Oregon Health Authority

TOBACCO PREVENTION & EDUCATION PROGRAM EVALUATION

interim report 1

08|2020

A SOCIAL IMPACT COMPANY
»redegroup

contents

FIGURES:

TABLES

terminology

ACRONYMS:

ADPEP: Alcohol and Drug Prevention Education Program
CBO: Community Based Organization
CCO: Coordinated Care Organization
CDC: Centers for Disease Control and Prevention
HERC: Health Evidence Review Commission
HPCDP: Health Promotion and Chronic Disease Prevention
ICAA: Indoor Clean Air Act
LPHA: Local Public Health Authority
IDS: Inhalant delivery systems
KEQ: Key evaluation question
LHD: Local Health Department
OHA: Oregon Health Authority
RHEC: Regional Health Equity Coalitions
RFA: Request for Application
TA: Technical assistance
TPEP: Tobacco Prevention and Education Program
TRL: Tobacco retail license
WEMS: Workplace Exposure Monitoring System

DEFINITIONS:

Effective basic TRL policy (basic TRL):
Effective, basic tobacco retail licensure means having meaningful fees and penalties that fully cover all program costs (e.g. administrative and enforcement costs), and escalating penalties that include the ability to suspend or revoke licenses for violations. It also includes enforcement of the policy.

Full - county-wide coverage:
The policy applies to all areas of the county including unincorporated areas and cities.

BACKGROUND & PURPOSE

The Rede Group is conducting the 2019-21 Tobacco Prevention and Education Program (TPEP) evaluation on behalf of the Oregon Health Authority, Health Promotion and Chronic Disease Section (OHA, HPCDP). This document reports activities and results of the TPEP evaluation during the first 12 months (July 2019 - July 2020) of the funding cycle.

The TPEP evaluation focuses on results of changes made to the TPEP local health department funding model in 2019 including:

- The impact of the tiered funding model on local policy and health systems change;
- The effect of state-to-local technical assistance; and
- Local TPEP programs progress in developing non-governmental partnerships.

Primary intended audiences identified for this evaluation include HPCDP staff and TPEP grantees.

It is important to note the essential role local and state health departments play in the 2019 Novel Coronavirus (COVID-19) response, as they have had to focus their attention on the health crisis over other activities including the TPEP evaluation. The need to prioritize COVID-19 efforts during the beginning of 2020 has delayed TPEP grantee engagement in the evaluation design and data collection activities. Grantee engagement will begin as soon as grantees are available to participate in evaluation activities.

KEY EVALUATION QUESTIONS

1. What level of progress, if any, did Tier 1, 2, and 3 grantees make towards advancing health systems change, tobacco retail policy, ICAA expansion policy, and/or tobacco-free gov't property policy?
2. In what ways does the 2019-21 TPEP TA structure facilitate or impede grantee progress on their work plans?
3. To what level did the program model facilitate creating non-governmental (outside of LHD, outside of ADPEP) partnerships that advanced toward co-leading initiatives?

EVALUATION ACTIVITIES COMPLETED JULY 2019-JULY 2020:

- HPCDP TPEP Evaluation Advisory Group engagement
- Theory of Change: Oregon TPEP Funding Model
- Stakeholder engagement plan
- TPEP evaluation plan
- TPEP TA structure and assessment tool development
- TPEP partnership structure and assessment tool development
- TPEP grant reporting: reviewed and aligned TPEP reporting forms for use in the evaluation, reporting period 1 analysis and reporting

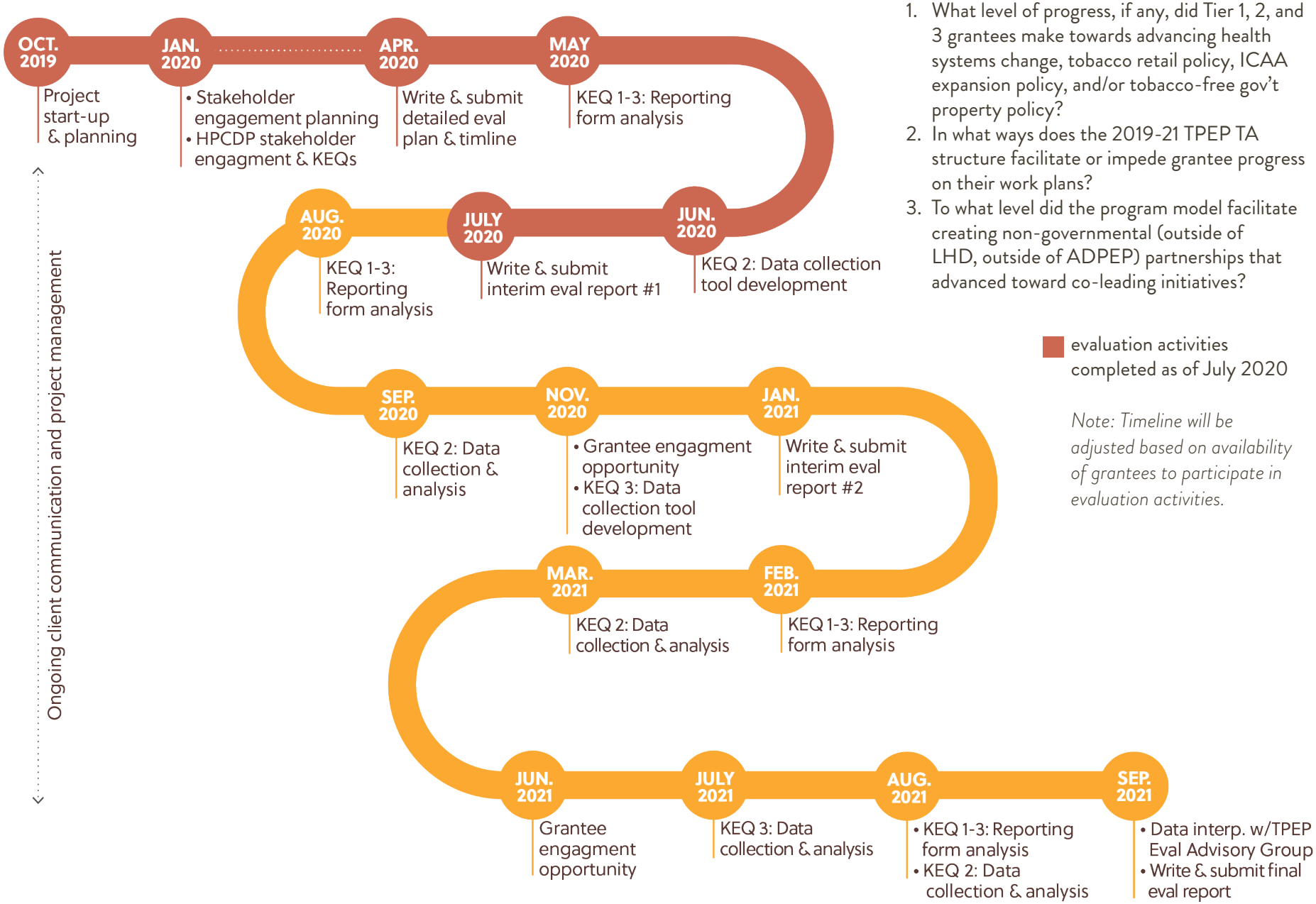
TPEP EVALUATION ADVISORY GROUP ENGAGEMENT

The TPEP Evaluation Advisory Group (see appendix A) is composed of 9 HPCDP staff, including a community program liaison, policy specialists, evaluation/surveillance leads, communication strategists, and managers. The group was convened to provide TPEP program insight and expertise and to guide the evaluation to ensure integrity and use. The entire TPEP Evaluation Advisory Group met in person in January 2020 for an evaluation kick-off meeting to provide details about the program model and discuss evaluation focus and design.

THEORY OF CHANGE: OREGON TPEP FUNDING MODEL

The theory of change for the Oregon TPEP funding model (see Figure 2) was developed through a collaborative process with the TPEP Evaluation Advisory Group and Rede. The model was developed to identify a common understanding of the inputs, activities, outputs, and outcomes of the TPEP funding model and will be used as a tool to guide the evaluation.

Figure 1: TPEP evaluation timeline: July 2020



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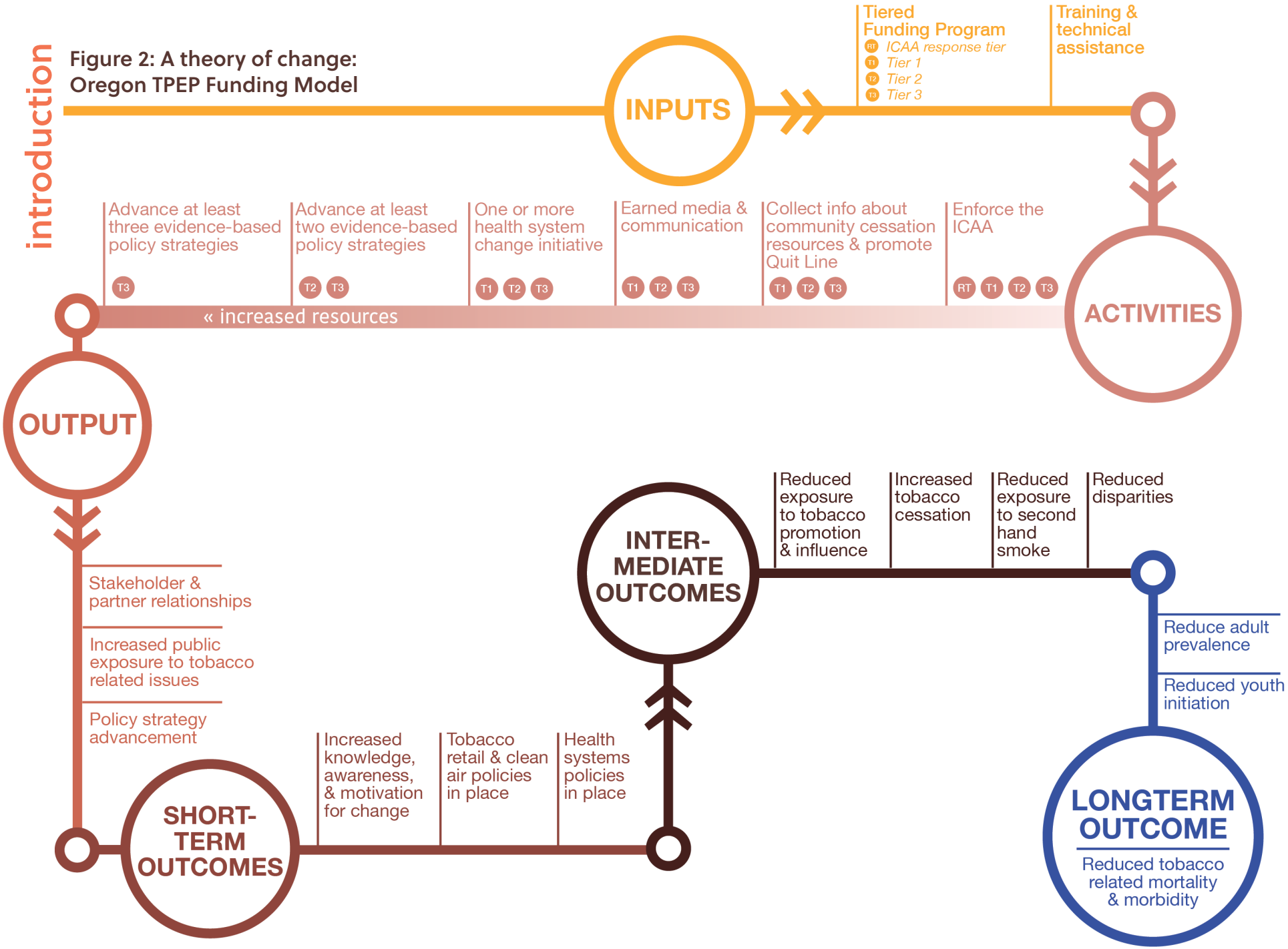
evaluation activities completed as of July 2020

Note: Timeline will be adjusted based on availability of grantees to participate in evaluation activities.

Figure 2: A theory of change: Oregon TPEP Funding Model



STAKEHOLDER ENGAGEMENT PLAN

The TPEP evaluation stakeholder engagement plan (see appendix B) was developed by Rede in collaboration with the TPEP Evaluation Advisory Group to clearly define stakeholders in the evaluation and their level of engagement.

TPEP EVALUATION PLAN

The TPEP evaluation plan (see appendix C) describes the program, key evaluation questions, and methods. This document will guide the evaluation through completion. Some aspects of the evaluation may be adjusted due to grantee availability and work plan adjustments as a result of COVID-19.

In previous TPEP grant cycles, all Local Public Health Authorities (LPHAs) were awarded a base funding with additional funding based on population size and one set of program activities applied to all grantees. In some previous grant cycles additional funds were available through competitive grants to accelerate tobacco prevention policy strategies. The 2019-21 TPEP tiered funding model was designed to offer flexibility to nimbly deliver resources to LPHAs based on total tobacco prevention funding made available to OHA. The model allows LPHAs to opt-in at the level of outcomes they can achieve.

As a component of the evaluation plan, Rede Group reviewed the TPEP RFA, program element, and had discussions with HPCDP staff to describe the tiered program model.

OVERVIEW OF TIERS AND REQUIRED ACTIVITIES

ICAA RESPONSE TIER

The ICAA Response Tier is for LPHAs that opt out of funding for tobacco prevention and only fulfill local duties and activities related to enforcing the ICAA as required by law.

TIER 1: FOUNDATIONAL TOBACCO PREVENTION

Tier 1 provides funding to conduct local duties and activities related to enforcement of the Oregon Indoor Clean Air Act (ICAA) and to engage in basic tobacco prevention education and advocacy. Tier 1 is a bridge to full engagement in policy and systems change processes. LPHAs that select Tier 1 include those that have not yet demonstrated support from executive leadership and/or elected officials to pass tobacco prevention policies but want to maintain a tobacco prevention program that builds local capacity.

TIER 2: TOBACCO PREVENTION MOBILIZATION

Tier 2 is for LPHAs that have support from executive leadership and/or elected officials to advance policy change strategies, as well as relationships in place with health system partners to implement health systems change initiatives.

TIER 3: ACCELERATING TOBACCO PREVENTION OUTCOMES

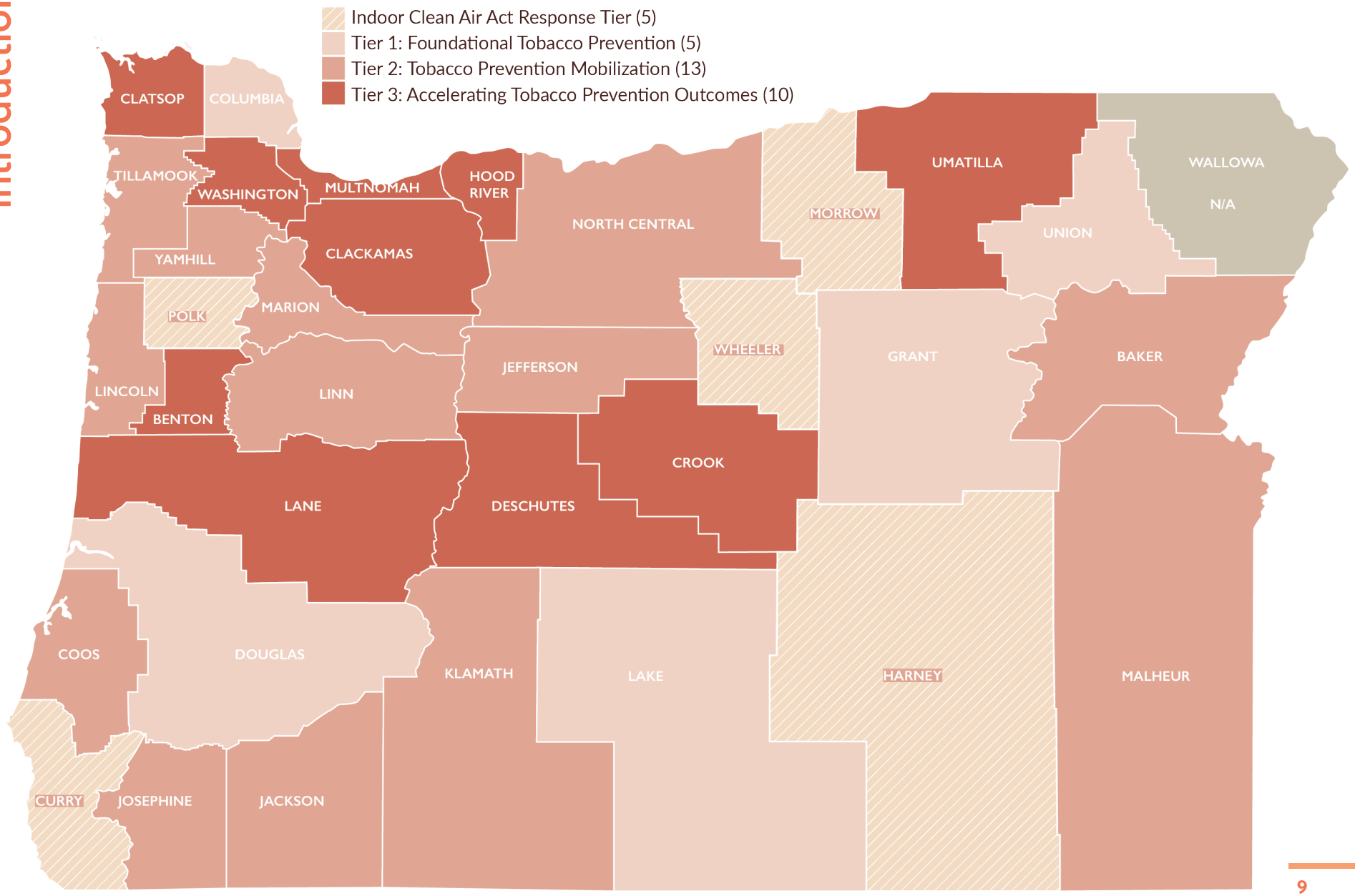
Tier 3 is for LPHAs that have demonstrated prior success by meeting six prerequisites outlined in the TPEP RFA and are prepared to lead statewide mobilization to decrease the harms of tobacco.

Table 1 shows required program activities for each tier (excluding activities specific to monitoring & evaluation, communication, training & technical assistance, and ADPEP coordination and alignment). Figure 3 maps the tier each county has selected, with 70% of Oregon Counties in Tier 2 or 3 working to advance tobacco prevention policy. Wallowa County does not have an LPHA, and therefore, does not receive TPEP funding.

Table 1: Program activities for TPEP funding tiers

Program Activities	ICAA Response Tier	Tier 1	Tier 2	Tier 3
Enforce the Oregon ICAA				
One or more health systems change initiative				
Promote the use of the Oregon Tobacco Quit Line with health system partners and the public				
Collect information about community cessation resources throughout the area covered by your program and provide this information to HPCDP and the regional CCO(s)				
Advance at least two evidence-based policy strategies (ICAA Expansion, Tobacco Retail and/or Tobacco-free Gov't Property)				
Advance at least three evidence-based policy strategies (ICAA Expansion, Tobacco Retail and/or Tobacco-free Gov't Property)				

Figure 3: TPEP funding tiers



EVALUATION ACTIVITIES

The following methods will be used to answer the evaluation questions:

KEQ 1: What level of progress, if any, did Tier 1, 2, and 3 grantees make towards advancing health systems change, tobacco retail policy, ICAA expansion policy, and/or tobacco-free gov't property policy?	**method** Analyze the stage of systems change/ policy progress for each strategy at four points in time. Tobacco retail and indoor clean air policies will be analyzed in comparison to data collected in previous evaluations.	**data source**: Tier 1, 2, and 3, TPEP reporting form data provided by HPCDP (28 grantees) **time frame**: May 2020 Aug. 2020 Feb. 2021 Aug. 2021 **grantee time commitment**: No additional time commitment
KEQ 2: In what ways does the 2019-21 TPEP TA structure facilitate or impede grantee progress on their work plans?	**method** Analyze training and TA section of TPEP reporting form data at four points in time	**data source**: Tier 1, 2, and 3, TPEP reporting form data provided by HPCDP (28 grantees) **time frame**: May 2020 Aug. 2020 Feb. 2021 Aug. 2021 **grantee time commitment**: No additional time commitment
	method Interview regarding the role training and TA played in system change or policy progress administered to: • Grantees who pass a policy or implement a systems change (word of mouth, TPEP listserv, TPEP reporting forms, etc.) • Grantees that advance one or more stages through the Policy Change Process Model identified through grantee reporting form data collected in July 2020, Jan. 2021, July 2021	**data source**: Tier 1, 2, and 3 grantees (up to 28 grantees) **time frame**: Ongoing: grantees that pass policies or implement a health systems change Grantees that show policy or health systems change advancement in July 2020, Dec. 2020 July 2021 (tentative based on time available to gather and analyze data prior to submitting the final evaluation report) **grantee time commitment**: 30 min. per interview

KEQ 3: To what level did the program model facilitate creating non-governmental (outside of LHD, outside of ADPEP) partnerships that advanced toward co-leading initiatives?	**method** Analyze partnerships sections of TPEP reporting form data at four points in time	**data source**	Tier 1, 2, and 3, TPEP reporting form data provided by HPCDP (28 grantees)
		time frame	May 2020 Aug. 2020 Feb. 2021 Aug. 2021
		grantee time commitment	No additional time commitment
	method Survey/interview to identify non-governmental partnerships and level of engagement in systems and policy change strategies	**data source**	Tier 1, 2, and 3 grantees (28 grantees)
		time frame	April 2021
		grantee time commitment	1 hour per grantee

TA STRUCTURE + ASSESSMENT TOOL DEVELOPMENT

Rede met with a subgroup from the TPEP Evaluation Advisory Group to gather information about the TPEP technical assistance structure. Rede has identified the focus of the TPEP TA evaluation to be assessing the TA structure provided by HPCDP through their regional support teams and how having access to the support team has supported grantees in their work plan. Over the next few months Rede will develop a tool for assessing the effects the TA structure and prepare to administer data collection to grantees. The timing of data collection will be affected by COVID-19 and a current understanding that LPHAs are focused on controlling the pandemic and, thus, not availing themselves to tobacco prevention technical assistance.

PARTNERSHIP STRUCTURE + ASSESSMENT TOOL DEVELOPMENT

Rede examined partnership assessment tools used in previous HPCDP grantee evaluations, available literature on tools for assessing grant partnerships, and models/scales for defining partnerships shared by HPCDP. Rede met with a select members of the TPEP Evaluation Advisory Group to gain insight into the expectations and goals for TPEP partnerships during this grant cycle and long term. Rede also spoke with a HPCDP staff member that works closely with the ADPEP grantees to understand the partnership structure for ADPEP grantees and opportunities for consistency in language and communication in evaluation activities. After conversations with HPCDP, Rede has identified a need to adjust the original evaluation question pertaining to TPEP partnerships to better fit the context of COVID-19 and priorities for HPCDP this year. Rede is at the initial stages of defining the methods for collecting data on TPEP partnerships and will work with HPCDP and TPEP grantees over the next few months to develop data collection tools.

GRANT REPORTING RESULTS

Reports from TPEP coordinators help HPCDP monitor grant compliance, inform program improvement activities, collect data to maintain secure funding, and track successes around the state.

Two times per year on the schedule outlined below, LPHAs must complete a progress report (see appendix D) and a follow-up interview with their HPCDP liaison to describe progress made on the approved local program plan over the past six months. Reports are completed during the following periods:

- Fall 2019
- Spring 2020*
- Fall 2020
- Spring 2021

Rede worked with HPCDP staff to review and align the TPEP reporting forms to gather data to inform the evaluation and eliminate duplicative reporting by grantees and confusion between grant monitoring and evaluation. Particular attention was taken to ensure that the TPEP stage of policy change data would align and could be compared with data collected in previous evaluations.

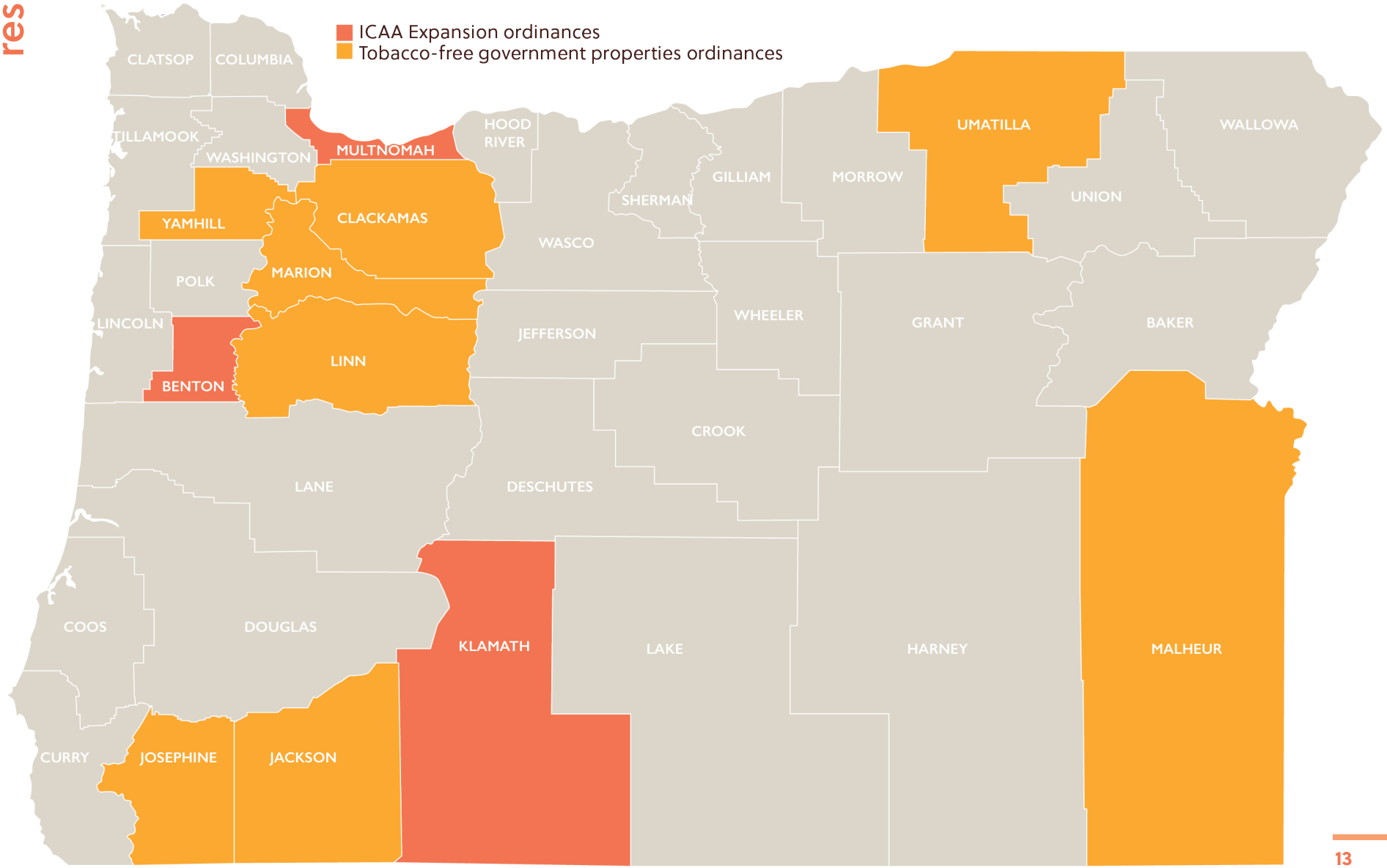
Tier 1-3 grantees are required to complete reporting forms with questions focused on health systems change initiative and policy change progress, communications activities, TA & training activities, among others. Reporting form data is one source of information for answering evaluation questions. During reporting period one (submitted in December 2019) data were collected from 27/28 (96%) Tier 1-3 grantees. One Tier 2 grantee did not submit reporting form data during the first reporting period.

POLICIES PASSED

During reporting period 1, 11 tobacco prevention policies passed including three ICAA expansion policies and eight tobacco-free government property policies. Four of the policies passed were revisions or amendments. Policies were passed by 50% of Tier 2 and 3 grantees. The map below identifies the counties that passed a policy during reporting period 1.

**Reporting impacted by COVID-19 and will likely resume in summer 2020.*

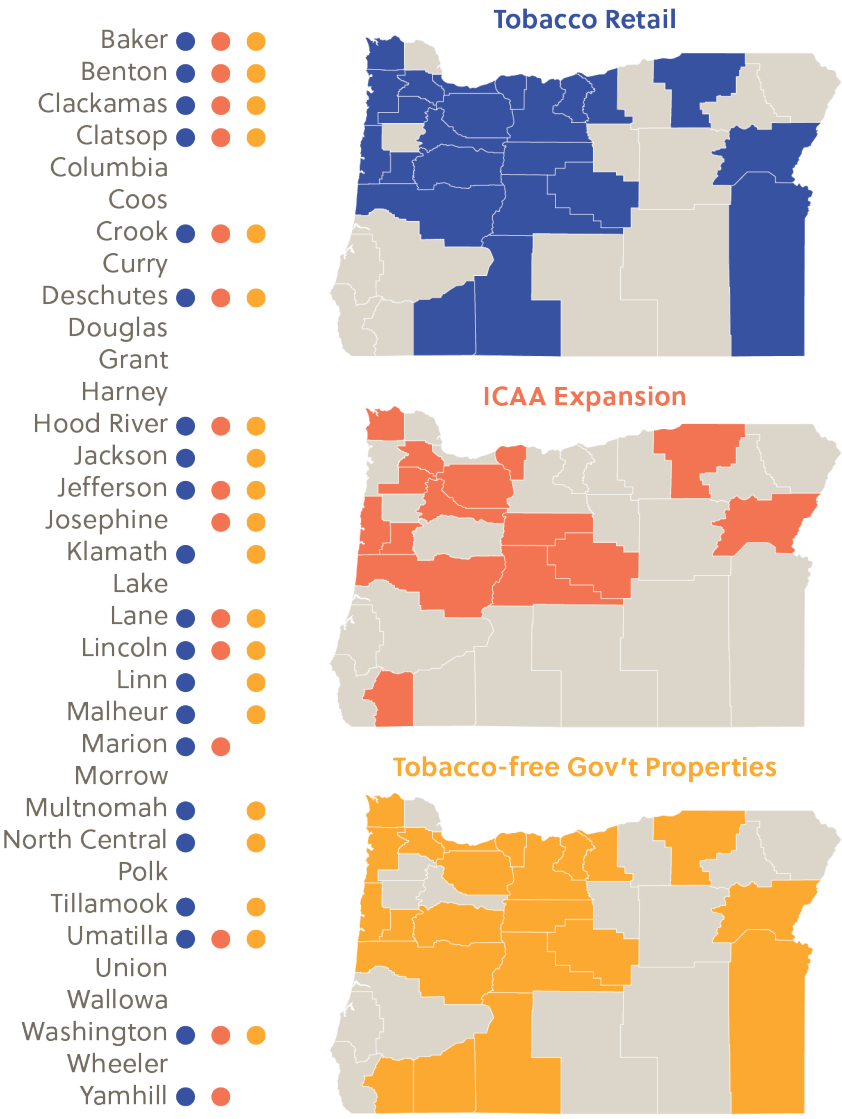
Figure 4: Tobacco prevention policies passed: July - December 2019



TOBACCO PREVENTION POLICY STRATEGIES: DEC. 2019

The graphic to the right shows the type of tobacco prevention policy strategies each Tier 2 and 3 grantee is working on as of December 2019. Tier 2 grantees are required to advance at least two evidence-based policy strategies and Tier 3 grantees are required to advance at least three evidence-based policy strategies. Evidence-based policy strategies include ICAA expansion, tobacco retail, and tobacco-free government property policies. There were 21 (95% of Tiers 2 and 3) grantees reporting working on a tobacco retail policy strategy, 15 (68% of Tiers 2 and 3) grantees working on an ICAA expansion policy strategy, and 20 (91% of Tiers 2 and 3) grantees working on a tobacco-free government property policy strategy.

Figure 5: Tobacco prevention policy strategies



TOBACCO RETAIL STRATEGIES

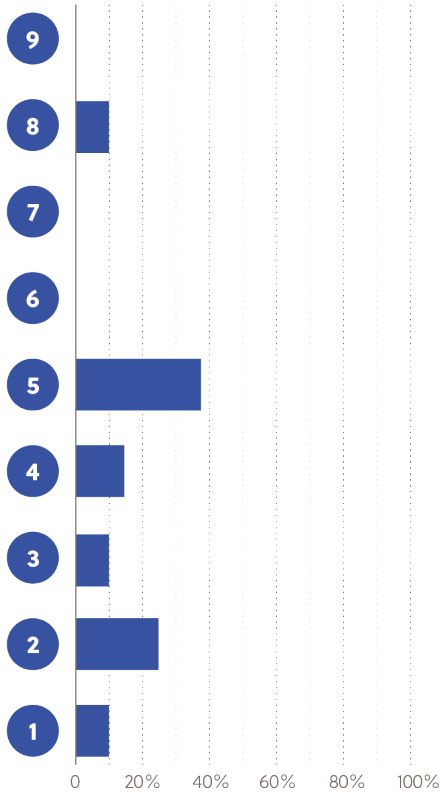
All grantees working to advance a tobacco retail strategy are required to advance an effective basic tobacco retail license ordinance (unless one is already in place) that covers the entire county, including incorporated cities (countywide coverage). Grantees identified as advancing a TRL only (29%) did not identify an additional retail strategy or were undecided on the additional retail strategy they would advance. One-third of grantees are advancing a policy to restrict outlet density through zoning ordinance requirements (e.g., restricting the proximity of tobacco outlets near places where children frequent or capping the number of retail licenses). Twenty-nine percent are working to prohibit the sale of all flavored tobacco products and inhalant delivery systems (including menthol) and 10% are working to increase the cost of tobacco through non-tax approaches (e.g. price promotion prohibitions).

The maps and bar chart in Figure 7 display the tobacco retail policy strategy each grantee is working on, percent of grantees working in each strategy, and jurisdictions that have full or partial TRL coverage.

The bar graph on this page shows the percent of grantees at each stage of policy change for their retail strategy. The majority of grantees are working in stages 1 (identify and frame the problem) through 5 (decision-maker engagement and education).

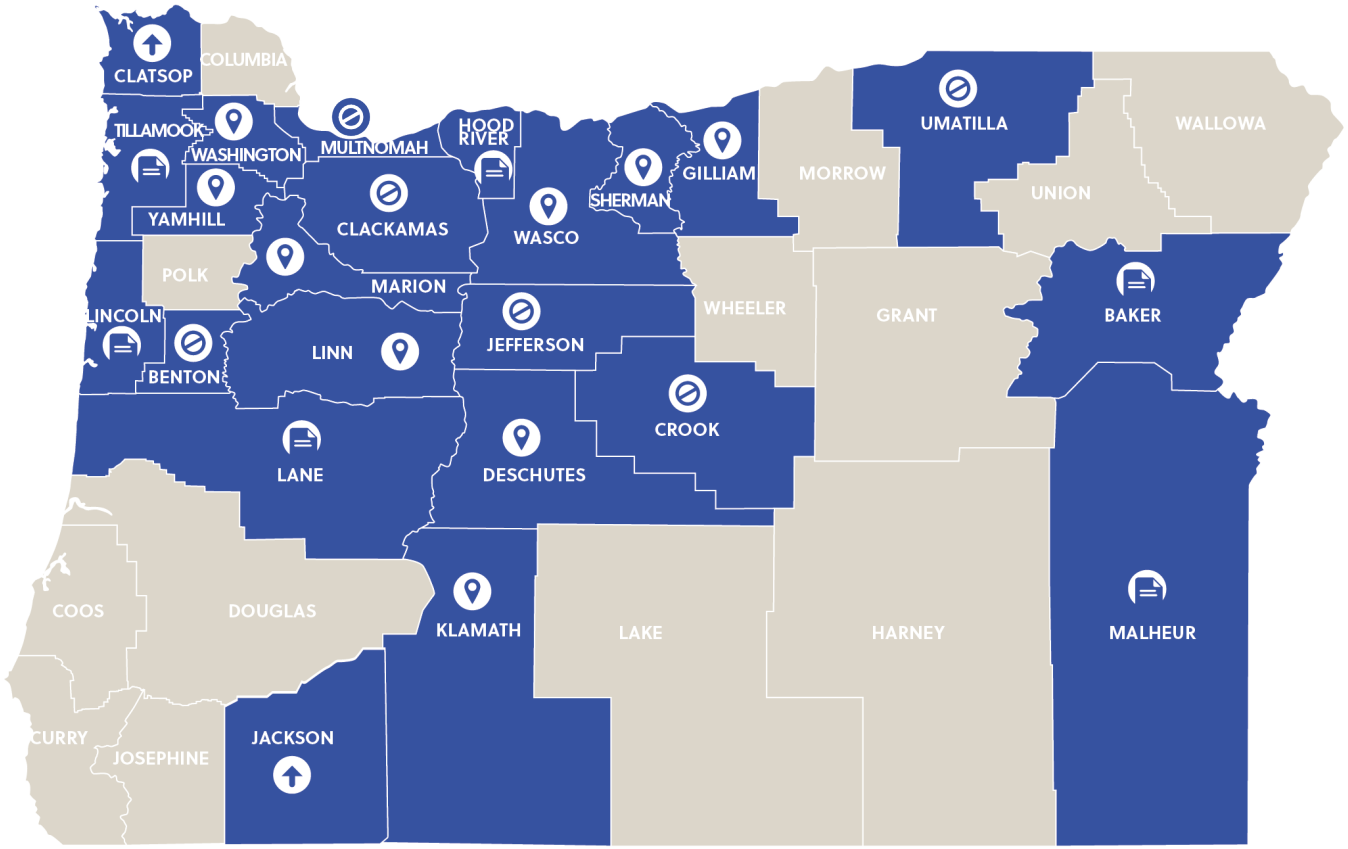
See appendix E for a map of jurisdictions that have passed a tobacco retail license policy as of April 2020.

Figure 6: Tobacco retail strategies by stage of policy change

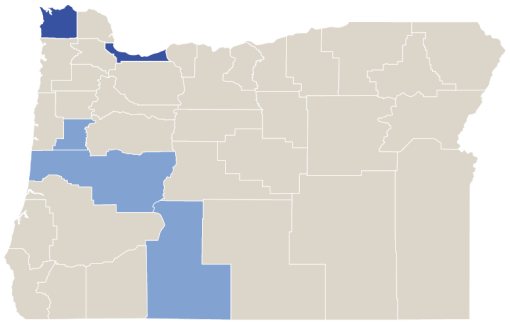


1: Identify the Problem
2: Engage Community & Stakeholders
3: Assess Readines for Change
4: Community Outreach & Education
5: Decision-maker Engagement
6: Draft Policy & Plan Implementation
7: Adopt Policy
8: Implement Policy & Support
9: Evaluate Impact

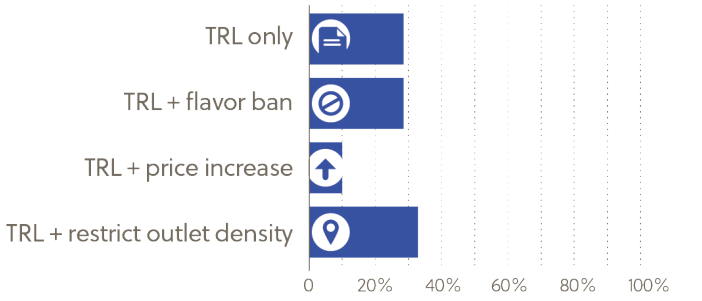
Figure 7: Tobacco retail policy strategy types + overview (Dec. 2019)



Tobacco Retail Policies Passed:



■ full - countywide coverage
■ partial - unincorporated areas + some city coverage



percent of grantees working on strategy

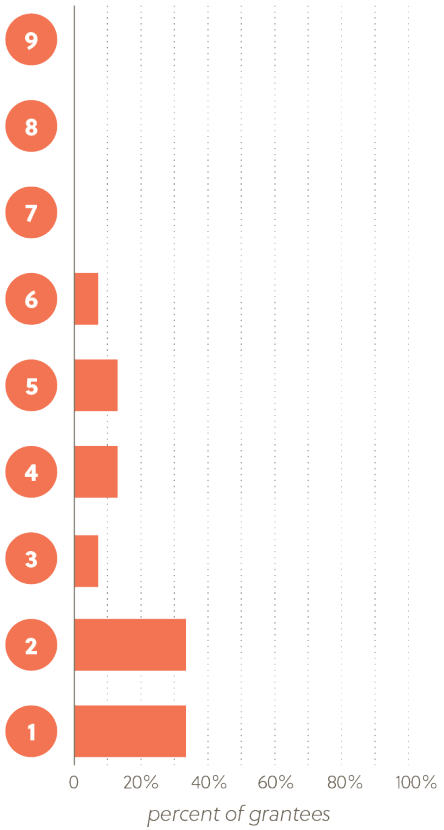
ICAA EXPANSION STRATEGIES

The Oregon ICAA creates smoke free public places and places of employment with the intent of protecting the health of employees and the public. The ICAA applies to smoking, vaporizing and aerosolizing of inhalants in and around public places and places of employment. Smoking, vaporizing, and aerosolizing of inhalants is also prohibited within 10 feet of all entrances (including stairs), exits (including stairs), and accessibility ramps that lead to and from an entrance or exit, windows that open, and air-intake vents.

TPEP grantees are working on a variety of policy strategies to expand the Oregon ICAA in their local jurisdictions. The greatest number of grantees (40%) are working on a policy to eliminate exposure to cannabis in public places and workplaces. Five grantees are working on multiple ICAA expansion strategies. See figure 9 for details.

ICAA expansion policy strategies are at varying stages of the policy change process as shown in the bar chart on this page, with two-thirds of strategies at stage 1 (identify and frame the problem) or 2 (engage key stakeholders and community groups). One grantee identified two stages of policy change (decision-maker engagement end education and community outreach, engagement and education).

Figure 8: ICAA strategies by stage of policy change



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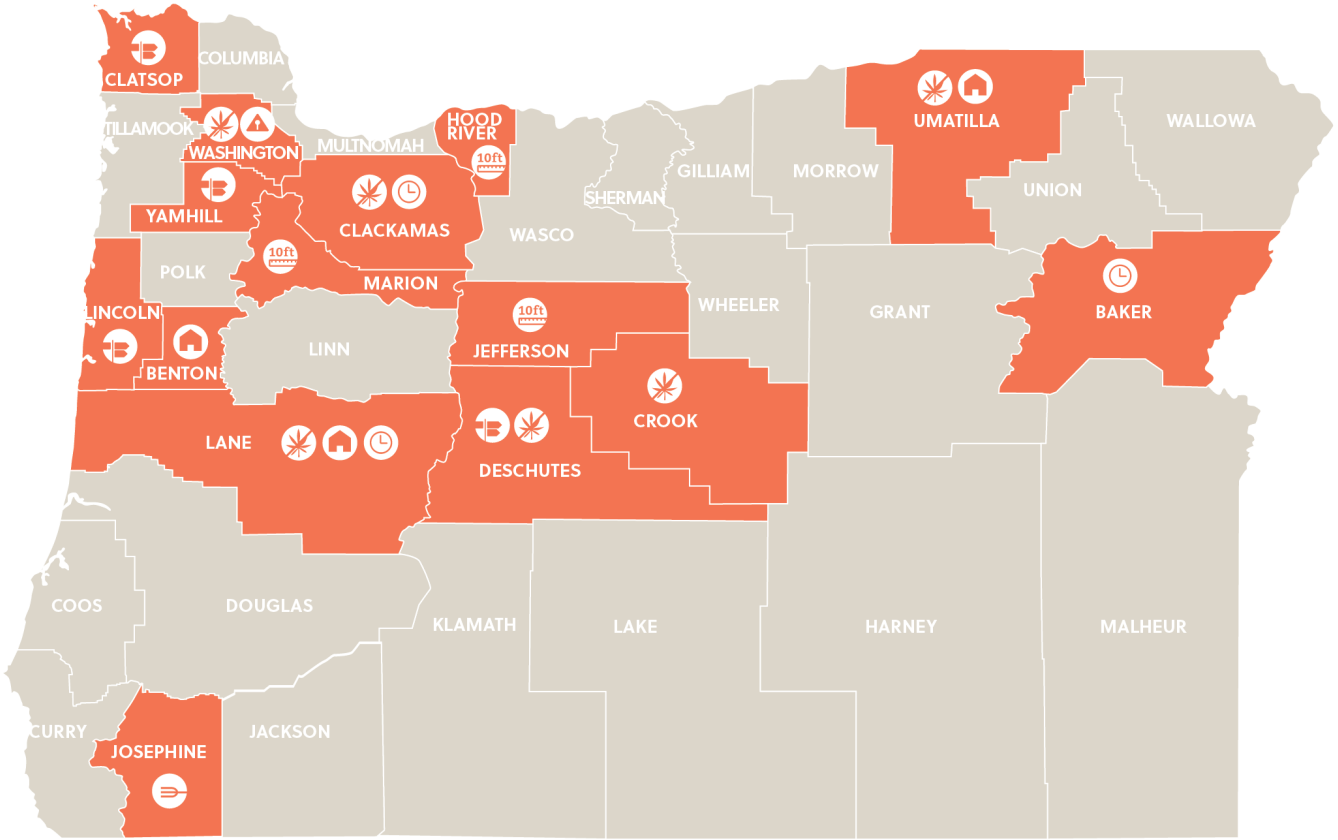
3: Assess Readines for Change
4: Community Outreach & Education
5: Decision-maker Engagement
6: Draft Policy & Plan Implementation
7: Adopt Policy
8: Implement Policy & Support
9: Evaluate Impact

Figure 9: ICAA policy strategy types + overview (Dec. 2019)



TOBACCO-FREE GOVERNMENT PROPERTY STRATEGIES

The majority of Tier 2-3 grantees are working to advance policies that establish smoke- and tobacco-free county or city agencies or other regional government campuses inclusive of prohibitions on inhalant delivery systems and cannabis products (Fig. 11). The types of tobacco-free government property strategies include tobacco-free county properties (40%), tobacco-free city properties (30%), tobacco-free section/building/entity of government properties (20%), tobacco-free parks (10%), and one grantee is working on strengthening the tobacco/e-cigarette policy at one or more K-12 school districts in the county.

Tobacco-free government property policy strategies are at a variety of stages of policy change as seen in the bar chart on this page with 70% of strategies at the early stages of policy change (identify and frame the problem, engage key stakeholders and community groups, or assess readiness for policy change). One grantee identified two stages of policy change for their ICAA expansion, tobacco retail, and tobacco-free government property policy strategies.

Figure 10: Tobacco-free government property strategies by stage of policy change

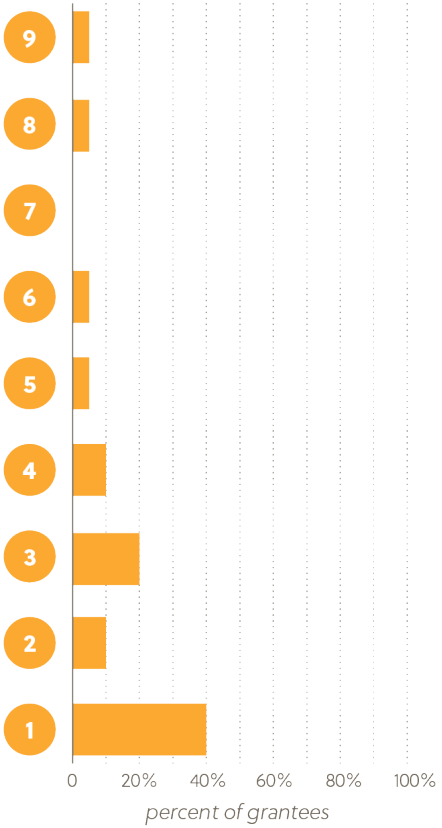


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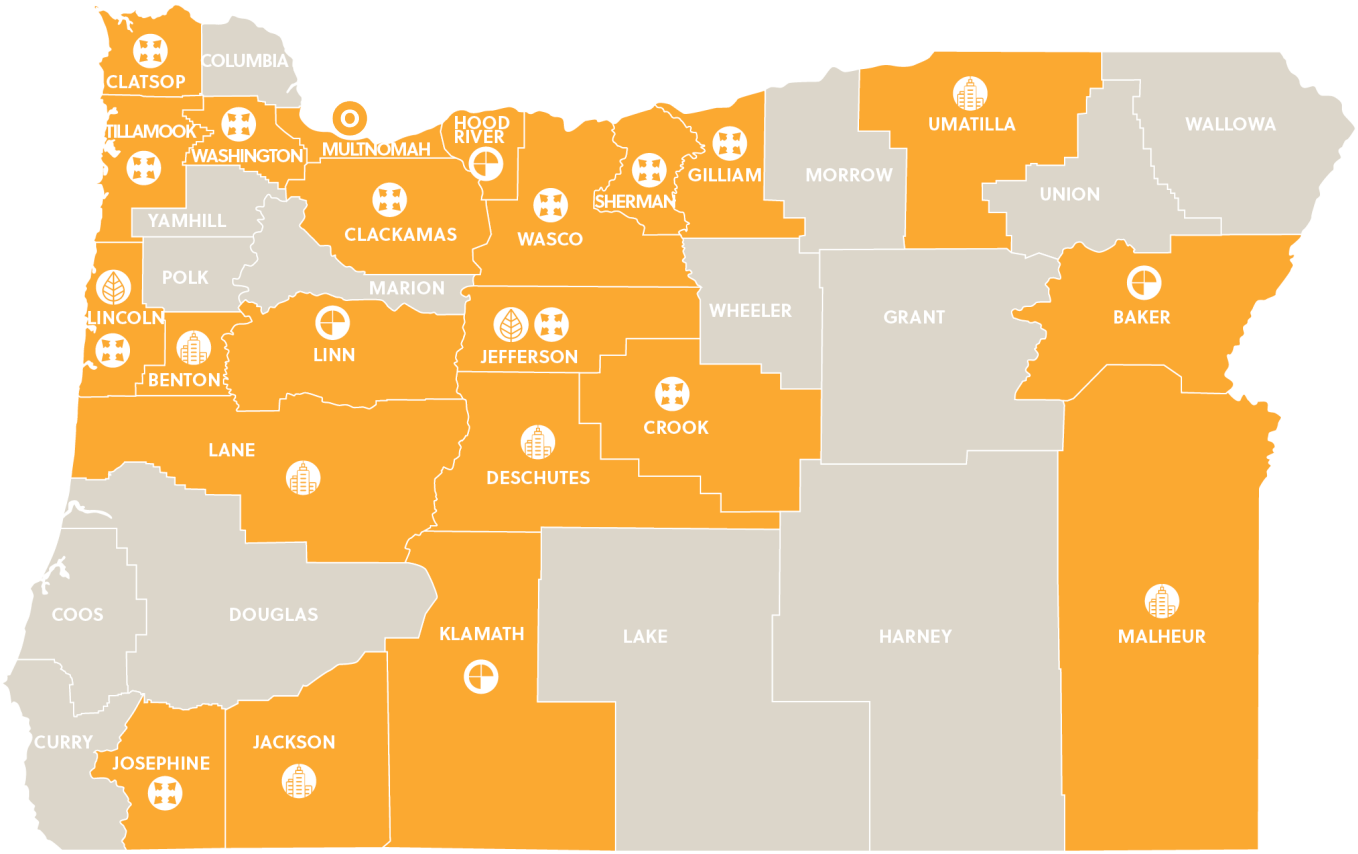
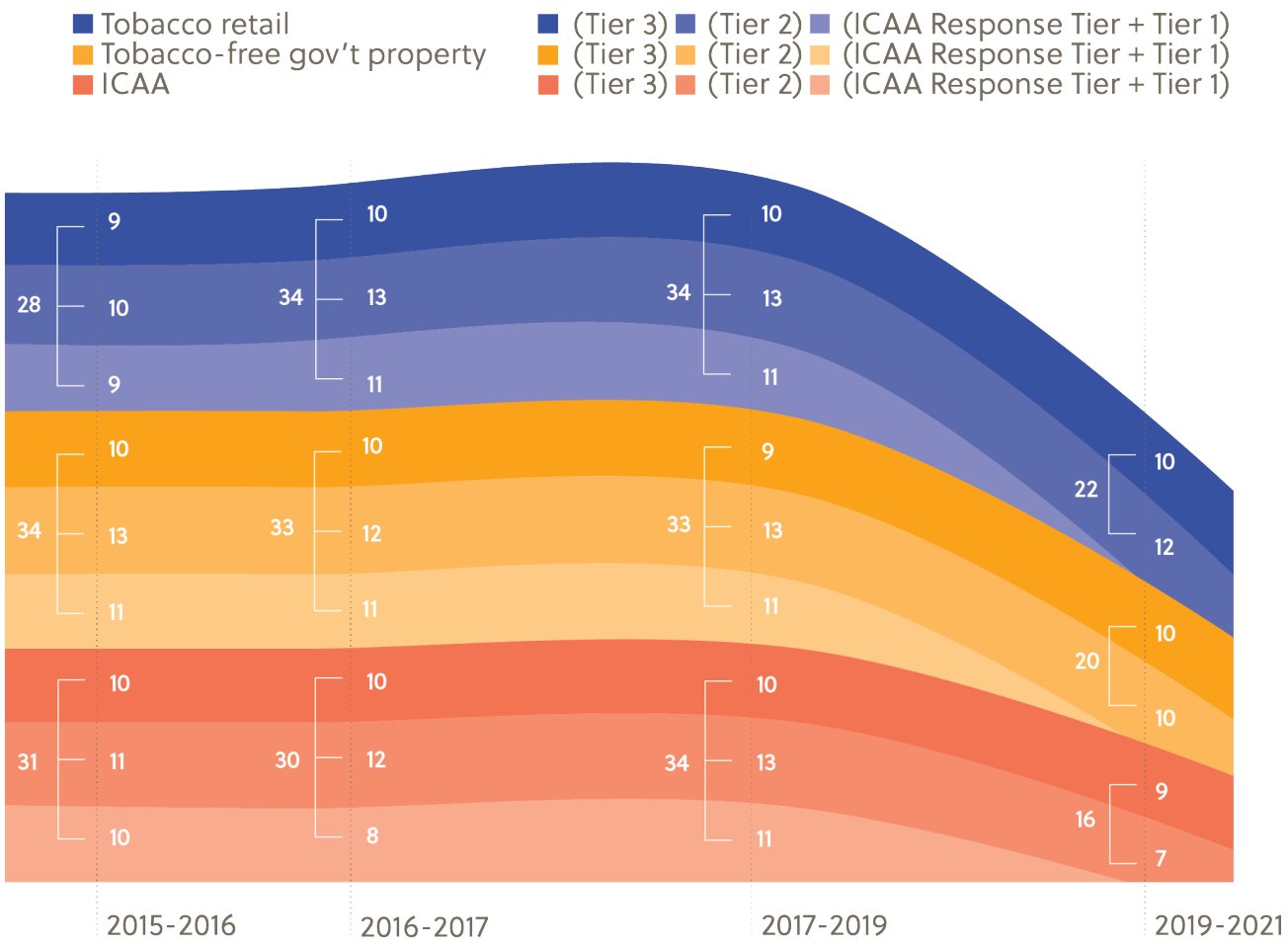
Figure 11: Tobacco-free government property policy strategy types + overview (Dec. 2019)



TPEP GRANTEES REPORTED WORKING ON TOBACCO PREVENTION STRATEGIES 2015-2021

Figure 12 shows the number of grantees at each tier working on tobacco retail, ICAA expansion, and tobacco-free government property policy strategies since 2015. The smaller number of grantees working to advance policy in the current grant period is due to the change in requirements that allow for grantees to opt into the amount of policy change that is feasible for their LPHA. ICAA response Tier and Tier 1 grantees are not required to work on policy change and Tier 2 and 3 grantees are not required to advance policy change in all three areas.

Figure 12: Number of TPEP grantees reported working on tobacco prevention strategies 2015-2021



Strategies identified in TPEP grantee work plans submitted to HPCDP were used to create this chart.

TOBACCO RETAIL AND ICAA EXPANSION POLICY PROGRESS

Rede has been evaluating TPEP tobacco retail policy change progress since 2016 and ICAA expansion policy progress since 2018. Nineteen grantees (90%) reported working on the same tobacco retail policy in July 2019 and December 2019. Of grantees working on the same policy strategy, 32% progressed one or more stages of policy change in the first 6 months of the grant period. Nine grantees (60%) reported working on the same ICAA expansion policy in July 2019 and December 2019. Of grantees working on the same policy strategy, one third progressed one or more stages of policy change in the first 6 months of the grant period.

HEALTH SYSTEM CHANGE PROGRESS

During reporting period 1, three health systems change initiatives were implemented:

1. Multnomah County implemented a systems change with Health Share of Oregon, in partnership with LPHAs and community-based organizations (CBOs), to implement a tobacco cessation mass communication campaign focused on communities experiencing health disparities across the Tri-County metro region.*
2. Tillamook County improved their closed-loop referral system for tobacco cessation referrals at Tillamook County Community Health Centers.
3. Malheur County coordinated with their Local Community Advisory Council members to involve TPEP and take more of a leadership role in community health resources fairs.

Of Tier 1-3 grantees, 11% implemented a health systems change initiative during the reporting period.

**Clackamas, Multnomah, and Washington Counties reported working on two regional health systems strategies although each County reported being at different stages of change for their regional strategies.*

HEALTH SYSTEMS CHANGE STRATEGIES

Tier 1-3 grantees are required to work on at least one health systems change initiative. These initiatives fall into one of two strategic categories: improving tobacco cessation and implementing multi-sector interventions. During reporting period one, 74% of grantees reported working on a strategy to assist health system partners to develop and implement sustainable closed-loop screening and referral systems. Twenty-six percent reported working with CCO(s) to implement at least one HERC-recommended multi-sector approach for tobacco prevention, with 11% working with CCOs to implement a mass-reach communication intervention for evidence-based tobacco prevention and 15% working with CCOs to engage the community via LPHAs to promote tobacco cessation, create tobacco-free places, and identify and eliminate tobacco-related disparities. One grantee is working on another proposed strategy with multi-sector partners, including at least one health system partner playing a primary role, based on the CDC Best Practices for Comprehensive Tobacco Control Programs. One grantee is working on a strategy that does not fall into the previously listed categories outlined in the TPEP RFA. One grantee was undecided about their health systems change initiative strategy (see Figure 14).

Figure 13: Health systems change initiative strategies by stage of policy change

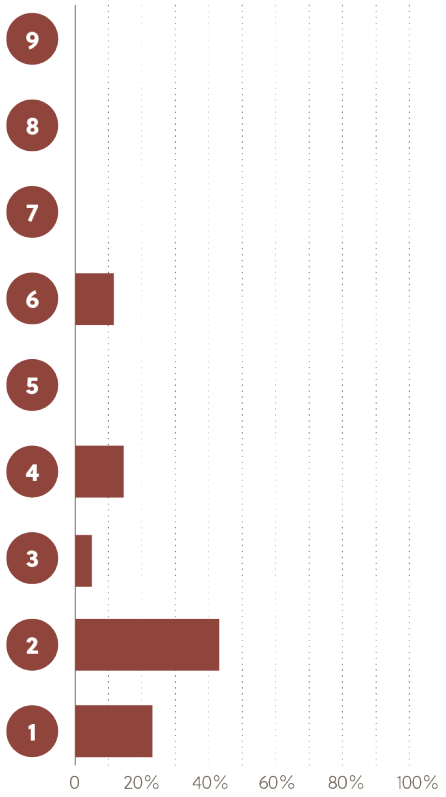


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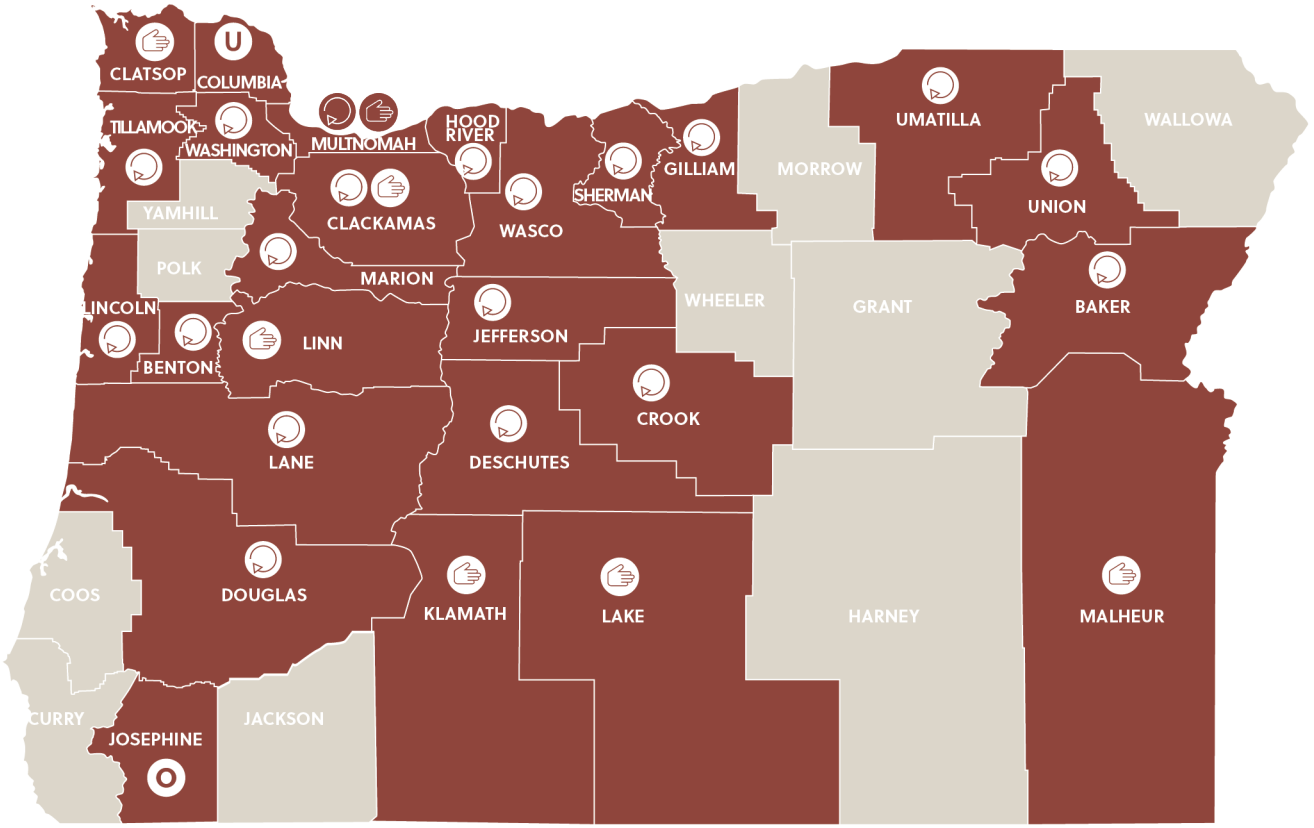
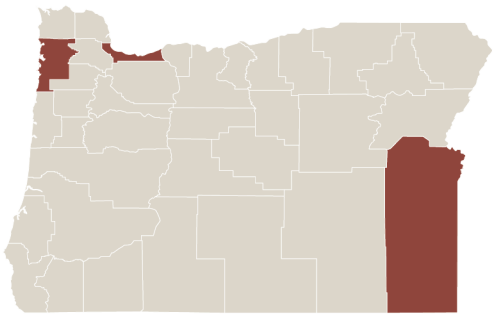
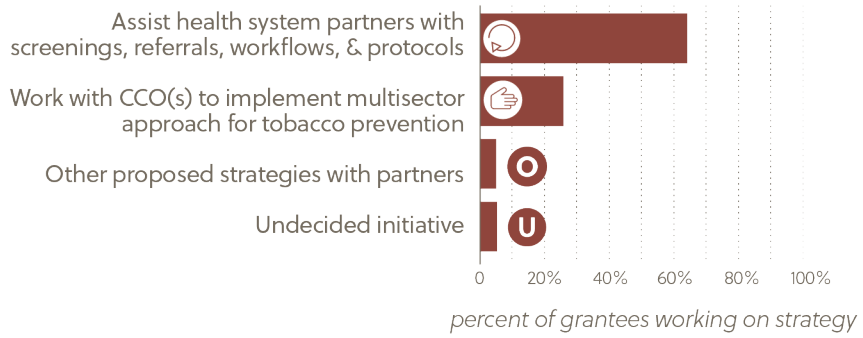
Figure 14: Health systems change initiative strategy types + overview (Dec. 2019)



Health System Change Initiatives Implemented:





TRAINING + TECHNICAL ASSISTANCE RECEIVED FROM HCPDP OR HPCDP CONTRACTORS

In an open-ended question, TPEP grantees (Tier 1-3) were asked to describe the training(s) or technical assistance received from HPCDP or a HPCDP contractor during the reporting period. Table 2 summarizes grantee responses.

The annual grantee and contractor meeting convenes all HPCDP grantees, HPCDP staff, and contractors to share and learn from each other and invited speakers about best practices for policy and systems change in support of health. These meetings also provide opportunities for networking and collaboration. Participation is required for Tier 1-3 grantees.

Regional support network (RSN) meetings convene all HPCDP grantees within a specific geographic area (defined as a region under HPCDP's technical assistance support model) to leverage funding within the region in support of policy, systems and environmental change goals. RSN meetings are opportunities for information sharing and training that aligns with regional needs. The RSN meetings provide a forum for building mutual support and collaboration on strategies to advance progress within the region and build statewide movement on policy strategies. Each RSN is supported by a team of HPCDP staff with expertise (liaison, policy specialist, surveillance/evaluation specialist, communications staff, and, and health systems) who answer questions, clarify requirements for grants, support RSN meeting planning and connect RSN members to other HPCDP resources as needed.

In addition to attending RSN meetings, grantees reported receiving TA from their HPCDP support team for:

- Assistance with Workplace Exposure Monitoring System (WEMS) complaints
- Support with TRL
- Clarification on ICAA regulations
- Guidance on TPEP work plan
- Local county data
- Survey development

Tobacco prevention policy calls (required for Tier 2-3, optional for other tiers) offer time to share updates on national, state and local tobacco policy initiatives. Policy calls have a tactical and operational focus, and are intended to provide a forum to share information with grantees in a timely manner, to provide peer support to inform each other's work, and to provide for group-level, operational support regarding grant requirements, program plans, lessons learned, and successes.

Grantees reported attending a number of HPCDP hosted webinars, including:

- TPEP coordinator orientation
- Lobbying videos
- Tobacco retail equity mapping project webinar
- Retailer education webinar
- TPEP RFA webinar
- TPEP budget webinar
- 2020 Oregon student health survey webinar
- Vaping epidemic webinar
- ICAA 101 training
- 2017-25 strategic plan webinar

Grantees reported receiving HPCDP contractor TA from Metropolitan Group for communications and TARA support, and from Rede Group for policy support.

Table 2: Training + TA received (n=27)

type of training or TA received	
annual grantee and contractor meeting	67%
TA from HPCDP support team	59%
webinar trainings	52%
HPCDP contractor TA	33%
Tobacco prevention policy calls	33%

NON-GOVERNMENTAL PARTNERSHIPS

Tier 1-3 grantees were asked to describe local and regional collaborations toward tobacco prevention strategies and partners engaged in ICAA expansion, tobacco retail, and tobacco-free government property policy. In response grantee listed a number of non-governmental and tribal partners they worked with to advance tobacco prevention policy and/or healthy systems changes during reporting period 1. The types of non-governmental and tribal partners and the level of partner engagement are summarized below.

Table 3: Partners engaged (n=27)

type of partners engaged	
Coalition/committee/workgroup	67%
Hospital/clinic/health system (other than CCO)	37%
education	26%
CCOs	26%
tribal	19%
RHEC	11%
CBO	7%
youth	4%

HEALTH SYSTEM PARTNERSHIPS

In the TPEP reporting form, grantees were asked to describe their health system partnerships. There were 67% of Tier 1-3 grantees reporting working with community partners, health system partners, or other stakeholders to improve cessation screening and closed-loop referral processes and nearly half (48%) worked with their local CCO during the reporting period. Nearly all (83%) Oregon CCOs were engaged in tobacco prevention work during the reporting period.

appendix

A. TPEP Evaluation Advisory Group
B. Stakeholder engagement plan
C. TPEP evaluation plan
D. TPEP reporting form
E. Map of jurisdictions that have passed ordinances to establish tobacco retail licensure: April 2020

Appendix A:

TPEP Evaluation Advisory Group

Name	Position
Steven Fiala	Evaluation and Surveillance Lead
Karen Girard*	HPCDP Section Manager (former)
Sarah Hargand	Surveillance and Evaluation Systems Lead
Ilana Kurtzig	Policy Specialist
Luci Longoria	Manager, State Policy, Systems and Environmental Change
Derek Smith	Tobacco Policy Specialist
Ashley Thirstrup	Manager, Community Policy, Systems and Environmental Change
Charina Walker	Community Program Liaison
Sarah Wylie	Health Promotion Strategist

*Left the advisory group in Summer 2020

»redegroup A SOCIAL IMPACT COMPANY

Appendix B:
Tobacco Prevention and Education Program Evaluation

TPEP Evaluation Purpose

1. Assemble data from the TPEP program to evaluate the effect of the tiered program model
2. Develop a better understanding of the best way to structure TPEP program technical assistance and partnerships development to meet desired outputs of increasing tobacco policy, systems, and environmental change

Stakeholder Engagement Proposal

HPCDP Engagement

The TPEP Evaluation Advisory Group is comprised of 9 HPCDP staff, including community program liaisons, policy specialists, data analysts, evaluation leads, communication strategists, and managers. The purpose of this group is to provide TPEP program insight and expertise and to guide the evaluation to ensure integrity and use.

The Advisory Group will be engaged to:

1. Inform the evaluation focus and design
2. Assist Rede in interpreting data
3. Inform product development and dissemination

Annual time commitment (anticipated): 10-15 hours and minimally 6 this year

TPEP Grantee Engagement

TPEP Supervisors and Local Health Department Administrators will be engaged through:

1. An email notification describing the evaluation and the ways LHD leaders can be involved in reviewing, planning, and executing the evaluation
2. An invitational webinar to discuss the evaluation plan and provide feedback
3. Participation in data collection
4. Biannual evaluation webinars to review preliminary results and provide feedback

Annual time commitment (anticipated): 3-10 hours; 3 hours before June 30, 2020

TPEP Coordinators

Two to five TPEP coordinators will be engaged to:

- Provide feedback on draft data collection tools
- Pilot test surveys/interviews conducted with grantees
- Participate in data collection
- Attend biannual evaluation webinars to review preliminary results and provide feedback

Annual time commitment (anticipated): 10-15 hours; 10 hours before June 30, 2020

Appendix C:

»Evaluation Plan:

Tobacco Prevention and Education Program Evaluation

» May 2020

»Contents

Rede Group » 240 N Broadway Suite 212 Portland Oregon 97227 » 503.764.9696 » redegroup.co

»Introduction

The Rede Group will conduct the Tobacco Prevention and Education Program Evaluation (TPEP Evaluation) under the direction of the Oregon Health Authority (OHA), Public Health Division (PHD), Health Promotion and Chronic Disease Prevention (HPCDP) Section and will engage Tobacco Prevention and Education Program grantees throughout the evaluation process. This is the third phase of the Oregon Tobacco Prevention Evaluation.

»Program Description

HPCDP is approaching strategies in tobacco prevention through the statewide annual funding stream (Tobacco Prevention and Education Program (TPEP)) that is distributed to all Local Public Health Authorities (LPHAs) to implement community tobacco prevention and education programs that are grounded in best practices for tobacco control and seek to make sustainable policy, systems, and environmental changes.

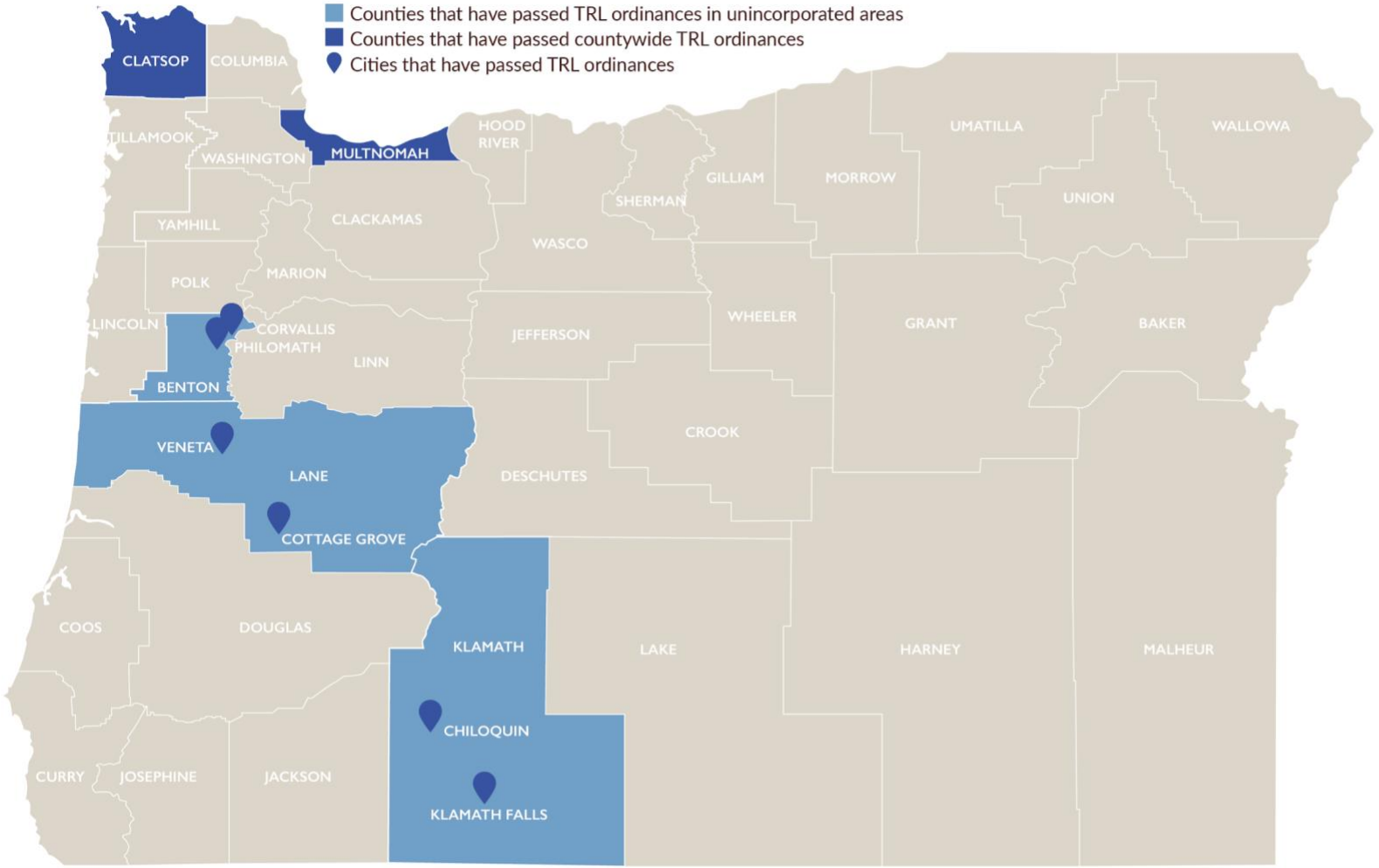
TPEP's priorities for comprehensive tobacco use reduction in Oregon are:

- Limiting the tobacco industry's influence in the retail environment;
- Increasing the price of tobacco, including through non-tax approaches (e.g., price promotion prohibitions, minimum pack size, etc.);
- Increasing the number of smoke- and tobacco-free government properties and public areas;
- Making cessation services available and accessible; and
- Educating decision-makers about the harms of tobacco.

Since 1998, Oregon TPEP has funded all county LPHAs to advance tobacco control efforts in local communities. TPEP grantees have been required to work on improving tobacco retail environments since the fiscal year 2013. This effort began with a requirement for each county to conduct a thorough observational assessment of the local retail environment. Since then, counties have been working to improve conditions through engagement and policy. In Oregon, two counties (Multnomah and Clatsop have passed a County-wide (covering all unincorporated and incorporated areas) ordinance to establish tobacco licensure and three counties (Benton, Klamath, and Lane) have passed a tobacco retail license policy in their unincorporated areas and in some additional cities (see map on page 2). In addition to tobacco retail strategies, HPCDP has prioritized tobacco-free government property policies and strategies to

strengthen and expand the Indoor Clean Air Act (ICAA). During the current TPEP funding stream HPCDP has also prioritized LPHAs to implement health system changes.

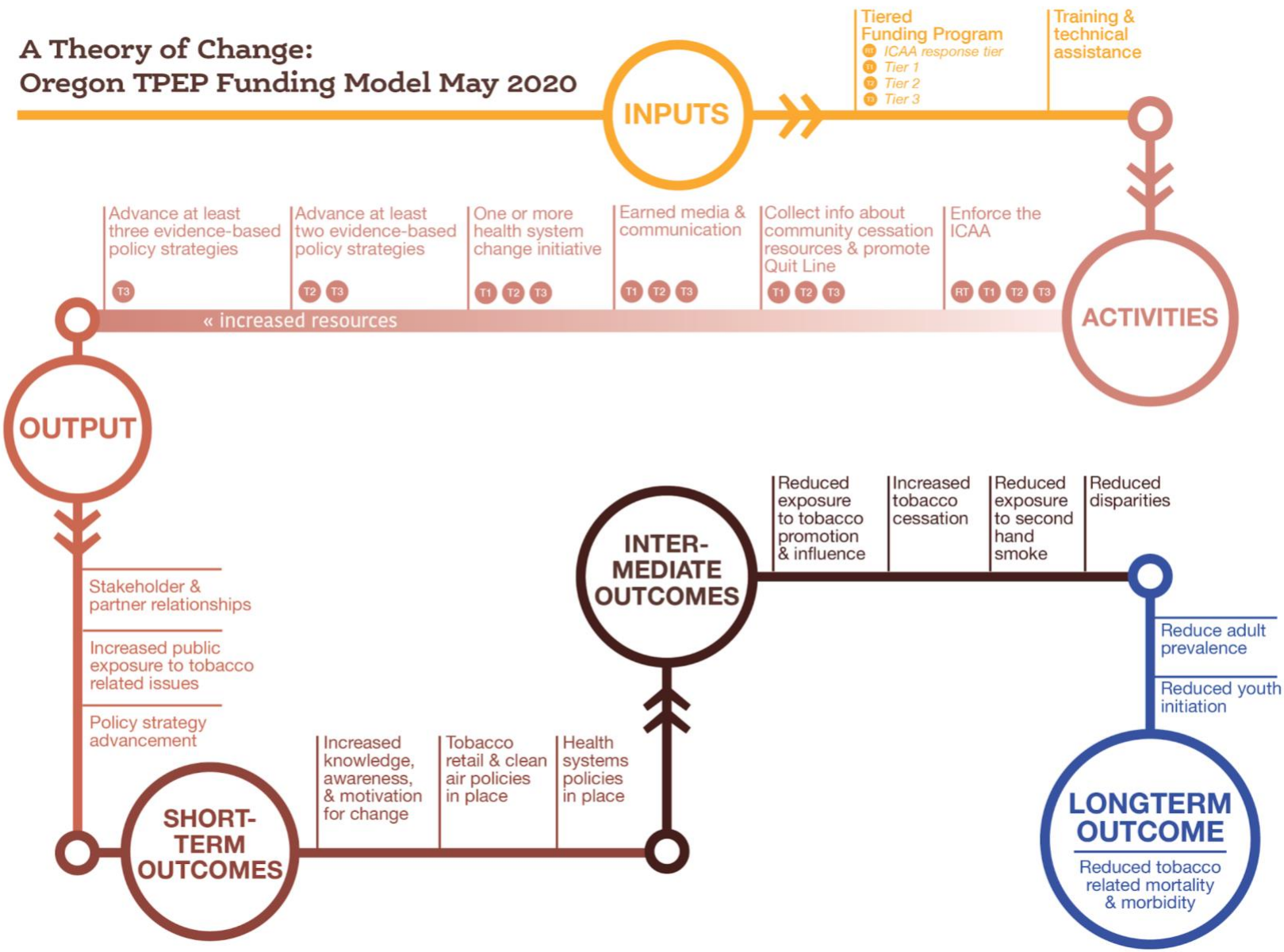
Jurisdictions that have Passed Ordinances to Establish Tobacco Retail Licensure: April 2020



During Summer 2017, OHA and the Conference of Local Health Officials (CLHO) committed to revising the TPEP funding formula to ensure program alignment with public health modernization strategies. A workgroup was formed to collaborate, plan, and offer criteria to ensure that the local TPEP investment is right-sized, and administered in the most effective manner possible statewide. The TPEP tiered funding model was developed with careful consideration of the 2018-2019 CLHO TPEP Funding Formula Workgroup recommendations, the Public Health Advisory Board funding principles[1], and the CLHO Funding Formula Checklist. The model offers the flexibility to nimbly deliver resources to LPHAs based on total tobacco prevention funding made available to OHA. The model allows LPHAs to opt in at the level of outcomes they can achieve. The model incorporates policy and systems change approaches that have traditionally been funded through competitive grants.

The theory of change (see page 4) for the Oregon TPEP funding model was developed through a collaborative process with the TPEP Evaluation Advisory Group and Rede (a group of HPDP staff and TPEP grantees selected to inform the evaluation design and interpret results). The model was developed to identify a common understanding of the inputs, activities, outputs, and outcomes of the TPEP funding model and will be used as a tool to guide the evaluation.

1 Public Health Advisory Board Funding principles for state and local public health


A Theory of Change:
Oregon TPEP Funding Model May 2020
INPUTS
Tiered Funding Program
ICAA response tier
Tier 1
Tier 2
Tier 3
Training & technical assistance
ACTIVITIES
Advance at least three evidence-based policy strategies
T3
Advance at least two evidence-based policy strategies
T2 T3
One or more health system change initiative
T1 T2 T3
Earned media & communication
T1 T2 T3
Collect info about community cessation resources & promote Quit Line
T1 T2 T3
Enforce the ICAA
RT T1 T2 T3
« increased resources
OUTPUT
Stakeholder & partner relationships
Increased public exposure to tobacco related issues
Policy strategy advancement
SHORT-TERM OUTCOMES
Increased knowledge, awareness, & motivation for change
Tobacco retail & clean air policies in place
Health systems policies in place
INTER-MEDIATE OUTCOMES
Reduced exposure to tobacco promotion & influence
Increased tobacco cessation
Reduced exposure to second hand smoke
Reduced disparities
Reduce adult prevalence
Reduced youth initiation
LONGTERM OUTCOME
Reduced tobacco related mortality & morbidity

Overview of Tiers and Required Activities

ICAA Response Tier

The ICAA Response Tier is for LPHAs that opt out of funding for tobacco prevention and only fulfill local duties and activities related to enforcing the ICAA as required by law.

Tier 1: Foundational Tobacco Prevention

Tier 1 provides funding to conduct local duties and activities related to enforcement of the Oregon Indoor Clean Air Act (ICAA) and to engage in basic tobacco prevention education and advocacy. Tier 1 is a bridge to full engagement in policy and systems change processes. LPHAs that select Tier 1 include those that have not yet demonstrated support from executive leadership and/or elected officials to pass tobacco prevention policies but want to maintain a tobacco prevention program that builds local capacity.

Tier 2: Tobacco Prevention Mobilization

Tier 2 is for LPHAs that have support from executive leadership and/or elected officials to advance policy change strategies, as well as relationships in place with health system partners to implement health systems change initiatives.

Tier 3: Accelerating Tobacco Prevention Outcomes

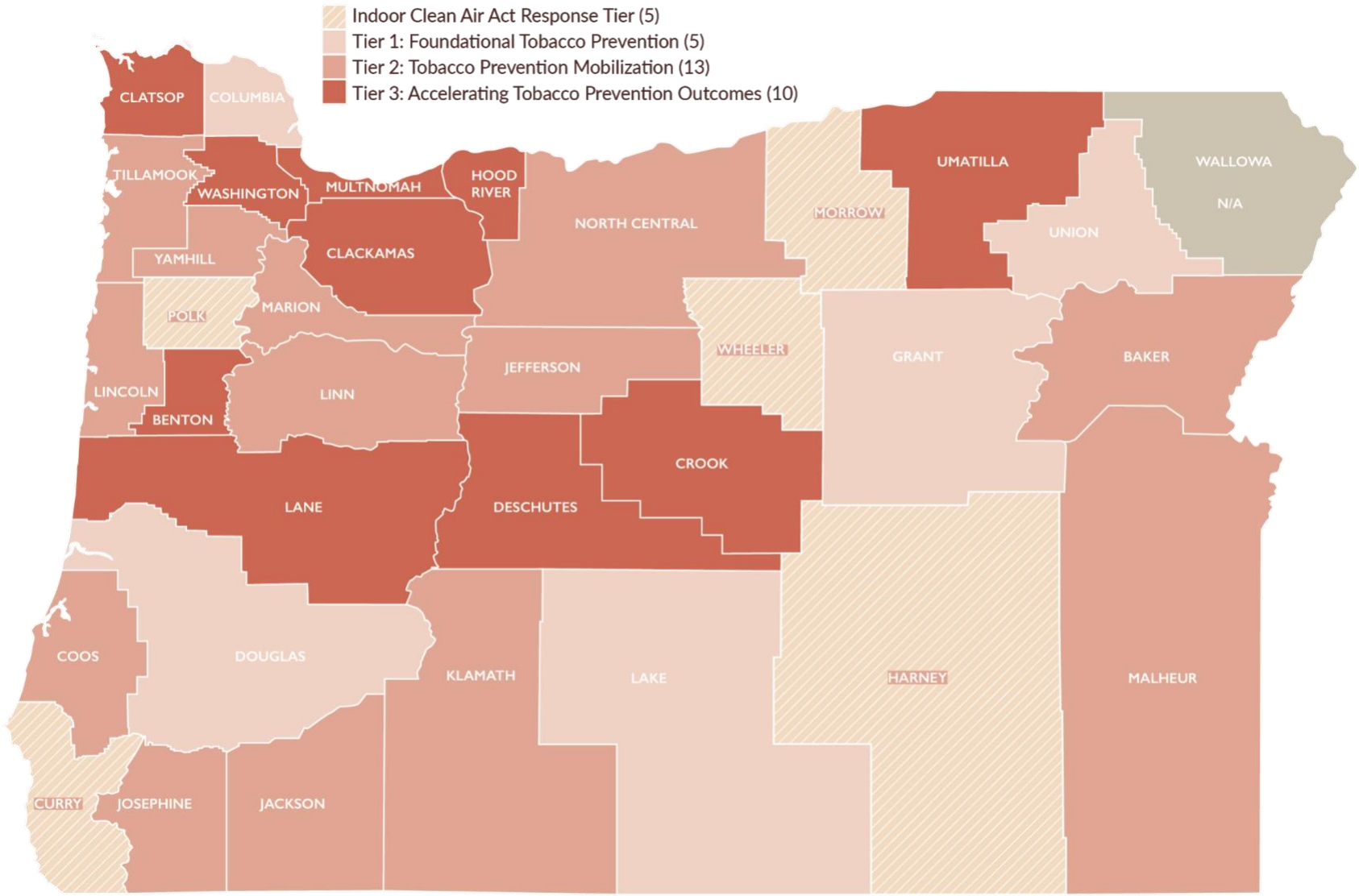
Tier 3 is for LPHAs that have demonstrated prior success by meeting six prerequisites outlined in the TPEP RFA and are prepared to lead statewide mobilization to decrease the harms of tobacco.

The table below displays required program activities for each Tier (excluding activities specific to monitoring & evaluation, communication, training & technical assistance, and ADPEP coordination and alignment)

Program Activities:	ICAA Response Tier	Tier 1	Tier 2	Tier 3
1. Enforce the Oregon ICAA	X	X	X	X
2. One or more health system change initiative		X	X	X
3. Promote the use of the Oregon Tobacco Quit Line with health systems partners and the public		X	X	X
4. Collect information about community cessation resources throughout the area covered by your program and provide this information to HPCDP and the regional CCO(s)		X	X	X
5. Advance at least two evidence-based policy strategies (ICAA Expansion, Tobacco Retail and/or Tobacco-free Gov't Property)			X	
6. Advance at least three evidence-based policy strategies (ICAA Expansion, Tobacco Retail and/or Tobacco-free Gov't Property)				X

The map on the following page shows the tier each county has selected, with 70% of Oregon Counties in Tier 2 or 3. Wallowa County does not have an LPHA and therefore does not receive TPEP funding.

Tobacco Prevention and Education Program Funding Tiers



»Situational Analysis

HPCDP and the contracted evaluation team have identified the following factors as important considerations for this evaluation.

Tiered Program and Funding Model

HPCDP implemented a new tiered model in August 2019 that allowed for TPEP grantees to opt into a level of funding and program requirements based on their leadership and community readiness for tobacco prevention policy. The implementation of the new model which included a period of work plan negotiation possibly delaying the start of TPEP work should be a consideration in this evaluation. Additional changes to the TPEP program model including modifications to the training and TA structure to better support TPEP grantees based on feedback provided by grantees in previous funding cycles and additional and more detailed communications requirements.

Co-Occurring Evaluations

LHDs will participate in multiple co-occurring evaluation projects such as the Tobacco Prevention Campaign Evaluation and the Tobacco and Alcohol Retail Assessment Evaluation during the timeframe of the TPEP Evaluation. These co-occurring activities may cause confusion among tobacco program coordinators who are new to their role. Care will be taken with the timing of data collection and dissemination of results to ensure optimal utilization.

Local Program Staff Turnover

Previous TPEP evaluations have shown that over one third of local TPEP coordinators leave their position each year and some positions remain vacant for months at a time. Because this evaluation seeks (in part) to measure policy change progress and achievements, the level of new staff should be taken into consideration as results and program improvements are measured and developed.

Tobacco Tax

The outcome of House Bill 2270 to increase cigarette tax, introduce a tax on inhalant delivery systems, and increase the cap on cigar taxes in November 2020 will likely impact the work of local tobacco programs across the state. If passed, it is possible that decision/policy makers may feel less motivation or inclination toward local policy change.

Public Health Crises: Lung Illness & Vaping Crisis and Novel Coronavirus-19

The timing of the nationwide lung illness and vaping crisis and the novel coronavirus-19 pandemic are essential considerations for the execution of the TPEP Evaluation. The response to these public health crises affect the availability of key stakeholders in this evaluation, such as HPCDP and LPHAs to contribute to the evaluation. The evaluation team acknowledges the challenge these crises may impose on data collection activities, stakeholder engagement, and meetings with HPCDP and TPEP grantees. All communications for the evaluation will take place virtually from March 23 until further notice.

Political Challenges Between CLHO and OHA

Determining allocation of resources between state health departments and local health often causes tension or conflict as enduring differences in values create different ideas about how funds should be spent.

»Framework & Focus

The 2019-21 Oregon TPEP evaluation will follow a utilization-focused evaluation framework.[2] The evaluation focuses on the outcomes of the implementation of the tiered funding model, policy and health systems work, state-to-local technical assistance, and non-governmental partnerships to inform the structure of future Oregon TPEP programs. The user groups identified for this evaluation include HPCDP and TPEP grantees.

Stakeholder Engagement

HPCDP Engagement: The TPEP Evaluation Advisory Group is composed of 9 HPCDP staff, including community program liaisons, policy specialists, evaluation leads, communication strategists, and managers. The purpose of this group is to provide TPEP program insight and expertise and to guide the evaluation to ensure integrity and use.

The Advisory Group will be engaged to:

1. Inform the evaluation focus and design
2. Assist Rede in interpreting data

[2] Patton, M.Q. (2008). Utilization-Focused Evaluation, 4th Edition. Thousand Oaks, CA: Sage Publications, Inc.

3. Inform product development and dissemination

TPEP Grantee Engagement

TPEP Supervisors and Local Health Department Administrators will be engaged through:

1. An email notification describing the evaluation and the ways LHD leaders can be involved in reviewing, planning and executing the evaluation
2. An invitational webinar to discuss the evaluation plan and provide feedback
3. Participation in data collection
4. Biannual evaluation webinars to review preliminary results and provide feedback

Two to five TPEP coordinators will be engaged to:

1. Provide feedback on draft data collection tools
2. Pilot test surveys/interviews conducted with grantees

All Tier 1, 2 and 3 TPEP coordinators will be engaged to:

1. Participate in data collection activities
2. Attend biannual evaluation webinars to review preliminary results and provide feedback

During evaluation webinars, attendees will be invited to ask questions and provide input on evaluation activities and results. The timing of all grantee engagement will be determined based on availability to participate in engagement activities.

Evaluation Activities

Assemble and Analyze Information to Answer 3 Key Evaluation Questions:

1. What level of progress, if any, did tier 1, 2, and 3 grantees make towards advancing health systems change, tobacco retail policy, ICAA expansion policy, and/or tobacco-free gov't property policy?

2. In what ways does the 2019-21 TPEP TA structure facilitate or impede grantee progress on their work plans?

3. To what level did the program model facilitate creating non-governmental (outside of LHD, outside of ADPEP) partnerships that advanced toward co-leading initiatives?

»Methods

KEQ 1: What level of progress, if any, did tier 1, 2, and 3 grantees make towards advancing health systems change, tobacco retail policy, ICAA expansion policy, and/or tobacco-free gov't property policy?

Method	Data Source	Timeframe	Grantee Time Commitment
Analyze the stage of systems change/policy progress for each strategy at four points in time. Tobacco retail and indoor clean air policies will be analyzed in comparison to data collected in previous evaluations.	Tier 1, 2, and 3, TPEP reporting form data provided by HPCDP (29 grantees)	PIT 1: May 2020 PIT 2: Aug. 2020 PIT 3: Feb. 2021 PIT 4: Aug. 2021	No additional time commitment

KEQ 2: In what ways does the 2019-21 TPEP TA structure facilitate or impede grantee progress on their work plans?

Method	Data Source	Timeframe	Grantee Time Commitment
Analyze training and TA section of TPEP reporting form data at four points in time.	Tier 1, 2, and 3, TPEP reporting form data provided by HPCDP (29 grantees)	PIT 1: May 2020 PIT 2: Aug. 2020 PIT 3: Feb. 2021 PIT 4: Aug. 2021	No additional time commitment
Interview regarding the role training and TA played in system change or policy progress administered to: 1. Grantees who pass a policy or implement a systems change (word of mouth, TPEP listserv, TPEP reporting forms, etc.) 2. Grantees that advance one or more stages through the Policy Change Process Model identified through grantee reporting form data collected in July 2020,	Tier 1, 2, and 3 grantees (up to 29 grantees)	Ongoing: grantees that pass policies Aug. 2020: grantees making progress from PIT 1 to 2 Feb. 2021: grantees making progress form PIT 2 to 3 Aug 2021: grantees making progress from PIT 3 to 4	30 min. per interview

Jan. 2021, July 2021		(tentative based on having enough time to analyze data prior to submitting final report)	

KEQ 3: To what level did the program model facilitate creating non-governmental (outside of LHD, outside of ADPEP) partnerships that advanced toward co-leading initiatives?

Method	Data Source	Timeframe	Grantee Time Commitment
Analyze partnerships sections of TPEP reporting form data at four points in time.	Tier 1, 2, and 3, TPEP reporting form data provided by HPCDP (29 grantees)	JPIT 1: May 2020 PIT 2: Aug. 2020 PIT 3: Feb. 2021 PIT 4: Aug. 2021	No additional time commitment
Survey/interview to identify non-governmental partnerships and level of engagement in systems and policy change strategies.	Tier 1, 2, and 3 grantees (29 grantees)	April 2021	1 hour per grantee

»Analysis

The evaluation team will perform basic analyses of surveys and interview data using qualitative and quantitative analysis methods. The TPEP Evaluation Advisory Group will be involved in reviewing this basic analysis and further developing the analytic framework as well as assisting with interpreting results. Analyses will be conducted with a continuous emphasis on results that will be most useful for primary intended users.

»Reporting & Dissemination

- The evaluation team will develop two interim evaluation reports and one comprehensive summary report with results and recommendations based on this evaluation.
- A dissemination plan of the evaluation results will be developed in collaboration with TPEP Evaluation Advisory Group.

- The evaluation team will conduct a meta-evaluation at the conclusion of the project.

»Timeline

Item	Evaluation Activities	Time Frame
1	Ongoing client communication and project management	Oct. 2019 – Sept. 2021
2	Project start-up	Oct. – Nov. 2019
3	Evaluation and stakeholder engagement planning	Nov. 2019 – March 2020
4	HPCPD stakeholder engagement in evaluation design and key questions	Dec. 2019 – March 2020
5	*Write and submit to HPCDP a detailed evaluation plan and timeline	April 2020
6	KEQ 1: PIT 1 analysis	May 2020
7	KEQ 2: Data collection tool development	May 2020
8	KEQ 2: Data collection & analysis	June 2020
9	Opportunity for all TPEP grantee, supervisor, and Local Public Health Administrator engagement	June 2020
10	KEQ 1: PIT 2 analysis	Aug. 2020
11	KEQ 2: Data collection & analysis	Sept. 2020
12	Data interpretation with TPEP Evaluation Advisory Group	Oct. 2020
13	*Write and submit interim evaluation report #1	Oct. 2020
14	Opportunity for all TPEP grantee, supervisor, and Local Public Health Administrator engagement	Nov. 2020

15	KEQ 3: data collection tool development	Nov. 2020
16	KEQ 1: PIT 3 analysis	Feb. 2021
17	KEQ 2: Data collection and analysis	March 2021
18	Data interpretation with TPEP Evaluation Advisory Group	April 2021
19	*Write and submit interim evaluation report #2	May 2021
20	Opportunity for all TPEP grantee, supervisor, and Local Public Health Administrator engagement	June 2021
21	KEQ 3: data collection and analysis	June – July 2021
22	KEQ 1: PIT 4 analysis	Aug. 2021
23	KEQ 2: Data collection and analysis (tentative based on timing of available PIT 4 data)	Aug. 2021
24	Data interpretation with TPEP Evaluation Advisory Group	Sept. 2021
25	* Write and submit final evaluation report	Sept. 2021

**Deliverables*

Appendix D:

TPEP Reporting Form: 2019-2021 Period 1

Tier information

1) Enter the first and last name of the individual filling out this form for your county*

_____

2) Please check the box next to your program's tier*

( ) Tier 1

( ) Tier 2

( ) Tier 3

---

90 Day Program Plan Reporting

3) Please list all activities (grouped by strategy) listed in your program plan during the initial 90-day plan period from July 1, 2019 – September 30, 2019- Please note if activities were completed, carried through to the next quarter or not completed*

_____

_____

_____

_____

4) Please list any additional information related to challenges, successes or contextual information related to your work during the first 90-days of the reporting period*

_____

_____

_____

_____

Training and Technical Assistance

5) What training(s) or technical assistance did you receive from HPCDP or a HPCDP contractor?*

_____

_____

_____

_____

6) What training(s) or technical assistance did you receive from other sources?*

_____

_____

_____

_____

Local and Regional Collaboration

7) How did you engage in local or regional collaboration toward tobacco prevention strategies?*

_____

_____

_____

_____

8) Did you have an opportunity to either provide or receive mentoring from another TPEP, ADPEP or RHEC grantee?*

( ) Yes

( ) No

9) Please describe, the mentoring you provided or received from another TPEP, ADPEP or RHEC grantee?*

_____

_____

_____

_____

10) Did you engage in joint strategies with the Alcohol and Drug Prevention Education Program in your community?*

( ) Yes

( ) No

11) How did you engage in joint strategies or activities with the Alcohol and Drug Prevention Education Program Coordinator in your community?*

[ ] Collaborated using data; (i.e. developed or conducted survey together, conducted a focus group together, etc.)

[ ] Co-presented to decision maker(s)

[ ] Developed policy or systems change strategy concepts together and/or aligned messaging

[ ] Educated youth or parents together

[ ] Co-presented or hosted community event(s) or collaboratives

[ ] Other - Write In (Required): _____*

Overall Program Successes and Barriers

12) Please provide information about your top one to two program successes during the reporting period.*

_____

_____

_____

_____

13) Provide additional information regarding your program's challenges during the reporting period. For example, have your planned activities been influenced by capacity constraints, lack of community support or infrastructure issues?*

_____

_____

_____

_____

Health Systems Strategy

14) For the next series of questions, please reference your Health Systems Strategy work during the full six month reporting period. If you have more than one health systems strategy you will be able add additional health systems strategies at the end of the section.

---

a. Briefly describe your health systems strategy*

_____

_____

_____

_____

b. During the reporting period, did your program work with community partners, health system partners, or other stakeholders to improve cessation screening and closed loop referral processes?*

( ) Yes

( ) No

c. If your program worked with community partners, health system partners, or other stakeholders to improve cessation screening and closed loop referral processes, briefly describe the work you did (If none enter NA)*

_____

_____

_____

_____

d. During the reporting period, did your TPEP program work with your local Coordinated Care Organization? (ex. integration of tobacco dependence treatment into workflows, tobacco prevention multi-sector interventions, etc.)*

( ) Yes

( ) No

e. If your TPEP program worked with your local Coordinated Care Organization, briefly describe the work you did (If none enter NA).*

_____

_____

_____

_____

f. At the end of the reporting period, which of the following best describes the stage of change of your health systems change initiative?*

( ) Identify and describe the problem: The problem and potential solutions to address it have been identified.

( ) Engage stakeholders: Organizations and stakeholders have been identified to build support for action.

( ) Assess readiness for change: Community partners and decision makers have been assessed for support. Meetings, focus groups have been convened and data has been collected.

( ) Community and Decision Maker Education- Capacity Building: Networks have been strengthened and engaged through relationships and advocacy. Concerns have been researched and resolved. A cohesive plan has been developed that ensures all organizations understand their role in the change.

( ) Systems Change Adoptions: The strategy has been adopted and is sustainable.

( ) Implement the plan and learn from action: The strategy has been implemented and is being monitored through continuous quality improvement. Accomplishments are shared with all partners involved. Learnings are communicated.

g. Describe any successes related to your health systems strategy

_____

_____

_____

_____

h. Describe any successes related to your health systems strategy

_____

_____

_____

_____

_____

Communications

15) Did you complete any of the activities related to your communications plan?*

( ) Yes

( ) No

16) Please check the box if you completed any of the following communications activities during the reporting period:

[ ] Presented information to community members or decision makers through a formal presentation

[ ] Posted messages from the Smokefree Oregon social media calendar on county social media sites

[ ] Used earned media template provided by HPCDP

ability to plan

17) Please check the box if you completed any of the following communications activities during the reporting period:

[ ] Presented information to community members or decision makers through a formal presentation

[ ] Posted messages from the Smokefree Oregon social media calendar on county social media sites

[ ] Used earned media template provided by HPCDP

[ ] Presented to a leadership body or members of that body about program's policy goals.

[ ] Provided program updates to external partners (ex. a listserv or blog)

[ ] Secured earned media piece (if yes – please upload pdf)

[ ] Hosted an earned media event. ("earned media event" is defined as any event where the media have been invited to further the program's health systems or policy objectives. This may include a special event hosted by the program's organization, an event hosted by a community partner, or another event with opportunities for media advocacy.)

18) Please upload PDF of earned media that was secured.*

_____1

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Indoor Clean Air Act

19) Were there any Indoor Clean Air Act enforcement issues or concerns to report during this period?*

( ) Yes

( ) No

20) Please describe the Indoor Clean Air Act enforcement issues or concerns to report during this period?*

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Policy Change

21) Were any polices adopted during the reporting period?*

( ) Yes

( ) No

22) The following questions are based on polices adopted during the reporting period.

a. Briefly describe the policy adopted*

_____

_____

_____

_____

b. What was the date the policy above was enacted?*:

_____

All adopted policies should be submitted to your liaison.

c. Have you submitted the actual policy to your liaison to enter into the HPCDP policy database?*

( ) Yes

( ) No

Policy Change: Indoor Clean Air Act local policy expansion

23) Are you working on Indoor Clean Air Act local policy expansion?*

( ) Yes

( ) No

24) Briefly describe your strategy*

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_____

25) Please indicate a single stage in the Policy Change Process Model where you are currently spending most of your time and effort in this area: *

( ) **Identify and describe the problem.** The problem and potential solutions to address it have been identified.

( ) **Engage Stakeholders.** Organizations and stakeholders have been identified to build support for action.

( ) **Assess Readiness for Change.** Community and local decision makers have been assessed for support. Interviews, focus groups and/or polls or surveys have been conducted.

( ) **Community and Decision-Maker Education- Capacity Building.** Networks have been strengthened and engaged through relationships and advocacy. Concerns have been researched and resolved. A cohesive education plan has been developed that incorporates multiple outreach methods.

( ) **Community/Policy Adoption.** Planned program strategy has been adopted and is sustainable.

( ) **Implementation the plan and learn from action.** Planned program strategy has been implemented and is being monitored through continuous quality improvement. Accomplishments are shared with HPCDP and all partners involved. Learnings are communicated.

26) Please briefly describe any challenges, successes, and partners engaged.*

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Policy Change: Tobacco retail licensure or tobacco retail policies?

27) Are you working on tobacco retail license or tobacco retail policies*

( ) Yes

( ) No

28) Briefly describe your strategy*

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29) Please indicate a single stage in the Policy Change Process Model where you are currently spending most of your time and effort in this area:*

( ) **Identify and describe the problem.** The problem and potential solutions to address it have been identified.

( ) **Engage Stakeholders.** Organizations and stakeholders have been identified to build support for action.

( ) **Assess Readiness for Change.** Community and local decision makers have been assessed for support. Interviews, focus groups and/or polls or surveys have been conducted.

( ) **Community and Decision-Maker Education- Capacity Building.** Networks have been strengthened and engaged through relationships and advocacy. Concerns have been researched and resolved. A cohesive education plan has been developed that incorporates multiple outreach methods.

( ) **Community/Policy Adoption.** Planned program strategy has been adopted and is sustainable.

( ) **Implementation the plan and learn from action.** Planned program strategy has been implemented and is being monitored through continuous quality improvement. Accomplishments are shared with HPCDP and all partners involved. Learnings are communicated.

30) Please briefly describe any challenges, successes, and partners engaged.*

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Policy Change: Tobacco free government properties

31) Are you working on tobacco free government property policy?*

( ) Yes

( ) No

32) Please describe your strategy*

33) Please indicate a single stage in the Policy Change Process Model where you are currently spending most of your time and effort in this area:*

( ) **Identify and describe the problem.** The problem and potential solutions to address it have been identified.

( ) **Engage Stakeholders.** Organizations and stakeholders have been identified to build support for action.

( ) **Assess Readiness for Change.** Community and local decision makers have been assessed for support. Interviews, focus groups and/or polls or surveys have been conducted.

( ) **Community and Decision-Maker Education- Capacity Building.** Networks have been strengthened and engaged through relationships and advocacy. Concerns have been researched and resolved. A cohesive education plan has been developed that incorporates multiple outreach methods.

( ) **Community/Policy Adoption.** Planned program strategy has been adopted and is sustainable.

( ) **Implementation the plan and learn from action.** Planned program strategy has been implemented and is being monitored through continuous quality improvement. Accomplishments are shared with HPCDP and all partners involved. Learnings are communicated.

34) Please briefly describe any challenges, successes, and partners engaged.*

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Additional information provided

35) Please add any additional information about TPEP work conducted not captured in the Program Plan Activity Report on the TPEP Online Report.

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(untitled)

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(untitled)

Appendix E: Map of jurisdictions that have passed ordinances to establish tobacco retail licensure: April 2020