interim report 2

03|2021

TOBACCO PREVENTION & EDUCATION PROGRAM EVALUATION

Oregon Health Authority

A SOCIAL IMPACT COMPANY

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terminology

ACRONYMS:

ADPEP: Alcohol and Drug Prevention and 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 Prevention Section (OHA, HPCDP). **This document reports activities and results of the TPEP evaluation during the first 12 months (July 2019 - June 2020) of the funding cycle with a focus on the second six months (January - June 2020).**

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 partnerships outside of their local health department.

Figure 1 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.

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 2020 has delayed TPEP grantee engagement in the evaluation design and data collection activities. Therefore, grantee engagement in the evaluation began in fall 2020.

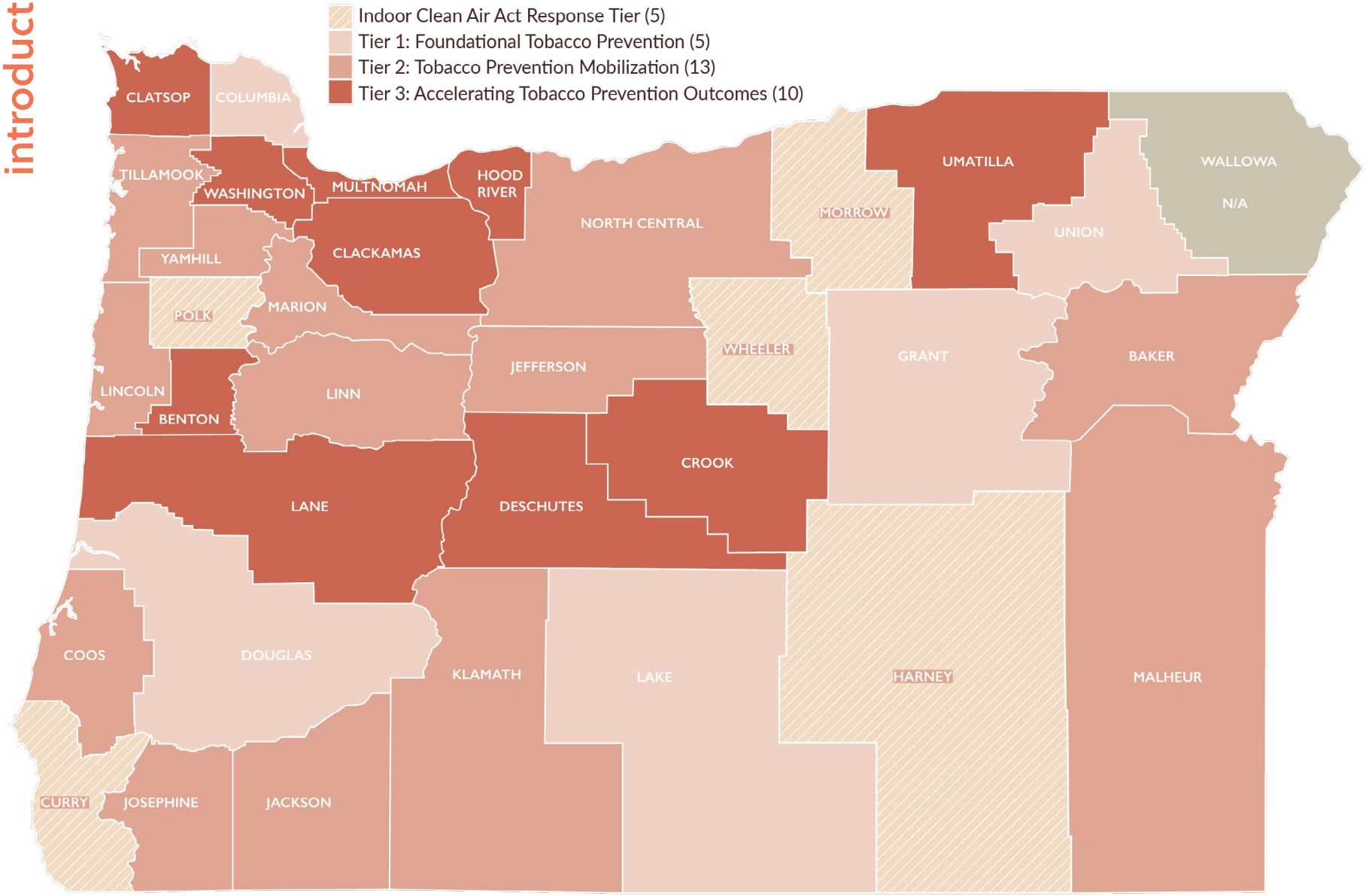
KEY EVALUATION QUESTIONS

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 did TA provided by HPCDP support advancing local work?
3. What types of partnerships (outside of TPEP and ADPEP) did TPEP programs engage in and how did their partnerships contribute to advancing their work?

EVALUATION ACTIVITIES COMPLETED AUGUST-DECEMBER 2020:

- TPEP Evaluation Advisory Group engagement including evaluation plan and theory of change model modifications
- TPEP reporting period 2 analysis
- Reviewed and summarized HPCDP communication to TPEP grantees during COVID-19 regarding program direction and requirements

Figure 1: TPEP Funding Tiers



TPEP EVALUATION ADVISORY GROUP ENGAGEMENT

Beginning in Fall of 2020, Rede Group began engaging grantees in this evaluation, expanding the TPEP Evaluation Advisory Group to include local public health representation. The Advisory Group (see appendix A) is now composed of four HPCDP staff (policy specialist, health promotion strategist, epidemiologist, and manager) and nine (geographically diverse) local programs representing Tiers 1, 2, and 3. Figure 2 shows which counties are represented on the Advisory Group.

In December, Rede Group convened the Advisory Group to discuss the role of the group, the work that had been completed up to this point, revisions to the theory of change (see appendix B for updated theory of change model), key evaluation questions, and data collection methods.

The Advisory Group has established a monthly meeting schedule for the remainder of the evaluation. The Advisory Group's role includes:

- Provide feedback on draft data collection tools
- Pilot test surveys/interviews conducted with grantees
- Participate in data collection
- Review preliminary results and provide feedback

TPEP 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, Tier 1-3 funded programs must complete a progress report and a follow-up interview with their HPCDP liaison to describe progress made over the past six months on the approved local program plan. Reports include the following periods:

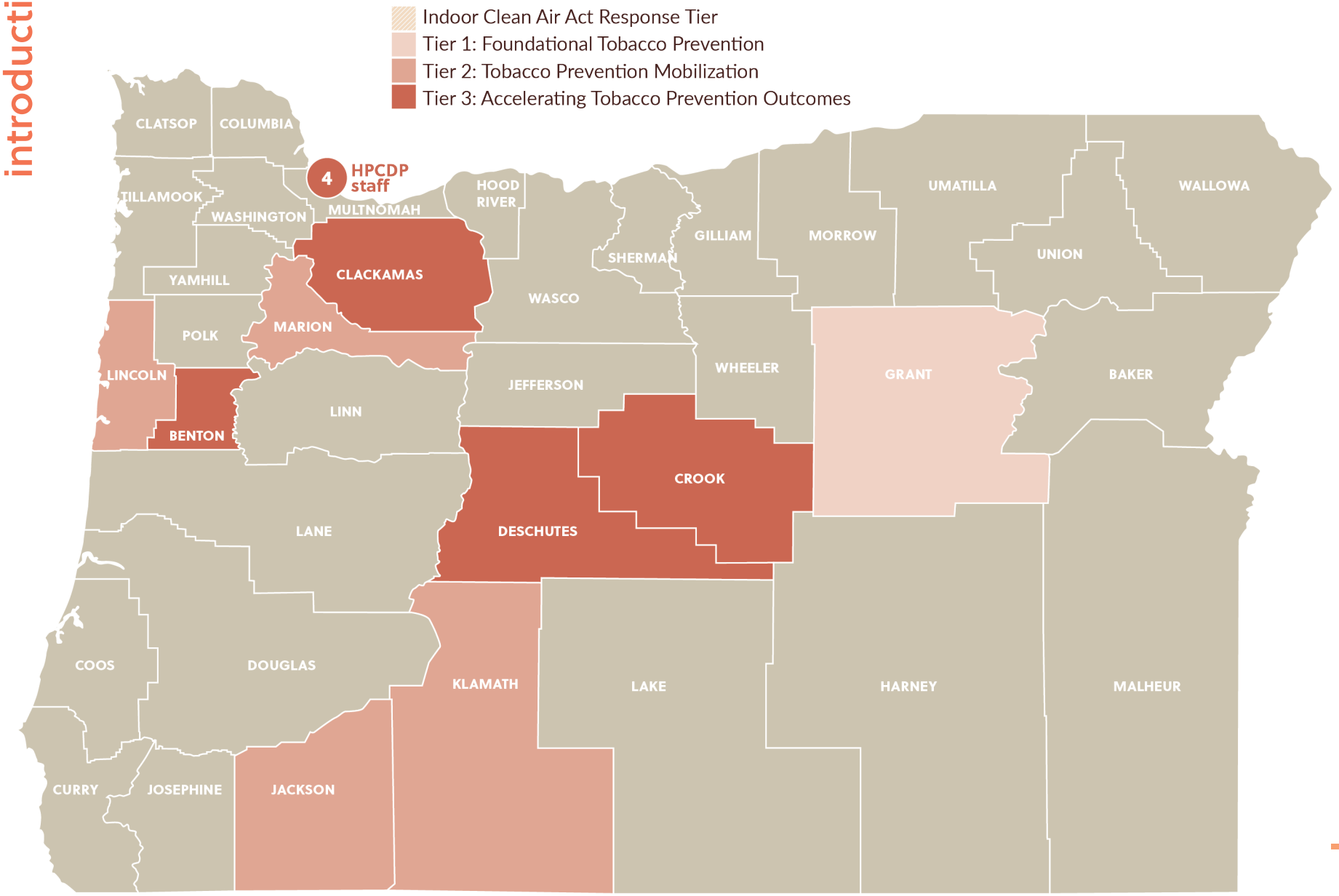
- Period 1 : Jul. - Dec. 2019
- Period 2: Jan. - Jun. 2020*
- Period 3: Jul. - Dec. 2020
- Period 4: Jan. - Jun. 2021

Rede Group 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 are one source of information for answering evaluation questions. Reporting period 2 (Jan.-Jun. 2020) data were collected from 24/28 (86%) Tier 1-3 grantees.

**Reporting form data collection happened on a reduced scale in the summer of 2020 due to the impact of COVID-19 on LPHAs.*

Figure 2: TPEP Advisory Group



PROGRAM DIRECTION AND CHALLENGES DUE TO COVID-19

Grantee reports included questions about the impact of COVID-19 on their work. All TPEP programs experienced challenges to advancing grant work due to COVID-19. Of the 24 grantees that submitted reports, 75% reported that LPHAs, including TPEP coordinators and supporting staff, were shifted to COVID-19 response and the focus was shifted away from TPEP objectives.

Due to COVID-19, 96% of TPEP programs had difficulty with lack of community, stakeholder, and partner engagement. Community closures and program activities were delayed, resulting in timelines and deadlines shifting. Many TPEP coordinators reported it was difficult transitioning to online engagement, troubles arose from technical difficulties, meetings were shortened, and policy change momentum slowed.

In March 2020, OHA suspended county-level Oregon Indoor Clean Air Act activities. At the time of this report, county-level enforcement activities have not resumed. This includes Initial Response Letters (IRLs), processing citations, and logging actions into the Workplace Exposure Monitoring System (WEMS). OHA assumed all responsibility for ICAA activities during this time period, except for conducting inspections, which are not currently happening.

TPEP funds were not allowed to be used for COVID-19 response. Optional program plan and budget revisions were due July 31, 2020 to allow time to review prior budgets and get a necessary contract amendment, if needed.

POLICIES PASSED

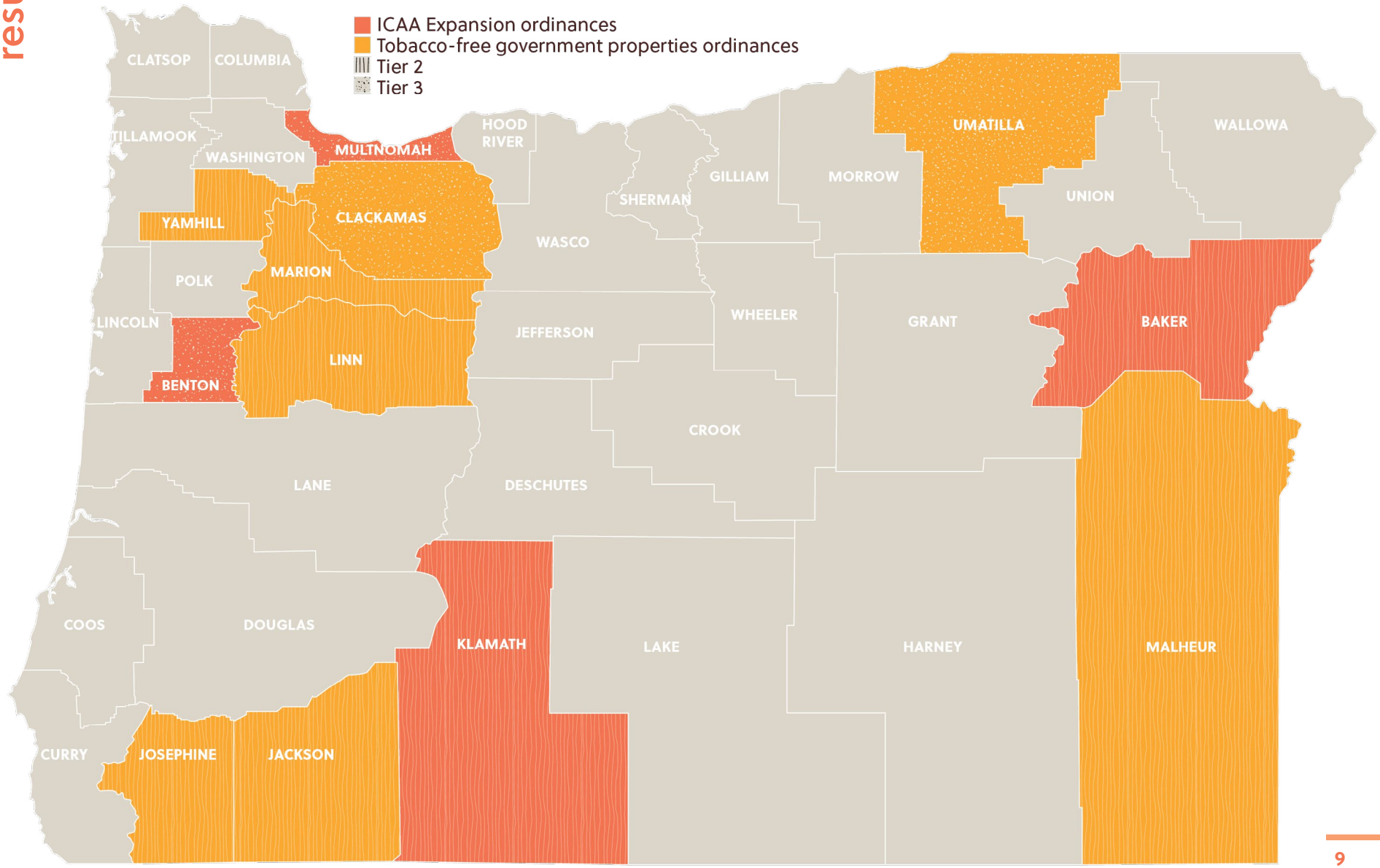
During reporting period 2, one county passed a tobacco prevention policy. The Baker County Health Department passed a marijuana and tobacco free policy.

Figure 3 on the following page identifies the counties that passed a tobacco prevention policy since the start of the grant cycle (July 2019-June 2020). Since July 2019, 12 tobacco prevention policies passed including three ICAA expansion policies and nine tobacco-free government property policies.

Percent of grantees passing a policy since July 2019 by tier:

- Tier 2 grantees (n=13) — **62%**
- Tier 3 grantees (n=10) — **40%**
- Tier 2 & 3 grantees (n=23)— **52%**

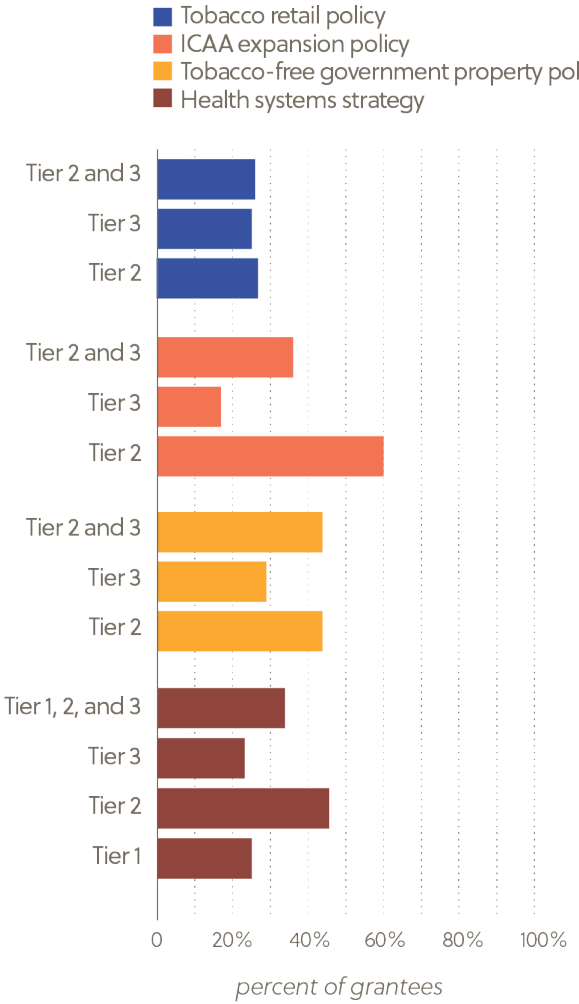
Figure 3: Tobacco prevention policies passed: July 2019 - June 2020



POLICY PROGRESS

TPEP grantees identify the stage of change of each of their tobacco prevention policies and health systems change strategies at each reporting period using the Policy Change Process Model (see appendix C). Figure 4 shows the percent of grantees progressing through one or more stages of policy/systems change from reporting period 1 to period 2. In the first six months of the grant, 33% of grantees have advanced a health system strategy. Grantees have progressed tobacco-free government property policies at a slightly higher rate than ICAA expansion and tobacco retail policies. At this stage of the evaluation, it does not appear that Tier 3 grantees are progressing policy/systems change at a greater rate than Tier 2 or 1 grantees.

Figure 4: Progress through one or more stages of policy change from reporting period 1 (Dec. 2019) to period 2 (June 2020):



TPEP PROGRAM SUCCESSES

In addition to identifying the stage of policy change for each of their policy strategies, grantees reported their top one to two program successes during the reporting period. The accomplishment that overlapped across all tiers was the dissemination of tobacco cessation information within the grantees' communities through traditional media and social media outlets. In addition, common Tier 2 and Tier 3 accomplishments included presenting information about tobacco-free policies to city/county decision makers and obtaining policy support from leadership. A more detailed description of program successes by tier is summarized below:

TIER 1: The most common program successes mentioned across Tier 1 grantees included media and community successes, such as the "dissemination of Smokefree Oregon Tobacco campaign on media/social media" and the "increase in Facebook community engagement per TPEP post." Additionally, these grantees also reported accomplishments in providing TA support to coalition staff and community, and implementing systems changes, such as offering a tobacco/vaping cessation screening tool.

TIER 2: The most common program successes mentioned across Tier 2 grantees included media and community achievements, presenting policy to city or county leadership, and the passing of an ordinance or policy. For media and community successes, grantees mainly reported accomplishments regarding attending and supporting community meetings, community education, or information dissemination through social media. In addition, grantees reported policy presentation accomplishments, such as, "presented policy to six jurisdictions and connected with city leaders to share findings from the 2019 county Substance Abuse Assessment Workgroup and county-level results from the state Tobacco & Alcohol Retail Assessment" and "presented to county parole & probation staff and county management team on benefits of tobacco-free county properties, including information of benefits and need for TRL." Successes regarding passing an ordinance or policy included the approval of tobacco and/or marijuana free zones in health services buildings, county departments, or outdoor dining parklets. Other accomplishments that were reported involved the administration or completion of the tobacco community readiness assessment, evidence of policy support by county/city leadership, and the promotion of the Quitline.

TIER 3: Tier 3 grantees reported the most successes in the areas of media and community, policy presentations to city/county leadership and their endorsement for the policy, and statewide policy support. Media and community accomplishments included filming TV messages and mass media campaigns, sending media releases to promote community forums, and mobilizing "community members and the Public Health Advisory Board to write letters of support on behalf of SB 1577 to ban flavored products." While some Tier 3 grantees were successful in presenting TRL information to city councils, public health administrators, and community members, others showed successes in obtaining the approval for the policy adoption from city councils or obtaining "permission and support from Board of County Commissioners to testify on behalf of SB 1577." A total of three Tier 3 grantees reported to have either provided information for testimony or to have presented testimony on behalf of SB 1577. Other accomplishments that were mentioned include providing TA support by "developing a training video for all school staff on youth substance use and prevention," implementing systems changes, such as "implementing e-referral to tobacco Quit Line centers and integrating cessation services across the clinic system," and relationship building.

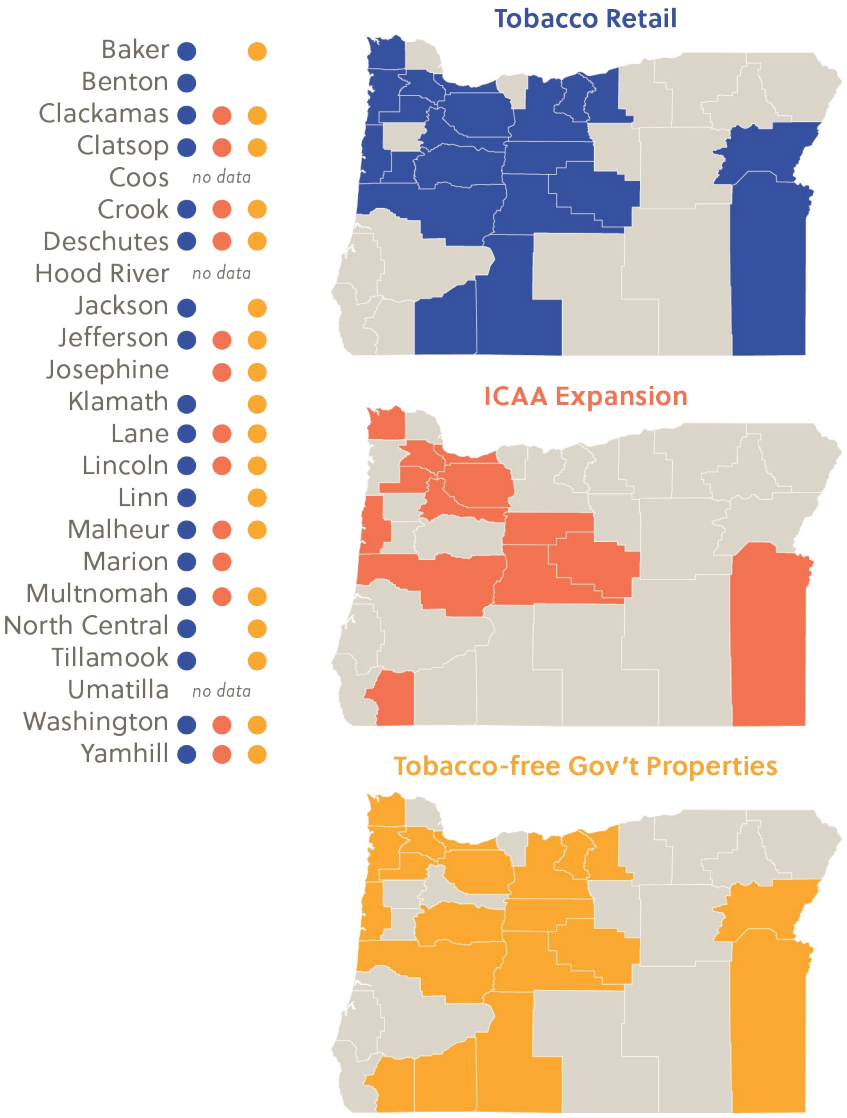
TOBACCO PREVENTION POLICY STRATEGIES: JUNE 2020

Figure 5 shows the type of tobacco prevention policy strategies each Tier 2 and 3 grantee was working on as of June 2020. 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.

Among Tier 2 and Tier 3 grantees:

- 19 reported working on a tobacco retail policy strategy
- 13 reported working on an ICAA expansion policy
- 18 reported working on a tobacco-free government property

Figure 5: Tobacco prevention policy strategies (Tier 2 and 3)



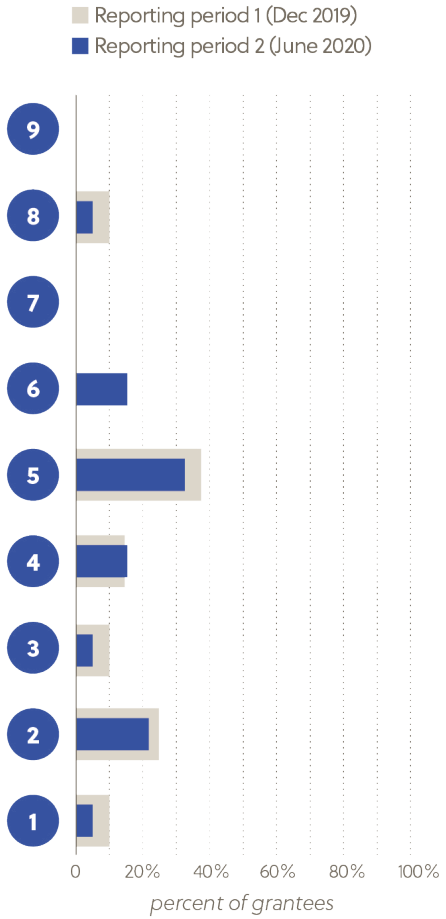
TOBACCO RETAIL STRATEGIES

At minimum, all grantees working on 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). Nearly half (42%) of grantees are working on advancing TRL only without any additional retail strategies identified. Nearly half (42%) 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). About a quarter of grantees (26%) are working to prohibit the sale of all flavored tobacco products and inhalant delivery systems (including menthol) and 11% are working to increase the cost of tobacco through non-tax approaches (e.g. price promotion prohibitions).

Figure 6 shows the percent of grantees at each stage of policy change for their retail strategy at reporting period 1 and 2. Policy advancement is shown by fewer grantees working in the preliminary stages 1-3 and an increase in grantees working at stages 4 and 6 at reporting period 2.

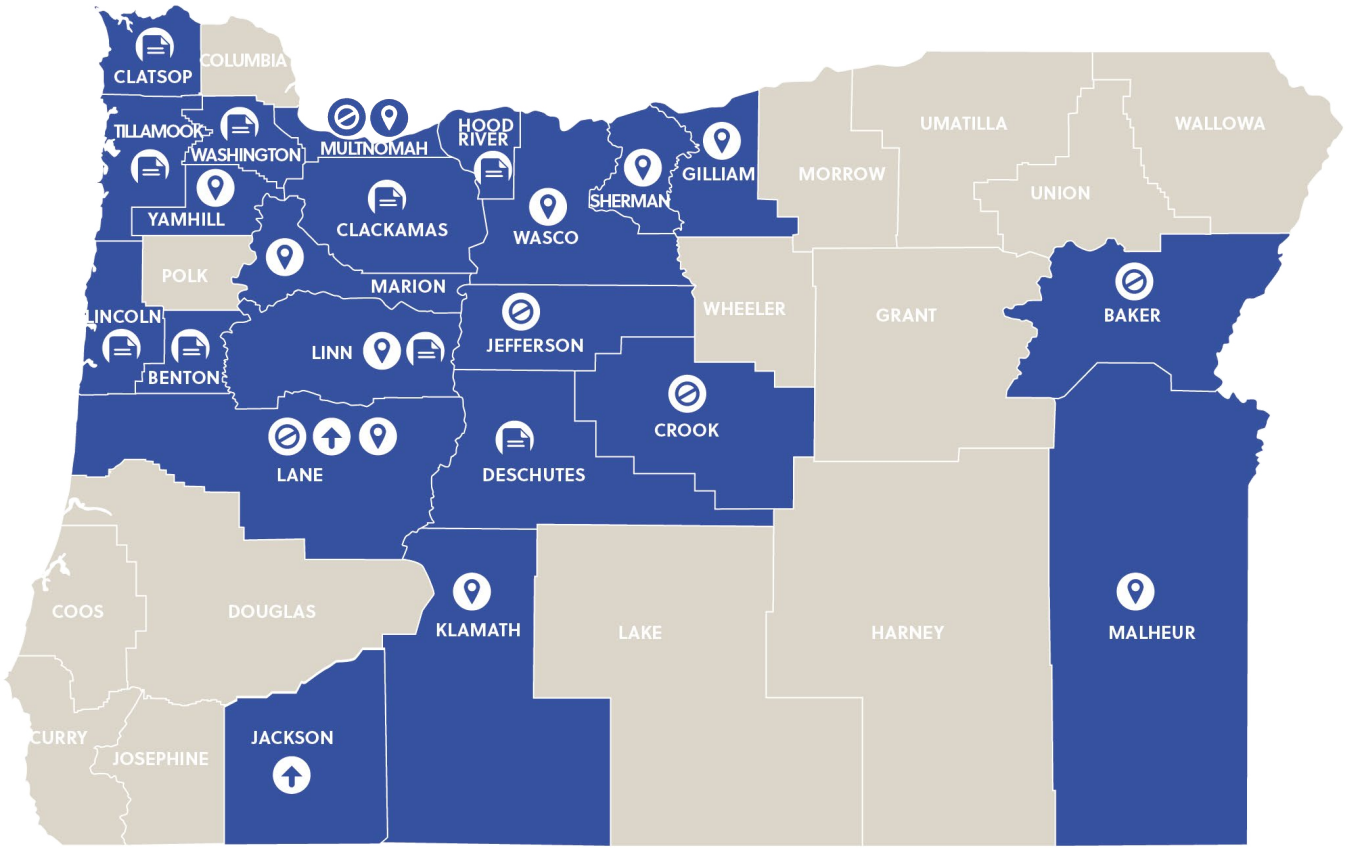
The maps and bar chart in Figure 7 display the tobacco retail policy strategy each grantee is working on, percent of grantees working in each strategy, and jurisdictions that have full or partial TRL coverage.

Figure 6: Tobacco retail strategies by stage of policy change

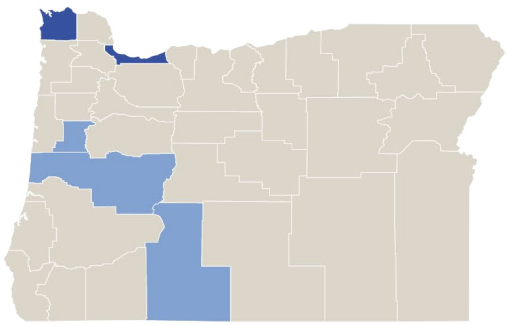


1: Identify the Problem
2: Engage Community & Stakeholders
3: Assess Readines for Change
4: Community Outreach & Education
5: Decision-maker Engagement
6: Draft Policy & Plan Implementation
7: Adopt Policy
8: Implement Policy & Support
9: Evaluate Impact

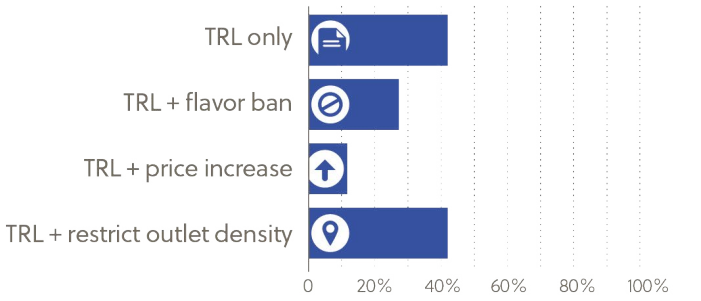
Figure 7: Tobacco retail policy strategy types + overview (June 2020)



Tobacco Retail Policies Passed:



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



percent of grantees working on strategy

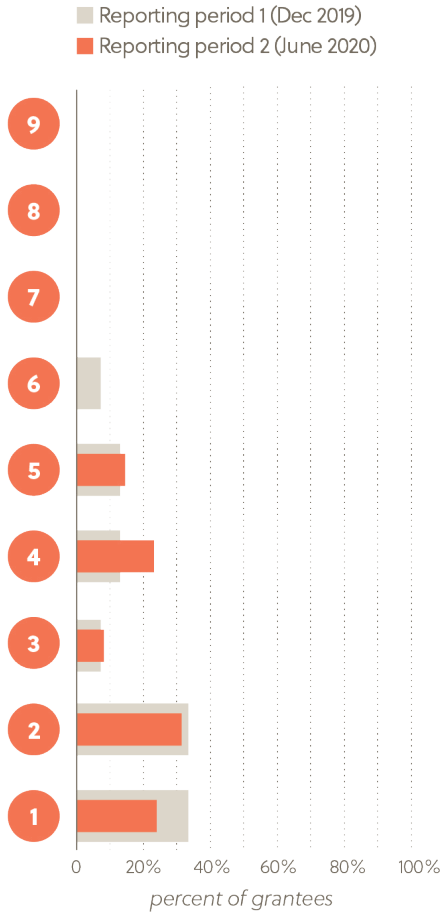
ICAA EXPANSION STRATEGIES

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 (31%) are working on a policy to eliminate exposure to cannabis in public places and workplaces and establishing smoke-free downtown/corridors. Two grantees are working on multiple ICAA expansion strategies. See Figure 9 for details.

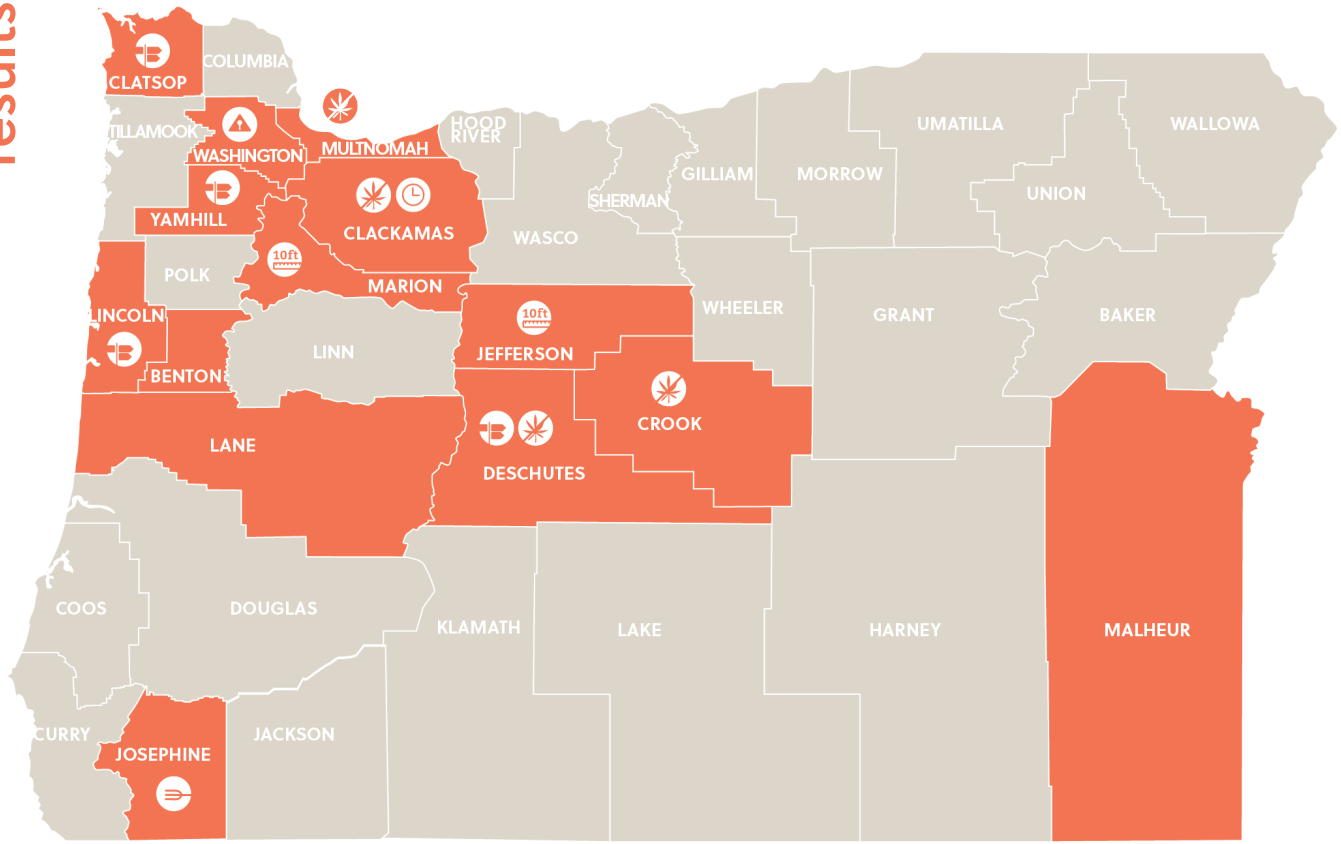
ICAA expansion policy strategies are at varying stages of the policy change process as shown in the bar chart (Figure 8) on this page. Policy advancement from reporting period 1 to reporting period 2 is shown by an increase in grantees at stages 3-5 at reporting period 2 and fewer grantees reporting at stages 1-2.

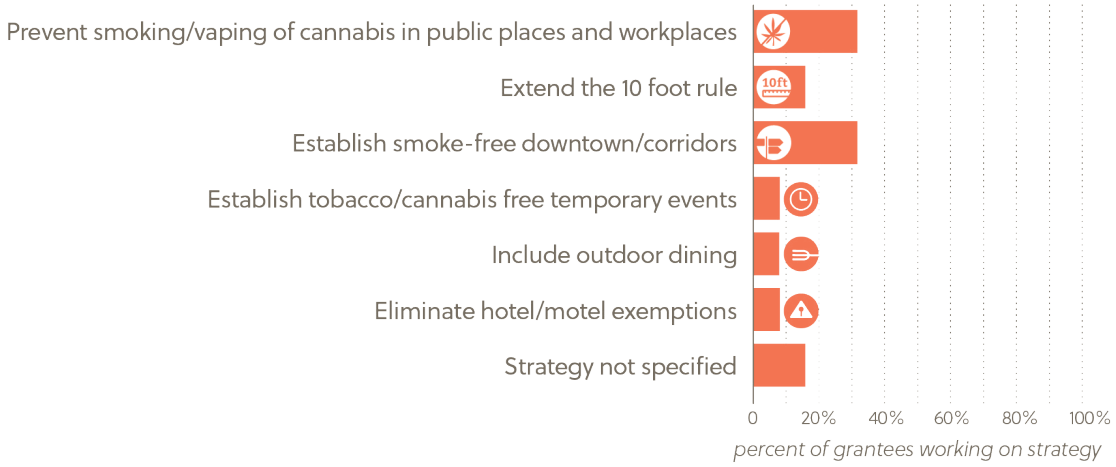
Figure 8: ICAA strategies by stage of policy change



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 9: ICAA policy strategy types + overview (June 2020)



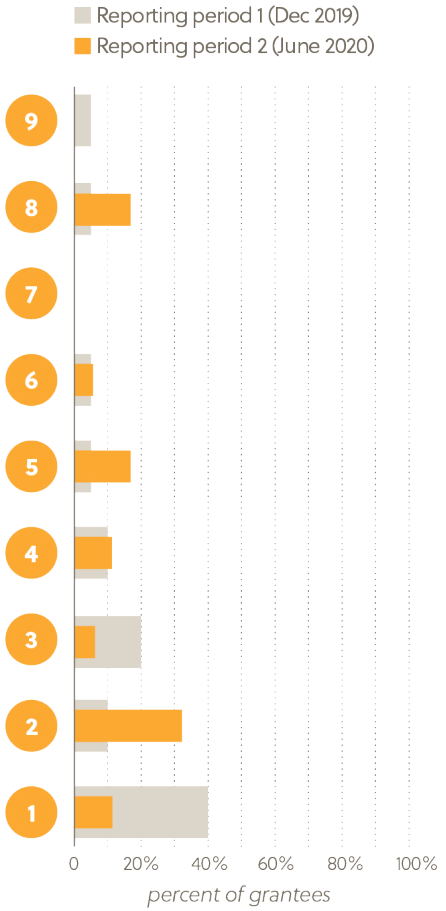


TOBACCO-FREE GOVERNMENT PROPERTY STRATEGIES

The majority of Tier 2-3 grantees (90%) 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 (Figure 11). Some grantees (17%) are implementing a tobacco-free government property policy. The types of tobacco-free government property strategies include tobacco-free county properties (39%), tobacco-free city properties (28%), tobacco-free section/building/entity of government properties (22%), and tobacco-free parks (17%).

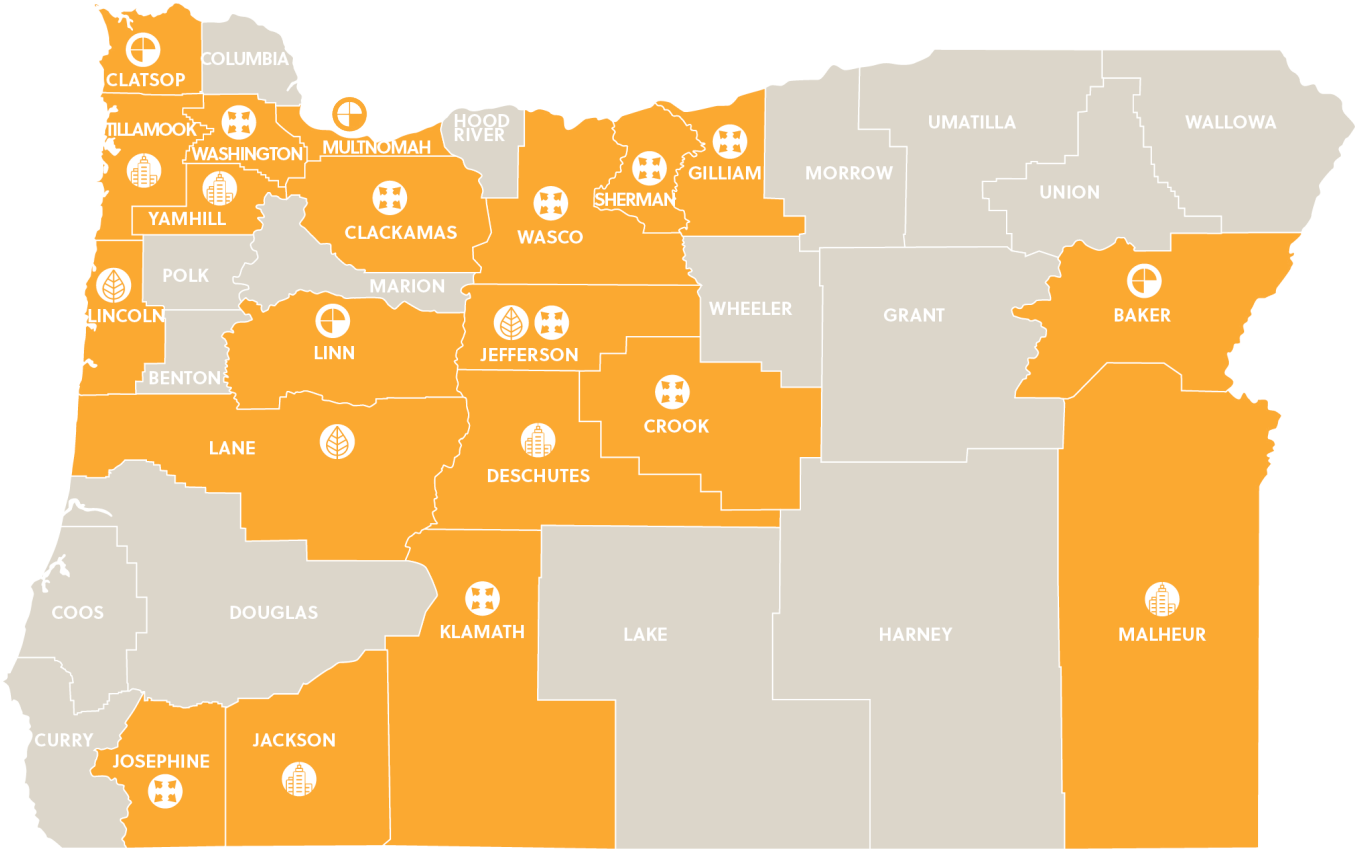
Tobacco-free government property policy strategies are at a variety of stages of policy change as seen in Figure 10, with one third of grantees at stage 2 (engage community & stakeholders). Policy progress is evident by fewer grantees in stage 1 (identify the problem) and more grantees at stage 2 (engage community & stakeholders) at reporting period 2 in comparison to reporting period 1.

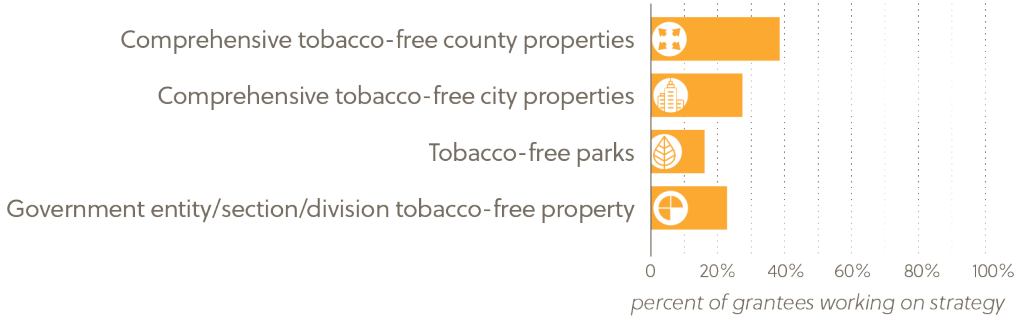
Figure 10: Tobacco-free government property strategies by stage of policy change



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

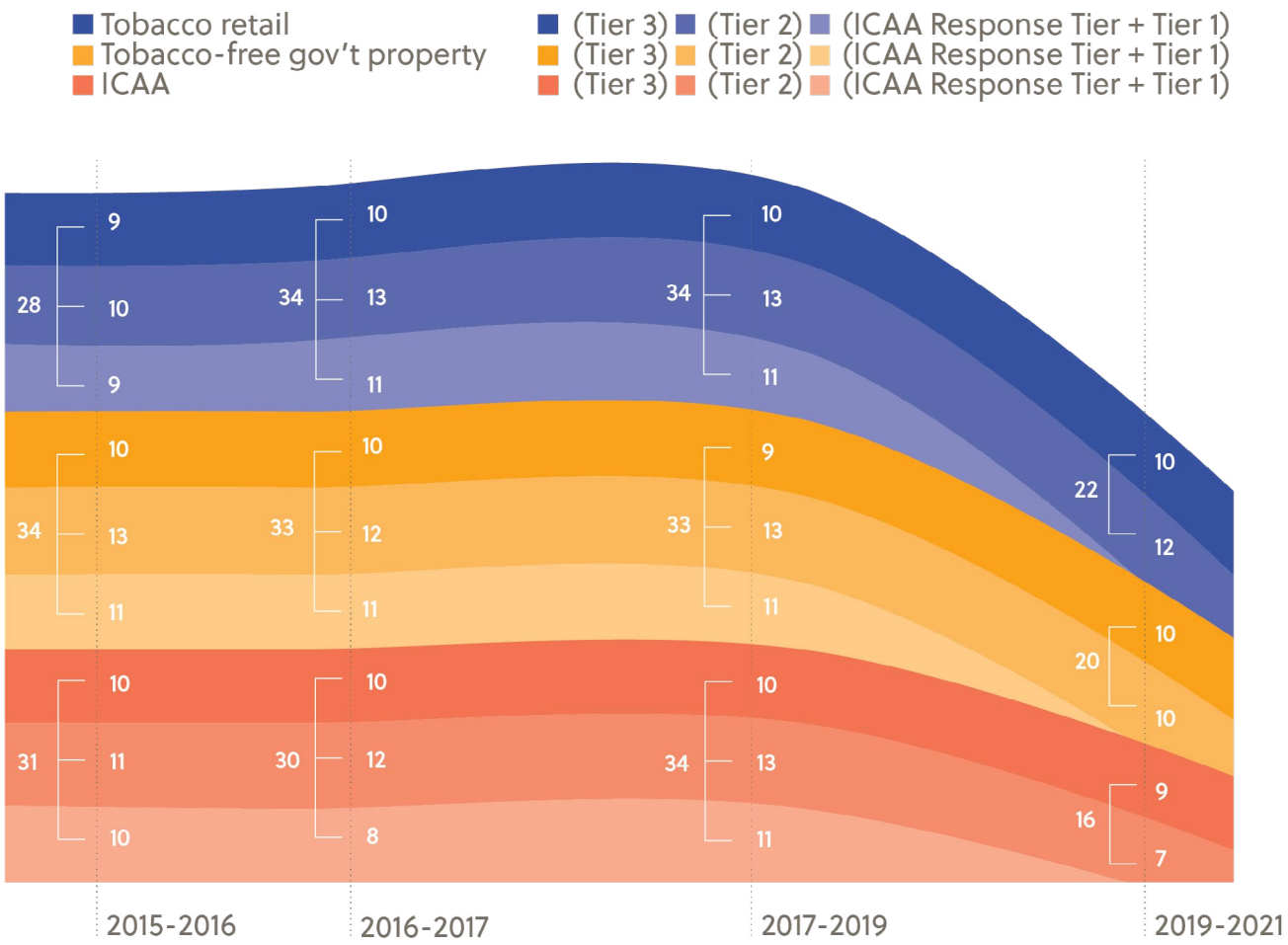




TPEP GRANTEES REPORTED WORKING ON TOBACCO PREVENTION STRATEGIES 2015-2021

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.

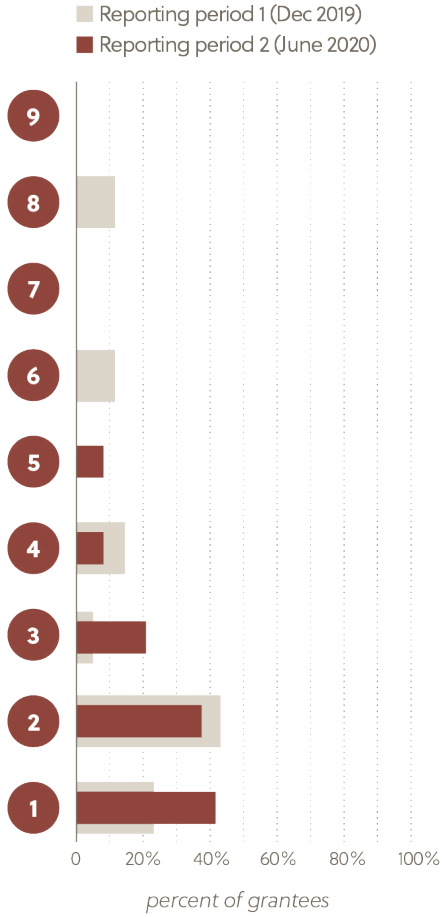
HEALTH SYSTEMS CHANGE STRATEGIES

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, namely: improving tobacco cessation and implementing multi-sector interventions. During reporting period two, 67% of grantees reported working on a strategy to assist health system partners to develop and implement sustainable closed-loop screening and referral systems, see Figure 14. Thirteen percent reported working with CCO(s) to implement at least one HERC-recommended multi-sector approach for tobacco prevention (working with CCOs to implement a mass reach communication intervention for evidence-based tobacco prevention or working with CCOs to engage the community via LPHAs to promote tobacco cessation, create tobacco-free places, and identify and eliminate tobacco-related disparities). Three grantees are 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. Four grantees are working on a strategy that does not fall into the previously listed categories outlined in the TPEP RFA.

For reporting period 2, the majority of grantees (80%) reporting being in stages 1 and 2 of policy change (identify the problem and engage community & stakeholders), and no one reported being in stages 6 through 9. This is a change from reporting period 2 when some grantees had reported being in stage 6 (draft policy and plan implementation) and stage 8 (Implement policy & support).

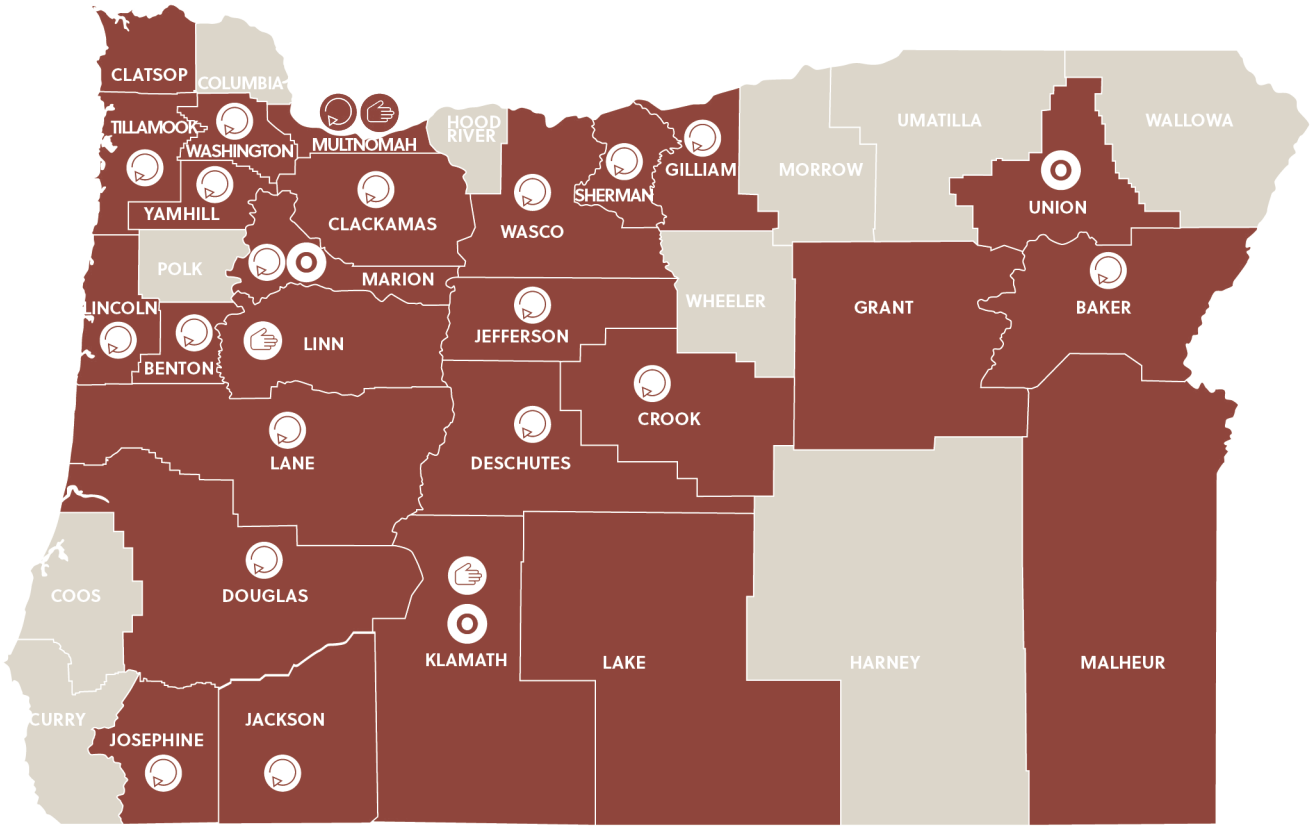
Note: The percent of grantees in Figure 13 equals more than 100% due to Clackamas, Multnomah and Washington Counties reporting stage of policy change for two health systems change strategies each.

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

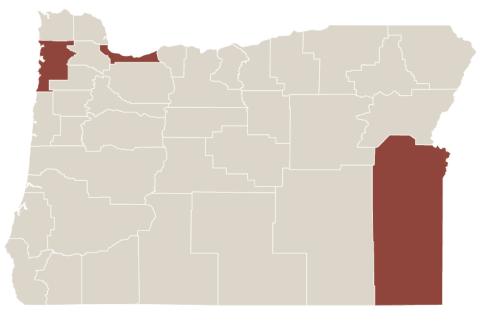


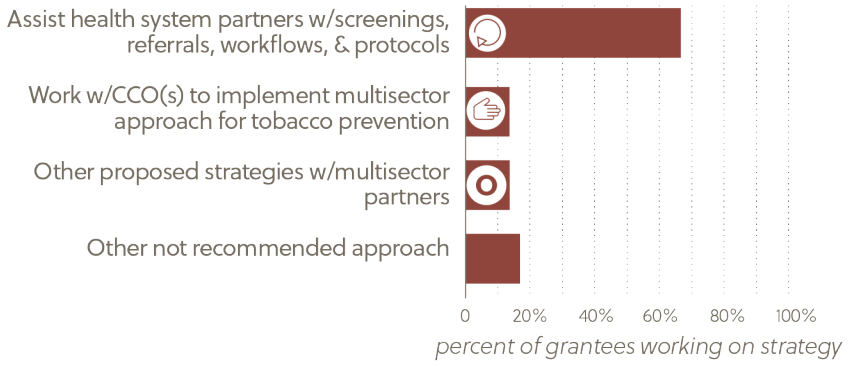
1: Identify the Problem
2: Engage Community & Stakeholders
3: Assess Readines for Change
4: Community Outreach & Education
5: Decision-maker Engagement
6: Draft Policy & Plan Implementation
7: Systems Change Adoption
8: Implement Plan and Learn from Action
9: Evaluate Impact

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

TPEP grantees were asked to describe the technical assistance and training(s) received from HPCDP throughout the reporting period.

Grantees reported attending various HPCDP hosted webinars and calls including:

- Finding, Using, and Requesting Data Support Webinar
- Appropriate Use of Public Funds Training
- Public Use of Cannabis and Indoor Clean Air Webinar
- Vaping and Adolescents Webinar
- Legislative Update Calls
- Tobacco Prevention Policy Calls
- Smokefree Oregon Movement Building Training
- TPEP Metro Region Tobacco Prevention and Campaign and Audience Assessment Call

Grantees reported receiving assistance in the following areas:

- TPEP communication plan
- Assistance regarding smoke free parks
- TA for closed-loop referral systems
- Adjustments to TPEP plan timelines
- How to approach leaders
- Support on addressing flavor ban

Grantees reported receiving HPCDP contractor TA from MET group in the following areas:

- Assistance on furthering communication plan
- OHA/Met group TA kick off call
- Met group Spanish language media prep call
- TA from Metropolitan Group to write talking points in response to the Crook County judge's concerns for TRL

NON-GOVERNMENTAL POLICY CHANGE 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, grantees listed a number of non-governmental partners they worked with to advance tobacco prevention policy during reporting period 2. The types of non-governmental partners are summarized below.

Types of non-gov't partners engaged

Coalition/committee/workgroup	25%
Community-based organization	13%
Youth	17%
Regional Health Equity Coalition	8%
Business	4%
Other	4%

HEALTH SYSTEM PARTNERSHIPS

In the TPEP reporting form, grantees were asked to describe their health system partnerships. Nearly all (88%) of Tier 1-3 grantees reported working with community partners, health system partners, or other stakeholders to improve cessation screening and closed-loop referral processes (see details below for types of non-CCO partnerships) and over half (63%) reported working with their local CCO during the reporting period. Over half (56%) of Oregon CCOs were engaged in tobacco prevention work during the reporting period.

Types of health system partners engaged*

Other public health dept/grantees	33%
Community health systems/providers	25%
Culturally specific organizations	4%
Behavioral health	4%
Student health	4%

**The percent of non-CCO health system partners engaged in this figure does not equal 88% of grantees who reported non-CCO partners because not all grantees reported on the types of partners they engaged.*

appendix

A. List of Advisory Group Members
B. Oregon TPEP Funding Model Theory of Change (updated January 2021)
C. Policy Change Process Model

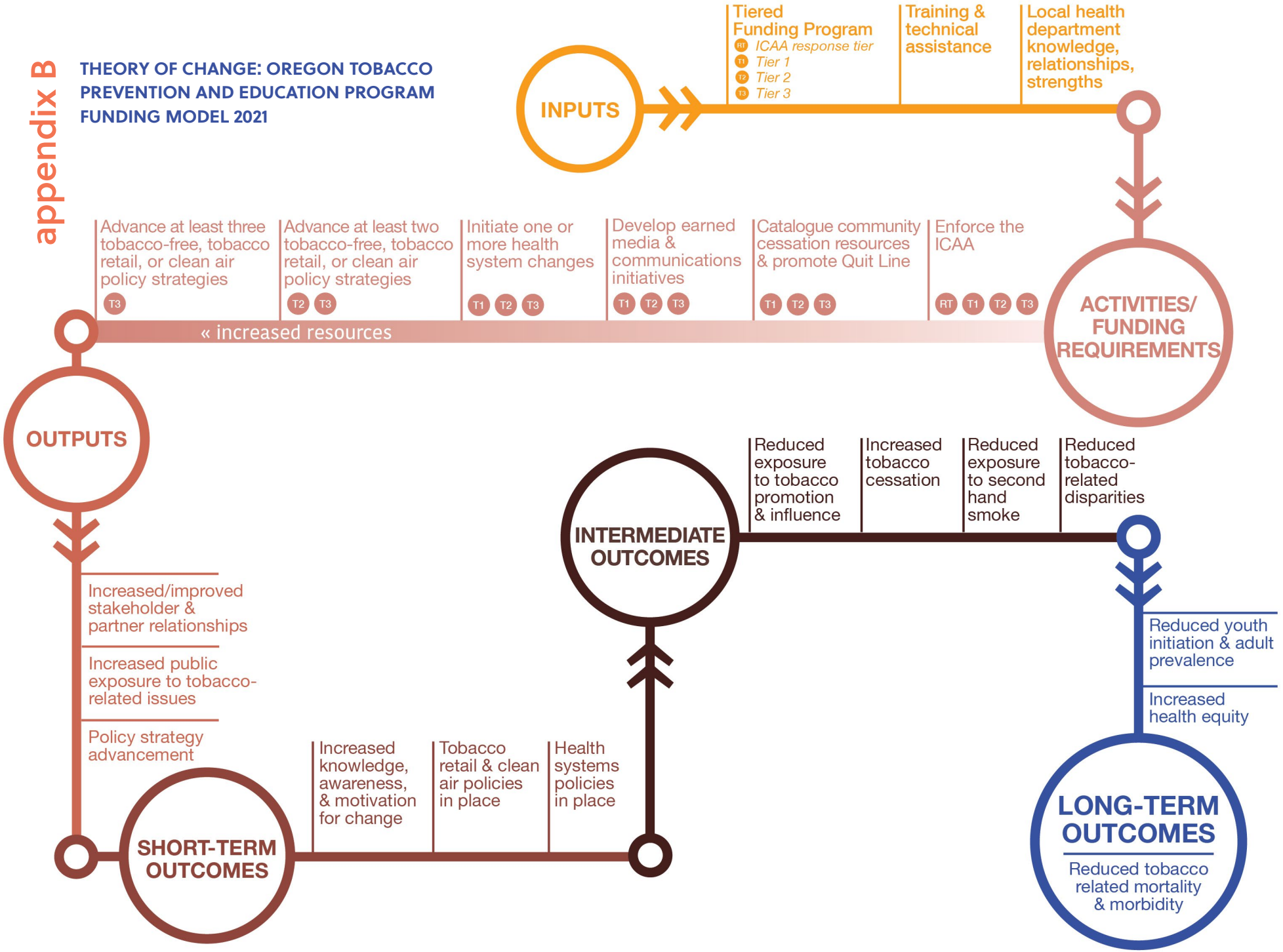
appendix A

LIST OF ADVISORY GROUP MEMBERS:

name	county	funding tier
Andy Chuinard	Benton County	3
Jamie Zentner	Clackamas County	3
Katie Plumb	Crook County	3
Karen Ard	Deschutes County	3
Russ Comer	Grant County	1
Sharon Coryell	HPCDP	n/a
Derek Smith	HPCDP	n/a
Rebecca Garza	HPCDP	n/a
Krista Murphy	Jackson County	2
Miranda Hill	Klamath County	2
Jennifer Little	Klamath County	2
Aimee Snyder	Lincoln County	2
Margaret MacNamara	Marion County	2
Ashley Thirstrup	HPCDP	n/a

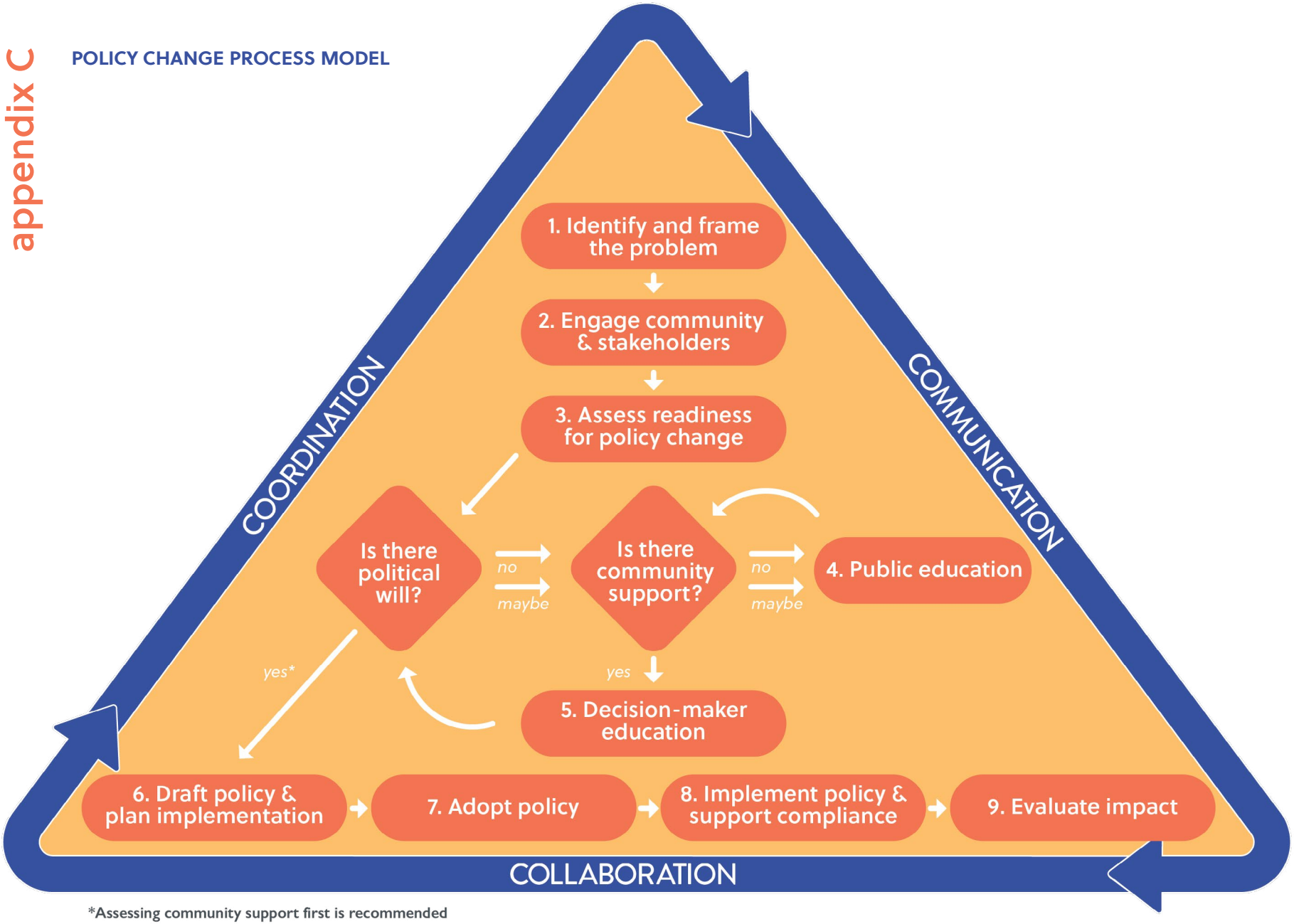
appendix B

THEORY OF CHANGE: OREGON TOBACCO PREVENTION AND EDUCATION PROGRAM FUNDING MODEL 2021



appendix C

POLICY CHANGE PROCESS MODEL



*Assessing community support first is recommended