California, Massachusetts, Florida, Oregon, Texas, and a few others), most state health departments currently do not implement comprehensive, statewide evaluations of their tobacco control programs.

All states have access to basic prevalence data for adults from the BRFSS, periodic data on attitudes and policies through the Current Population Survey (CPS) tobacco use supplements, and School Health Education Profile (SHEP). CDC synthesizes the available state-level data on many behavioral and policy areas in the State Tobacco Activities Tracking and Evaluation System (STATE). Beyond these “common denominator” data sources, some states collect additional data through youth or adult surveys, policy tracking systems, media tracking systems, or other specific data collection methods. The intensity of resource use for data collection and analysis will obviously be less for those “common denominator” data sources than for other sources.
3. **Utility**—extent to which you believe that the indicator would help to answer key statewide comprehensive tobacco control program evaluation questions. Although these indicators may also be appropriate and useful for community-level evaluation, the utility criterion refers primarily to state efforts.
4. **Face validity**—your estimation of how valid the indicator would appear to be in the eyes of policy makers and decision makers who may be users of tobacco control program evaluation results.
5. **Uniqueness**—your opinion of whether the indicator contributes distinct information for the evaluation of tobacco control efforts. If you believe that the indicator is not unique, please note the redundant indicator in the space provided. [Note: Pilot study reviewers suggested that the best way to rate indicators on their uniqueness was to review all indicators in a given area once through, and then adjust ratings on this criterion as necessary.]
6. **Conformity with accepted practice**—your opinion of the degree to which use of the indicator is consistent with currently accepted, “real-world” tobacco control practice.

7. **Overall quality**—a summary rating that reflects your opinion of the overall quality of the indicator.
8. **Priority rating**—your opinion of how essential this indicator is for the evaluation of comprehensive, statewide tobacco control programs. [Note: Pilot study participants suggested that this criterion be reviewed again and adjusted once all indicators in an area have been rated.]

Reviewer Comments

In addition to providing comments and suggestions regarding the proposed indicator, data sources, and measures in the spaces provided, reviewers are encouraged to write notes anywhere on the rating forms or provide additional information, references, or other documentation, as necessary.

Product

Expert ratings of the indicators will be taken into account when determining the final list of key indicators. The report will also present information on each indicator, as in Box 1.

Box 1: Indicator Summary (Sample)

Proposed Indicator:	Proportion of youth who report never having tried a cigarette
Goal Area:	Preventing Initiation of Tobacco Use Among Youth
Logic Model Component:	Long-term—Reduced initiation among youth
Definition:	Proportion of respondents under 18 years of age who report that they have never tried even one puff of a cigarette.
Purpose: <input type="checkbox"/>	By employing periodic cross-sectional surveys of youth sampled from school or communitywide frames, this indicator may be used to track the rate of initiation of cigarette smoking among youth in a given population. With sufficient sampling, initiation may be measured with good precision in various subpopulation groups to look at gender, age, geographic, and ethnic/racial group disparities.
Rationale: <input type="checkbox"/>	Reduced initiation of tobacco use by youth will lower the youth smoking prevalence rate in the population. And, if youth reach adulthood without any tobacco use, chances are they will not initiate use as an adult.
Demographic Group: <input type="checkbox"/>	Youth, under the age of 18 years.
Data Sources/Measures: <input type="checkbox"/>	CDC Youth Tobacco Survey Have you ever tried cigarette smoking, even one or two puffs? Yes No
Additional Data Needs: <input type="checkbox"/>	Age, gender, race, ethnicity, city/county of residence.
Limitations: <input type="checkbox"/>	None
Other Information: <input type="checkbox"/>	This indicator may also encompass measurement of other forms of tobacco use, such as smokeless tobacco.

References

1. MacDonald G, Starr G, Schooley M, Yee SL, Klimowski K, Turner K. *Introduction to program evaluation for comprehensive tobacco control programs*. Atlanta, GA: Centers for Disease Control and Prevention; 2001.
2. SAS Institute, Inc. *SAS Language reference: dictionary*. Version 8. Cary, NC: SAS Institute Inc.; 1999.

CDC/OSH Tobacco Control Indicator Rating Form

Proposed Indicator: Proportion of schools/districts with policies that regulate display of tobacco industry promotional items (01.06.XX)

Goal Area: Preventing Initiation of Tobacco Use Among Youth (01)

Logic Model Component: Short-term—Changes in school curricula and policies (06)

Data Sources/Measures: CDC SHPPS, State School Policy and Environment (2000)

Has your [school/district] adopted a policy that prohibits students from wearing tobacco name-brand apparel or carrying merchandise with tobacco company names, logos, or cartoon characters in it?

Other Information: Question modified for use with school and/or district samples

Reference: _____

Indicator Ratings

a. Please circle the response number that reflects the extent to which evaluation evidence supports use of the indicator for the associated construct:

No Support	Minimal Support	Moderate Support	Strong Support	Don't Know <input type="checkbox"/>
1	2	3	4 <input type="checkbox"/>	0

b. Please circle the response number that reflects your estimate of the intensity of resource utilization required to collect and analyze indicator data adequately:

Low Intensity	Moderate Intensity	High Intensity	Very High Intensity	Don't Know <input type="checkbox"/>
1	2	3	4 <input type="checkbox"/>	0

c. Please circle the response number that reflects your rating of the utility of the indicator to answer important questions on program effectiveness and impact:

No Utility	Low Utility	Moderate Utility	High Utility	Don't Know <input type="checkbox"/>
1	2	3	4 <input type="checkbox"/>	0

d. Please circle the response number that reflects your estimation of how face valid the indicator would appear to be in the eyes of policy- and decision-makers:

Not at All Valid	A Little Valid	Somewhat Valid	Highly Valid	Don't Know
1	2	3	4 <input type="checkbox"/>	0

e. Please circle the response number that reflects your opinion of whether the indicator contributes unique information for tobacco control evaluation efforts:

Unique	Not Unique	If "Not Unique" write the number(s) of the redundant indicator(s):	Don't Know
1	2 <input type="checkbox"/>		0

f. Please circle the response number that reflects your opinion of the degree to which use of the indicator is consistent with currently accepted, "real-world" tobacco control practice:

Not at all Consistent	A Little Consistent	Somewhat Consistent	Highly Consistent	Don't Know
1	2	3	4 <input type="checkbox"/>	0

g. Please circle the response number that reflects your view of the overall quality of the indicator:

Low <input type="checkbox"/>				High
1	2	3	4 <input type="checkbox"/>	5

h. Please circle the response number that reflects your summary rating of how essential this indicator is for the evaluation of comprehensive state tobacco control programs:

Not Essential	Optional	Essential
1 <input type="checkbox"/>	2	3

Reviewer Comments

a. Please provide any additional comments on your ratings of this indicator:

b. If you feel there is a better indicator of this logic model construct, please specify here:

c. Please provide comments on the proposed data sources/measures for this indicator:

d. If you feel there are better data sources/measures, please specify here:

Expert Panel Members

We thank the following panel of experts members (in alphabetical order) who rated the indicators. Without their generosity in sharing their expertise and donating their time, this publication would not have been possible.

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Oregon Department of Human Services and Multnomah County Health Department □

Data Source Indicator Table

The following table cross-references example data sources and indicators in this publication. The example data sources do not represent all data sources available. When possible, Web addresses are provided. For additional information on tobacco-related data sources and data collection methods, refer to *The Introduction to Program Evaluation for Comprehensive Tobacco Control Programs* or *Surveillance and Evaluation Data Resources for Comprehensive Tobacco Control Programs*.^{1,2}

Data source	Indicator numbers	For more information
Addressing Tobacco in Managed Care (ATMC), Survey of Health Plans, 1997–1998	3.7.5; 3.9.1; 3.9.8; 3.10.1	▶ http://www.aahp.org/atmc/mainindex.cfm
Adult Tobacco Survey (ATS): CDC Recommended Questions: Core, 2003	2.3.5; 2.3.6; 2.3.7; 2.4.2; 2.4.3; 2.4.4; 2.6.1; 2.6.4; 2.7.3; 2.8.2; 2.8.3; 3.8.3; 3.9.2; 3.9.3; 3.9.5; 3.11.1; 3.11.3; 3.13.1; 3.13.2 ^{NR} ; 3.14.1	▶ State health departments ▶ Office on Smoking and Health, Centers for Disease Control and Prevention, (770) 488–5703
Adult Tobacco Survey (ATS): CDC Recommended Questions: Supplemental Section C: Cessation, 2003	3.7.4; 3.8.6; 3.9.2; 3.9.3	▶ State health departments ▶ Office on Smoking and Health, Centers for Disease Control and Prevention, (770) 488–5703
Adult Tobacco Survey (ATS): CDC Recommended Questions: Supplemental Section D: Environmental Tobacco Smoke, 2003	2.3.4; 2.3.7	▶ State health departments ▶ Office on Smoking and Health, Centers for Disease Control and Prevention, (770) 488–5703
Adult Tobacco Survey (ATS): CDC Recommended Questions: Supplemental Section F: Policy Issues, 2003	1.6.4; 1.6.5; 1.6.7 ^{NR} ; 2.3.10 ^{NR} ; 3.8.5	▶ State health departments ▶ Office on Smoking and Health, Centers for Disease Control and Prevention, (770) 488–5703
Adult Tobacco Survey (ATS): CDC Recommended Questions: Supplemental Section G: Parental Involvement, 2003	1.10.4	▶ State health departments ▶ Office on Smoking and Health, Centers for Disease Control and Prevention, (770) 488–5703
American Lung Association’s State Legislated Actions on Tobacco Issues (SLATI)	1.8.1	▶ http://slati.lungusa.org ▶ See “Policy tracking”

FDA

U.S. Food and Drug Administration.

Goal area

One of the four components of the overall goal of CDC's National Tobacco Control Program. □

HHS

U.S. Department of Health and Human Services.

Implementation

Carrying out or putting into effect a plan or program.

Indicator

An observable and measurable characteristic or change that shows the progress a program is making toward achieving a specified outcome.

Indicator profile

The term used in this manual for a table with detailed information on one indicator listed in this publication (see page 29 for an example).

Indicator rating table

The term used in this publication for the list of the indicators associated with one outcome in one NTCP logic model. The experts' rating for each indicator is also included (see page 28 for an example).

Inputs

Resources used to plan and set up a tobacco control program.

Intervention

The method, device, or process used to prevent an undesirable outcome or create a desirable outcome.

Logic model

A graphic depiction of the presumed causal pathways that connect program inputs, activities, outputs, and outcomes.

Media messages

Anti-tobacco information provided to the public through various media □ (e.g., television, radio, billboards). □

Minors

Persons younger than 18 years of age.

Morbidity

Disease or disease rate.

NCI

National Cancer Institute.

Never-smoker

A person who gives a negative answer to the question "Have you tried cigarette smoking, even one or two puffs?"

NIH

National Institutes of Health.

NTCP

National Tobacco Control Program.

