Oregon Health Authority

Tobacco Prevention + Education Program

2023 Evaluation Report

Acknowledgments

This report was produced by Rede Group in September 2023.

Rede Group produced this report on behalf of the Oregon Health Authority, Health Promotion and Chronic Disease Prevention Section. We want to acknowledge the many people who contributed to this assessment, including the TPEP coordinators who submitted quarterly grant reporting forms; the Geographic Differences Workgroup, who provided invaluable feedback throughout the evaluation process, participated in a survey, and conducted interviews with community members; and all of the public health professionals, CBO staff and leadership, and Oregonians who participated in interviews and surveys.

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Terminology

The following acronyms are used in this document.

ADPEP: Alcohol and Drug Prevention Education Program
AI: Articifical Intellegence
BCC: Benton County Code
CCO: Coordinated Care Organization
CDC: Centers for Disease Control and Prevention
CLHO: Coalition of Local Health Officials
FQHC: Federally Qualified Health Center
HPCDP: Health Promotion and Chronic Disease Prevention
ICAA: Indoor Clean Air Act
IRB: Institutional Review Board
LPHA: Local Public Health Authority
NiTR: Nicotine Treatment and Recovery
OHA: Oregon Health Authority
PHD: Public Health Division
PRT: Proposed Research Topics
RFA: Request for Application
TARA: Tobacco and Alcohol Retail Assessment
TPEP: Tobacco Prevention and Education Program

Introduction

The primary intended users of results from this evaluation are OHA, HPCDP, and TPEP grantees.

Purpose

Rede Group conducted the 2021-23 Tobacco Prevention and Education Program (TPEP) evaluation on behalf of the Oregon Health Authority, Health Promotion and Chronic Disease Prevention Section (OHA, HPCDP). The TPEP evaluation focused on three components:

- Measuring progress in changing local tobacco prevention policies and strategies (statewide) to reduce the availability of tobacco products, reduce exposure to secondhand smoke/vapor, and improve health systems capacity to diagnose and treat nicotine addiction.
- Understanding and improving Local Public Health Authority (LPHA) approaches to working with health systems to address the tobacco use disparities among people with substance use disorders and mental health conditions.
- Understanding community conditions that may contribute to/underlie commercial tobacco/nicotine use in Oregon's rural populations.

The primary intended users of results from this evaluation are OHA, HPCDP, and TPEP grantees. This evaluation report is based on program activities conducted within a biennium that began in July 2021 and ended in June 2023.

The findings from this evaluation will be used to improve program effectiveness by making recommendations for program improvements in the next biennium, describing the state of tobacco prevention in Oregon, highlighting state and local program successes, and identifying unmet needs.

Background

The Oregon TPEP in the HPCDP, OHA, Public Health Division (PHD) grants funding to LPHAs to implement community tobacco prevention and education programs grounded in best practices for tobacco control and seeks to make sustainable policy, systems, and environmental changes.

The program uses a tiered funding model developed by HPCDP in partnership with the Coalition of Local Health Officials (CLHO) to advance tobacco prevention policy and systems change initiatives in communities with attention and focus on eliminating tobacco-related health disparities. The model offers the flexibility to deliver resources to LPHAs during the biennium and allows LPHAs to opt into a tier with achievable outcomes based on staff capacity, leadership support, and community readiness. LPHAs can also incorporate policy and systems change approaches that have traditionally been funded through competitive grants.

In the summer of 2022, additional funding was made available to all LPHAs through the Ballot Measure 108 Tobacco Tax.[1] This funding was intended to provide additional capacity and resources to address commercial tobacco use inequities and develop or enhance community partnerships. Thirty-two LPHAs accepted this funding for work conducted between July 2022 and June 2023. Of those LPHAs, five were in the TPEP ICAA response tier (see description in the following section) who, through this

1. Oregon Ballot Measure 108 (2021) increased taxes on distributors of tobacco products and other nicotine delivery systems, such as e-cigarettes.

funding, were able to complete more activities in addition to enforcing the Oregon ICAA. Activities proposed for the additional funding were meant to complement and reinforce current TPEP workplan activities. Eligible activities fell within the guidelines of the 2021-23 TPEP Request for Application (RFA) with the exception of direct cessation delivery and Nicotine Replacement Therapy (NRT), which were made allowable due to an update to Program Element 13.[2]

Overview of Tiers

The following description of the tiered funding model and activities were in place during the 2021-23 biennium. These requirements have changed for the 2023-25 biennium.

ICAA Response Tier

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

Tier 1: Foundational Tobacco Prevention

Tier 1 provided funding to conduct local duties and activities related to enforcing the ICAA and to engage in basic tobacco prevention education and advocacy. Tier 1 was a bridge to full engagement in policy and systems change processes. LPHAs that selected Tier 1 included those that had not yet demonstrated support from executive leadership and/or elected officials to pass tobacco prevention policies but wanted to maintain a tobacco prevention program that builds local capacity.

2. Program Element #13: Tobacco Prevention Education Program (TPEP). 2023.

Tier 2: Tobacco Prevention Mobilization

Tier 2 was for LPHAs that had 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 was for LPHAs that had demonstrated prior success by meeting six prerequisites (see Appendix A) outlined in the TPEP RFA and were prepared to lead statewide mobilization to decrease the harms of tobacco.

TPEP Strategies

Tier 1-3 grantees were required to work on at least one health systems change strategy and Tier 2 and Tier 3 grantees were required to work on a minimum of two and three policy or program strategies respectively. The following pages detail the specific strategies in each category.

Health Systems Change Strategies

- Increase the total number of healthcare providers with capacity to refer patients to Quitline by assisting health system partners in developing and implementing sustainable closed-loop screening and referral systems, workflows, and/or protocols for evidence-based tobacco cessation.
- Work with regional Coordinated Care Organization (CCO) to implement at least one culturally relevant approach for tobacco prevention, which included but were not limited to:

  - CCO leadership support for development of smoke-free policies in workplaces and public spaces,
  - CCO implementation of mass-reach communication interventions for evidence-based tobacco prevention, and
  - CCO community engagement via LPHA to promote tobacco cessation, create tobacco-free places, and identify and/or eliminate tobacco-related disparities.
- Other proposed strategies with multisector partners, including at least one health system partner playing a primary role, based on best practices and/or innovative, culturally informed practices.

Policy and Program Strategies

Strategy Area A: Reduce the Availability of Tobacco Products

- Tobacco retail licensure
- Prohibit the sale of flavored tobacco products
- Increase the cost of tobacco through non-tax approaches (e.g. prices promotion prohibitions)
- Restrict outlet density through zoning, distance requirements (e.g. restrict the proximity to tobacco outlets near places where children frequent, cap the number of retailers)
- Increase promotion of healthy products, while decreasing the advertising and prominence of alcohol and tobacco products
- Other proposed retail strategies

Strategy Area B: Reduce Exposure to Secondhand Smoke/Vapor

- Advance jurisdiction-wide smoke and vape-free policies (e.g. local ordinances)

for public places to prohibit businesses that allow indoor smoking or expose employees to secondhand smoke, including certified smoke shops or cigar bars

- Advance jurisdiction-wide smoke and vape-free policies (e.g. local ordinances) for public places to prohibit future businesses from exposing the public or employees to secondhand smoke or vapor, including potential cannabis use establishments
- Advance jurisdiction-wide smoke and vape-free policies (e.g. local ordinances) including outdoor dining, other service areas, or construction sites
- Advance jurisdiction-wide ordinance to extending the prohibition of smoke beyond the current 10 feet from entrances, exits, or windows
- Advance policies that establish tobacco-free county or city agencies or other regional government campuses inclusive of prohibitions on e-cigarettes/inhalent delivery systems
- Other proposed strategies to reduce exposure to secondhand smoke/vapor

Strategy Area C: Flexible Tobacco Prevention Strategy

- Develop cooperative agreements with 2-3 stores offering healthy retail options such as agreeing to minimize or eliminate tobacco and alcohol shelf space and advertising, stocking healthy snack options, and ensuring access to produce, etc.
- Develop alternatives to suspension policy with collaboration with schools and/or school districts to ensure possession of tobacco products and/or use of these products does not result in missing educational time, and instead provides the necessary support to young people to quit
- Build a cohort program of youth advocates to be involved in peer education, participating in youth tobacco sale surveys, and TARA (Tobacco and Alcohol Retail Assessment) for data collection
- Develop and implement a new virtual, or in person, tobacco prevention (or chronic disease prevention) coalition with youth and adult participants. Invite those who

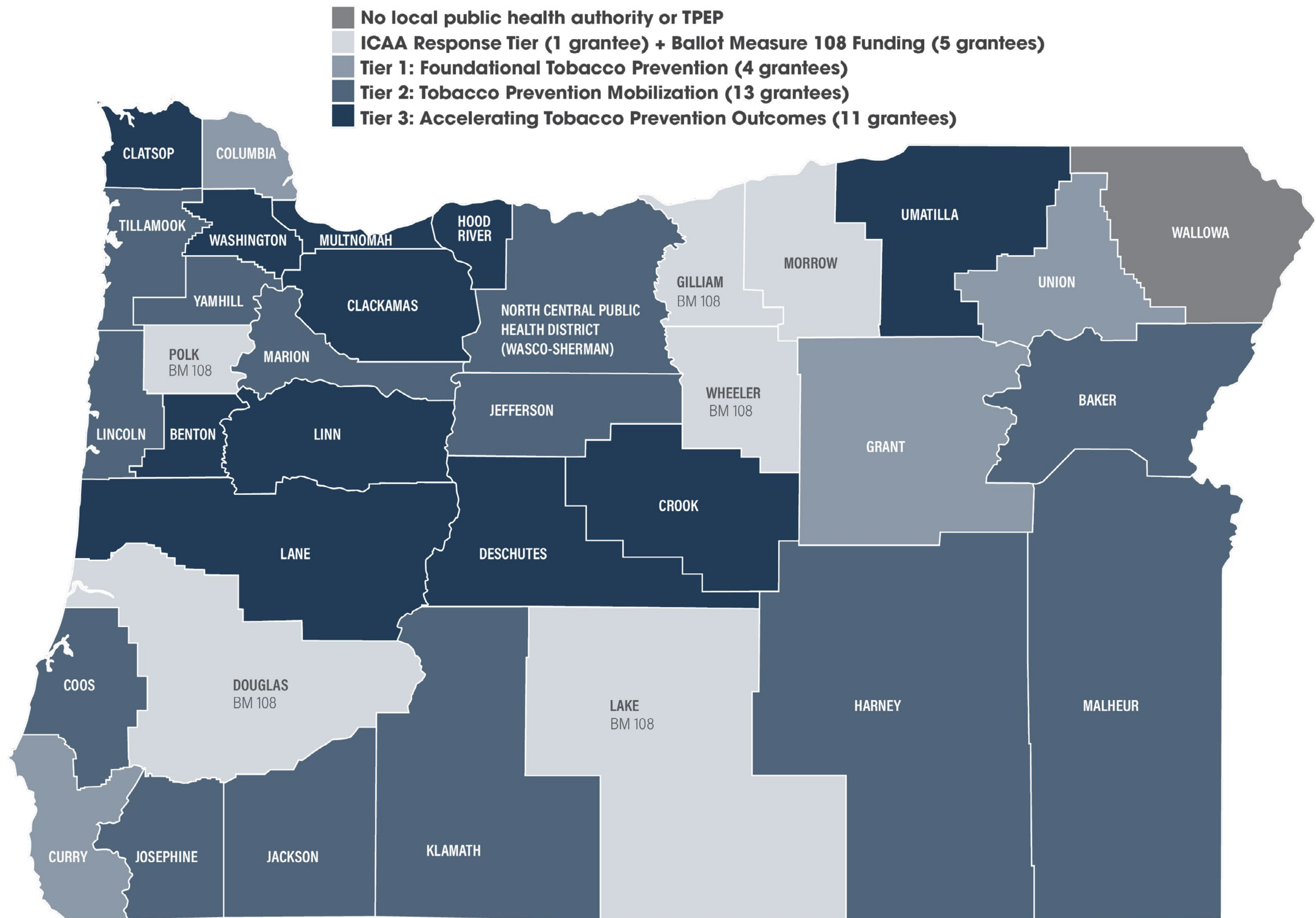
call with complaints/concerns and/or participate in social media to be part of the coalition.

- Create a collaborative tobacco (and other local issues of interest) health equity local impacts report and/or GIS project
- Develop and update a resource to highlight the local and state decision-making process; outline all the local and statewide decisionmakers, their key priorities, and share this knowledge with other partners and coalitions
- Create a local tobacco impacts report and/or interactive web presence to highlight the various ways in which tobacco affects youth, seniors, priority communities, job security, and illness in the community. Develop a distribution plan to present or share this resource with allied groups and leaders
- Develop a college internship program to build a pathway to public health careers and have an intern develop a tobacco 101 educational series. Create a presentation and sharing plan to utilize this material for new coalition members or staff onboarding, and to share with allied partner coalitions
- Develop non-tobacco sponsorship policies for major events such as rodeos and concert venues that are known to allow advertising and sponsorship from the tobacco industry
- Other important approaches that the community feels will make a difference and support a tobacco-free world

Table 1: Program activities for TPEP funding tiers (2021-23)

Program Activities	ICAA Tier	Tier 1	Tier 2	Tier 3
Enforce the Oregon ICAA	✔	✔	✔	✔
One or more health systems change strategy		✔	✔	✔
Two or more priority policy or program strategies, at least one policy strategy from Categories A and/or B			✔	✔
Three or more policy or program strategies, at least two policy strategies from Categories A and/or B				✔

Figure 1: TPEP Funding Tiers (Jun. 2023)



Key Evaluation Questions

This report includes findings from key evaluation questions one and three below.

Work completed to investigate key evaluation question two was conducted through the Nicotine Treatment and Recovery (NiTR) project and will be included as a portion of the NiTR report to be submitted to OHA in October 2023. Appendix B includes a summary of the work done by the NiTR project team to address key evaluation question two.

1. What progress toward systems and policy change in health systems, tobacco retail, and secondhand smoke/vape free environments has occurred?
2. How can local tobacco programs support behavioral health systems to reduce tobacco-related disparities among people experiencing mental health or substance use disorders?
3. How can the state tobacco program address tobacco-related disparities in rural Oregon?

Methods

Analyzing Grantee Reporting Forms

Rede reviewed TPEP grant reporting forms submitted to OHA at four points in time (Jan. 2022, Jul. 2022, Jan. 2023, and Jul. 2023) for tobacco prevention and health systems change strategies, progress, and successes, communication strategies, and work with behavioral health providers and Federally Qualified Health Centers (FQHCs).

Tobacco prevention policy and program strategy progress

Rede reviewed grantee reporting forms at four points in time for any local tobacco prevention policies adopted between Jul. 2021 - Jun. 2023. We acknowledge that policy and systems changes often take time and can take longer than two years, depending on many factors, including other public health priorities such as COVID-19, community readiness, and political will. To assess incremental policy and program progress during the biennium, Rede reviewed grantee reporting forms from periods 1 and 3 for completed and in-progress activities related to their tobacco prevention and health systems strategies. Rede analysts reviewed activities listed for each strategy in reporting periods 1 and 3 and used the Equity-Centered Policy Change Model[3] (see Appendix C) to identify a single stage of the model where the grantee was spending most of their time (based on information in the reporting form). Analysts established a high level of inter-rater reliability (the degree of agreement between independent coders) prior to dividing up grantee reporting forms to assess the stage of policy change.

3. Equity-Centered Policy Change Model

Rede used this information to document the number of grantees who progressed through one or more stages of the Equity-Centered Policy Change Model between reporting periods 1 and 3. In addition to policies passed and progress through stages of the Equity-Centered Policy Change Model, Rede also tracked and calculated the number of grantees working on various types of tobacco prevention and health systems change strategies. Rede used Google Sheets to document and calculate this information.

Tobacco prevention and health systems change successes

Rede reviewed grantee reporting forms at three points in time for any successes in policy, programs, and health systems changes between Jul. 2021 - Dec. 2022. Within the reporting form, Rede reviewed sections where grantees were asked to report on successes during the reporting period and the completed activities for each strategy (where successes were often captured in the reporting form). A total of 69 reporting forms from 27 grantees were analyzed. Rede completed a qualitative analysis using Dedoose software,[4] where a Code Tree was developed to identify key themes and categories of successes.

TPEP work with behavioral health providers and FQHCs

Rede reviewed grantee reporting forms at three points in time for any TPEP work with behavioral health providers and FQHCs between Jul. 2021 - Dec. 2022. To assess for TPEP work with behavioral health providers and FQHCs during the grant period, Rede reviewed grantee reporting forms from period 1-3 for mention of work that involved behavioral health and FQHCs in activities and collaboration with partners. A total of 62 reporting forms from 26 grantees were analyzed. Rede completed a qualitative analysis using Dedoose software where a Code Tree was developed to

4. Dedoose [Data analysis software]. (2016). Retrieved from www.dedoose.com

identify the number of grantees who worked with behavioral health providers and FQHCs and the categories of work these partners were engaged with.

Communications strategies and support requested

Rede reviewed communications questions in reporting forms to summarize the most frequently used communication strategies and the communication support requested by TPEP grantees. Grantee reporting period 1-4 forms were analyzed using Google Sheets to tabulate frequency of multiple choice responses and common themes in open-ended responses, including 102 forms from 31 grantees with content for analysis.

Grantee reporting forms submitted

Table 2 details the number of grantee reporting forms received and analyzed at each point in time. Some reporting forms received in periods 1-3 did not contain any data for analysis, with grantees listing no progress on TPEP activities due to COVID-19. ICAA Response Tier grantees were not required to complete grant reporting however, grantees who received BM 108 funding began submitting reporting forms in periods 3 and 4.

Table 2: Grantee reporting forms submitted

	Grantee reporting forms received	Grantee reporting forms with content for analysis
Reporting period 1	27	21
Reporting period 2	28	23
Reporting period 3	29	27
Reporting period 4	31	31
Total	115	102

Methods to Explore Geographic Differences in Commercial Tobacco Use in Oregon

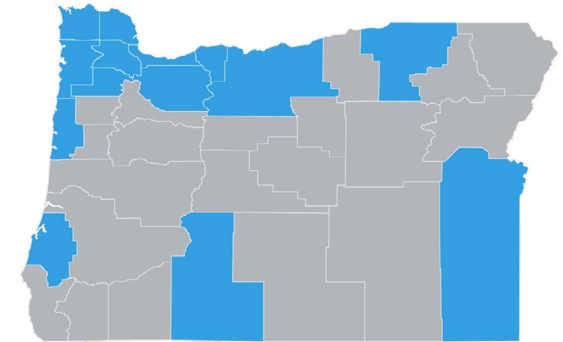
In partnership with OHA, HPCDP, Rede convened the Geographic Differences Workgroup (hereafter, "workgroup") from Feb. 2022 - July 2023. The majority of workgroup members were TPEP Coordinators in rural or frontier counties, with a few workgroup members representing counties that serve both rural and urban communities that agreed to focus on their work in rural areas within this workgroup. The workgroup also included a Community Liaison from OHA who worked with counties primarily in Eastern Oregon, and an Epidemiologist from OHA who was a client on this project.

To accommodate shifts in the TPEP workforce as well as changes to capacity for and interest in this work, participation in the workgroup was flexible and new members were added in early 2023. The counties shaded blue in this map represent all the counties represented in the workgroup.

The workgroup was created to address the third component of this evaluation: understanding community conditions that may contribute to/underlie commercial tobacco/nicotine use in Oregon's rural populations. To explore this question, the workgroup developed three guiding questions:

1. What are community members' beliefs about drivers or causes of disparities in tobacco use in different geographic areas/counties in Oregon?

Figure 2: Workgroup member counties



2. How do different policy and capacity conditions affect tobacco prevention work in different communities? (Examples of policy and capacity conditions include local partnerships, county health department staffing, local perception of government, etc.)
3. What do people think about the intersection of place and health? What do they think about the government's role in making their place healthier?

To answer these questions, Rede and the workgroup members conducted three data collection efforts:

1. Interviews with public health professionals and community informants
2. Survey of TPEP Coordinators and Ballot Measure 108 grantees in rural areas
3. Survey of current and past tobacco or nicotine users

Detailed methodologies for each of these efforts, and a description of the co-analysis process with workgroup members, are described below.

Interviews with public health professionals and community informants

To understand community perceptions about the drivers of tobacco use and causes of tobacco use disparities among rural Oregonians, the workgroup conducted interviews with public health professionals and community informants. Interview guides were drafted by Rede and reviewed and revised by the workgroup. Interviewees were recruited through convenience sampling. Workgroup members reached out to public health professionals (e.g., epidemiologists and data analysts, public health administrators, public health nurses, and program managers and coordinators) and

community informants (e.g., community-based organization directors or program coordinators, clinical providers, and community health workers and outreach coordinators) they knew to invite them to participate in interviews. Between September and October of 2022, workgroup members conducted 17 interviews, including one group interview, with a total of 19 interviewees. Thirteen interviewees were public health professionals and six were community informants.

Data from interviews were collected and shared with Rede in multiple formats, including written notes, audio and video recordings, and audio and video transcripts. Rede compiled all interview data and performed thematic analysis to develop a summary of key findings, including commonalities and differences in perceptions about the drivers of tobacco use across informant types (public health professionals and community informants).

Survey of TPEP Coordinators and Ballot Measure 108 grantees in rural areas

To assess policy and capacity conditions affecting tobacco prevention work in Oregon, a survey of TPEP Coordinators and Ballot Measure 108 (BM 108) grantees was developed by the workgroup and administered by Rede. Survey questions were developed over several workgroup meetings and the final survey was programmed into SurveyMonkey. Using a contact list provided by OHA, Rede invited the TPEP Coordinator from each county to participate in the survey. If the TPEP Coordinator position was vacant or the individual did not have the capacity to participate, they were allowed to invite their ADPEP Coordinator, Prevention Specialist, or a similar position to participate. Rede also worked with OHA to identify 14 community-based organizations (CBOs) that received BM 108 funding for commercial tobacco prevention activities in rural or frontier counties. In total, 46 organizations were invited

to participate in the survey between Feb. - March 2023, and Rede received responses from 32 organizations. Twenty-five respondents were from local health departments (all classified as "TPEP" for analysis) and seven were from BM 108 grantees.

Survey responses were exported from SurveyMonkey and analyzed in Google Sheets. Partial surveys with at least 80% of questions completed were included in the data set. The primary approach to analysis was descriptive, and subclass analysis was performed by region group (frontier, rural, and rural-urban) using classifications by the Oregon Office of Rural Health,[5] as well as respondent type (TPEP or BM 108 grantee). Charts and other data visualizations were created to aid with data interpretation and highlight key findings.

Survey of current and past tobacco or nicotine users

Upon analysis and interpretation of findings from their first two data collection efforts, the workgroup identified a desire for further information on their key evaluation questions and to hear directly from current and past tobacco or nicotine users. The workgroup developed a statewide survey of current and past users of commercial tobacco and/or nicotine products to gather data on the third key evaluation question: What do people think about the government's role in making their places healthier? Some survey questions were adapted from a similar survey conducted in Washington state and refined by the workgroup over several meetings, and others were newly developed by the workgroup. Because the survey included questions about potentially sensitive information (e.g., optional demographic questions, information about health behavior, and and mailing addresses to receive incentives), the survey was vetted by the Proposed Research Topics (PRT) team at OHA to ensure best research practices and determine if additional approval would be needed by an Institutional Review Board (IRB). Once

5. Map of ORH Urban/Rural/Frontier Designation Areas. OHSU - Oregon Office of Rural Health (n.d.). Rede and the workgroup used "rural-urban" to describe rural counties in Oregon that contained at least one urban center as shown on this map.

the PRT team approved the survey and made the determination that additional IRB review was not necessary, the survey was translated into Spanish and programmed into SurveyMonkey and administered from late May to mid-June 2023.

This survey used convenience and snowball sampling, and digital and printable fliers to promote the survey were created in English and Spanish. Rede and workgroup members reached out to CBOs to ask for their support in promoting and distributing the survey, for which they were offered a stipend. Eleven CBOs agreed to help promote the survey, and some of their activities included distributing fliers in food boxes, distributing fliers at vaccine events, and posting on social media. Rede also piloted the use of a radio ad to reach more individuals in Eastern and Southeastern Oregon, but the ad did not increase response rates. Further piloting of varied ad lengths, frequencies, and timing may be helpful for future community data collection efforts.

Within 48 business hours of closing the survey, all response data was exported to a secure drive and deleted from SurveyMonkey per Rede's data security agreement with OHA. Mailing addresses were collected on a separate form and reviewed separately from survey response data. All data was analyzed in Excel and partial surveys with at least 80% of questions completed were included in the data set. The primary approach to analysis was descriptive, and subclass analysis was performed by region group (frontier, rural, and rural-urban) using classifications by the Oregon Office of Rural Health,[2] as well as response choice for certain questions (e.g. analyzing which resources were used most by those who identified as having quit all commercial tobacco and/or nicotine products). Charts and other data visualizations were created to aid with data interpretation and highlight key findings.

Co-analysis with the workgroup members

Findings from all data collection methods were reviewed and discussed in depth with workgroup members. Data review and interpretation occurred throughout the workgroup process with each data collection method, and in July of 2023, workgroup members synthesized key findings for each key evaluation question, referencing all the data collected. These key findings are detailed in the findings section of this report.

Limitations

Coronavirus disease (COVID-19)

Some of the grantee reporting forms Rede received from OHA for analysis lacked sufficient data to analyze due to a grantee's inability to make progress on policy and health systems change activities because the grantee needed to prioritize COVID-19-related activities at that time. This was most prominent in reporting period 1 (Jul. - Dec. 2021), with 6/27 reporting forms excluded from analysis, 5/28 reporting forms in period 2 (Jan. - Jun. 2022), and 2/29 reporting forms in period 3 (Jul. - Dec. 2022).

Identifying stages of policy progress

The Rede analysts' ability to identify an accurate stage of policy progress was dependent on the amount of information provided in the reporting form. Some grantees provided more information than others in reporting forms. Grantees also reported working on activities that fell into multiple stages of policy change, in these cases, the analyst used their best judgment to identify where in the policy change model the grantee was spending the majority of their time. The Rede and

OHA study team decided at the onset of the project to rely solely on Rede analysts to identify stages of policy change and not to engage grantees to validate the stages. This decision was made to decrease the burden of evaluation on grantees while transitioning their focus from COVID-19 response efforts back to TPEP work. Additionally, progress through stages of the policy change model could only be assessed where grantees reported a consistent policy across reporting periods. There were 16/27 grantees who reported a consistent tobacco prevention strategy between reporting period 1 and 3.

Timing of grantee period 4 reporting and the evaluation

In the initial contract, the end of the evaluation coincided with the end of the biennium, which would not have allowed any time to analyze reporting period 4 data submitted to OHA in Jul./Aug. 2023. To allow some time to analyze reporting period 4 data and incorporate that information into this report, the evaluation contract was extended by three months with one month to incorporate reporting period 4 data. Given this time constraint, Rede was not able to incorporate reporting period 4 data into all aspects of the report findings, and therefore, some data relies on information provided in reporting periods 1-3 only. If policy, program, and health systems change progress based on reporting period data is part of future TPEP evaluations, Rede would recommend allowing sufficient time to analyze reporting period 4 forms before the evaluation report is due to capture the work completed for the entire biennium.

Verifying authentic survey responses

The Geographic Differences workgroup involved in the third component of this evaluation – understanding community conditions that may contribute to/underlie commercial tobacco/nicotine use in Oregon's rural populations – worked with Rede to develop and administer a statewide survey of current and past users of commercial tobacco and/or nicotine products. Because this survey was incentivized and a direct link was likely posted on social media to promote the survey, Rede received numerous bot and AI responses. An analyst at Rede conducted a thorough review of the survey data and eliminated as many inauthentic responses as possible, however, there is a chance that some inauthentic responses were included in the data set.

Findings: Tobacco Prevention + Health Systems Change Strategy Progress

Key findings

- Eight local tobacco prevention policies were adopted.
- 101 local tobacco prevention strategies and 57 health systems strategies were underway during the biennium
- 27 local tobacco prevention strategies progressed through one or more stages of the Equity-Centered Policy Change Model between July 2021 - Dec. 2022.
- The most prominent success for grantees in their TPEP work was the development of partnerships to support and collaborate on tobacco prevention and health systems change strategies.
- 50% (n=15) of Tier 1, 2, and 3 grantees worked with behavioral health partners and 20% (n=6) worked with a FQHC on a health system strategy.

Policies adopted

Tier 2 and 3 grantees were required to work on passing tobacco prevention policies. TPEP reporting form data revealed local jurisdictions adopted a total of eight tobacco prevention policies during the biennium; a quarter (n=6) of Tier 2 or 3 grantees had a tobacco prevention policy adopted within their jurisdiction. Half of the local policies adopted were focused on reducing exposure to secondhand smoke/vapor and the other half on reducing the availability of tobacco products. Despite the challenges faced by local health departments during the COVID-19 pandemic, TPEP programs were able to advance a number of tobacco prevention policies. Table 3 on the following page lists each of the policies adopted.

Table 3: Tobacco prevention policies adopted from Jul. 2021 - Jun. 2023

Grantee	Policy	Date	Policy Type
Benton	Various updates to Chapter 17 of the Benton County Code (BCC). One example is 17.010 Identification Required. It shall be a violation of BCC Chapter 17 for a retailer to sell or permit to be sold any tobacco products to an individual under the age of 27 without requesting and examining photographic identification identifying the purchaser's age as twenty-one (21) or greater.	May 2022	Reduce the availability of tobacco products
Klamath	Klamath County Government Center became a smoke-free property.	Not found	Reduce exposure to secondhand smoke/ vapor
Klamath	Klamath County tobacco retail license expansion limiting new retailers to be at least 1/4 mile (1320 feet) from any childcare facility or public or private schools and limits retailers from being within 1000 feet of another retailer.	May 2023	Reduce the availability of tobacco products
North Central	Sherman County tobacco-free workplace policy. For the policy, "tobacco" includes the smoking of any tobacco-based product, smoking in any form (including, without limitation, cigars and e-cigarettes), and the use of oral tobacco products of "chew/spit" tobacco. Marijuana is also prohibited under this policy.	July 2022	Reduce exposure to secondhand smoke/ vapor
North Central	The Dalles City Council adopted an ordinance making Lewis & Clark Festival Park tobacco and vape-free.	May 2023	Reduce exposure to secondhand smoke/ vapor
Lane	The City of Florence unanimously passed a resolution proposal that places non-punitive restrictions of any tobacco usage or smoking in five city parks. All selected parks were child-centric parks with existing play structures.	Dec. 2022	Reduce exposure to secondhand smoke/ vapor
Multnomah	A flavored tobacco prohibition was added to the local Tobacco Retail License ordinance to take effect January 1, 2024.	Dec. 2022	Reduce the availability of tobacco products
Washington	Washington County Board of County Commissioners passed Ordinance 878. The ordinance bans retail sales of any flavored tobacco products, including menthol cigarettes, flavored synthetic nicotine, and inhalant delivery systems such as e-cigarettes, e-cigars, vape pens, and e-hookahs that impart a taste or smell other than the taste or smell of tobacco.	Nov. 2021	Reduce the availability of tobacco products

Tobacco Prevention and Health Systems Change Strategies: Dec. 2022

Tier 1, 2, and 3 grantees were required to work on at least one health systems change strategy and Tier 2 and 3 grantees were required to work on at least two and three tobacco prevention policy or program strategies respectively. Table 4 and Figure 3 on the following pages show the types of strategies each grantee was working on as documented in reporting period 3 (Jul. - Dec. 2022).

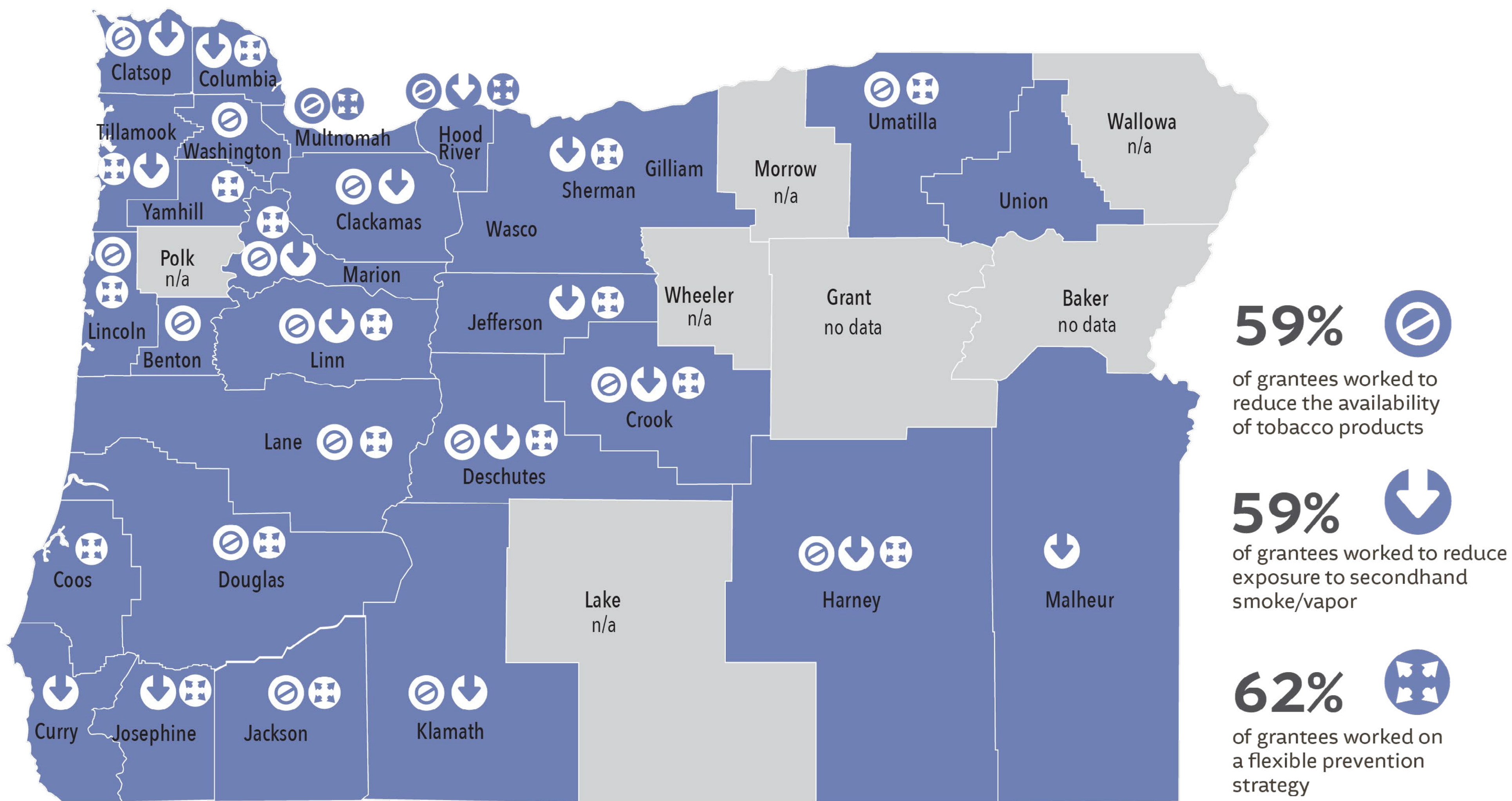
Note: Baker and Grant Counties did not report on any tobacco prevention or health systems strategies because COVID-19 or other pressing issues prevented their program from conducting any activities to report.

Douglas County, although in the ICAA Response Tier, received Ballot Measure 108 funds and completed a reporting form during this period. Therefore, their information is included with Tier 1-3 grantees on the following pages.

Table 4: Grantee tobacco prevention and health systems strategies: Dec. 2022

Grantee	Tier	Tobacco prevention strategies			Health systems change strategies		
		Reduce the availability of tob. products	Reduce exp. to secondhand smoke/vapor	Flexible prevention strategy	Increase health care providers referring to the Quitline	Work w/CCO on culturally relevant approach to tob. prevention	Other proposed strategy
Benton	3	✔			✔		✔
Clackamas	3	✔	✔		✔	✔	
Clatsop	3	✔	✔			✔	✔
Columbia	1		✔	✔			✔
Coos	2			✔	✔		
Crook	3	✔	✔	✔	✔		✔
Curry	1		✔		✔	✔	
Deschutes	3	✔	✔	✔	✔		✔
Douglas	ICAA + BM 108	✔		✔			✔
Harney	2	✔	✔	✔	✔		
Hood River	3	✔	✔	✔	✔	✔	
Jackson	2	✔		✔			✔
Jefferson	2		✔	✔	✔	✔	✔
Josephine	3		✔	✔	✔		
Klamath	2	✔	✔			✔	
Lane	3	✔		✔			✔
Lincoln	2	✔		✔	✔		
Linn	3	✔	✔	✔	✔		✔
Malheur	2		✔		✔		
Marion	2	✔	✔	✔	✔		
Multnomah	3	✔		✔	✔	✔	
North Central	2		✔	✔			✔
Tillamook	2		✔	✔	✔		
Umatilla	3	✔		✔	✔		
Union	1						✔
Washington	3	✔			✔		
Yamhill	2			✔			✔

Figure 3: Tobacco prevention strategies overview (Dec. 2022)



Tobacco prevention strategies

Among the 29 Tier 1, 2, and 3 grantees (and Douglas County who was in the ICAA Response Tier receiving BM 108 funds):

- 59% (n=17) reported working on a policy strategy to reduce the availability of tobacco products
  - 21% (n=6) reported working on tobacco retail licensure
  - 21% (n=6) reported working on a policy strategy to prohibit the sale of flavored tobacco products
  - 10% (n=3) reported working on a policy strategy to increase promotion on healthy products, while decreasing the advertising and prominence of alcohol and tobacco products
  - 7% (n=2) reported working on a policy strategy to restrict outlet density through zoning, distance requirements (e.g. restrict the proximity of tobacco outlets near places where children frequent, cap the number of retailers)
  - 7% (n=2) reported working on other proposed retail strategies
  - 3% (n=1) reported working on a policy strategy to increase the cost of tobacco through non-tax approaches (e.g. price promotion prohibitions)
- 59% (n=17) reported working on a policy strategy to reduce exposure to secondhand smoke/vapor
  - 38% (n=11) reported working on a policy strategy to advance jurisdiction-wide smoke and vape-free policies (e.g. local ordinances) including outdoor dining, other service areas, or construction sites

  - 17% (n=5) reported working on a policy strategy to advance policies that establish tobacco-free county or city agencies or other regional government campuses (identified in the submitted program plan) inclusive of prohibitions on e-cigarettes/inhalant delivery systems
  - 10% (n=3) reported working on a policy strategy to advance jurisdiction-wide smoke and vape-free policies (e.g. local ordinances) for public places to prohibit businesses that allow indoor smoking or expose employees to secondhand smoke or vapor, including potential cannabis use establishments
  - 10% (n=3) reported working on a policy strategy to advance jurisdiction-wide ordinance to extending the prohibition of smoking beyond the current 10 feet from entrances, exits, or windows
  - 3% (n=1) reported working on other proposed strategies to reduce exposure to secondhand smoke/vapor
- 62% (n=18) reported working on a flexible tobacco prevention strategy
  - 41% (n=12) reported working on another important approach that their community felt would will make a difference and support a tobacco-free world
  - 28% (n=8) reported working on a policy strategy to create a local tobacco impacts report and/or interactive web presence to highlight the various ways in which tobacco affects youth, seniors, priority communities, job security, and illness in their community and develop a distribution plan to present or share this resource with allied groups and leaders
  - 24% (n=7) reported working on a policy strategy to develop alternatives to suspension policy with collaboration with schools and/or school districts

to ensure possession of tobacco products and/or use of these products does not result in missing educational time, and instead provides the necessary support to young people to quit

- 14% (n=4) reported working on a policy strategy to develop a college internship program to build a pathway to public health careers and ask their intern to develop a tobacco 101 educational series; and create a presentation and sharing plan to utilize this material for new coalition members or staff onboarding and to share with allied partner coalitions
- 10% (n=3) reported working on a policy strategy to build a cohort program of youth advocates to be involved in peer education, participating in youth tobacco sale surveys, and TARA data collection
- 10% (n=3) reported working on a policy strategy to create a collaborative tobacco (and other local issues of interest) health equity local impacts report, and/or GIS project
- 7% (n=2) reported working on a policy strategy to develop cooperative agreements with 2-3 stores offering healthy retail options such as agreeing to minimize or eliminate tobacco and alcohol shelf space and advertising, stocking healthy snack options, and ensuring access to produce, etc.
- 7% (n=2) reported working on a policy strategy to develop and implement a new virtual or in person tobacco prevention (or chronic disease prevention) coalition with youth and adult participants and invite those who call with complaints/concerns and/or participate in social media to be part of the coalition
- 7% (n=2) reported working on a policy strategy to develop and update a resource to highlight the local and state decision-making process; outline

all their local and statewide decision-makers, their key priorities, and share this knowledge with other partners and coalitions

Although Tier 1 grantees were not required to advance tobacco prevention strategies some listed these strategies in their reporting forms and are included in the data above.

Successes in progressing policies to reduce the availability of tobacco products

- Developed and strengthened partner relationships
- Supported state TRL
- Gained support on flavor bans from retailers and key decision makers
- Developed and provided education materials about the dangers of tobacco and vaping
- Gave presentations to retailers and decision makers on tobacco harms
- Identified healthy alternatives with nutrition partners for retail stores to replace tobacco products
- Created and shared social media and media posts about the dangers of tobacco products
- Focused on availability of tobacco products based on location with an equity lens

Successes in progressing policies to reducing exposure to secondhand smoke/vapor

- Developed and strengthened partner relationships
- Ordinances drafted for smoke free zones and properties
- Drafted policies
- Gave presentations on the impacts of secondhand smoke exposure schools and decision makers

- Created and shared social media and media posts for smoke-free properties
- Developed and provided education materials on the benefits of smoke-free areas

Successes in progressing flexible tobacco prevention strategies

- Developed and strengthened partner relationships
- Collaborated with schools to provide healthy alternative to suspension from tobacco use
- Developed and provided education materials on tobacco cessation options
- Focused on prevention with an equity lens by focusing on culturally appropriate advertising and availability of tobacco products by location
- Created coalitions and/or committees to increase awareness of cessation programs and provide tobacco education
- Invested in additional resources to support prevention strategies (ie. new staff, internship programs, volunteers)
- Created and shared social media and media posts to end the sale of all flavored tobacco in the state
- Gave presentations on flexible prevention strategies to decision makers, retailers, and school administrators
- Identified healthy alternatives for products in stores to replace tobacco products

Progress through the policy change model

Rede assessed progress by comparing the status of grantee activities for each of their tobacco prevention strategies at reporting periods 1 and 3. In reporting forms across periods 1 and 3, a total of 101 tobacco prevention strategies were underway

by 27 grantees. Of those strategies, 57 (56%) were consistently listed on two or more reporting forms and could be used to assess progress through the policy change process. Of the consistent strategies, 27 (47%) (conducted by 16 grantees) progressed through one or more stages through the Equity-Centered Policy Change Model (see Appendix C). Strategies from all three strategy types progressed through the policy change model, with a higher percentage of strategies progressed in the flexible tobacco prevention strategy category (see Figure 4).

Figure 5 shows the percentage of grantees with one or more tobacco prevention strategy at each stage of the policy change model. Progress through the policy change process was evidenced by more grantees working on strategies in stages further along in the policy process at reporting period 3 than period 1. For example, only 6% of grantees were working on a strategy in stage eight of the model during reporting period 1 and 31% were working on a strategy in that stage at reporting period 3.

Figure 4: Tobacco prevention strategies progressed by strategy type

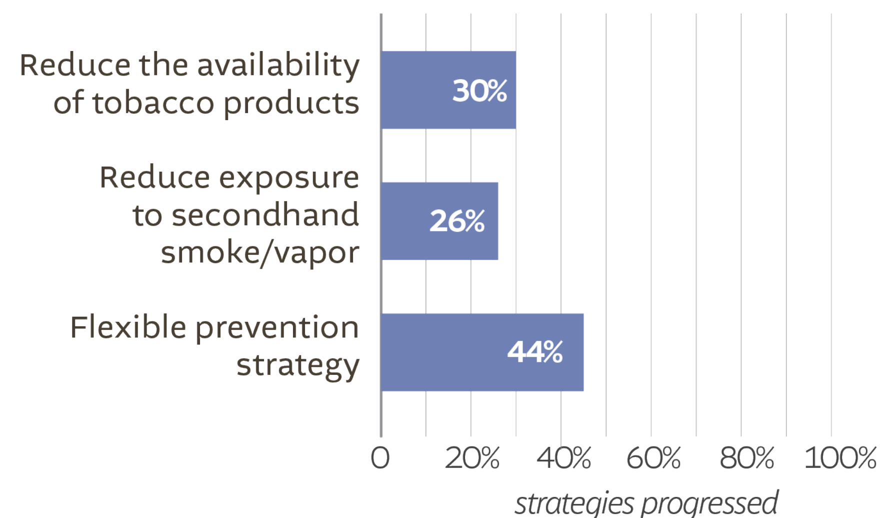
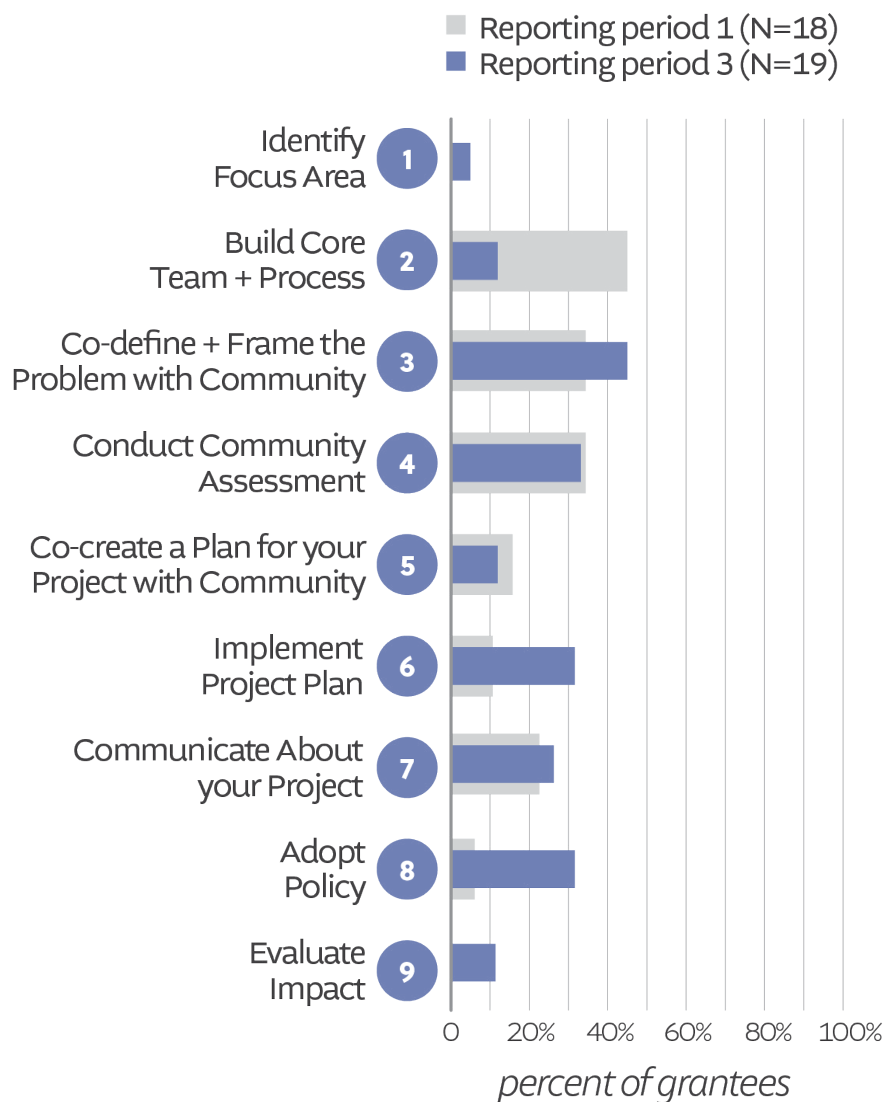
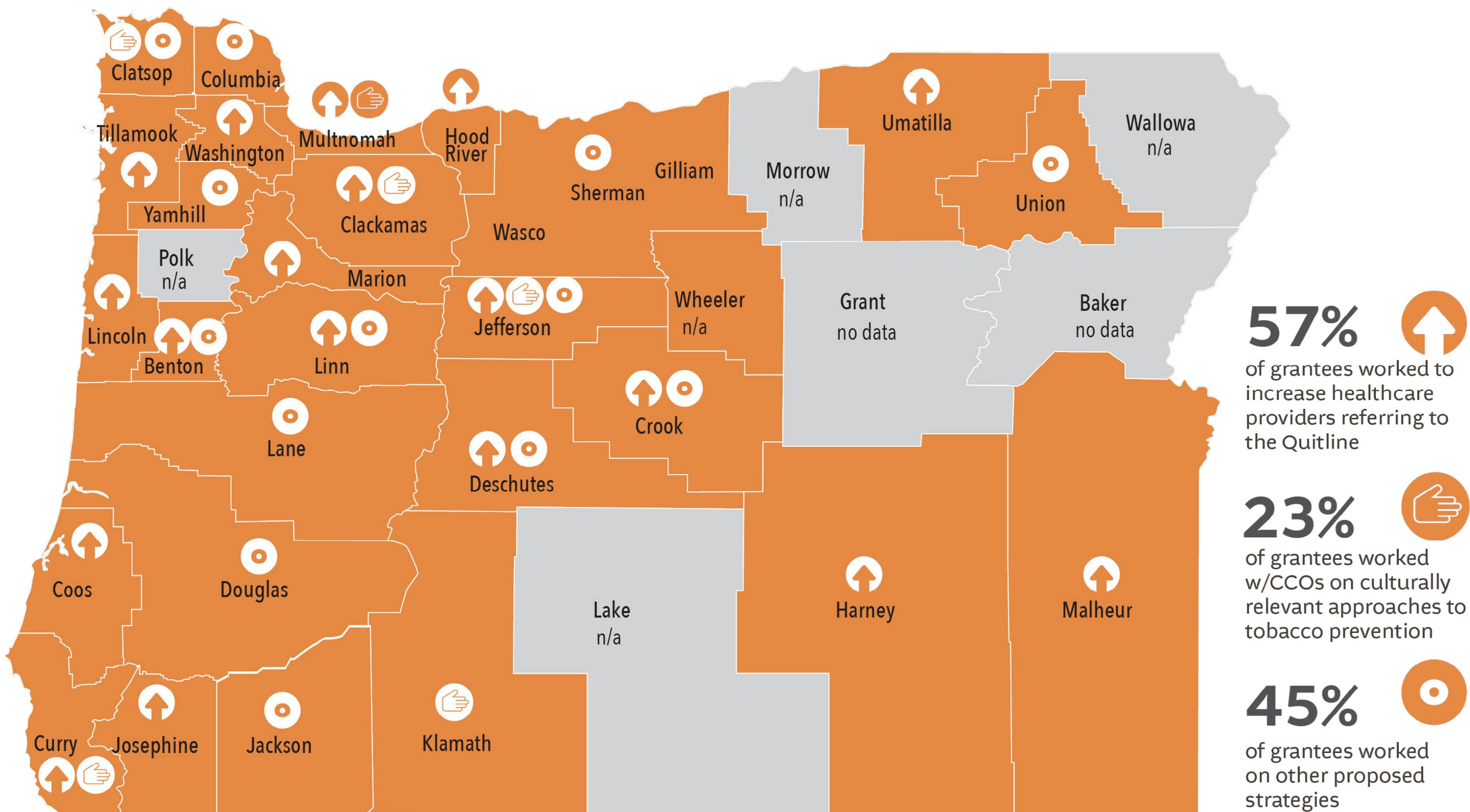


Figure 5: Amount of grantees with a tobacco prevention strategy underway at each stage of the Equity-Centered Policy Change Model



	Reporting period 1 (N=18)	Reporting period 3 (N=19)
Stage 1	0%	5% (n=1)
Stage 2	44% (n=8)	11% (n=2)
Stage 3	33% (n=6)	47% (n=9)
Stage 4	44% (n=8)	42% (n=8)
Stage 5	17% (n=3)	11% (n=2)
Stage 6	11% (n=2)	32% (n=6)
Stage 7	22% (n=4)	26% (n=5)
Stage 8	6% (n=1)	31% (n=6)
Stage 9	0%	11% (n=2)

Figure 6: Health systems change strategies overview (December 2022)



Health systems change strategies

Among the 29 Tier 1, 2, and 3 grantees (and Douglas who is ICAA but submitted a reporting form for period 3):

- 93% (n=27) reported working on a health systems strategy
  - 57% (n=17) reported working on a strategy to increase the total number of health care providers with capacity to refer patients to Quitline
  - 24% (n=7) reported working on a strategy working with regional Coordinated Care Organization (CCO) to implement at least one culturally relevant approach to tobacco prevention
  - 45% (n=13) reported working on another proposed strategy with multi sector partners

Successes in advancing health systems strategies:

- Built interest and partnerships with clinical, dental, behavioral health, and public health managers to improve and increase referrals to tobacco cessation services
- Strengthened partnerships with community health organizations to create closed loop referral system
- Identified support, interest, and needs of the behavioral health department staff
- Increased the visibility for tobacco issues in the perinatal population and youth population
- TPEP coordinators completed training to facilitate tobacco education/cessation programs
- Increased interest by CBOs on referral process to cessation programs
- Partnered with local schools to provide cessation information and vaping/tobacco prevention to youth

- Promotion of e-referrals by the community and clinics to the Oregon Tobacco Quitline
- Developed educational materials on tobacco cessation for community partners to utilize
- Launched mass social media campaigns to promote tobacco cessation and prevention
- Hired staff for more robust support to TPEP work
- Expanded Nicotine Replacement Therapies (NRT) prescribers
- FQHCs updated their internal protocols for tobacco cessation and secondhand smoke exposure

Summary of Work with Behavioral Health System Partners

54% (n=15) of grantees reported work with behavioral health system partners between Jul. 2021 - Dec. 2022. Work with behavioral health system partners included:

- Closed loop referral system for Quitline and tobacco cessation services
- Options for health care providers to discuss risk of tobacco use/nicotine addiction
- Enhanced capabilities to refer individuals to Quitline and cessation services
- Training to facilitate smoking cessation for youth and adults who are looking to quit smoking
- Development and adoption of procedure to integrate tobacco dependence treatment into behavioral health clinic workflow

Summary of Work with Federally Qualified Health Center (FQHC) Partners

21% (n=6) of grantees reported work with FQHCs between Jul. 2021 - Dec. 2022. Work with FQHCs included:

- Partnering with FQHCs to implement referral process to Quitline
- Partnering with FQHC to create Tobacco Prevention Coalition
- Partnering with FQHC to engage cessation program in local high school
- Getting one FQHC to update their internal protocol for tobacco cessation and secondhand smoke exposure

Communication Strategies & Support Requested

Communication Strategies

TPEP grantees were asked to share communication strategies used and requested during each grant reporting period.

The most common communication strategies utilized by grantees in their TPEP work during reporting periods 1-3 included:

- Posting messages from the Smokefree Oregon social media calendar on county social media sites
- Presenting to a leadership body, or member of the body, about a program's policy goal
- Utilizing Smokefree Oregon campaign toolkit materials

See Appendix D for additional detail on communication strategies reported by TPEP grantees.

Communication Support Requested

TPEP grantees were also asked to describe any communication support, skills, or learnings that would be helpful to move their program work forward and support their communities TPEP goals. A total of 36 reporting forms from periods 1-4 from 19 grantees included a response. Communication support requests varied by grantee with few thematic responses. A few common communication needs included:

- Training and support on using and maximizing the use of communication through social media
- Support on developing or improving websites that share information about tobacco prevention and cessation resources
- Continued availability of social media calendars and toolkits in English and Spanish. Recommendations were provided to make the images in these resources larger, improve the formatting of Facebook posts, provide content earlier to allow time to get content scheduled for social media posts, and offer the toolkit materials in additional languages

For a full list of communication support requested by TPEP grantees, see Appendix D.

Findings:
Geographic Differences in Commercial Tobacco Use + Needed Support

The data collection and analysis led by the Geographic Differences Workgroup resulted in important findings related to each of the three key evaluation questions for this component of the evaluation. Interviewees and survey respondents (hereafter, "participants") provided valuable insights and also elevated opportunities for improving tobacco-related education, support, and resources for rural and frontier communities. Findings and recommendations are summarized below, and support for these findings is included in Appendix E

Question 1: What are community members' beliefs about drivers or causes of disparities in tobacco use in different geographic areas/counties in Oregon?

Public health professionals, community organization representatives, and community members all provided insights about their beliefs and perceptions on tobacco use in rural and frontier communities.

The primary drivers of tobacco use in rural and frontier communities include:

1. **Trauma,** including past and ongoing experiences of abuse and unaddressed behavioral health needs. Given the behavioral health care crisis in Oregon and

provider shortages that disproportionately impact rural and frontier communities, unmet behavioral health needs exacerbate tobacco use. Many participants described community member and behavioral health provider perceptions that tobacco use is "safer" than using other substances to cope with trauma.

2. **Chronic stress related to poverty,** lack of resources, and chronic health conditions. Rural and frontier communities experience higher rates of poverty compared to urban communities. Alongside poverty, lack of access to resources like stable housing, food, and adequate health care result in chronic stress. Participants described tobacco use as their only relief from the burden of these stressors.
3. **Cultural norms**, including within social groups, families, and the community at large. Seeing tobacco use in the places they spend their time (e.g., work settings, community events, restaurants and bars) normalizes tobacco use. Peer pressure and familial pressure was a factor noted by participants in tobacco initiation for youth; using tobacco products was described as a "rite of passage". When tobacco use is prevalent in family and social groups, individuals have easy access to tobacco products as well.
4. **Inadequate information and education about tobacco use.** Participants described existing education and communication campaigns as "not tailored to rural communities" and disconnected from their experience and needs. Some described feeling blamed and judged for their tobacco use, particularly by the state or larger metropolitan communities. In addition, participants noted there is a lack of trusted messengers who can provide information about resources for quitting.
5. **Inadequate cessation resources and supports.** Participants in rural and frontier communities prefer in-person resources for quitting, including 1:1 counseling and group support. Many described Quitline services as "inadequate" or "not

responsive to rural communities". Rural and frontier community members also desire better access to nicotine replacement therapies (NRT).

6. **Struggling local economies** that impact individual experiences like high rates of economic hardship as well as systemic and political conditions. Public health and health care systems are unable to provide sufficient care to community members due to a lack of resources and provider shortages driven by economic factors. Participants also observed a lack of political buy-in to regulate the tobacco industry when tobacco product sales drive economic activity.

Recommendations

Through analyzing data and in discussions with workgroup members, several important recommendations emerged for addressing the drivers of tobacco use in rural communities:

- Improve access to behavioral health care in rural and frontier communities to address trauma, chronic stress, and behavioral health conditions.
- Provide community-wide education that is tailored to rural and frontier communities about the impacts of tobacco use and resources for quitting.
- Identify trusted messengers in rural and frontier communities who can help counter cultural norms of tobacco use and refer community members to resources for quitting.
- Improve cessation resources and support by increasing access to NRT and increasing in-person cessation services.

Question 2: How do different policy and capacity conditions affect tobacco prevention work in different communities?

Policy and capacity conditions include factors such as the quality and quantity of local partnerships, county health department staffing and resources, local distrust of government, and provider shortages. These conditions greatly impact the ability of local public health systems to address the complex drivers of tobacco use and provide adequate and responsive resources for community members.

The policy and capacity conditions impacting tobacco prevention work in rural and frontier communities include:

1. **Limited staffing capacity,** with rural and frontier LPHAs and CBOs often having less than 1 full time staff dedicated to commercial tobacco prevention work.
2. **Lack of resources** for addressing the specific drivers of tobacco use in rural and frontier communities. Participants noted that they need more information, skills, and resources for changing cultural norms in particular.
3. **Lack of cessation resources** tailored to the preferences of rural and frontier communities (e.g., in-person counseling and support and NRT).
4. **Lack of strategic focus** while navigating competing priorities and limited resources. While all participants noted that the complex and deeply rooted drivers of tobacco use are difficult to address, participants in rural and frontier communities were more likely to have limited resources for their work which made it more difficult to decide where to focus and what activities to prioritize. LPHAs desired more support from the state and more opportunities for peer sharing and learning with other rural and frontier TPEP programs.
5. **Need for more local data**, including more consistent statewide data collection

and reporting as well as training and technical assistance for local data collection efforts. Participants noted that having more consistent, accessible, and relevant local data would also help rural and frontier tobacco prevention programs determine their strategic focus.

6. **Limited partnerships,** with rural and frontier LPHAs and CBOs reporting they have fewer partners and are less satisfied with their partnerships.
7. **Need for buy-in from local leaders and elected officials** for enforcing and/or changing tobacco-related policy and for systems and environmental change. Some local leaders in rural and frontier communities downright oppose tobacco prevention, education, and control measures while others are ambivalent and don't want to take a public stand.

Recommendations

During data analysis and interpretation, workgroup members elevated these recommendations for improving policy and capacity conditions:

- Increase TPEP funding for rural and frontier LPHAs to support them to "staff up" and increase FTE on tobacco prevention and education.
- Acknowledge that hiring and retaining staff can be more difficult in rural and frontier communities, so augment state support for rural and frontier programs and facilitate collaboration and peer learning across rural and frontier programs.
- Expand resources and support tailored to rural and frontier communities, including those that address the strong cultural norms that encourage tobacco use. Participants noted a need for youth resources in particular, including education on youth vaping and tailored cessation resources.
- Improve statewide maintenance of and access to data and communication/

education materials. Some participants and workgroup members desired a document sharing and project management platform such as Basecamp for maintaining easy access to all up-to-date state and local tobacco prevention materials.
- Improve statewide support and facilitate peer learning related to building local buy-in for policy, systems, and environmental change. Rural and frontier LPHAs desire technical assistance for identifying what local leaders and elected officials care most about and tailoring messaging in support of tobacco prevention, education, and control accordingly (e.g., making the case for how policy change can support/bolster the local economy).

Question 3: What do people think about the intersection of place and health and the government's role in making their place healthier?

Place is a key determinant of health outcomes. Public health professionals, community organization representatives, and community members all reflected on the government's role in making places healthier, and how this role may look different in rural and frontier places compared to more urban places.

Key learnings about commercial tobacco prevention and cessation in rural and frontier places include:

1. Strong recognition of the health impacts of commercial tobacco and nicotine use and a desire for more information about getting motivated to quit, making a

plan and stick with it, adopting healthy behaviors, and finding support were all highlighted by participants.

2. **Family is an effective motivator,** as many participants in rural communities identified that their primary motivation to quit was because they got pregnant or because they did not want to use commercial tobacco products around kids in their life.

Key challenges affecting commercial tobacco prevention and cessation work in rural and frontier places include:

1. **Limited resources and competing priorities,** with many participants noting that issues like opioid addiction and houselessness are much more visibly harmful in their communities and pull a lot of public health and community focus.
2. **Lack of social and political will** to strengthen anti-tobacco policies among community members, businesses, and elected officials in rural and frontier counties for fear of infringing upon individual freedoms of commercial tobacco users.
3. **Desire for more training** in strategies for commercial tobacco prevention, especially among local health department staff and BM 108 grantees in frontier counties. Participants specifically noted a need for training on building buy-in among local leaders to advance commercial tobacco prevention policies.
4. **Desire for expanded cessation resources**, with participants expressing that they specifically desired improved access to NRT and in-person counseling for tobacco cessation. Participants in frontier and rural counties expressed mixed feelings about the Quitline, with some desiring expanded access and others expressing dissatisfaction with the Quitline's "impersonal" feel and a preference for in-person

individual or group counseling. Participants in frontier counties were also more likely to attempt to quit "cold turkey."

Recommendations

Through data analysis and review of these learnings with workgroup members, the following recommendations emerged to improve place-specific approaches to commercial tobacco prevention and cessation in rural and frontier communities:

- Identify and cultivate relationships with trusted messengers within rural and frontier communities to strengthen commercial tobacco prevention and cessation activities in these communities.
- Use messaging that resonates with rural communities. For example, framing tobacco prevention policies as protecting the rights and health of children, and encouraging social connection and support among those who want to quit.
- Increase access to cessation resources in rural communities, especially NRT and in-person individual and/or group counseling. Some data collection participants also expressed a need for population-specific strategies within their larger communities (e.g., getting information and resources to shelters for people who are unhoused, working with schools on youth prevention, etc.)

Appendix

The following appendices are referenced throughout this report.

A. TPEP Tier 3 Prerequisites
B. Key Evaluation Questions Two Summary of Work Completed
C. Equity-Centered Policy Change Model
D. Grantee Communication Strategies
E. Geographic Differences

Appendix A: TPEP Tier 3 Prerequisites

The 2021-23 TPEP request for applications required that Tier 3 grantees have at least six of the following ten prerequisites.

1. Required for Tier 3 grantees: Formal statement of support from Board of County Commissioners or high-level executive leadership to prioritize advancing and passing priority tobacco prevention strategy (i.e. tobacco retail policy, strengthened smoke-free/vape-free policy, etc.)
2. Leveraged funding commitment from CCO, federal grant, or foundation partner for tobacco prevention and cessation activities
3. Tobacco prevention ordinance passed by government within the last three years (updated policy may count as well; examples include strengthening a smoke-free policy to include all tobacco products or removing exemptions)
4. Comprehensive county tobacco-free policy in place
5. Demonstrated current health system partnerships (e.g., memorandum of understanding in place, funding agreement, current initiative) for tobacco prevention
6. Evidence of convening and/or funding partners representing communities most burdened by tobacco in pursuit of priority tobacco prevention strategies (commitment to health equity)
7. Demonstrated implementation of communications strategy, including earned media, to support tobacco prevention strategy(s) in the previous biennium (2019-2021)
8. Evidence of shared regional strategy and collaboration in pursuit of priority tobacco prevention strategies
9. Evidence of local public health accreditation
10. Evidence of participating in the statewide conversation toward establishing tobacco retail licensure, flavor restrictions, strengthening the ICAA or another priority initiative (i.e. LPHA, community champions, or Board of County Commissioners providing testimony during legislative session)

Appendix B: Key Evaluation Question Two Summary of Work Completed

Key Evaluation Question Two: How can local tobacco programs support behavioral health systems to reduce tobacco-related disparities among people experiencing mental
health or substance use disorders?

Note: This document covers work done by the Nicotine Treatment and Recovery (NiTR) project team that speaks to the question above.

TPEP grantee Nicotine Treatment Health Systems Affinity Group

Between October 2021 and June 2023, Rede staff attended meetings with a self-directed group of LPHA TPEP grantees who met monthly to share knowledge and experiences related to working with behavioral health providers to integrate nicotine dependence treatment and recovery practices into their treatment approaches. Initially called the TPEP Behavioral Health Systems Strategy Coordination Group and later the Nicotine Treatment Health Systems Affinity Group, members of this group of approximately eight to ten participants shifted over time with staff turnover at the county level.
HPCDP staff also attended meetings that focused on problem-solving to address specific issues the LPHA's encountered in their work, such as:

- How to engage behavioral health providers in tobacco cessation work
- The process of becoming registered with the Oregon Pharmacy Board in order to distribute NRTs
- Developing tracking sheets for NRT distribution
- Group planning for TPEP cessation objectives, including alternatives to suspension in schools, closed-loop referrals in FQHCs and other clinical settings, and NRT distribution

Rede did not conduct a formal evaluation of this group's effectiveness in improving grantees' capacity to work with behavioral health partners; however, we observed the following indicators of effective professional practice collaboratives:

- Clarity of purpose

- Self-direction in planning and agenda-setting
- Peer-to-peer problem solving, especially at the tactical level
- Sharing resources such as articles, partner contacts
- Sharing successes

LPHA collaboration on free NRT pilot

As a part of a process to determine the feasibility of providing free NRT to SUD providers for use with their clients who want to quit commercial tobacco use, Rede met twice with three (self-identified) LPHA TPEP grantees to review the concept and develop messaging that TPEP grantees could use to promote the pilot project. During these meetings, TPEP grantees shared their insights about community members' needs related to tobacco cessation, including issues and challenges around obtaining and paying for NRTs. They also provided expertise about how different providers in their community structure services. Rede shared information about the pilot concept and HPCDP's Nicotine Treatment and Recovery Panel's vision for the pilot as being focused on making it easier for providers to initiate cessation treatment with their clients. The knowledge exchange in these conversations was beneficial in determining the project's viability.

Tobacco cessation training for behavioral health

Rede hosted a one-day, six-hour training facilitated by Dr. Jill Williams on the integration of tobacco cessation into behavioral health settings in May 2023. The primary audience for the training was behavioral health providers. TPEP coordinators helped recruit for the training in their counties, and several TPEP coordinators attended the training.

Appendix C: Equity Centered Policy Change Model

At every step of the process, did you...

- Think about who else needs to be there and recruit them
- Authentically include community members, centering people of color

Ensure adequate time for building strong relationships

- Use an equity & racial justice lens
- Consider how to support transformative justice in the process
- Clarify roles, responsibilities and process
- Define decision making process that is transparent, equitable & community driven
- Ensure transparency
- Identify and address barriers and incentives for community participation
- Adapt your process & tools to make it relevant & accessible for different groups (i.e. plain language, translation, interpretation)
- Value life experience
- Create consistent messages
- Surface, discuss & address power imbalances
- Address conflict, harm or failures, and unintended consequences
- If community is not onboard, go back to the beginning

1. Identify Focus Area

- This is broader than the goal or strategy, and informed by community priorities and data (qualitative and quantitative) that have emerged from the community. Find something specific enough to start a conversation, but not too narrowly defined before community has a chance to participate in goals and strategies. For example, alcohol use in the community.

2. Build Core Team and Process

- Include community members and center people of color in the core team.
- Include community members, especially those disproportionately impacted, and center people of color in the core team.
- Create process for information sharing, decision making, transparency and language access (Including both translation/ transcreation and easy to understand content, i.e. plain language).
- Create agreements for shared ownership.
- Start to define strategy for strengthening government accountability in the process.
- Provide group members tools for increasing self-awareness about their own beliefs and behaviors related to equity, accountability and team work.
- Continually encourage additional members to expand learning and participation.

3. Co-Define and Frame the Problem With Community

- Define, assess and frame the problem using the most current and relevant information available, including stories and qualitative information.
- Recruit a broader coalition than core team that includes people of color and those experiencing health disparities. Create clear criteria for who is at the table and their participation.
- Create a plan for surfacing, addressing, and managing power dynamics.
- Build a shared understanding within your group of health equity,social determinants of health and the policy change process to ground your team in the larger context.
- Crosswalk language and concepts to ensure common understanding; strive to use accessible language
- Create a process to assess and resolve concerns as they surface.
- Find champions and supporters – people who are respected in their communities and motivated or willing to speak on the issue.

4. Conduct Community Assessment

- Assess who, what, when, how community members and people of color are affected and how to center their perspectives. Use data, community priorities and stories.
- Map the system and landscape. Identify and consider how the issue connects with existing work being done. Discuss the limits of the current system.
- Crosswalk and align priorities and agendas of community members and government representatives participating in core team.
- Assess external dynamics and context that influence the problem and the plan.
- Assess decision maker readiness.
- Assess community coalition & policy environment strengths, opportunities, weaknesses, threats.
- Assess existing power structures in community and government settings.
- Assess current policies and laws in place related to the focus area. With this information, you can identify where improvement should be considered.
- Assess if political will and community support for policy change can be activated and understand where there may be opposition to the policy change.
- Collect and review actions and successes from other places.
- Estimate the health, fiscal, administrative, legal, social and political implications.
- Connect with agencies/organizations who would be involved in implementing and enforcing policies.

5. Co-create a Plan for Your Project With Community

- Create a vision for your ideal system, community and environment!
- Discuss shared goals, values, priorities and commitments that center community priorities.
- Consider how the group can support community priorities beyond policy work.
- Identify possible policy and systems changes needed to address problem. Choose a policy or system to target for change.
- Examine evidence-based practice & practice-based evidence for fit with community needs.
- Assess potential for the solutions to improve equity—are they inclusive? who benefits?
- Create project timeline.
- Secure resources and create project budget Consider how to compensate community members and community-based organizations supporting project.
- Make clear criteria and process for group accountability.
- Define clear roles, opportunities for participation, expectations and commitments of group members (e.g. testifying, policy drafting, education, etc.)
- Define success and how it will be measured.

6. Implement Project Plan

- Policy development process, if applicable
    - Learn about local agency process for drafting policy.
    - Identify resources, like model policies, from other partners.
    - Plan a policy review process that incorporates legal and policy expertise.
    - Develop a plan to implement, monitor and evaluate the policy (e.g., develop budgets, rules, procedures, materials).
- Document your process and decisions made.
- Team members follow shared agreements to work together and hold each other accountable with clear expectations of roles.
- Discuss strategies for sustaining the change.

7. Communicate About Your Project

- Develop a cohesive communication and education plan that incorporates multiple methods of outreach.
- Co-create and share consistent messages about your project alongside community. Include policy impacts to particular communities.
- Discuss multiple formats for engagement (i.e. not just digital).
- Carefully articulate (frame) why the policy solution is necessary using community information and data to describe and frame the problem.
- Communicate about the focus area chosen and health equity impacts with partners to make it public (community members, organizations, decision makers, government).
- Connect with potential government leaders and champions.
- Engage with decision-makers about the public health need and policy solution. Provide decision makers with information and options for changing policy to improve health equity. Listen to decision-maker priorities and provide fact-based information to build the case for necessary change. Hold decision makers and leadership accountable for community commitments.
- Integrate two-way feedback between team and community.
- Communicate and elevate successes.

8. Adopt Policy

- Work with policy makers to formally adopt the policy.
- Plan for public comment to support the policy. Alert coalition members and the public with timely accurate information about all opportunities to comment on the proposed policy. Assist coalition members to develop testimony and comments (when appropriate).
- Provide information to decision-makers.
- Count votes before the actual vote. This step involves asking or estimating how many decision-makers are likely to support or oppose the policy. This can be done by talking to advocates who have asked decision-makers about their opinion on the policy or talking directly to decision-makers. Either way, it's important to have some sense of how decision-makers may vote prior to a public hearing.
- Anticipate possible last-minute amendments.

9. Evaluate Impact

- Evaluate the impact of the policy change through an equity lens.
- Track the implementation process (Is the policy and plan functioning as intended?).
- Take appropriate action to address evaluation results about violations when needed.
- Evaluate the effectiveness of the policy change process. For example, what lessons learned can be gleaned from your policy change process? What would you do differently in future policy change projects? What would you do the same?
- Make changes if the policy isn't working.
- Communicate findings back to community members.
- Incorporate evaluation findings into future planning.
- Evaluate equitable enforcement. Address unanticipated effects or inequities.

Appendix D: Grantee Communication Strategies

This document provides detailed information from TPEP grantee reporting forms during the 2021-23 biennium in response to questions about communication activities and needs. This data supports the high-level findings found in the evaluation report.

Tables 1-4 below detail the percentage of grantees participating in each communication activity during each reporting period.

Communication Activities

Table 1: Grantee Communication Activities During Reporting Period 1 (Jul. - Dec. 2021), N=27

Communication Activities	**Percent of grantees**
Presented to a leadership body or member of that body about a program's policy goal	63% (n=17)
Posted messages from the Smokefree Oregon social media calendar on county social media sites	52% (n=14)
Presented information to community members or decision-makers through a formal presentation	37% (n=10)
Participated in any paid promotions	30% (n=8)
Used Smokefree Oregon campaign toolkit materials	30% (n=8)
Provided program updates to external partners	22% (n=6)

Used campaign toolkit materials from other sources (ex. regional initiative or national organization)	22% (n=6)
Built a relationship with a reporter or news organization	15% (n=4)
Secured earned media piece	15 % (n=4)
Used earned media template provided by HPCDP	11% (n=3)
Hosted an earned media event	0% (n=0)
Other	7% (n=2)

Note: grantees could select multiple response options

Table 2: Grantee Communication Activities During Reporting Period 2 (Jan. - Jun. 2022), N=28

Communication Activities	**Percent of grantees**
Posted messages from the Smokefree Oregon social media calendar on county social media sites	61% (n=17)
Presented to a leadership body or member of that body about a program's policy goal	39% (n=11)
Provided program updates to external partners	32% (n=9)
Used Smokefree Oregon campaign toolkit materials	32% (n=9)
Used campaign toolkit materials from other sources (ex. regional initiative or national organization)	21% (n=6)

Presented information to community members or decision-makers through a formal presentation	18% (n=5)
Participated in any paid promotions	13% (n=4)
Built a relationship with a reporter or news organization	11% (n=3)
Secured earned media piece	11% (n=3)
Used earned media template provided by HPCDP	7% (n=2)
Hosted an earned media event	4% (n=1)
Other	36% (n=10)

Note: grantees could select multiple response options

Table 3: Grantee Communication Activities During Reporting Period 3 (Jul. - Dec. 2022), N=29

Communication Activities	**Percent of grantees**
Posted messages from the Smokefree Oregon social media calendar on county social media sites	69% (n=20)
Provided program updates to external partners	48% (n=14)
Used Smokefree Oregon campaign toolkit materials	48% (n=14)
Presented information to community members or decision-makers through a formal presentation	41% (n=12)

Presented to a leadership body or member of that body about a program's policy goal	31% (n=9)
Built a relationship with a reporter or news organization	28% (n=8)
Participated in any paid promotions	28% (n=8)
Secured earned media piece	24% (n=7)
Used campaign toolkit materials from other sources (ex. regional initiative or national organization)	17% (n=5)
Hosted an earned media event	14% (n=4)
Used earned media template provided by HPCDP	3% (n=1)
Other	31% (n=9)

Note: grantees could select multiple response options

Table 4: Grantee Communication Activities During Reporting Period 4 (Jan. - Jun. 2023), N=31

Communication Activities	**Percent of grantees**
Posted messages from the Smokefree Oregon social media calendar on county social media sites	68% (n=21)
Used Smokefree Oregon campaign toolkit materials	42% (n=13)
Presented information to community members or decision-makers through a formal presentation	39% (n=12)

Participated in any paid promotions	29% (n=9)
Provided program updates to external partners	26% (n=8)
Used campaign toolkit materials from other sources (ex. regional initiative or national organization)	26% (n=8)
Presented to a leadership body or member of that body about a program's policy goal	19% (n=6)
Built a relationship with a reporter or news organization	16% (n=5)
None, we did not complete any communications activities during the reporting period	13% (n=4)
Hosted an earned media event	10% (n=3)
Secured earned media piece	6% (n=2)
Used earned media template provided by HPCDP	3% (n=1)
Other	32% (n=10)

Note: grantees could select multiple response options

Grantees used the following *other* communication strategies during the biennium (Jul. 2021 - Jun. 2023):

- Ordered posters from https://digitalmedia.hhs.gov/tobacco/print_materials/search
- Ordered minor countdown calendars for retailers from https://digitalmedia.hhs.gov/tobacco/print_materials/search
- Used posts from Truth Initiative
- Great American Smoke Out
- County Prevention Newsletter: Flavored E-Cigarette Companies Marketing to Youth

- A legislative update from the 2021 regular session
- Truth Initiatives vaping campaign
- Various PTTC and MHTTC training around drug and alcohol use reduction.
- Standing submission for the Aumsville monthly newsletter or the County Prevention Team
- Our TPEP-specific Social Medical posts were posted. Subjects include I COVID-Quit Smoking video, Vaping, and youth during Halloween, and the Great American Smokeout
- Utilized Basecamp site for the TPEP Behavioral Health Systems Strategy Workgroup
- Created social media posts about TRL and Oregon Quit Line
- Wrote and planned the release of a PH Impact Paper about youth vaping and flavored products
- Planning a Health Advisory and a presentation to our City Council in August
- Reviewed and updated the County website
- Created Prevention webpages on the County's website with a section dedicated to tobacco education and cessation services
- Created three social media pages for our Prevention department (Facebook, Instagram, and Twitter) and posted at least once a week
- Procured a special page for our prevention department on a school district's website and we encouraged them to post social media posts about prevention on their social media
- The Center for Black Health & Equity's/Tobacco Free Kids No Menthol Sunday 2022
- One-on-one interaction with brief education with different local CBOs
- Social media posts in English and Spanish referencing cigarette smoking
- Placement of vaping youth media collaborative with neighboring countries
- Pivoting our MailChimp account that promoted flavored tobacco art contests to become a large tobacco coalition update email list
- Library display care for prevention week
- Created social media posts about the need for Tobacco Free Outdoor Spaces.
- Created social media posts reminding of a city tobacco-free park policy.
- Worked with the Communication Coordinator to design a billboard
- Presented information to community members or decision-makers through an informal presentation

- Updated Environmental Health Specialist and collaborated to educate retailers as needed. Provided FAQ, Fact Sheet on retail licensure
- Encouraged coalition members to share Smokefree Oregon social media posts
- TRL toolkit promotions
- Hosted an informational booth at Red Ribbon Banquet
- Hosted an informational booth at the county fair
- Stocked local health care providers with informational pamphlets
- Visited all county tobacco retailers and provided information and signage
- Distributed our own marketing materials directly to dentists
- The TPEP coordinator was interviewed on local radio and wrote a newspaper article for the Great American Smokeout as part of a local chronic disease prevention coalition
- Created presentation slides for CRMA presentation
- Created presentation slides for tobacco-free parks
- Encouraged coalition members to share our agency's tobacco-related social media posts
- Kept Environmental Health Specialist updated on TRL so that he had information for his establishments
- Promoted anti-vape/support to quit metro media campaign for youth
- SFO posts are translated monthly and posted in both Spanish and English
- Personal outreach to community partners about tobacco cessation help
- Met with Headstart
- Received TA and worked with TPCD communication team
- Radio Ads for SmokeFree Oregon Quitline
- Social media posts on County Health Department Twitter, Facebook, and Instagram
- Smokefree Oregon campaign tool kit materials for the Quitting for Real customization for TriMet campaign
- Communication materials distributed in both English and Spanish languages
- CRAM Press Release
- Created motivational social media posts
- Article about seasonal affective disorder for a parent magazine (connected vaping to mental health challenges as a risk factor)

- Press release on the Social Emotional Wellness grant opportunity

Communication Support Requested (Jul. 2021- Jun. 2023)

Grantees were asked to describe any communication support needs they had. The following responses were provided in reporting periods 1-4.

- Ongoing support from the Metropolitan Group to review communications materials and support communication needs
- We need a youth-friendly vaping website with real information and cessation support. We are experiencing extreme rates of youth vaping and our school resources officers are asking for support
- Information and design tips for our agency TPEP web page
- We always appreciate when HPCDP provides social media calendars and media toolkits to use, especially in English and Spanish
- Have the Social Media Calendar content a week before the next month starts. We're getting them literally the day before a new month starts and that doesn't always allow us to get the content scheduled for social media. The format for the Facebook posts is very difficult for posting and requires a lot of extra editing. You cannot just copy and paste into Facebook scheduling tools. It is time-consuming
- Overview or training for new staff on all communication resources available through HPCDP
- The image links for the Smokefree Oregon social media communications calendar all direct to Dropbox, which is blocked on our county's computers. If it is possible to provide those images in an alternative format that would be excellent! Our Prevention Team is also scaling up its communication capabilities with the recent addition of youtube and Instagram accounts. We are actively searching for capacity building trainings for our staff on social media use so that we can maximize these platforms. Any TA or resources that OHA can provide would be welcomed
- An informative session about how to grow your social media pages, including how to use hashtags
- Communication support when it comes to posting on social media platforms would be incredibly helpful in moving forward with my program's work and supporting my community's TPEP goals
- Example PSAs (Public Service Announcements) for the local radio, smokeless tobacco education examples, trainings on how to use Canva or other social media tips or trainings
- Updated materials for Smokefree OR to provide supplemental information with the promotion of e-referrals

- Provide images in the Smoke Free Oregon (SFO) and PM outreach calendars in larger sizes so we can use in scheduled media posts
- Getting local news outlets to pick up and publish a press release created by a TPEP coordinator with information on new requirements for tobacco retail licensure
- Having "swiss cheese" templates for tobacco prevention messaging would be helpful, so counties can utilize pre-populated information and just add in their local data and information. For example- Newsletter for parents about vaping, smokefree ordinances, restricting the sale of flavored tobacco products
- How to successfully attain or receive earned media
- It would be helpful to have a better understanding of how to provide language access that is culturally relevant, versus just a translation from English to Spanish for example
- Continue working with Rebecca and Emily for support and collaboration on selection and implementation of expanded media campaign investment with BM 108 funds
- I was looking at the 2014 Grantee TID workbook and thinking how some of the ideas could be really useful. I was wishing I had seen it earlier. Then I realized it was from 2014. I'm sure things can be adapted. Now that I've found it, I wonder if there is something similar and more recent that I have missed. The ideas to get media interest were great, are there more creative ideas for getting decision-makers attention for policy changes?
- We struggled to establish a system with Public and Government Affairs to regularly post SFO messages on County social media. We anticipate being more active on social media now that CCPHD has an internal social media calendar to schedule social media across all program areas
- More substance-specific harms/risk and protective factors trainings
- Designed video and workbook/information detailing step by step what the Quitline offers and how that might vary based on insurance types and what that looks like. Additionally, we have had low participation in our Freedom From Smoking groups and it would be helpful to have support with developing a communications plans for where and how to disseminate the information about the group in an effective manner to reach our target population
- Good resource for "How To's" for Smartsheet software
- As part of our upcoming Health Equity Plan, we need to create an enabling environment for open discussions about health equity
- External communication capacity assessment and plan

- Smokefree Oregon campaign toolkit materials in other languages besides English and Spanish
- We signed up for assistance with communication planning for the 2023-2025 Biennium. Program staff could use a link to revisit regarding the difference between lobbying and other activities and when each is allowed when trying to promote policy change to avoid making mistakes. Program staff feel comfortable to reach out as other needs arise
- General TPEP knowledge would be great, communication, how to talk to community decision-makers, and I think it would be great to be able to connect with people more with in-person meetings!

Appendix E: Geographic Differences

Commercial Tobacco Control Prevention

Support for key findings and recommendations

A workgroup of Oregon TPEP Coordinators was created to address the third component of this evaluation: understanding community conditions that may contribute to/underlie commercial tobacco/nicotine use in Oregon's rural populations.
To explore this question, the workgroup developed three key evaluation questions:

1. What are community members' beliefs about drivers or causes of disparities in tobacco use in different geographic areas/counties in Oregon?
2. How do different policy and capacity conditions affect tobacco prevention work in different communities? (Examples of policy and capacity conditions include local partnerships, county health department staffing, local perception of government, etc.)
3. What do people think about the intersection of place and health? What do they think about the government's role in making their place healthier?

To answer these questions, Rede and the workgroup members conducted three data collection efforts, detailed below and in the Methods section of the full report. Findings from all data collection methods were reviewed and discussed in depth with workgroup members. Preliminary analyses and data visualizations were created to elevate the key learnings and recommendations included in the body of this report. The appendix contains preliminary analysis and data visualizations that are most relevant to the key findings and recommendations in the report.

Themes from individual interviews with public health professionals and community informants

Workgroup members reached out to public health professionals (e.g., epidemiologists and data analysts, public health administrators, public health nurses, and program managers and coordinators) and community informants (e.g., community-based organization directors or program coordinators, clinical providers, and community health workers and outreach coordinators) they knew to invite them to participate in interviews. Rede and the workgroup aimed to conduct 20 interviews total. Between September and October of 2022, workgroup members conducted 17 interviews, with a total of 19 interviewees, for a response rate of 85%. Six of these interviews (35%) were with community informants, and 11 (65%) were with public health professionals.

Figure 1. Map of public health professional and community leader interviewees

Public Health Professionals

Describe your agency/role

- Majority of interviewees work at LPHAs and a few work at behavioral health agencies.
- Several interviewees' work was focused broadly across public health issues (e.g., public health director, epidemiologist).
- Several interviewees had roles focused on prevention across SUD and tobacco use.

Do you see tobacco use or nicotine addiction as an issue within the populations you serve? How so?
Is tobacco use one of the bigger health issues in your community?
If not, what are some of the bigger health issues affecting your community?

- All but one interviewee noted that tobacco and nicotine use is a significant issue in the regions they work and with the specific populations they serve.
- Many interviewees specifically noted youth tobacco use as a top concern.
- Interviewees referenced vaping as a significant issue both for youth and adults as well as smoking and chewing, noting that smoking and chewing are especially common in rural and frontier communities and are part of the culture and passed on generationally.
- Interviewees see tobacco and nicotine use as a top concern because it is a leading contributor to chronic disease.
- While interviewees agree tobacco use is a big issue, community members may not agree. They may see other issues as more pressing, such as mental health needs, crime, and economic stability. And some community members see tobacco use as helpful for coping with stress and anxiety.
- Some interviewees cited other public health issues as being more significant in their regions, such as alcohol use, drug use, mental health conditions.
- A few interviewees noted the root causes of tobacco use, such as poverty, trauma. and adverse childhood experiences, are more important to focus on than the symptoms because they affect so many health conditions.

Do you ever review information about tobacco use in your community? (This could include quantitative data sources, lived experience, etc.). If so, what sources of information do you review?
Do you use any population-level data sources?

How meaningful or important is the information derived from these sources to your work?
Are there any information sources you wish you had access to?

- Most frequent sources of data used by interviewees are BRFSS data from OHA, county-level data from County Health Rankings, and some population-specific data (e.g., Medicaid beneficiary data from CCOs or school/school district data from student health surveys).
- Many interviewees also noted Community Health Assessment data gathered/compiled by hospitals, CCOs, and public health partners as a data source they pull from.
- For interviewees in a direct service or supervisory role, they shared about using client and program-level data on tobacco use (e.g., whether clients use tobacco, how often and how much, how long, whether they've attempted to quit previously, etc.).
- Interviewees noted that data is very important for driving decision-making, especially around targeting prevention and intervention efforts.
- Some interviewees named that they primarily use quantitative data and would appreciate more qualitative data.
- Interviewees working in a direct service or supervisory role noted that they frequently hear client stories about tobacco use and its root causes, which helps provide perspective on the bigger community issues like poverty, trauma, and lack of health-supporting social activities to engage in in the community.
- Most interviewees named a desire to have more population- and setting-specific data, for example data by zip code, by racial and ethnic groups, or by school. Especially in smaller rural and frontier counties, data is often suppressed due to small sample sizes or grouped across multiple counties, which is a challenge.
- More resources to do local data collected was named by interviewees as a need.
- A couple interviewees would like to have more comprehensive death data (vital records) to analyze tobacco-related deaths.
- One interviewee would like to have tobacco sales data from local distributors.
- One interviewee would like to engage youth more to understand their use of tobacco.

Data from OHA indicate that adults in your county use tobacco [More or Less] than the statewide average. Does this information ring true to you?

- For the majority of interviewees, OHA data comparing county to state tobacco use rates rings true.

- For a couple interviewees, the data does not ring true. Two interviewees in counties with a tobacco use rate lower than and about the same as the state rate were surprised their county rates were not higher.
- Several interviewees noted the limitations of county-level data and felt the data did not represent the realities of specific populations for whom rates may be much higher, for example individuals with SUD and mental health conditions.
- Several interviewees also named that comparing to state-level rates could provide a false sense of security about tobacco use being "normal" or "not a big concern" if county-level rates are about the same as state-level rates, when the reality is that rates across the board are way too high.
- As named above, most interviewees noted their desire to have more population-specific data to look at.
- Interviewees noted several factors that could be driving disparities, including the cultural and generational normalizing of tobacco use, social isolation, high prevalence of stress and anxiety overall, lack of health care services, and low socioeconomic status (high poverty).

Is there anything else you'd like to share?

- Still a long way to go to shifting the community mindset (e.g., making the community tobacco free and smoke-free); local leadership is lacking
- Concerns with vaping prevalence and youth initiation, and the high level of comfort with vaping indoors that is leading to higher exposure across the board and for children in particular.
- Treating tobacco addiction needs to address the underlying trauma and support healing from that trauma. For many people with trauma and living in poverty, tobacco use is helping them cope and they will not quit unless they have another way to address their underlying needs. Counseling and coaching from doctors, a quick quit line, aren't going to be adequate.
- Need for more education and awareness in rural communities to build knowledge, reach them where they're at, and ensure there is not blaming or judgment from the state or big metro areas.
- Some of the populations with high tobacco use aren't even old enough to buy tobacco products but they still have access, so that's a challenge. In inpatient settings there are ways to get access, like having other clients share their tobacco products or having family members give tobacco products in care packages.

- Some of the messages I try to use when talking about tobacco use cessation are all of the health benefits, how much better they'll feel, how much money they'll save, and how they'll have an improved chance of not relapsing (in their SUD recovery) if they quit smoking.
- I wish there were more services to help people who want to quit tobacco.

Community Informants

In this interview, we use the word "community" to describe the population that you serve in your work. How would you define "community" for yourself?

- Some interviewees defined community in general terms, as those who surround you or are in your "sphere of mutual influence"
- Most interviewees defined community in terms of the population they served, including the county, school district, or specific populations receiving services.

Can you please tell me about your connection to your community?
Who do you work with? What group(s) do you serve?

- All interviewees defined their connection to their community through their work in the health department, the school or school district, media work, or community outreach and support.
- One interview also said that their connection to their community came from being a resident of their community.
- A number of specific populations served were named by interviewees, including:
- Clients of home visiting programs
- People who utilize OHP, DHS, and/or WIC services
- The Micronesian population of Oregon
- General social services
- One interviewee mentioned previous work in community programs like 4H, FFA, youth sports, family advocacy, etc.
- County specific Safe Communities Coalition

In your work, how often do you interact with commercial tobacco/nicotine users?

- Both interviewees working within school districts said they did not interact with tobacco/nicotine users either because they just don't see it or because other staff (security, disciplinary staff, etc.) are more involved with student substance use.
- One interviewee said "fairly often…multiple times a month."
- Many interviewees said they frequently interact with commercial tobacco and nicotine users, saying:
    - "All the time, in the community they chew tobacco and a few they smoke."
    - "I find it rare to work with someone who does not use commercial tobacco products."
    - "I encounter people who use tobacco retail products as primary substances."
    - "Frequently, most of the parents/families I have worked with, and also foster kids I have taken in."
    - "At least 3-5 times a week."

Is tobacco use one of the bigger health issues in your community?
[If not], what are some of the bigger health issues affecting your community?

- Interviewees working in schools or school districts did not think that tobacco was one of the bigger issues in their community. Instead, they named alcohol, other drug addiction, and homelessness.
- Most interviewees said that tobacco was among the top issue within their community, but maybe not #1. Other issues competing with commercial tobacco and nicotine use are alcohol abuse, chronic conditions such as diabetes, lack of access to health care, housing insecurity, mental health issues, and other drug abuse.
- In a group interview, one interviewee said it was the biggest issue for their community, and another said that they agreed, although they weren't sure if community members would put commercial tobacco and nicotine use at the top of their list - they would probably name the downstream effects they are now suffering from such as high blood pressure or lung cancer.
- One interviewee said, "Yes, it is probably in the top three – in terms of addiction: alcohol, tobacco, and opioids. Also in terms of chronic disease - cardiac and respiratory diseases."

Do you see high rates of commercial tobacco/nicotine use in your community?

- Interviewees working in schools and school districts did not report seeing a high rate of smoking in their community.

- One interviewee attributed this to peer pressure and changing attitudes about smoking [thinking she is only talking about cigarettes]. “Maybe people don’t smoke as much now because they know how bad it is for you – and there’s peer pressure, too, and perceived as dirty or just not good. It smells bad.
- Another said that she thinks other substances, like marijuana, are more popular with students.
- One interviewee said that they felt there were high rates overall, and especially high rates among youth. “Higher in youth, so maybe 60% of youth use vs. 40% of youth who don’t. And adult use is the opposite, 40% use and 60% don’t. Use is probably higher everywhere due to lack of education and COVID.”
- Many interviewees said that in general, they see high rates of tobacco use in their communities.
- One interviewee said, “It seems pretty common all over, but there are some cultural norms. Some people frown on smoking, for instance, the casino which is the main source of entertainment, and place of work for a number of people, was a pro-smoke environment. The rodeos also seem to allow a lot of tobacco advertising, like huge Copenhagen banners. So both of those have contributed to the number of smokers in our county.”

Data from OHA indicate that adults in your county use tobacco [More or Less] than the statewide average. Does this information ring true to you?

- When asked about OHA data, none of the interviewees felt that the information was false. One interviewee did say that they thought the % in their community would be even higher if they did a survey of the specific population they work with.

Thinking about your “community” as you’ve defined it, do you think quitting commercial tobacco/nicotine use is a priority for people? Why or why not?

- Many interviewees said that they did not feel like quitting commercial tobacco was a priority in their communities.
- One interviewee said that quitting gets “put on the back burner” as people deal with other stressors in their lives.
- Many interviewees said they have seen people try to quit but that their attempts were ultimately unsuccessful, or they switch to vaping thinking it is a healthier alternative.
- One interviewee said they think quitting is a priority for the community - “it leads to health problems in the future and it’s expensive.”

Have you heard community members talk about wanting to quit? What have you heard from community members about their efforts to quit?
[If yes,] What resources or strategies do people find successful? What barriers do people run into when they try to quit?
[If no,] What other priorities come up for people? What have you heard people struggling with?

- Most interviewees said they have heard about or seen a desire to quit among community members
- Two interviewees said they had not heard about or seen any desire from community members to quit. Both of these interviewees also did not report working directly with tobacco users.
- A few interviewees mentioned that people experience barriers to quitting, such as programs that are hard to find or pay for, or a lack of support navigating assistance programs.
- "Lack of support, barriers, too much isolation or triggers. The quit line seems so detached. Need real people who are supportive."
- One interviewee mentioned referring people to resources from the American Cancer Society and other behavior modification resources [unnamed]. "Thinks people trying to quit should avoid other smokers and environments that trigger cravings…Try to focus on something else when a craving happens."
- A few interviewees mentioned that people have other priorities, such as other substance abuse or other life stressors that get in the way of their attempts to quit.
- "Maybe that knowledge isn't out there enough. It is also used as a crutch when people try to quit other substances. Even a lot of professionals will say things like 'smoking is so much preferable to what he was doing before!'"
- A few interviewees noted that it is difficult to quit when your social circle smokes.
- Two interviewees said someone they knew quit "cold turkey" and that worked best for them. One of these interviewees said that a few people they knew who went this route had to quit because smoking [cigarettes?] was so expensive.

Is there anything else you'd like to share?

- People feel judged for smoking but not supported in quitting.
- People want to quit, but there is a lack of targeted approaches and trusted messengers for specific communities.
- More community education could be helpful. "Learn what's going into their lungs"

Figures from the survey of TPEP Coordinators and Ballot Measure 108 grantees in rural areas

To assess policy and capacity conditions affecting tobacco prevention work in Oregon, a survey of TPEP Coordinators and Ballot Measure 108 (BM 108) grantees was developed by the workgroup and administered by Rede. In total, 46 organizations were invited to participate in the survey between February and March of 2023, and Rede received responses from 32 organizations, for a response rate of 69.6%. Twenty-five respondents (78.1%) were from local health departments (all classified as "TPEP" for analysis) and seven (21.9%) were from BM 108 grantees.

Figure 2. Map of TPEP and BM 108 grantee survey respondents

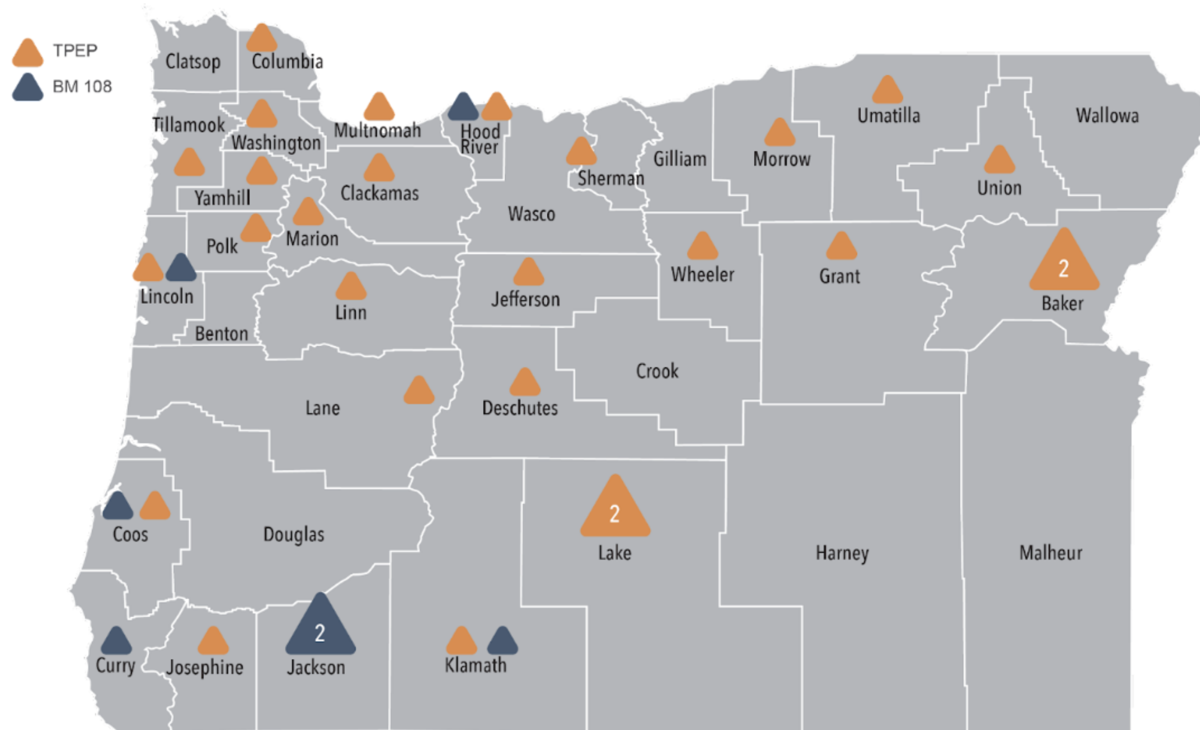


Figure 3. Frontier counties more likely to focus on health communications in their tobacco prevention work, while rural and rural-urban most focused on policy and systems change.

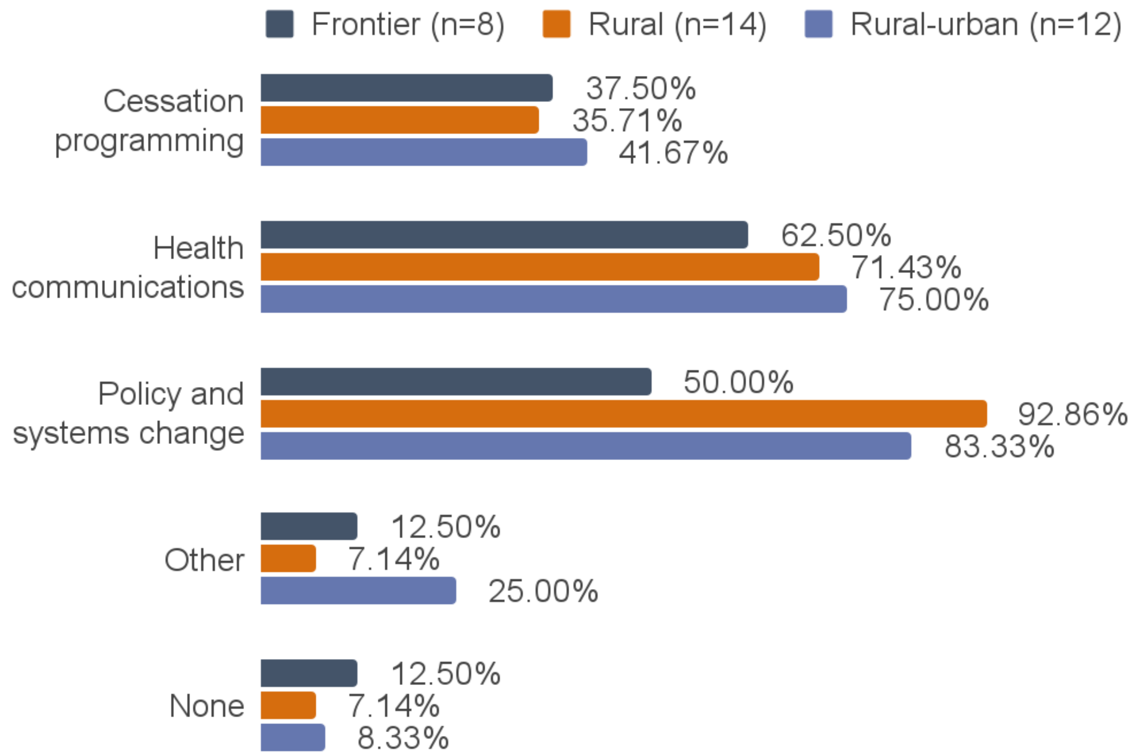


Figure 4. Frontier and rural counties more likely to have less than 1 FTE for tobacco prevention work, while rural-urban counties have one or more.

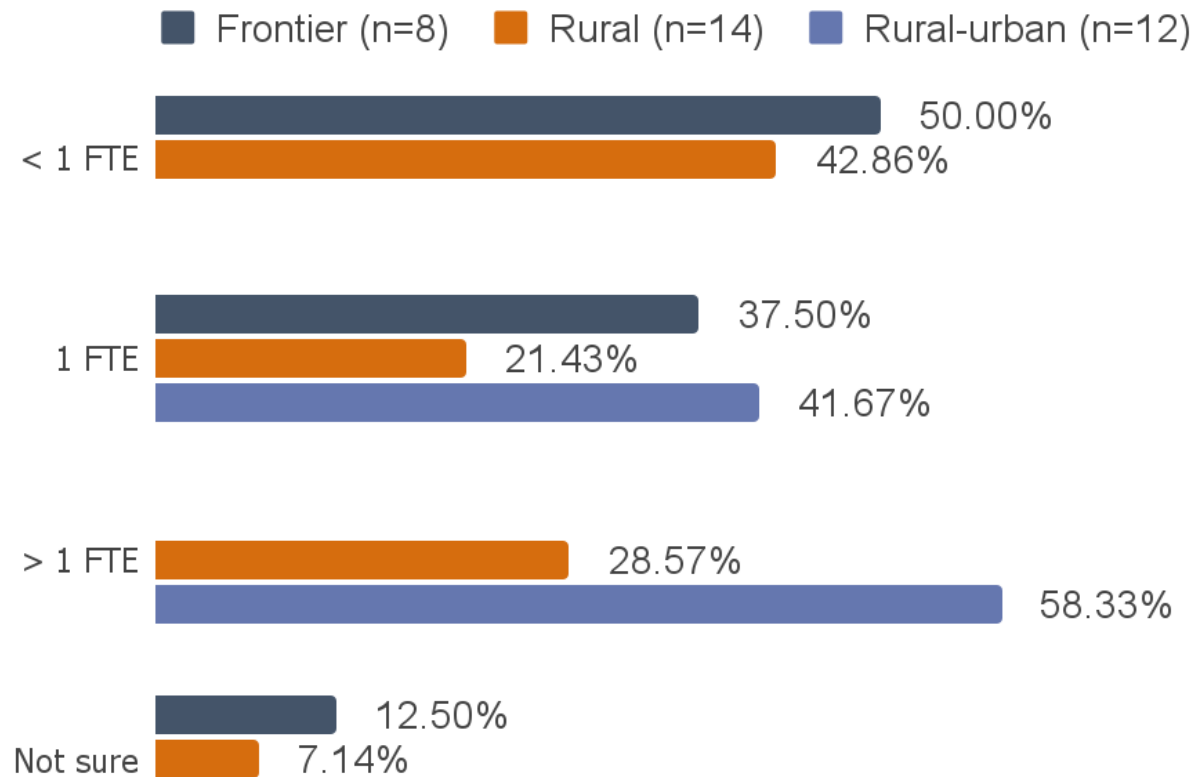


Figure 5. Higher levels of self-reported success among rural and rural-urban counties in their tobacco prevention work, compared to frontier counties.

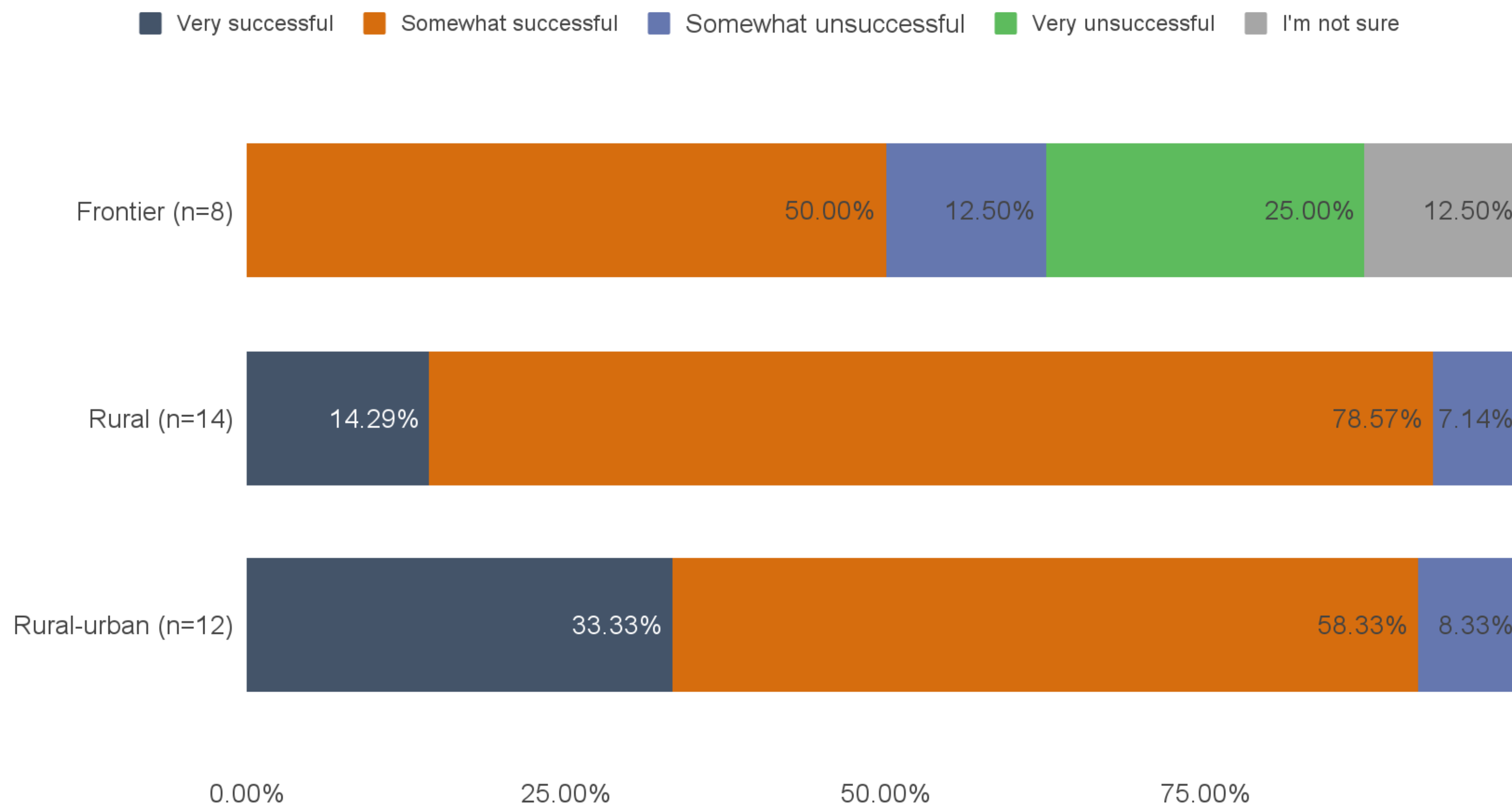


Figure 6. Frontier counties most likely to partner with schools and CBOs, while rural counties most likely to partner with clinics and youth programs. Rural-urban counties likely to have a variety of partners.

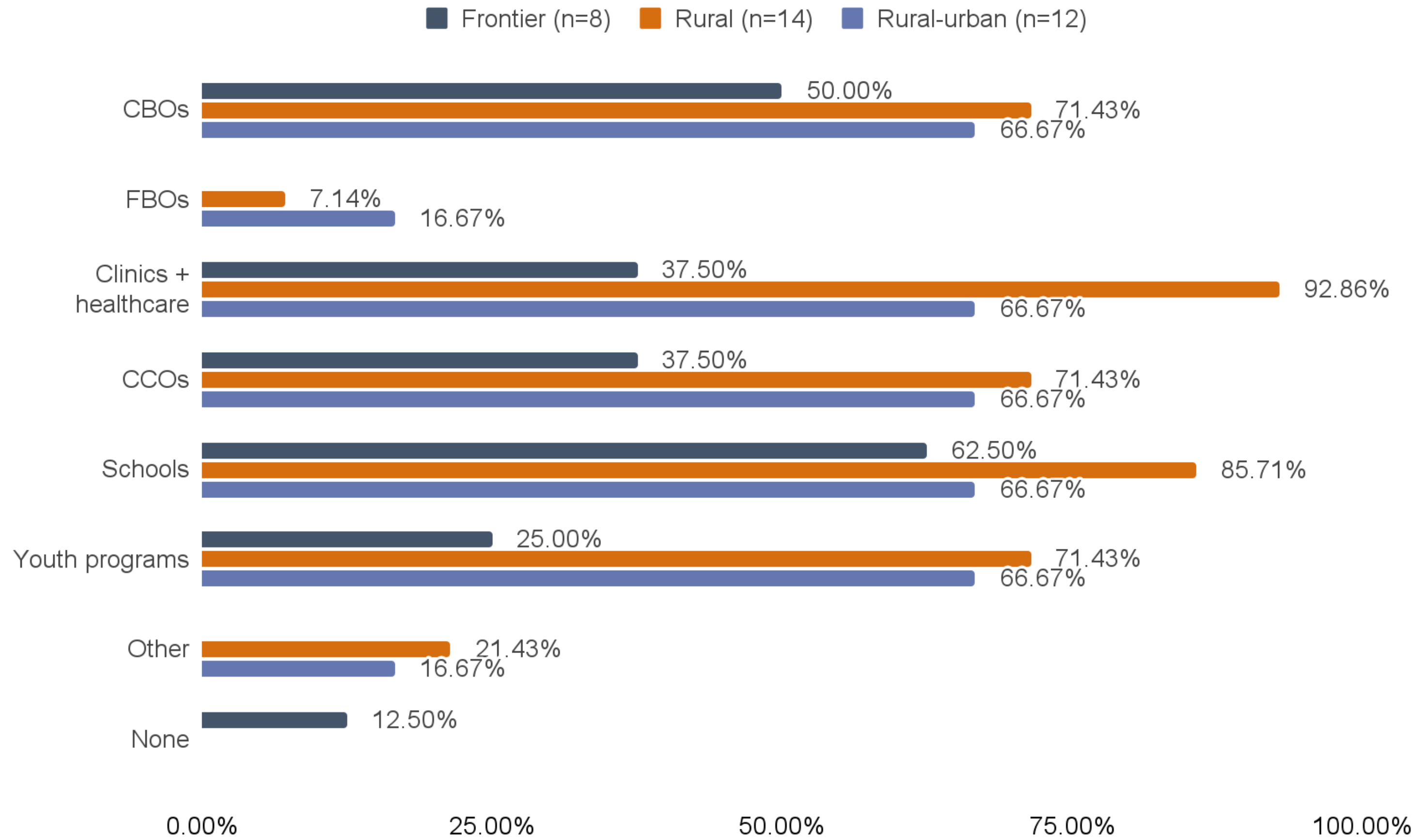


Figure 7. Most respondents work effectively with many or a few key partners.

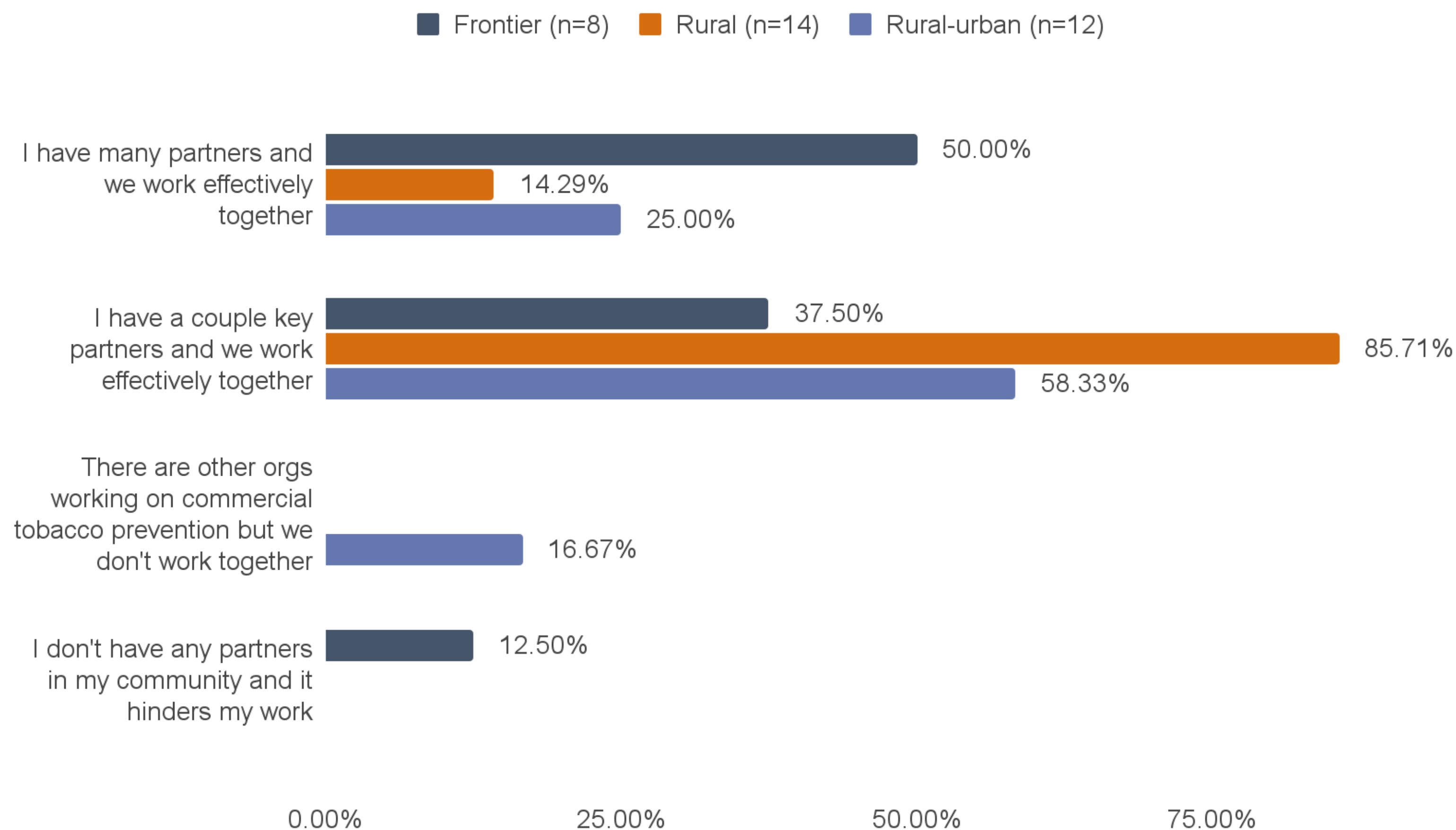


Figure 8. Frontier and rural counties more likely to report lack of staff as a major barrier compared to rural-urban counties

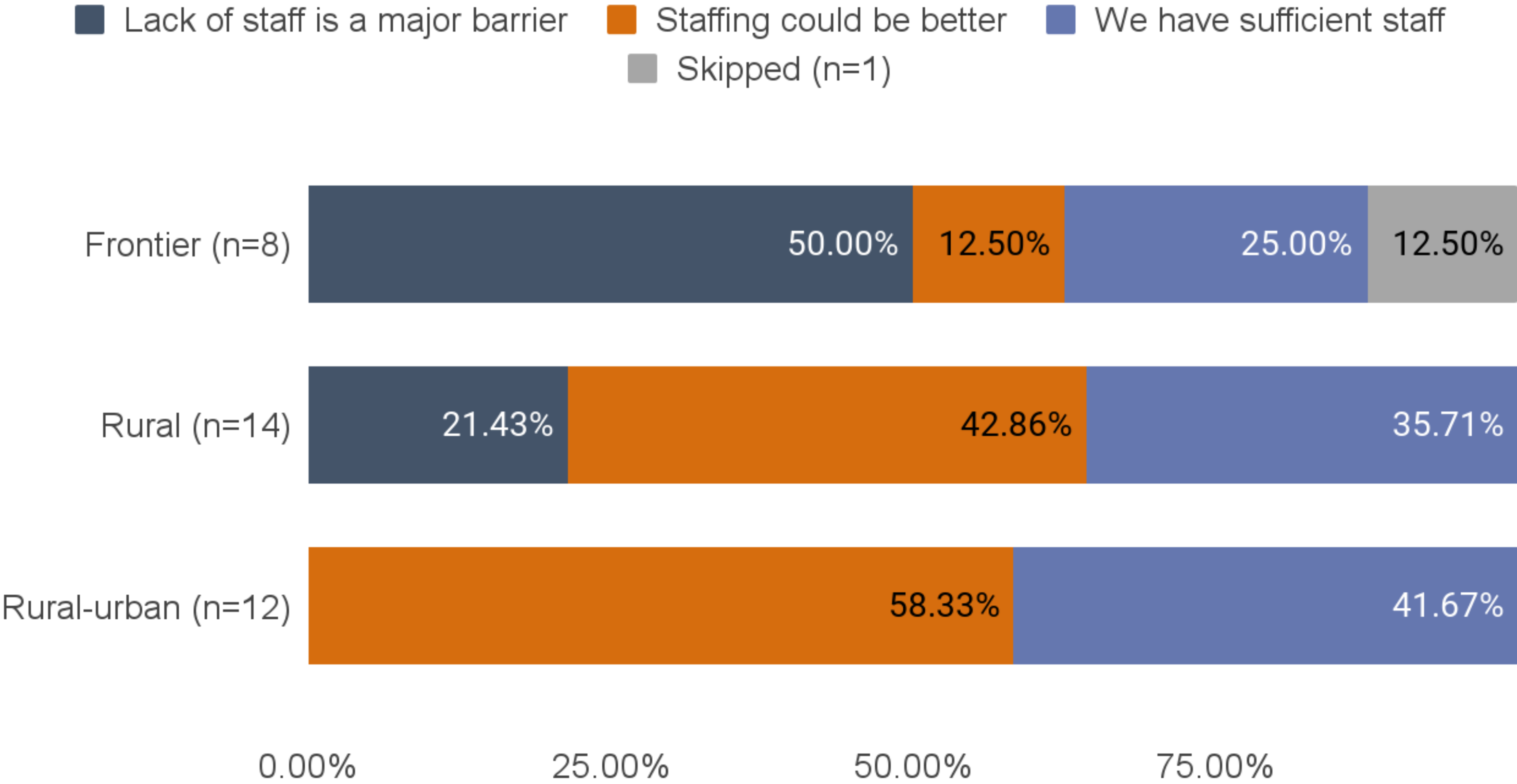


Figure 9. Overall, respondents reported that trainings and other opportunities to build expertise in commercial tobacco prevention could be better.

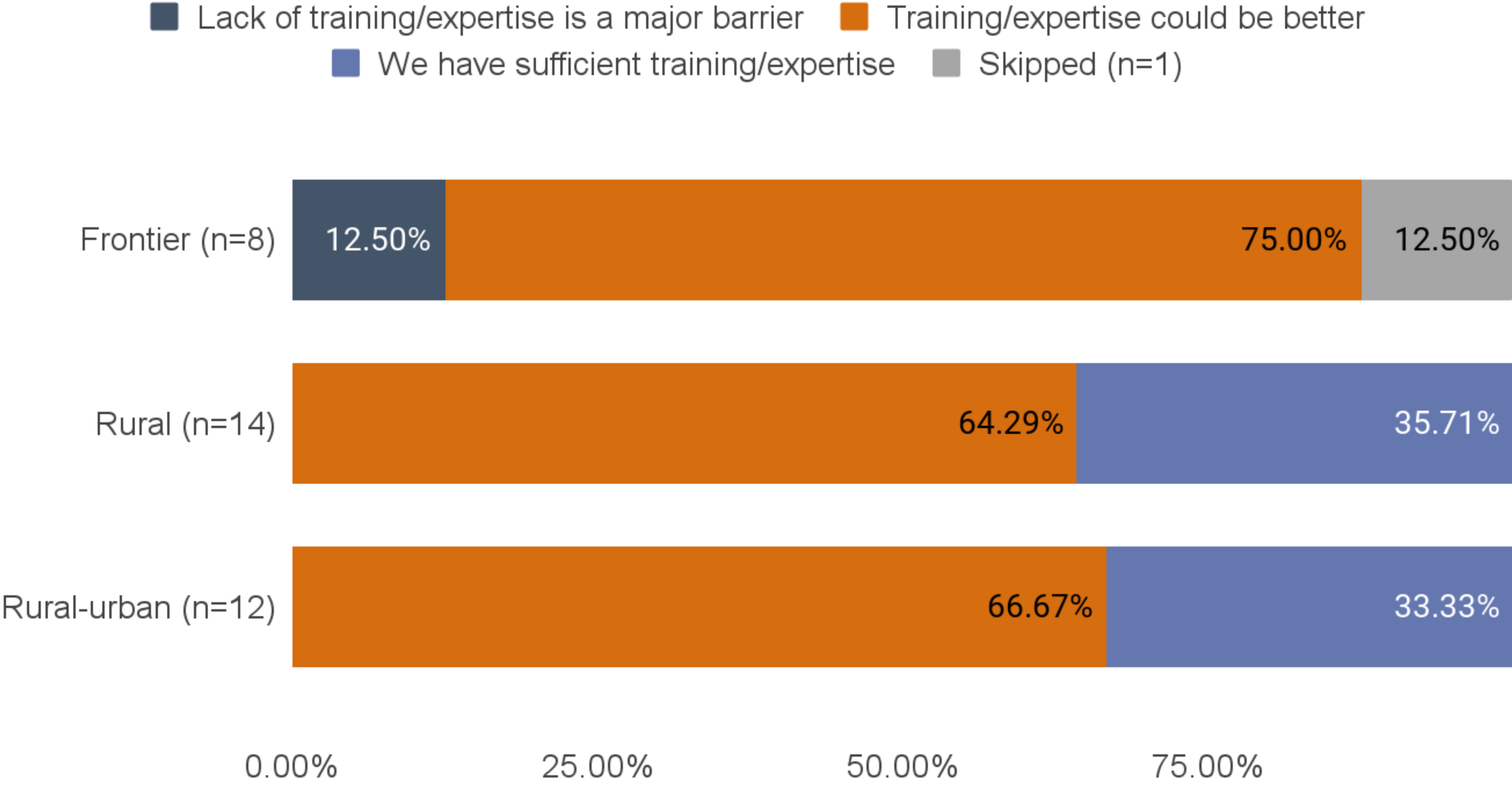


Figure 10. Frontier and rural counties more likely to report a need for technical assistance (TA) that is hindering their commercial tobacco prevention work.

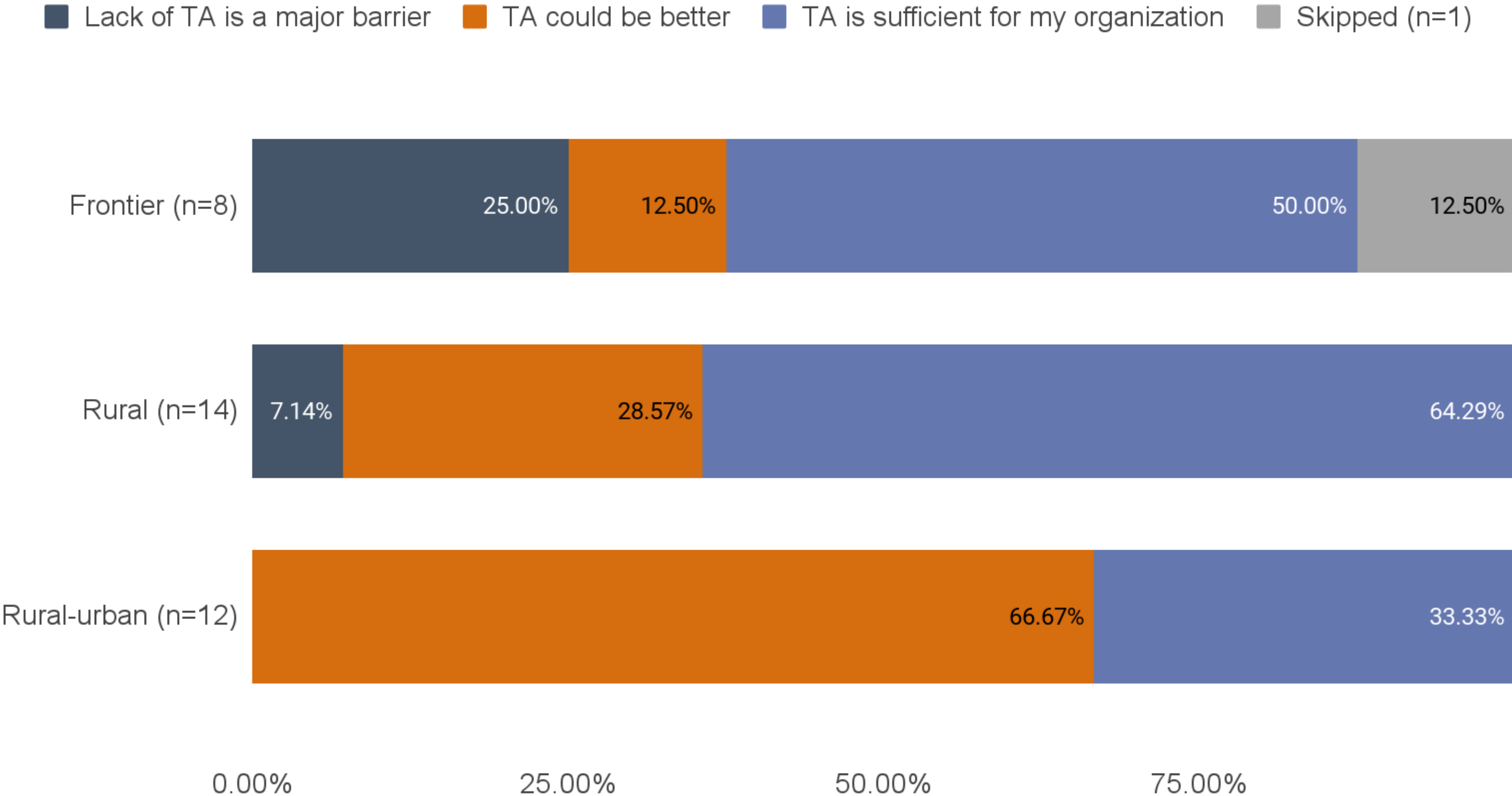


Figure 11. Rural-urban counties more likely to report that they somewhat or strongly agree that there is community member support for commercial tobacco prevention

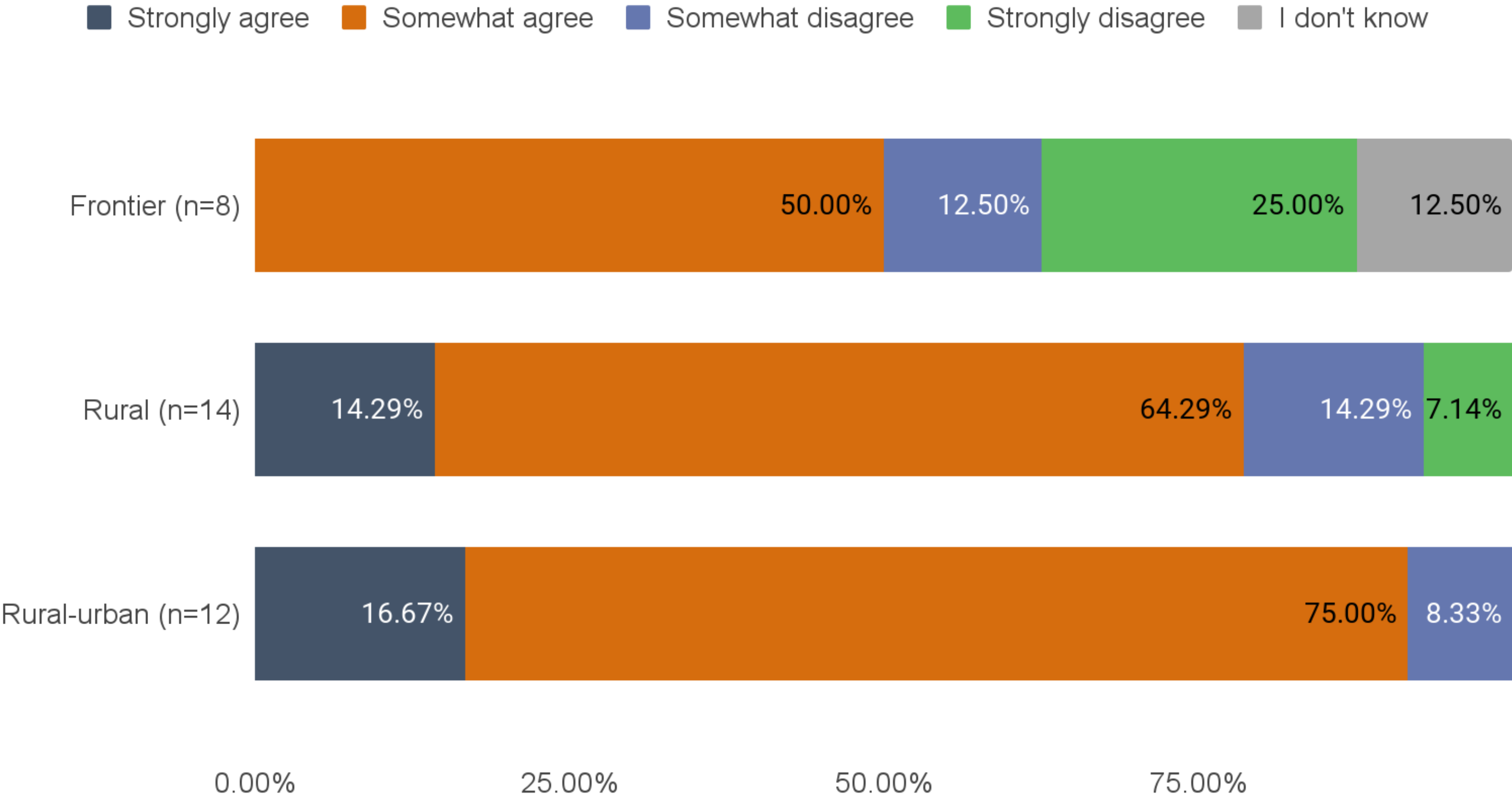
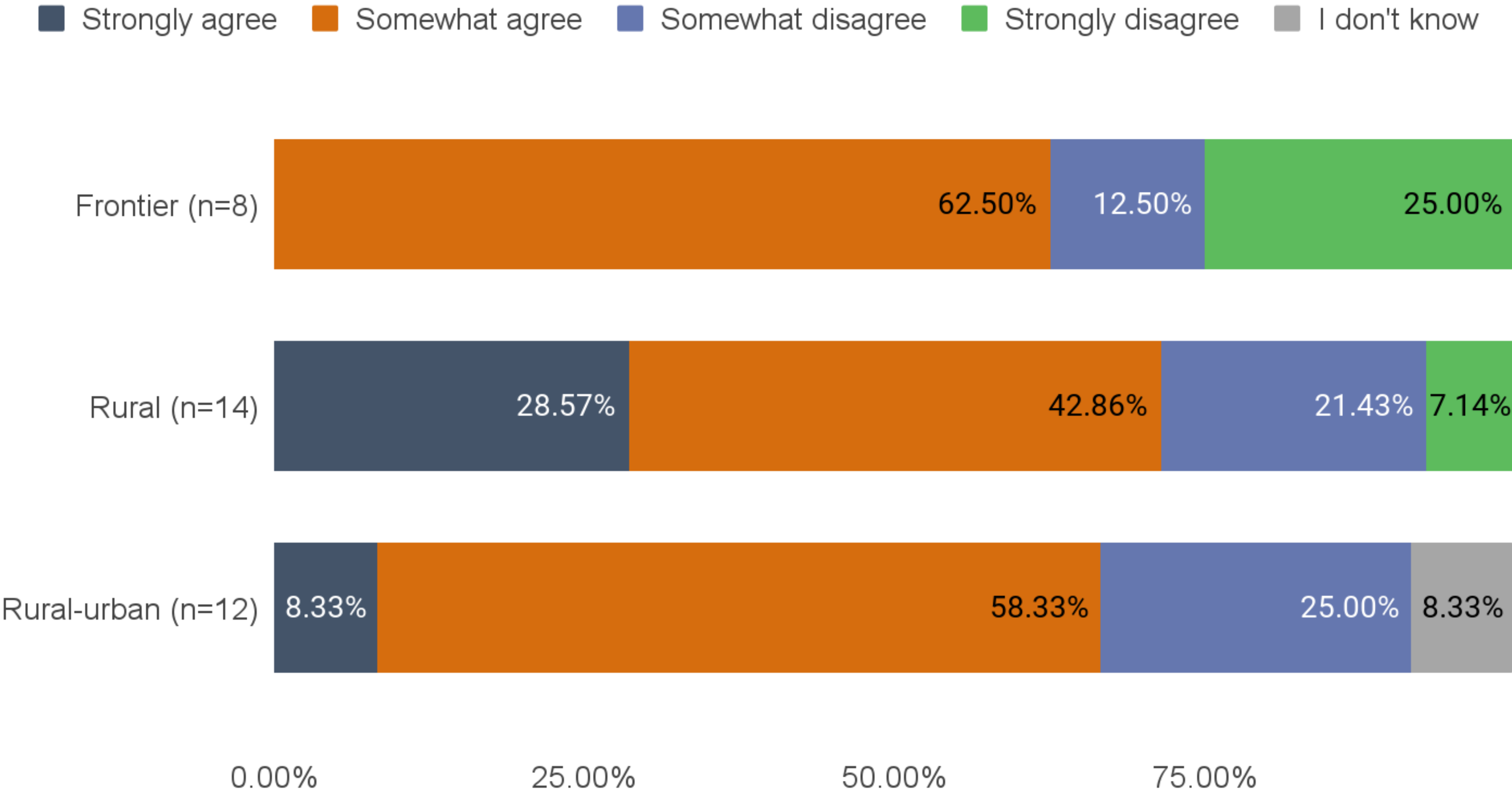


Figure 12. Rural and rural-urban counties more likely to somewhat or strongly agree that there is support for commercial tobacco prevention from businesses in their county



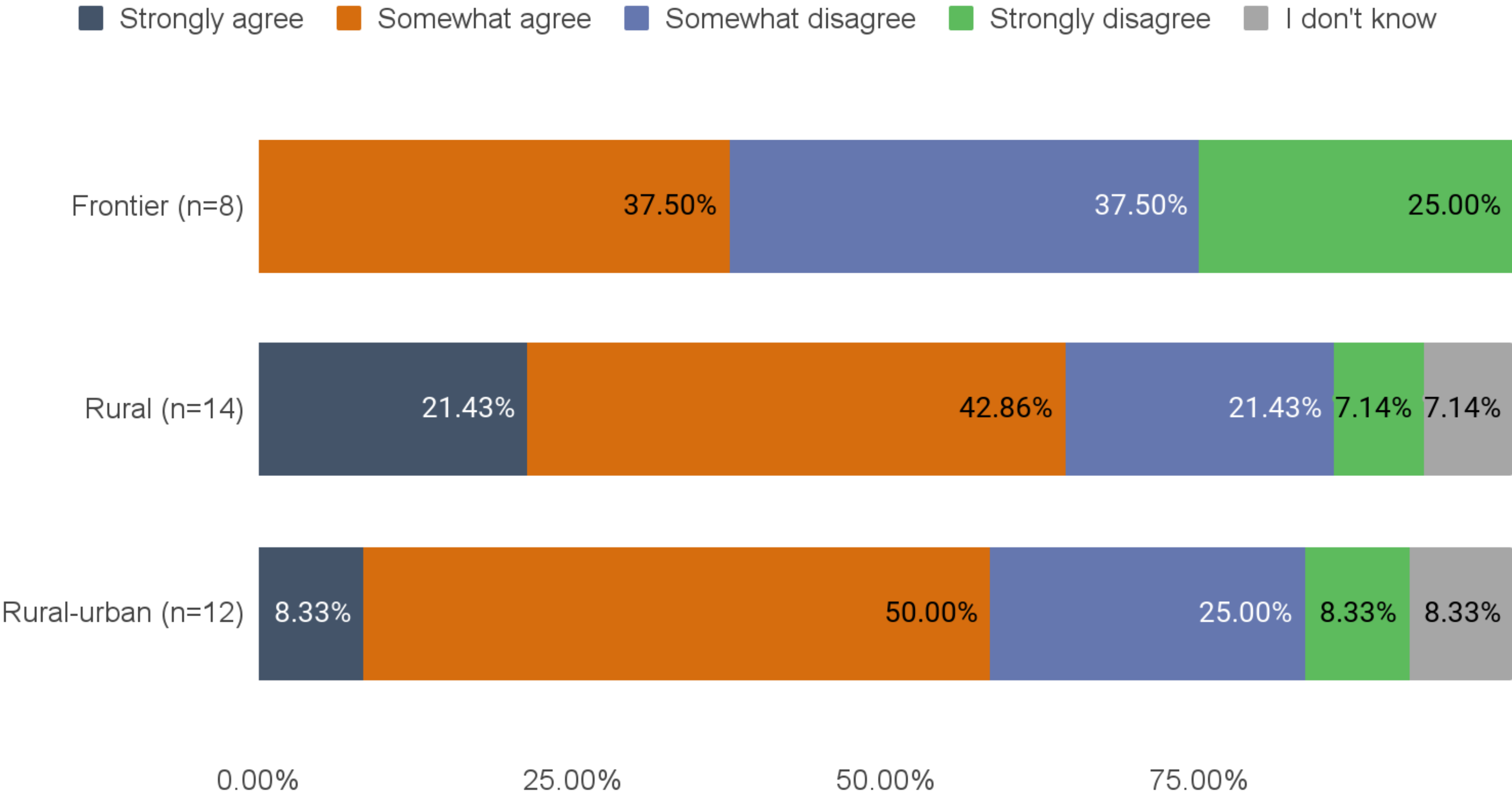
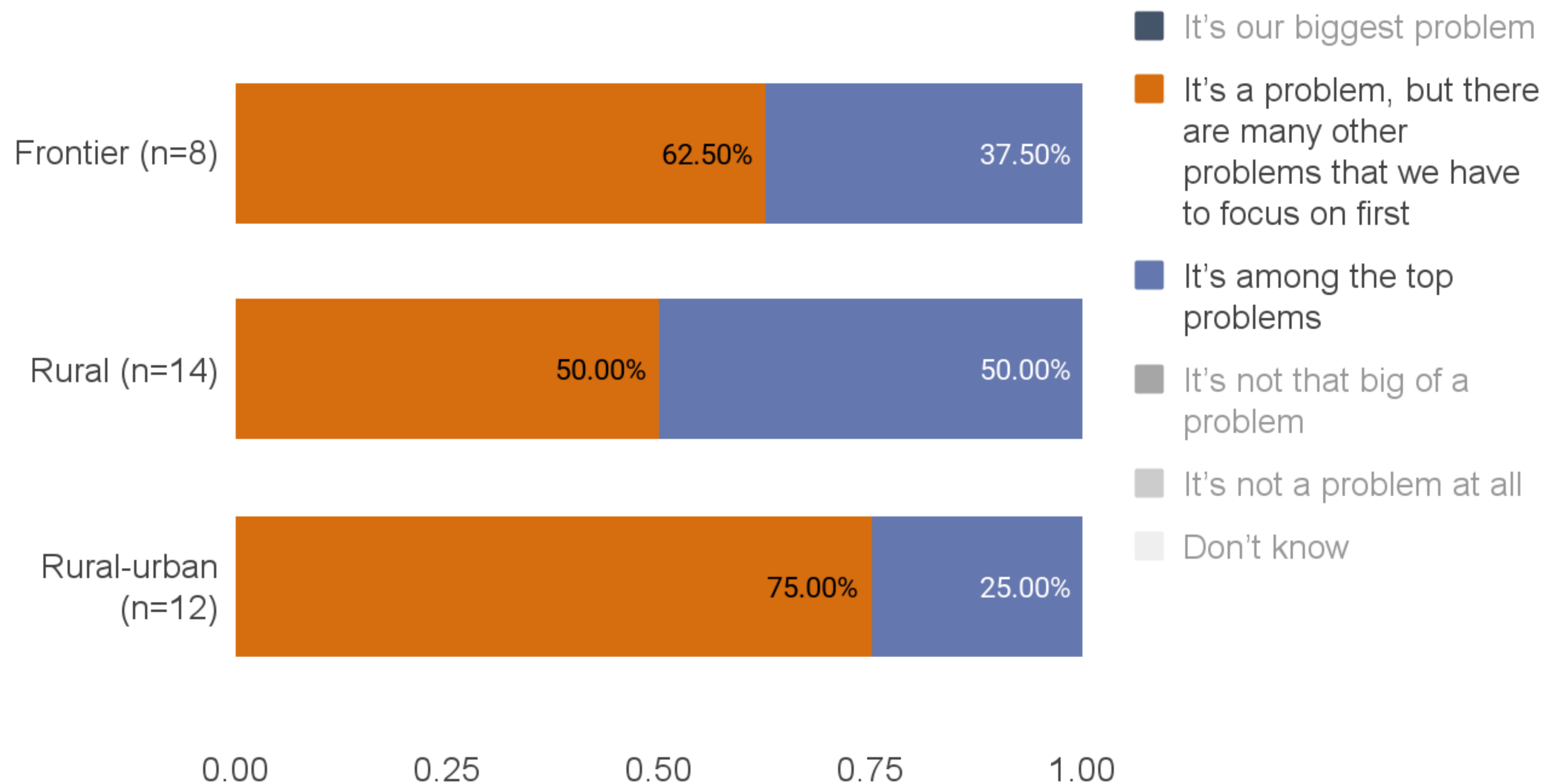


Figure 13. Rural or rural-urban counties more likely to report that there is buy-in from city and/or county leadership on commercial tobacco prevention.
Strongly agree
Somewhat agree
Somewhat disagree
Strongly disagree
I don't know
Frontier (n=8)
37.50%
37.50%
25.00%
Rural (n=14)
21.43%
42.86%
21.43%
7.14%
7.14%
Rural-urban (n=12)
8.33%
50.00%
25.00%
8.33%
8.33%
0.00%
25.00%
50.00%
75.00%

Figure 14. All respondents reported that commercial tobacco use is among the top problems in their county



Figures from the survey of current and past commercial tobacco or nicotine users

The workgroup developed a statewide survey of current and past users of commercial tobacco and/or nicotine products to gather data on the third key evaluation question: What do people think about the government's role in making their places healthier? The survey was administered in English and Spanish from late May to mid-June 2023, and a total of 313 survey responses were included in the data set for analysis.

Figure 15. Map of community survey respondents' counties of residence

Figure 16. Community survey respondents were mostly from rural-urban areas, and almost a third were from rural areas

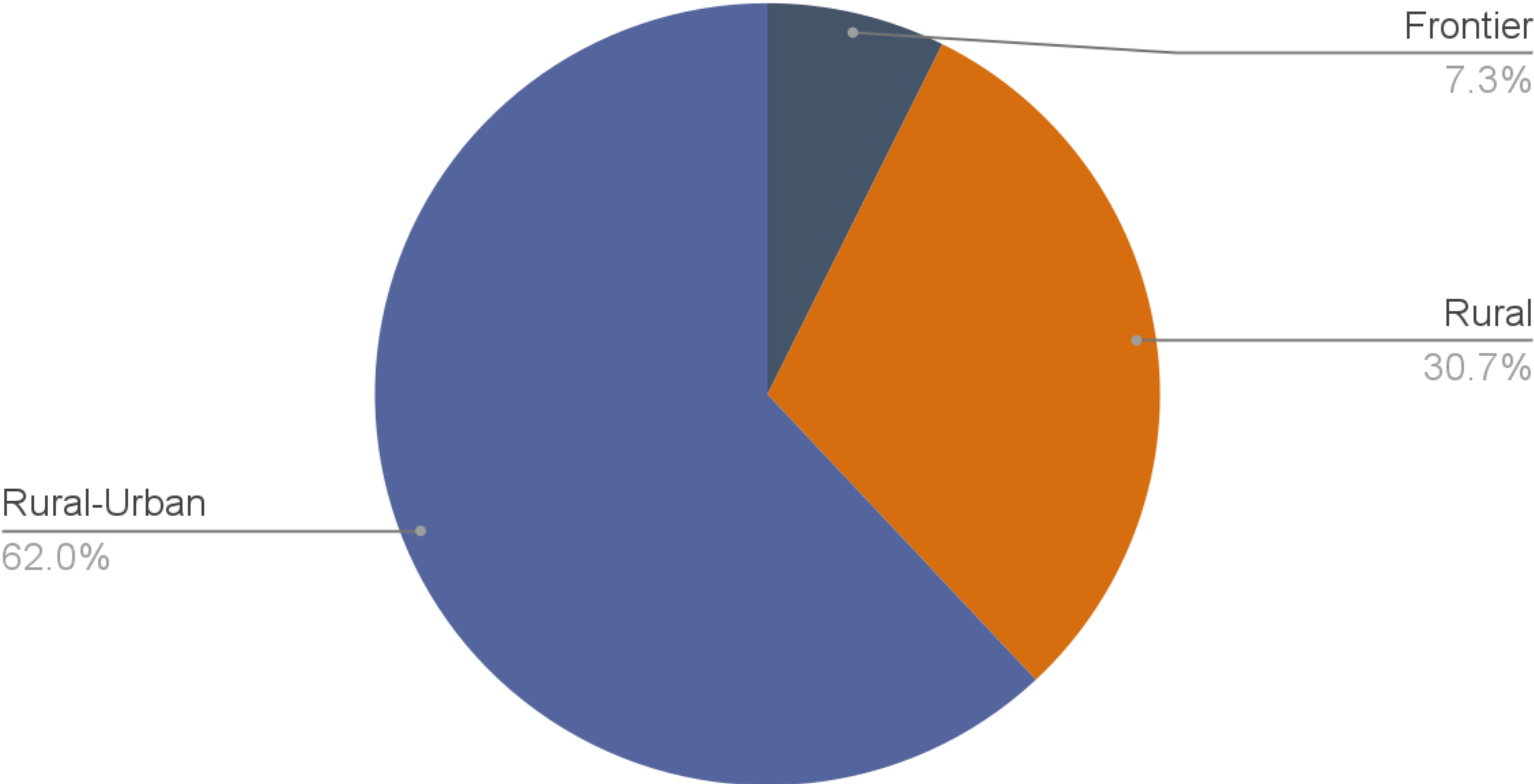


Figure 17. Most survey respondents described themselves as in the process of quitting tobacco and/or nicotine products

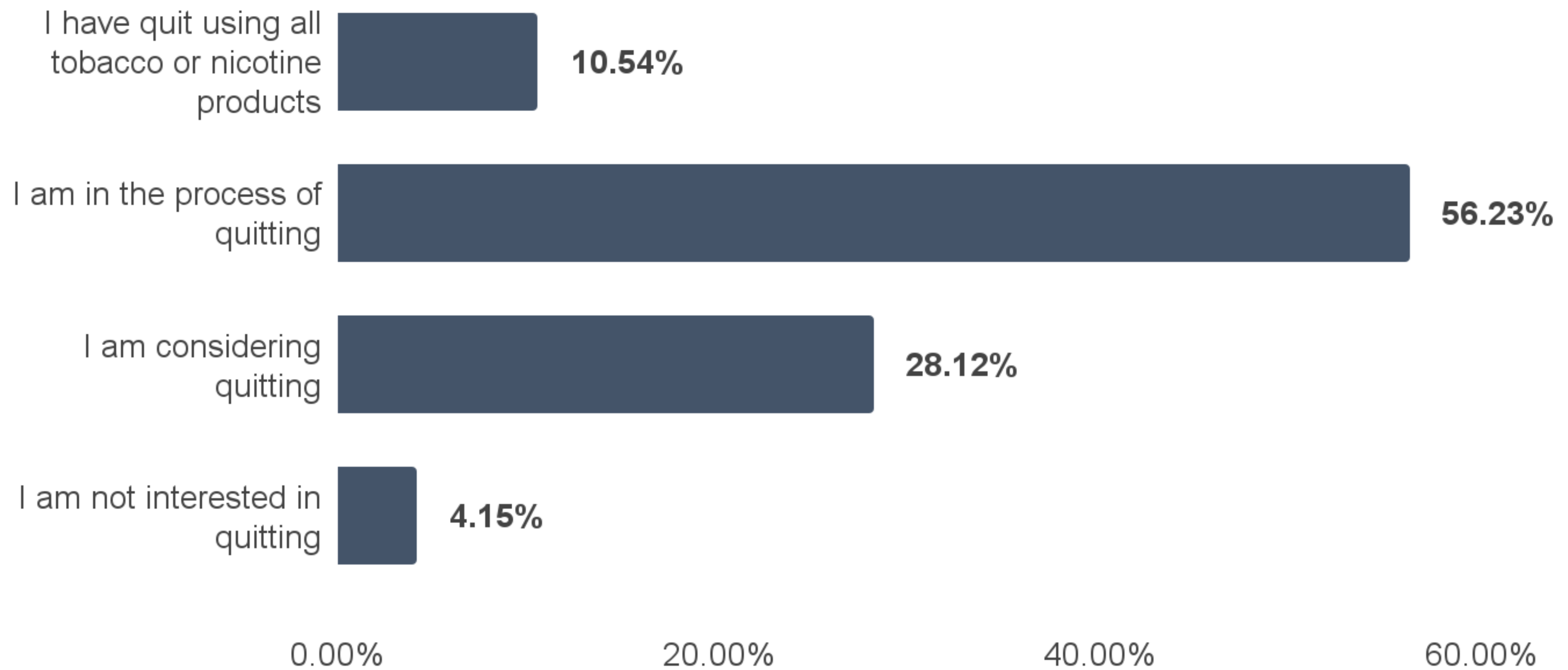


Figure 18. Cigarettes, e-cigarettes, cigars, and cigarillos most poular tobacco/nicotine products

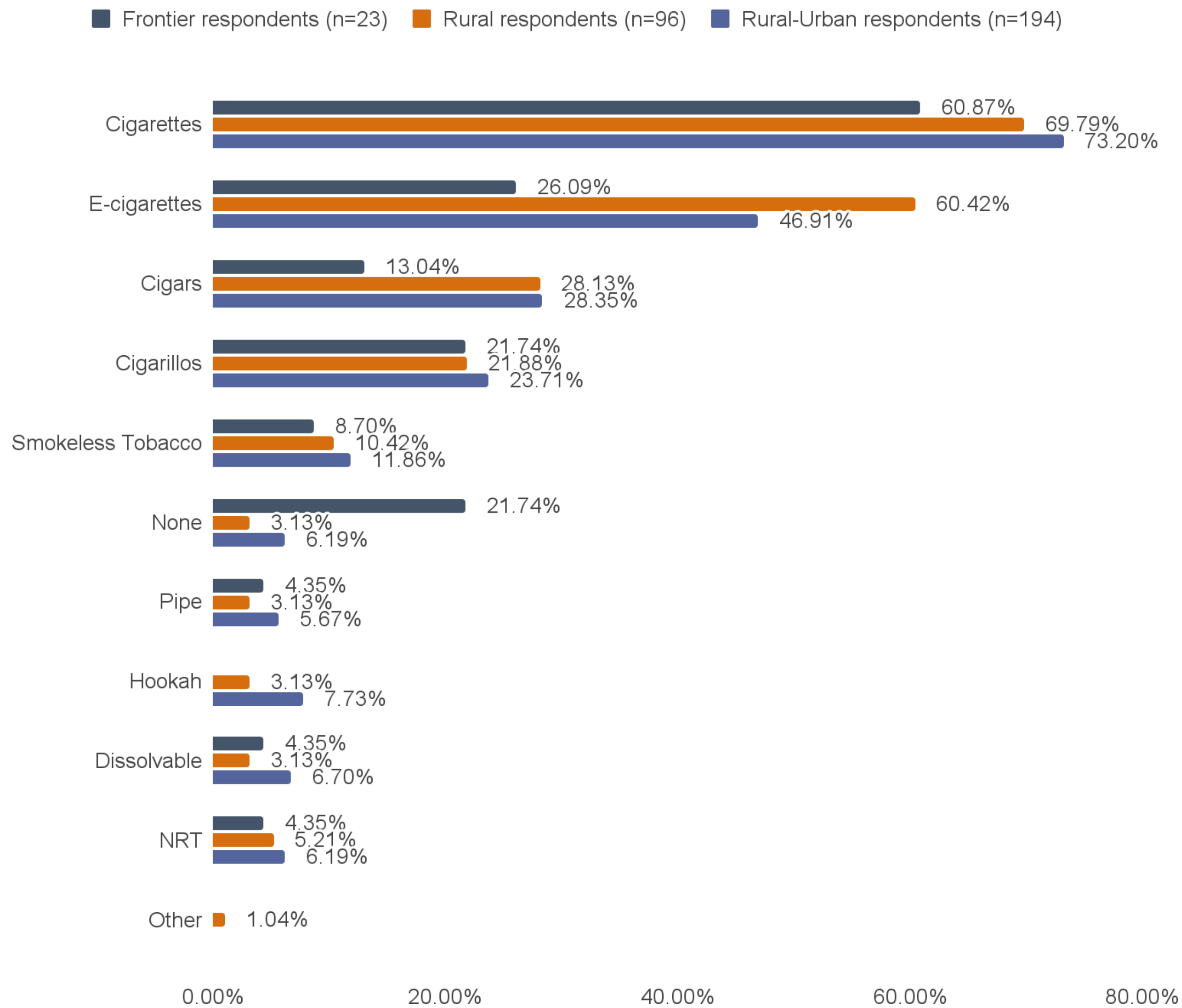


Figure 19. Nicotine replacement therapies (NRT) the most popular resource to quit among all respondents

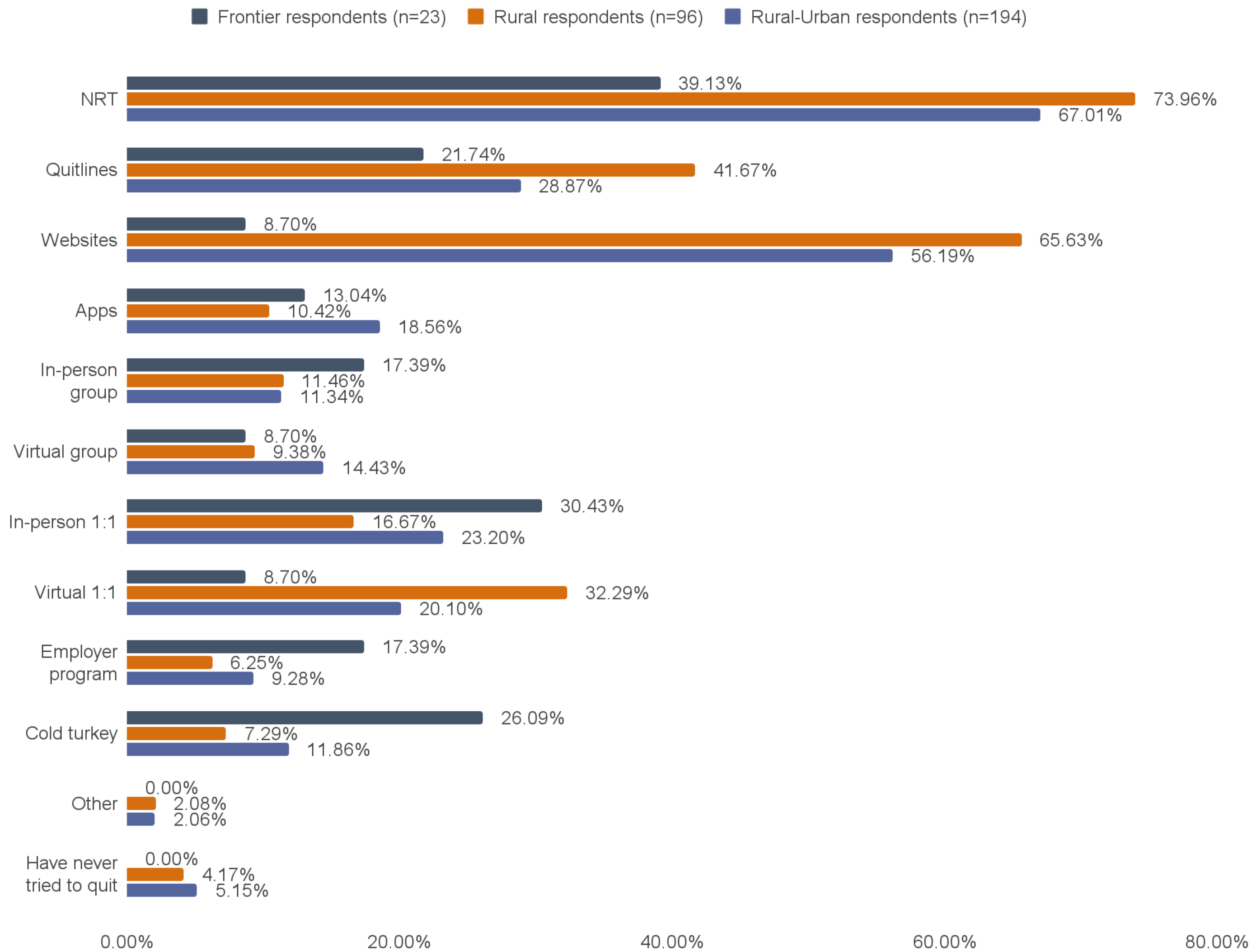
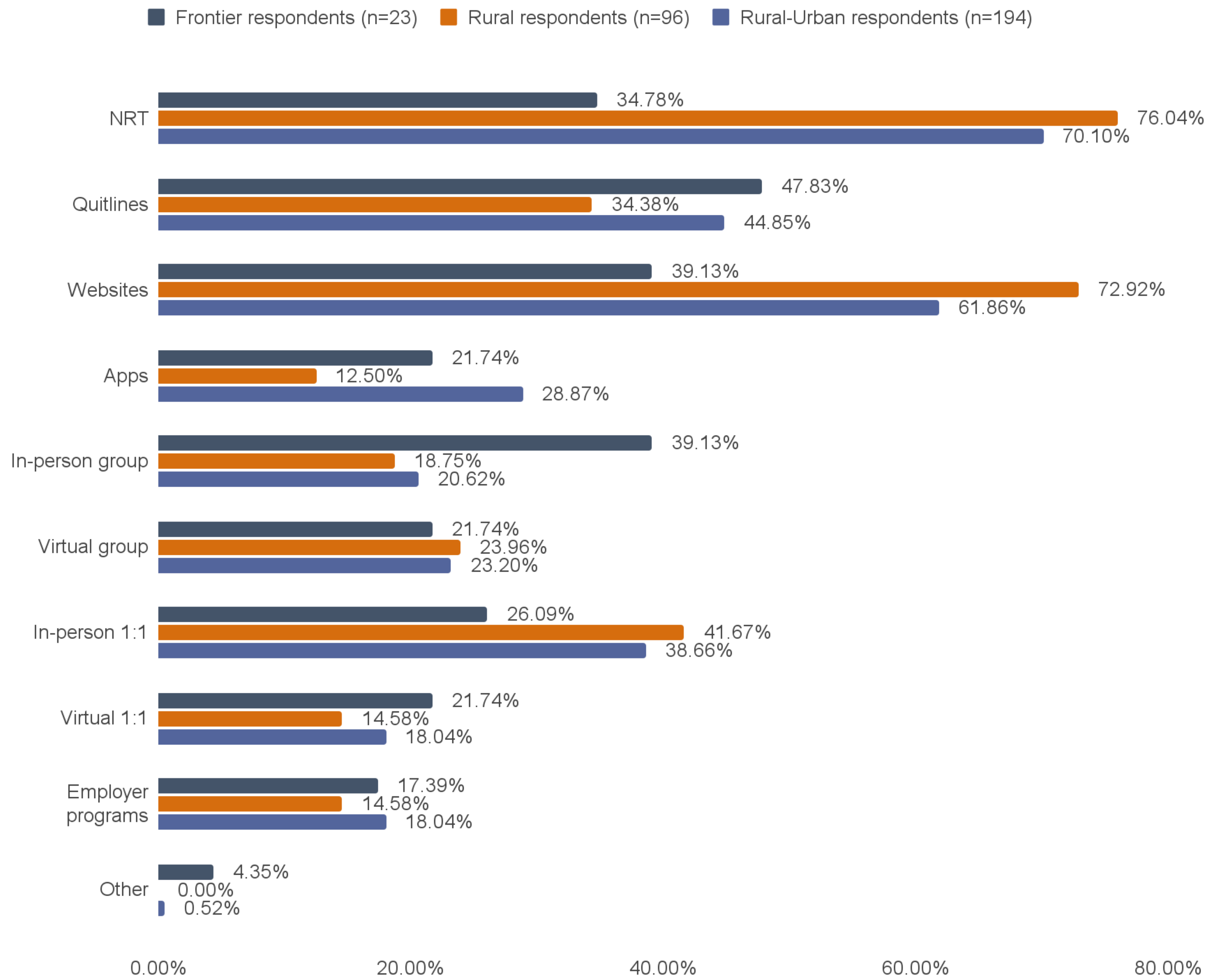


Figure 20. Frontier respondents desire expanded access to the Quitline, in-person group counseling, and NRT. Rural and Rural-urban respondents desire more access to NRT and websites to quit tobacco/nicotine products



A total of 33 (10.54%) survey respondents said that they have quit all tobacco/nicotine products. The top resources they used were "cold turkey" (21.13%), NRT (19.72%), and websites (11.72%). When asked if they could share some examples of tools they used and if they found them useful, some respondents reported the following:

- Chantix was the only one that worked
- Going to prison for 4+ years.
- I used the gum but didn't find it very helpful. I found personal counseling helpful.
- Patches worked for me
- I quit once I became pregnant.
- Statistics on the damage that smoking can do, how it can shorten your life and alter your lifestyle, limit exercise, just overall unhealthy
- I can't smoke while I'm in the hospital. I tried chewing gum. The effect is OK
- I tried quitting about 10 years ago cold turkey and that didn't go well so then I started using the gum and that helped for a few months. After that I started back up again and about a year ago I tried chentex prescribed by my doctor and that did the trick.

Figure 21. All respondents most motivated to quit using tobacco/nicotine products for health reasons.

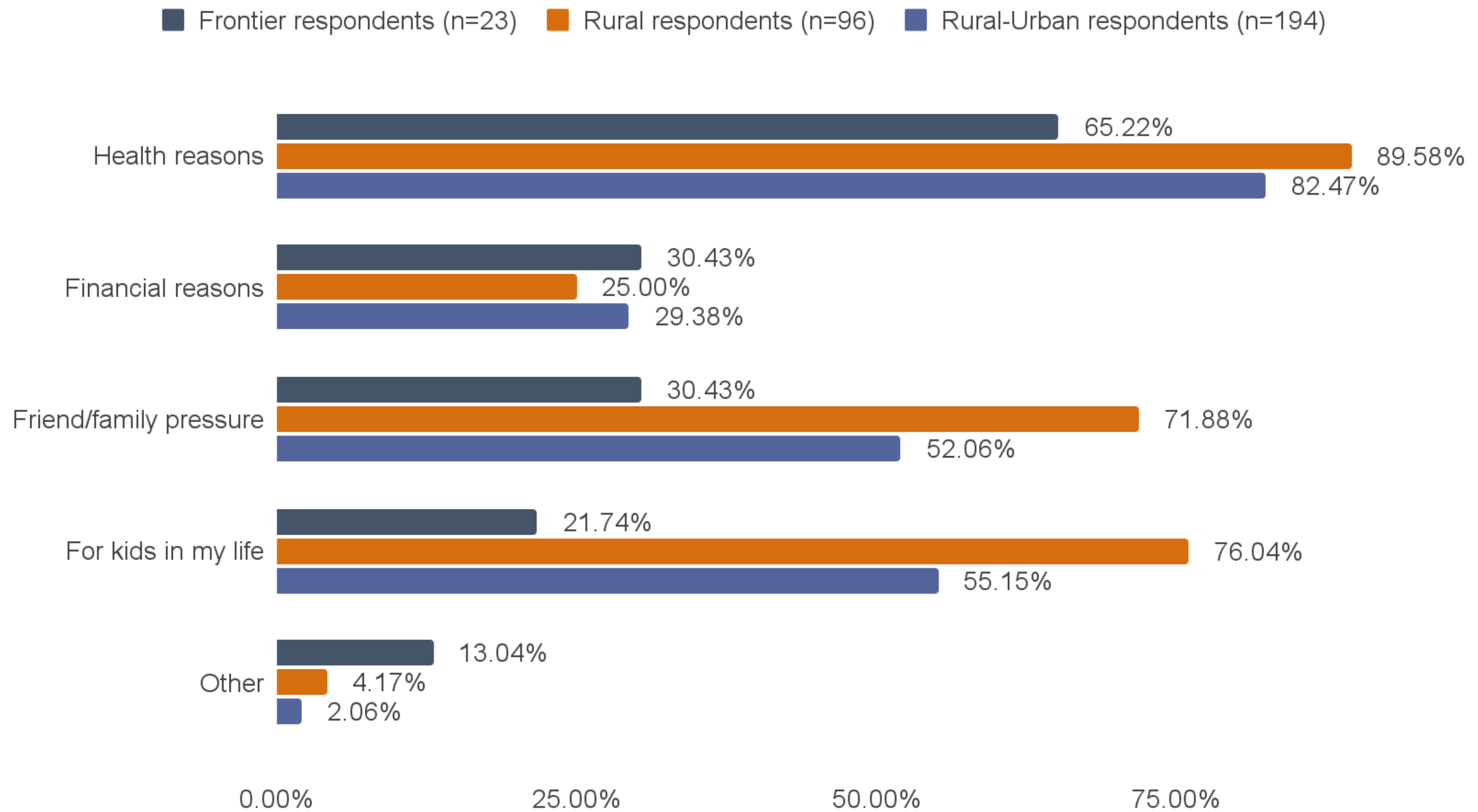


Figure 22. Respondents overall would like more information about the health effects of using tobacco/nicotine products, making and sticking to a quit plan, and finding inspiration/motivation to quit

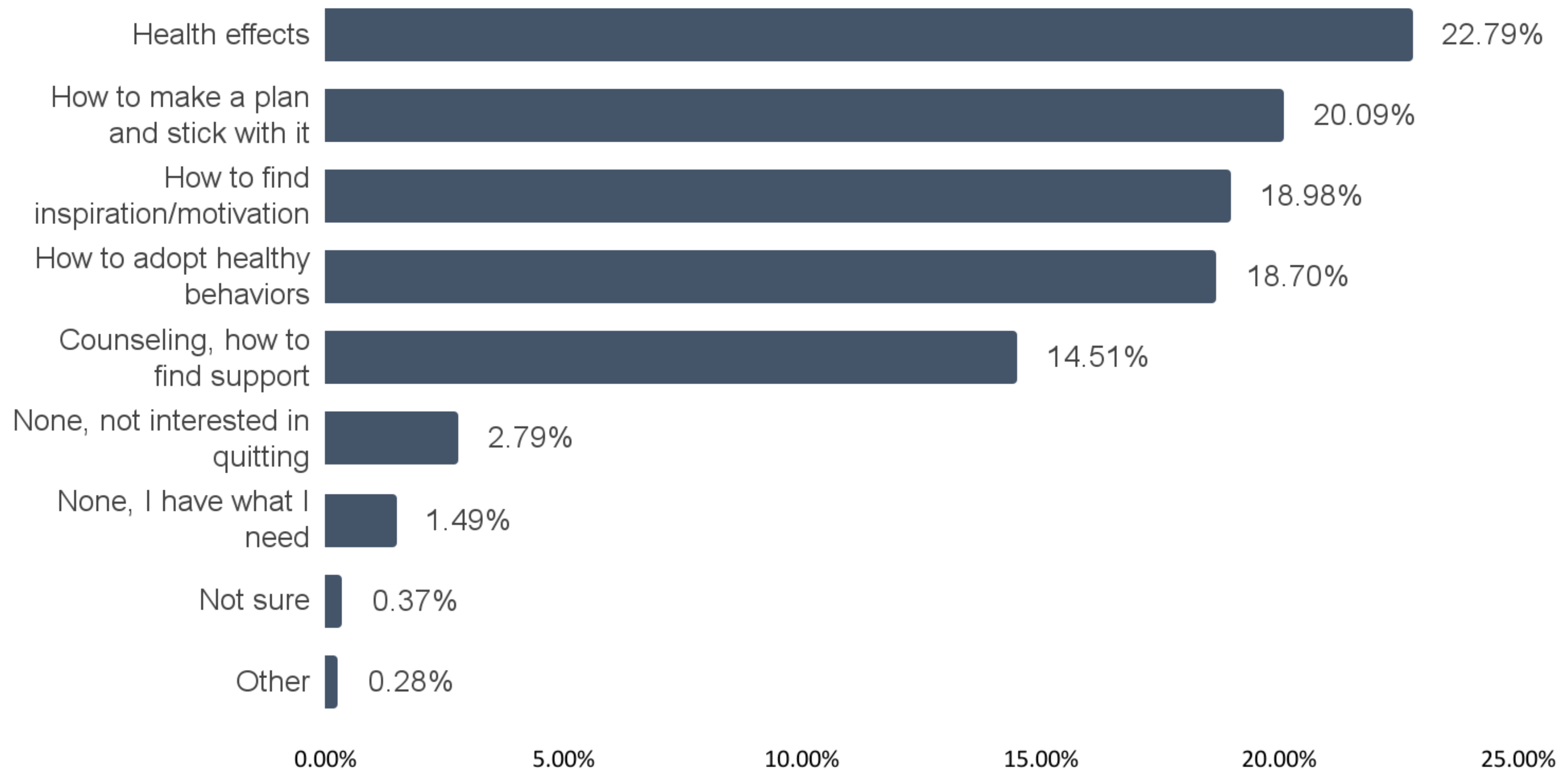


Figure 23. Overall, respondents reported that they most prefer to get information about quitting tobacco/nicotine products from their clinicians, community events and gatherings, and social media