Oregon Tobacco Prevention and Education Program (TPEP)

Local Public Health Authority (LPHA) Grants

2023-2025 Request for Applications (RFA)

Issue Date:	March 16, 2023
Budgets/Cover Letters Due:	3 p.m. PST, May 5, 2023
Workplans Due:	3 p.m. PST, May 5, 2023
Grant Period:	July 1, 2023 – June 30, 2025
Issuing Office:	Oregon Health Authority (OHA) Public Health Division Health Promotion and Chronic Disease Prevention Tobacco Prevention and Education Program 800 NE Oregon Street, Suite 730 Portland, OR 97232 971-673-0984 971-673-0994 fax www.healthoregon.org/tobacco

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I. INTRODUCTION AND ELIGIBILITY

a. Glossary of Acronyms

Throughout this application, there are numerous acronyms used. Please reference this glossary for definitions.

- ADPEP = Alcohol and other Drug Prevention and Education Program
- BM 108 = Ballot Measure 108
- CBO = Community Based Organizations
- CCO = Coordinated Care Organizations
- CHIP = Community Health Improvement Plan
- CLHO = Coalition of Local Health Officials
- COVID-19 = Coronavirus disease of 2019
- CPL = Community Programs Liaisons
- FTE = Full Time Employee
- GIS = Geographic Information Systems
- HERC = Health Evidence Review Commission
- HPCDP = Health Promotion and Chronic Disease Prevention
- ICAA = Indoor Clean Air Act
- IDS = Inhalant Delivery Systems
- IGA = Intergovernmental agencies
- LGBTQ2IAS+ = Lesbian, Gay, Bisexual, Transexual, Queer, Questioning, Two Spirit, Intersex, Asexual, and other identities
- LPHA = Local Public Health Authority
- NRT = Nicotine Replacement Therapy
- OHA = Oregon Health Authority
- PE = Program Element
- PHD = Public Health Division
- PIO = Public Information Officer
- PST = Pacific Standard Time
- RFA = Request for Applications
- RFP = Request for Proposals
- RHECS = Regional Health Equity Coalitions
- TARA = Tobacco and Alcohol Retail Assessment
- TPEP = Tobacco Prevention and Education Program
- WEMS = Workplace Exposure Monitoring System

A. Purpose

The Oregon Tobacco Prevention and Education Program in the Health Promotion and Chronic Disease Prevention Section (HPCDP) of the Oregon Health Authority (OHA), Public Health Division (PHD) seeks applications from Local Public Health Authorities (LPHA) to implement commercial[*] tobacco prevention, education, and cessation programs. It is recommended that these programs are grounded in best and promising practices, developed in collaboration with and/or supported by community, and seek to make sustainable policy, systems and environmental changes that reduce overall commercial tobacco use and eliminate racial and other disparities in commercial tobacco use in Oregon.

Tobacco prevention research shows that a combination of state and community interventions, mass media communications, and support for people who want to quit is effective at reducing the burden of tobacco use in and between communities, including from cigarettes, smokeless, other tobacco products (e.g., hookah), and e-cigarettes or other vape pens that contain nicotine. Priorities for comprehensive tobacco prevention include the following best and promising practices:

- Limiting the tobacco industry's influence in the retail environment;
- Increasing the price of tobacco, including through non-tax approaches (e.g., price promotion prohibitions, minimum pack size);
- Increasing the number of smoke and tobacco-free government properties and public areas;
- Making cessation services available, culturally relevant, and accessible;
- Supporting the creation, delivery, and evaluation of community-driven, culturally specific prevention programs; and
- Educating decision-makers and community members about the harms of tobacco

B. Burden of Tobacco in Oregon

In Oregon, fundamental components of health such as nutritious food and smoke-free spaces to play and be active are out of reach for too many people. Tobacco use remains the leading cause of preventable death in Oregon, despite significant reductions in tobacco use and

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[*] The term "tobacco" used throughout this RFA refers to commercial tobacco. "Commercial tobacco" is defined as tobacco that is sold by the tobacco industry, including cigarettes, vape or e-cigarettes, chewing tobacco, cigars and other products that contain addictive nicotine. The term commercial tobacco is used to separate it from sacred tobacco used by some American Indian/Alaska Native communities and Tribal Nations in Oregon.

tobacco-related disease and death over time. Tobacco use contributes to thousands of deaths in Oregon each year, among both people who smoke and those who do not, and costs billions of dollars in direct medical costs, lost productivity, and early death.

There is no safe level of exposure to commercial tobacco smoke, which can cause heart disease and cancer and worsen respiratory conditions, such as asthma. Certain populations are more susceptible to the health risks associated with commercial tobacco smoke, such as, pregnant people, children, older adults, and people with chronic illness.

Certain communities experience disproportionate *harms* from tobacco, including people who are Black/African American/African, Pacific Islander, Indigenous people living in urban areas and/or without access to Tribal health care, Latino/a/x, Asian and Southeast Asian, LGBTQ2IAS+ people, people with disabilities, and people living with mental health conditions. These tobacco-related health disparities are due to inequities that exist in physical places, such as our homes, schools, neighborhoods, and workplaces; and in the social conditions that shape our lives, such as different education and income levels, discrimination, and racism. These disparities are also the result of variations in policy protections and the tobacco industry's ongoing targeting of these communities with marketing and promotions. Youth use of other tobacco products, such as e-cigarettes, also remains a public health concern. There is strong evidence that these products increase youth nicotine addiction and youth initiation of conventional tobacco products, like cigarettes. Smoking and the use of other tobacco and nicotine-containing products, like e-cigarettes, in public places can normalize smoking behavior in the population and influence youth uptake.

See Appendix A for more information on the burden of tobacco in Oregon.

C. OHA Commitment to Equity

OHA has committed to racial equity as a driving factor to improve health outcomes for all communities that experience inequities. The agency has set a 10-year strategic goal to eliminate health inequities. This means people can reach their full potential and well-being, and are not disadvantaged by their race, ethnicity, language, disability, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances.

Health equity must be the foundation of all tobacco prevention work, including in how we gather and interpret data; communicate and educate; and build relationships through community engagement and coalition building. In Oregon, health equity requires strong partnerships between and across Tribes, Regional Health Equity Coalitions (RHECs), community-based organizations (CBOs) and other community leaders, health care systems, state agencies, and the people of Oregon. Together we can advance the vision of eliminating racial and other health inequities by 2030.

D. Background on TPEP Tiered Funding Model

A Tiered funding model for TPEP was developed in partnership with the Conference of Local Health Officials (CLHO) and considered the 2018-2019 CLHO TPEP Funding Formula Workgroup recommendations, the Public Health Advisory Board funding principles, and the CLHO Funding Formula Checklist. The model aims for flexibility with LPHAs opting into a funding Tier based on capacity building needs and program, political and community readiness for tobacco prevention policy and systems change strategies.

The scopes of work within each Tier align with TPEP Program Element 13. Scopes of work and example activities are described in detail in the Description of Tiers section below. Funding ranges are provided within Tiers, and final awards will be determined based on available funding to OHA, proposed strategies, clear use of a health equity lens, population size served, and average number of Oregon Indoor Clean Air Act (ICAA) complaints. Tier 3 award amounts will also be based on demonstration of past success and capacity to advance tobacco prevention program and policy strategies. The model also includes the ICAA Response Tier. This Tier is recommended for LPHAs that would like to opt out of higher funding levels given organizational and/or political constraints to advancing tobacco prevention policy change but will still fulfill duties to enforce the ICAA.

LPHAs may form consortia to gain efficiencies in providing tobacco prevention and education support within a region. LPHAs are encouraged to examine potential partnerships with neighboring LPHAs in applying for this grant. TPEP will accept only one application per LPHA or consortium.

E. Description of Tiers

Below is a table summarizing required program deliverables across Tiers followed by a detailed description of the requirements. **Program Deliverables for TPEP Funding Tiers (2023–2025)**

Program Deliverables	ICAA Response	Tier 1	Tier 2	Tier 3
Enforce the Oregon ICAA	✓	✓	✓	✓
Advance at least one strategy to build capacity for equitable and community-driven tobacco prevention efforts		✓		
Advance one or more health systems change initiative(s) (*if county chooses this option*)		✓	✓	✓
Promote the use of the Oregon Tobacco Quit Line with health systems partners and the public		✓	✓	✓
Collect information about community cessation resources and provide to HPCDP and region CCO(s)		✓	✓	✓
Develop communications plan that connects to each health systems and policy strategy in the given Tier		✓	✓	✓
Conduct or facilitate tobacco and alcohol retail assessments (TARA) in coordination with HPCDP			✓	✓
Advance at least two evidence-based and/or community-driven program or policy strategies			✓	✓
Advance at least three evidence-based and/or community-driven program or policy strategies				✓

Appendix B: Additional Guidance for Selecting a Tier provides additional guidance on selecting a Tier by describing processes, experience and achievements that can help applicants succeed in each Tier.

LPHA applicants may self-select into a Tier on the TPEP Cover Sheet (Attachment 1), and confirmation is contingent on OHA's approval of a submitted Workplan (Attachment 2) and Line-Item Budget and Narrative worksheet (Attachment 3). The following is a description of each Tier and the related scope of work.

ICAA Response Tier

The ICAA Response Tier is for LPHAs that opt out of funding for tobacco prevention and only fulfill local duties and activities related to enforcing the ICAA as outlined in Appendix F LPHA Delegation Agreement.

The ICAA Response Tier provides funding for assistance with enforcement of Oregon ICAA. On behalf of OHA, LPHAs that agree to engage in enforcement of the law conduct educational and remediation activities with businesses. Programs in ICAA Response Tier are not expected to advance policies, systems, or environmental change initiatives or to engage in tobacco prevention education and advocacy with the funds received from this Grant.

Tier 1: Foundational Tobacco Prevention and Capacity Building

Tier 1 provides funding to conduct activities related to local enforcement of the Oregon ICAA and to engage in basic tobacco prevention education and advocacy. Ideally, Tier 1 is a bridge to engagement in policy and systems change strategies in the future. LPHAs that select Tier 1 may not yet have support from executive leadership and/or elected officials to advance tobacco prevention policies but want to maintain a program that builds local capacity.

Tier 1 programs are expected to develop and maintain partnerships with community partners, health care systems, and other sectors and partners. Tier 1 programs understand, follow, and recommend evidence-based and community-driven policy strategies to partners, decision-makers, and internal leadership. Programs collaborate with community-based organization and other leaders to identify shared prevention activities that align with community priorities. Programs assist partners with resources and information, as requested. Programs in Tier 1 are expected to build capacity to eventually advance tobacco prevention policy strategies and health systems change initiatives.

Tier 1 programs are required to advance **at least one program strategy to build capacity** for equitable and community-driven tobacco prevention efforts. A goal for Tier 1 programs is to build capacity to advance local policy, so the program strategy should include strategic planning activities and/or community coalition development. This program strategy should include a communications component to ensure that the appropriate audience(s) are reached through appropriate channels. See Appendix C for Communications Guidance. Additional examples of capacity building strategies related to equity and partnerships development can be found in Appendix L. BM 108 Eligible Activities Guidance.

Tier 1 programs have the option to advance one or more health systems change initiative in collaboration with local health systems.

Additional requirements related to monitoring and evaluation, training and technical assistance, and communications are detailed in the Program Services by Tier section of the RFA. This section includes recommendations for partner engagement and alignment.

Tier 2: Tobacco Prevention Mobilization

Tier 2 is for LPHAs that have support from the community, executive leadership and/or elected officials to advance policy strategies. Tier 2 programs also have existing relationships with health system partners to advance health systems change initiatives.

Tier 2 programs are required to advance **at least two evidence-based and/or community-driven policy strategies,** selected by the local program from a list of options located in the Program and Policy Strategies section of the RFA. Programs must choose at least one policy strategy from Category A or Category B (with selections based on local political readiness for policy change and community priorities).

Tier 2 programs have the option to advance **one or more health systems change initiatives.** Refer to the Health Systems Change Initiatives section of the RFA for potential initiatives.

Additional requirements related to monitoring and evaluation, training and technical assistance, and communications are detailed in the Program Services by Tier section of the RFA. This section also includes recommendations for partner engagement and alignment.

Tier 3: Accelerating Tobacco Prevention Outcomes

Tier 3 is for LPHAs that have demonstrated prior policy successes and demonstrates leadership and community readiness to address commercial tobacco use inequities.

Tier 3 programs are required to advance **at least three evidence-based and/or community-driven policy strategies,** selected by the local program from a list of options located in the Program and Policy Strategies section of the RFA. Programs must choose at least one policy strategy from Category A and/or Category B (with selections based on local political readiness for policy change and community priorities).

Tier 3 programs have the option to advance **one or more health systems change initiatives** in collaboration with health system and community partners. Refer to the Health Systems Change Initiatives section of the RFA for potential initiatives.

Additional requirements related to monitoring and evaluation, training and technical assistance, and communications are detailed in the Program Services by Tier section of the RFA. This section also includes recommendations for partner engagement and alignment.

Additional eligibility requirements for Tier 3 programs: LPHAs must have completed at least six of the ten prerequisites below to be eligible for Tier 3 funding. Documentation should be submitted with the Tier 3 Prerequisites Checklist (Attachment 4). The timeframe for the

following prerequisites is within the previous two biennial funding cycles unless otherwise stated below:

Tier 3 prerequisites:

1. **Required**: Formal statement of support from Board of County Commissioners or high-level executive leadership to prioritize advancing and passing priority tobacco prevention policy strategy (i.e., tobacco retail policy, strengthened smoke-free/vape-free policy, etc.)
2. 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)
3. Comprehensive county tobacco-free policy in place
4. Demonstrated current health system partnerships (e.g., memorandum of understanding in place, funding agreement, current initiative) for tobacco prevention
5. Leveraged funding commitment from CCO, federal grant or foundation partner for tobacco prevention and cessation activities
6. Demonstrated current partnerships with community-based organizations and/or community members most burdened by tobacco for tobacco prevention (note: LPHA is required to submit a letter of partnership from the community-based partner; see Appendix E for Letter of Partnership Guidance).
7. Demonstrated implementation of communications strategy, including earned media, to support tobacco prevention strategies within the previous two biennia (2019-2023)
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 tobacco retail licensure, flavor restrictions, strengthening the ICAA or another priority initiative (e.g., Board of County Commissioners providing testimony during legislative session)

Additional Considerations

Ballot Measure 108 Carryover Funding

In January 2023, TPEP grantees began receiving a portion of Ballot Measure 108 funding that was allocated based on consultation with CLHO. The purpose of this additional funding is to increase TPEP capacity to address commercial tobacco use inequities and develop or enhance community partnerships, including with CBOs that received new OHA Public Health Equity funding. Applicants are encouraged to include any health equity and community partnerships activities began or were enhanced with the additional BM 108 funding in their 2023-2025 Workplans and budgets. Applicants should apply for a Tier and funding amount that reflect

both readiness to advance policy and systems change strategies and activities related to health equity and partnership development, including those that was new or enhanced through carryover funds.

Program Element 13

The TPEP Program Element 13 was revised in July 2022 to allow funds to be used for direct, evidence-based, or culturally appropriate cessation delivery including the provision of Nicotine Replacement Therapy (Tiers 1-3). Please refer to Section 4c of Program Element 13 for the full revised language. Please also refer to Appendix G for the 2022 LPHA Cessation Guidance on Clinical and Health Systems Strategies.

II. DESCRIPTION OF PROGRAM SERVICES BY TIER

A. Oregon Indoor Clean Air Act (ICAA) Enforcement Activities

ICAA Response Tier and Tiers 1-3 (all Tiers)

LPHAs agree to participate in enforcement of the Oregon ICAA as outlined in Appendix F, the LPHA Delegation Agreement. The Delegation Agreement is a component of the standard LPHA Financial Assistance Agreement. Through the Delegation Agreement, LPHAs are responsible for certain education and remediation activities associated with ICAA enforcement (OAR 333-015-0025 and 333-015-0090). LPHA responsibilities include but are not limited to responding to and investigating received complaints, assisting businesses in achieving compliance, conducting compliance inspections, and coordinating with OHA for training and enforcement. Non-compliant businesses are to be referred to OHA for further administrative action. For more information on required activities related to ICAA enforcement, visit the ICAA Enforcement Toolkit. LPHAs must carry out the Delegation Agreement to be compliant with both the standard LPHA Financial Assistance Agreement and with Program Element 13 (see Appendix H).

B. Program Components by Tier

HPCDP, in collaboration with CLHO, identified the following program components that LPHAs must fulfill to receive TPEP funding.

Program components	**Required for Tiers:**
1. Monitoring and Evaluation	ICAA Response Tier and Tiers 1-3
2. Training and Technical Assistance	ICAA Response Tier and Tiers 1-3
3. Community Engagement and Alignment	Tiers 1-3
4. Communications	Tiers 1-3
5. Policy and Program Strategies	Tiers 2-3

Note: The Health Systems Change Initiative program component was removed from this table since it is now optional, and not required. See Health Systems Change Initiative section for more details.

1. MONITORING AND EVALUATION

Monitoring and evaluating tobacco prevention policies and interventions are essential to a comprehensive tobacco prevention program. Local data collection can be used to identify program and policy priorities, inform and engage decision-makers and community champions, guide quality improvement efforts, and demonstrate program effectiveness.

Participation in the following monitoring and evaluation activities is **required based on the selected Tier**:

ICAA Response Tier and Tiers 1-3

- Enforce the ICAA as outlined in the LPHA Delegation Agreement (Appendix F), including maintaining a public-facing website with at least annual updates to content and adapting communications products provided
- Maintain communication with OHA on enforcement activities (particularly if cases escalate)
- Participate in statewide coordinated evaluation on the TPEP Tiered funding model and other applicable statewide evaluations.
- Participate in TPEP triennial reviews, as required per the global OHA-PHD intergovernmental agreement (IGA).

Tiers 1-3

All monitoring evaluation activities described above and the following:

- Engage in community-driven evaluation work, including but not limited to: community needs assessments; community research co-led with residents to identify tobacco prevention priorities and strategies; or any evaluation activities leading to identifying and eliminating tobacco-related health disparities among priority populations.
- Support capacity for equitable data collection and analysis, such as community-specific surveys and/or qualitative storytelling; and providing stipends to community members to support data collection, analysis, interpretation, and reporting.
- Participate in Workplan review of progress and lessons learned with your Community Programs Liaison (CPL) throughout the biennium. This includes regular check-ins with your CPL, which can include success stories; optional site visits; four period reports; and reporting interviews, as needed.
- Submit all local tobacco policy changes to your CPL.
- Use tools and recommendations from the Equity-Centered Policy Change Process Model. See Appendix I.

- As applicable, support monitoring, evaluation, and implementation of the Governor's Tobacco-free State Properties Executive Order. Participation in activities may include, but are not limited to: promoting the policy, providing public comment, responding to surveys or assessing policy compliance.

Tiers 2 & 3

All monitoring and evaluation activities described above and the following:

- Conduct or facilitate tobacco and alcohol retail assessments (TARA) in coordination with HPCDP, including advising on content, participating in trainings, coordinating assessors, and submitting results for analysis. A statewide TARA is planned for the end of the 2023-2025 biennium: beginning in January of 2025.
- If you need additional supports to conduct or facilitate the tobacco and alcohol retail assessments in your jurisdiction (e.g., stipends for volunteers, temporary staff, a contractor), please include these supports as a line item in your Year 2 budget proposal (2024-2025).

2. TRAINING AND TECHNICAL ASSISTANCE

The following describes required and encouraged training and technical assistance opportunities by Tier. Training and technical assistance opportunities will continue to be offered remotely until it is safe to resume meeting in person. Training and technical assistance opportunities are focused on current and emerging priorities determined by LPHAs and HPCDP and are intended to develop and enhance skills necessary to effectively advance policy and health systems strategies. Training and technical assistance may also focus on authentic engagement of community and other partners in the commercial tobacco prevention system to advance program priorities. Trainings aim to support networking and collaboration with peers and provide opportunities to share lessons learned.

ICAA Response Tier and Tiers 1-3

The TPEP main point of contact and any staff engaging in activities related to ICAA enforcement, including but not limited to conducting ICAA site visits and entering information into the Workplace Exposure Monitoring System (WEMS), is required to attend trainings and technical assistance opportunities related to ICAA enforcement when provided by HPCDP. Training and technical assistance opportunities may include, but are not limited to, webinar trainings, online community of practice groups, 1:1 consultation, and ICAA-focused office hours. TPEP staff are encouraged to regularly review materials and guidance for county TPEP programs available in the ICAA Enforcement Toolkit.

Tiers 1-3 (optional for ICAA Response Tier)

The TPEP main point of contact and any staff funded at 0.5 FTE or more by TPEP are required to complete the Appropriate Use of Public Funds training and New Coordinator Orientation training (if applicable). Other training and technical assistance opportunities described below

(and those identified later) are encouraged but not required. Please note that HPCDP reserves the right to require other TPEP-funded staff to attend trainings or meetings, as needed.

Type	Description	Timing
Required		
Self-guided e-learning module	Remote overview of Appropriate Use of Public Funds to ensure that we are good stewards of funds that belong to the public. This training seeks to ensure that all staff are considering local and state rules as they work alongside community activists in the field of Public Health.	January 2024 January 2025
New Coordinator orientation	Remote orientation to TPEP, HPCDP, best and promising practices in tobacco control. New TPEP coordinators and other TPEP-funded staff are required to participate in a new coordinator training session delivered by their assigned HPCDP liaison or in a cohort training.	The frequency of orientations will be determined by the capacity of HPCDP staff and availability of new TPEP Coordinators
Encouraged		
Tobacco Prevention and Education Program Monthly Calls	TPEP grantee cohort calls with a tactical and operational focus; intended to provide a forum to share information with grantees in a timely manner, to provide peer support to inform each other's work, and to provide for group-level, operational support regarding grant requirements, work plans, lessons learned and successes, updates on national, state, and local tobacco policy initiatives.	Every 4th Tuesday, 11 am – 12 pm PST
Technical Assistance Opportunities	Consulting and strategic planning support are provided by HPCDP staff and contractors, who are available to consult on the development and implementation of local policy and	This consulting will occur at a frequency agreed on by HPCDP and local TPEP staff

	systems change strategies and on core program functions, including monitoring and evaluation, strategic communications, and community engagement.	
In-person or webinar trainings	Webinars or online meetings focusing on specific content areas, including but not limited to policy and systems change strategies in Workplans, statewide communications campaigns, state surveillance data, and new state or federal regulations that impact local programs.	Based on strategic needs or identified opportunities for capacity-building and alignment
Affinity Groups and peer-to-peer mentoring	Peer-to-peer learning and strategic opportunities facilitated by local TPEP coordinators and supported by contractors. Affinity groups can be created any time by consulting with HPCDP staff. Existing groups include: • Healthy Retail • Flavors • Behavioral Health Systems and Cessation	Varies – connect with HPCDP Staff to learn more about affinity groups and mentoring opportunities

Budgeting for Training

Grantees may budget for anticipated travel costs to attend in-person trainings. Please note that HPCDP-sponsored training and technical assistance opportunities will be offered remotely until it is safe to resume meeting in person. Currently, HPCDP is **not planning any required in-person trainings** for 2023-2025. However, if you expect to participate in non-HPCDP training opportunities that require travel, be sure your program budget covers estimated costs for participating in those training events.

3. COMMUNITY ENGAGEMENT AND ALIGNMENT

Community Engagement

Building collaborative partnerships with community-based organizations and community members is important for increasing capacity, amplifying community voice, and leveraging diverse skills and expertise for sustaining change in tobacco prevention. Community

engagement is the development of long-term, evolving relationships with community partners. HPCDP strongly encourages TPEP grantees to engage community organizations and members with lived experience, especially those experiencing systemic inequities, for issue identification, problem solving, community outreach and education, decision-making, implementation, evaluation, and funding opportunities to address their needs.

Grantees can identify and engage existing and new partners, including those who may not work in tobacco prevention and control, to foster collaboration and incorporate community assets and networks. Community engagement can include new partners mobilized in response to the COVID-19 pandemic, as well as partners interested in preventing cancer, heart disease, arthritis, and stroke. Additionally, grantees' community engagement work can directly support/fund community partners through contracting, resources, and language access. See Appendix D for resources on Building Equitable Partnerships and Appendix L for Ballot Measure 108 Eligible Activities Guidance.

Community Alignment

Many organizations, including CBOs, Tribes, cities, other county programs, schools, health systems, and CCOs, are actively working to improve the health and quality of life for people across Oregon. Community alignment takes into consideration the various strengths and values across community groups working on commercial tobacco prevention and cessation; it recognizes that working across multiple perspectives can create more sustainable change.

TPEP grantees are encouraged to work with diverse partners and organizations. By identifying, aligning, and leveraging shared priorities, staff time, and resources across organizations, grantees can advance health equity, health promotion and tobacco prevention work as part of a broad community partnership.

Examples of community engagement and alignment activities include the following:

- Engage and financially compensate community (e.g. provide stipends) to participate in program planning, budgeting and policy development to ensure cultural and linguistic appropriateness
- Participating in Regional Health Equity Coalition policy committees
- Support another county TPEP to increase readiness for work on equity and community partnerships development (for example, share or co-design assessments to measure community knowledge/attitudes, share strategies to identify key community partners)
- Develop shared strategies with county Alcohol and Drug Prevention Education Program (ADPEP) and build shared ownership for strategies with community partners
- Collaborate with Maternal and Child Health partners to develop a closed loop referral process to ensure quit resources for pregnant or parenting women accessing services
- Identify shared tobacco prevention and cessation strategies with CCOs, including those that connect to Community Health Improvement Plan (CHIP) priorities
- Provide networking opportunities for LPHAs, CBOs, and other community partners

- Other activities to engage and convene partners, and cultivate leadership and vision for prevention and health promotion policies, programs and strategies as described in the Prevention and Health Promotion section of the Public Health Modernization Manual.
- Applicants will be asked to describe current and/or anticipated community engagement and alignment activities for each selected strategy in the project plan. Applicants are encouraged to include community partnerships activities began or enhanced with BM 108 carryover funding in their 2023-2025 Workplans and budgets. If the project plan indicates a partnership with a CBO or other community leader, the applicant is required to submit a letter of partnership from the community-based partner demonstrating the active partnership and commitment to shared implementation of the project plan strategy. See Appendix E for letter of support guidance.

4. COMMUNICATIONS STRATEGIES

Local TPEP Tiers 1 – 3 are **required** to develop a communications plan for each of the selected program and policy strategies. Communications strategies leverage program communications, owned and social media, earned media, and paid media to reach key communities and support health systems, program, and policy strategies. A communications plan outlines the key audiences, messaging, and how to reach the key audiences through different communications channels. For guidance on developing the communications section of your Workplan, please refer to Appendix C.

Communications Requirements:

- Complete the Communications Section of the Workplan
- Complete the TPEP Communications Approval (Attachment 5). This will require that you connect with the Public Information Officer (PIO) in your county to discuss the Workplan and communications strategies. Discussing communications strategies with your PIO can help determine if your communications plan is feasible.
- ***Optional but strongly encouraged****.* Meet with Metropolitan Group or HPCDP Communications Staff to receive technical assistance in developing a communications plan for the selected program and policy strategies. To complete this process, email HPCDP.Media@dhsoha.state.or.us or your Community Programs Liaison, or check the box on the Workplan template.

Local TPEP grant funding is not intended for purchase of media without prior approval from HPCDP. If you are planning to purchase media, please connect with HPCDP.Media@dhsoha.state.or.us **before** submitting your project plan and budget.

5. HEALTH SYSTEMS CHANGE INITIATIVES

Applicants in Tiers 1-3 have the *option* to work on one or more of the following **health systems change initiatives**. Please note that previous applications required this component; however, it

is now optional to allow for more flexibility in workplans. This decision was based on collaborative discussions between state and county partners. These initiatives fall into one of two strategic categories:

- Improving clinical interventions for tobacco cessation, and
- Engaging healthcare partners in community-driven interventions

Background on each strategy is provided below.

Health Systems Change Requirements:

While health systems change initiatives are optional, programs in Tiers 1-3 are **required** to participate in the following activities:

- Educate healthcare partners and the public about the Oregon Tobacco Quit Line for tobacco cessation and promote the use of the Quit Line in appropriate contexts. These activities can be included as part of the submitted communications plan.
- Collect information about community cessation resources throughout the geographic area covered by your program, such as your county or counties in your consortium, and provide this information to HPCDP and the regional CCO(s) upon request.

Background and examples of *optional* Health System Change Initiatives

One potential role of TPEP is to inform healthcare partners about the health and economic burden of tobacco use and share information about evidence-based clinical cessation practices and community interventions that can improve the health of patients and reduce health care costs associated with tobacco-related chronic diseases. (See links in this section and the Health Systems Resources Appendix G for additional resources for implementing clinical and community interventions in collaboration with healthcare partners.)

The goal is to help providers establish formal clinical protocols that can be sustained over time. TPEP can help to ensure that every patient is screened for tobacco use with their status documented, as well as ensure that treatment or a referral to treatment is provided to anyone who wants to quit.

In the clinical setting, TPEP is not expected to provide or coordinate trainings to integrate tobacco cessation into clinical workflows or to provide cessation materials for patients, such as brochures and palm cards. (For more information about restrictions on the use of TPEP funds, see page 35.)

HPCDP staff and OHA contractor, Coraggio Group, are available for consulting and technical assistance as applicants develop a health system strategy. For support, please contact Sarah Lechner at mailto:sarah@coraggiogroup.com.

For the purposes of this guidance, "healthcare partners" are defined broadly and include, but are not limited to, CCOs and other health insurance plans, Federally Qualified Health Centers,

community clinics, county clinics and health services, hospitals and other health systems, behavioral health providers and facilities (including mental health care and substance use disorder treatment), dental and oral health providers and pharmacists.

For these TPEP strategies, partners may also include entities that regularly connect clients to medical services and health-related social needs, including but not limited to Community Health Workers, and Traditional Health Workers, and organizations that provide services that address Health-Related Services and Social Determinants of Health.

Some examples of how LPHAs have collaborated with health systems partners can be found in this Reducing Tobacco Prevalence Handout.

Clinical Tobacco Cessation Strategies

Tobacco cessation is a key component of a comprehensive tobacco control program. Quitting smoking has immediate and long-term health benefits. Almost 70 percent of Oregonians who smoke want to quit; however, most people who use tobacco need to make multiple quit attempts before they are successful. Healthcare partners have multiple opportunities to motivate and assist people who use tobacco in quitting. A systematic approach to tobacco cessation within healthcare delivery systems ensures people who use tobacco receive ongoing support at every clinical encounter to help with quit attempts.

Every patient who uses tobacco should be identified, advised to quit, and offered evidence-based treatments. LPHAs can educate healthcare partners about best practices for delivering and improving tobacco use screening, cessation services and referral systems.

In addition, LPHAs can support CCOs, and other healthcare partners identify and remove systemic barriers to accessing cessation services. LPHAs can do this through:

- Educate healthcare partners about best practices for delivering and improving tobacco use screening, cessation services and referral systems;
- Supporting clinical linkages to tobacco cessation interventions, including to the Quit Line and among culturally specific and community-based clinics
- Supporting tobacco cessation interventions via Community Health Workers and Traditional Health workers
- Ensuring equitable language access to tobacco screening and treatment in clinical and pharmacy settings
- Fostering partnerships with community pharmacies to implement the Oregon Pharmacist NRT Program

Engaging Healthcare Partners in Community Settings

Because many effective, evidence-based interventions occur in community settings, healthcare partners can also be important collaborators outside of the clinic. Recognizing this, Oregon's Health Evidence Review Commission (HERC) has developed several "multisector intervention statements" to address the fact that improvements in health outcomes can occur outside of the clinic.

In 2016, the HERC issued a statement on multisector approaches for tobacco prevention. LPHAs can engage with CCOs around strategies including but not limited to:

- Developing of smoke-free policies in workplaces and public spaces;
- Implementing of mass-reach communication interventions for evidence-based tobacco prevention, and;
- Community engagement via LPHA to promote tobacco cessation, creating tobacco-free places, and identifying and eliminating tobacco-related disparities.

LPHAs can also play an important role in ensuring CCOs fully implement cessation benefits required under the Affordable Care Act and Oregon law and have the tools and understanding they need to meet the Cigarette Smoking Prevalence incentive metric. In Oregon, all public and private health insurance plans must cover a minimum standard of tobacco cessation coverage. Approximately 95% of Oregonians have health insurance coverage.

However, many communities in Oregon continue to experience disparities in health systems. Communities may not be aware of their insurance benefits or experience barriers to care such as lack of access. LPHAs can work with CCOs to ensure their members are aware of their insurance benefits and evaluate access.

The HERC also determines what services are covered by Medicaid in Oregon, and in certain circumstances, CCOs can use Medicaid funds to implement community interventions as nonmedical services. LPHAs can use the HERC guidance to educate and engage CCOs and other healthcare partners in community interventions. LPHAs are at a critical junction between CCOs and their communities, and so an important component of this strategy includes triangulating between culturally specific and community-based organizations and their CCOs. See the Community Engagement and Alignment section of this RFA for more information.

LPHAs interested in developing relationships with local CCOs can begin this work by:

- Reviewing Health Systems webinars and training materials, available on the TPEP Portal (login required).
- Connecting with your liaison to learn about Health Systems technical assistance.

- Engaging with Oregon Health Authority Innovator Agents, who can help your teams form relationships with local CCOs and strategize around meeting program priorities.
- Attending CCO Community Advisory Council meetings.
- Work with CCO(s) to implement at least one HERC-recommended multisector approach for tobacco prevention.
- Work with CCO(s) to ensure they're fully implementing cessation benefits required under the Affordable Care Act and Oregon law.
- Ensuring CCO(s) have the tools and understanding they need to meet the Cigarette Smoking Prevalence incentive metric.
- Facilitate engagement between CCOs and CBOs, including through CCO Community Advisory Councils.
- Other proposed strategies with multisector partners, including at least one healthcare partner playing a primary role, based on best practices and/or innovative, culturally informed practices.

TPEP Program Element 13 was revised in July 2022 to allow funds to be used for direct, evidence-based, or culturally appropriate cessation delivery including the provision of Nicotine Replacement Therapy (Tiers 1-3). Refer to Appendix G for the 2022 LPHA Cessation Guidance on clinical and health systems strategies. While TPEP funds are now able to be used to deliver direct cessation services, including providing counseling and Nicotine Replacement Therapy, funding sustainability remains a priority. Local TPEP can engage healthcare partners to identify appropriate resources for local investment to ensure long-term program success.

6. PROGRAM AND POLICY STRATGIES

LPHAs in Tier 1 are required to advance at least one community-identified program strategy aligned with capacity building and tobacco prevention efforts. The goal is to build capacity to eventually advance local policy, so the program strategy should include strategic planning activities or community coalition development.

Only LPHAs in Tier 2 and Tier 3 are required to advance policy strategies.

Tier 2 programs are required to advance **at least two evidence-based and/or community-driven policy strategies** from the menu of policy and program strategies below. Programs must choose at least one policy strategy from Category A or Category B.

Tier 3 programs are required to advance **at least three evidence-based and/or community-driven policy strategies** from the menu of policy and program strategies below. Programs must choose at least two policy strategies from Category A and/or Category B. Tier 3 applicants must also meet the prerequisites described in the Description of Tiers section and in Attachment 4.

We encourage TPEP grantees to utilize the Equity-Centered Policy Change Model to guide their work on advancing policy strategies in their community.

Menu of Policy & Program Strategies

Tiers 2 and 3

Strategy Area A: Reduce the Availability of Tobacco Products

- Prohibit the sale of flavored tobacco products and e-cigarettes/inhalant delivery systems (IDS), including menthol.
- Increase the cost of tobacco through non-tax approaches (e.g. price promotion, coupons, discounts prohibitions).
- Restrict outlet density through zoning, distance requirements (e.g. restrict the proximity of tobacco outlets near places where children frequent, such as schools, cap the number of retailers).
- Other proposed strategies that align with community priorities.

Strategy Area B: Reduce Exposure to Secondhand Smoke

- Advance jurisdiction-wide tobacco- or smoke-free policies (i.e. local ordinances) for public places to prohibit businesses that allow indoor smoking or expose employees to secondhand smoke, including certified smoke shops, cigar bars or hotels.
- Advance jurisdiction-wide tobacco or smoke-free policies (i.e. 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 tobacco or smoke-free policies (i.e. local ordinances) including outdoor dining, parks, other service areas, or construction sites.
- Advance jurisdiction-wide ordinance to extend the prohibition of smoking beyond the current 10-foot requirement from entrances, exits, or windows.
- Advance policies that establish tobacco-free county or city agencies or other regional government campuses (identified in the submitted work plan) inclusive of prohibitions on inhalant delivery systems.
- Other proposed strategies that align with community priorities.

Strategy Area C: Flexible Tobacco Prevention Strategy

- Develop initiatives in partnership with community that addresses racism, discrimination and/or other social and structural factors that contribute to commercial tobacco use inequities.
- Collaborate with local Alcohol and other Drug Prevention and Education Program (ADPEP) and/or Opioid Overdose grantees to develop and advance a shared strategy for polysubstance use prevention.
- Advance strategy aligned with the state health improvement plan, Healthier Together Oregon (HTO). See Appendix J.
- Develop alternatives to suspension policy in collaboration with schools or school districts to ensure that possession or use of tobacco products results in addiction treatment, not missed educational opportunity.

- Build a cohort program of youth advocates to engage in peer education and advocacy skill building.
- Develop a college internship program to build a pathway to careers in public health. Work with interns to develop a “Tobacco 101” educational series. Create a presentation on how to use this material with new coalition members or LPHA staff onboarding and ways to share with allied partner coalitions.
- Convene community-driven coalition focused on reducing tobacco use inequities; provide stipends for youth and community engagement.
- In partnership with CBOs, identify, co-develop, and provide culturally relevant training and technical assistance opportunities for community members, CBOs, or other LPHAs.
- Develop cooperative agreements with two to three stores offering healthy retail options such as agreeing to minimize or eliminate tobacco and alcohol shelf space and advertising, stocking healthy snack options, ensuring access to produce, etc.
- Develop non-tobacco sponsorship policies for major events such as rodeos and concert venues that allow advertising and sponsorship from tobacco industry.
- Create a collaborative commercial tobacco (and other county-based public health topics of interest) and health equity impact report or Global Information Systems (GIS) tobacco retail mapping project.
- Create a local tobacco impact report and/or interactive web presence to highlight the various ways in which tobacco affects youth, seniors, priority communities, job security and illness. Develop a distribution plan to present or share this resource with allied groups and leaders.
- Develop and update a resource to highlight the local and state decision-making process; outline all local and statewide decisionmakers, their key priorities, and share this knowledge with other partners and coalitions, including youth and historically underrepresented community partners.
- And/or another strategy that aligns with community priorities.

D. Staffing and Budget

Staffing is a budget priority for program resources. To ensure adequate staffing and accountability for completion of the work plan, most grant funds are expected to be invested in qualified program staff. Staff time paid by TPEP funds must be dedicated only to approved activities in the work plan.

Each Tier includes a biennial funding range that includes **requirements or recommendations** for minimum FTE:

Tier	Biennial funding range	Minimum staffing
ICAA Response Tier	$16,500 (fewer than 10 complaints per year based on 3-year average) $38,000 (more than 10 average complaints per year based on 3-year average)	No FTE requirement or recommendation
Tier 1	**Up to $99,999**; varies by program and based on requirement to fund at least 0.5 FTE	At least .5 FTE required*
Tier 2	$100,000 - $349,999	At least .75 FTE recommended*
Tier 3	$350,000 - $1,000,000	At least 1.5 FTE recommended*

FTE Considerations

FTE to support leadership and program administration is allowed. Staffing proposals should be commensurate with proposed work plan. All staff funded through TPEP PE 13 must be identified with associated activities in the approved work plan, including leadership and administration. FTE can be a combination of staff internal to your TPEP program and/or shared with another program in your agency (e.g., ADPEP, opioid overdose prevention). FTE, in part or in whole, can also be allocated to an external organization that meets a TPEP program need (e.g., outreach to culturally specific populations).

Funding Range Changes

The award ranges within tiers have been increased since the 2021-2023 biennium and are meant to reflect the integration of policy and systems change strategy requirements and new or enhanced activities for equity capacity building and community partnership development. **For the ICAA Response Tier**, the increase in amount is meant to reflect the cost-of-living increase of 8% for the biennium (a 4% increase each year). The expansion of the Tier 2 award range is meant to support local programs that do not want to take on additional policy and systems change strategies (by opting into Tier 3) but do need additional resources/staff to advance equity and community partnership activities.

The LPHA is expected to designate a TPEP Coordinator who will serve as the main point of contact between the local program and HPCDP and who will have sufficient FTE to support regular, consistent communication and coordination with HPCDP. In most cases, the TPEP Coordinator is responsible for ensuring completion of all activities in the work plan. For LPHAs with multiple program staff, the TPEP Coordinator also ensures that other program staff members conduct the activities in the work plan.

E. Line-Item Budget and Narrative

LPHAs determine the amount requested in the budget based on activities in the project plan and the funding range of the Tier. Funding ranges and minimum FTE requirements and recommendations is included in the table above.

Submit the proposed 24-month budget for the fiscal period July 1, 2023 – June 30, 2025, using the required Line-Item Budget and Narrative Worksheet (Attachment 3). The budget template includes two (2) worksheets, one for each fiscal year, and both worksheets must be completed. Use the formulas in the budget worksheets to perform automatic calculations.

Please note**:** During the biennium, TPEP programs must submit a revised budget for approval by HPCDP if expenditures exceed any budget line by 10% or more.

Meetings and Events

When using TPEP funds for meetings and events, grantees shall make their best effort to hold events and trainings in a manner that is supportive to health. This includes holding events and trainings at tobacco-free locales, making accommodations for participants to breastfeed or pump breast milk, and offering breaks for voluntary movement or activity for at least 10 minutes per hour of meeting time.

Restrictions

Restrictions on the use of TPEP funds include, but are not limited to the following:

- Providing direct services or to support reimbursement models as part of policy implementation, e.g., funding cannot be used to reimburse entities for any perceived or demonstrated difference of cost between healthy options versus unhealthy options.
- Purchasing media or media campaign materials without prior approval from HPCDP.
- Covering staffing to support local COVID-19 response.
- Providing Tobacco Retail License (TRL) activities such as retailer education and enforcement, as this is now covered under Program Element 76, see Appendix K.
- Supplies: Provide a total amount for supplies. Supplies may include office supplies or meeting supplies including food and drinks for community meetings, events, etc. If expenditures are allocated for educational materials, the narrative must include a justification that describes how such materials are related and essential to specific activities listed in the plan. Funds may not be used for clinical services, treatment, vaping detection devices or medications.

Budget categories

The Line-Item Budget and Narrative Worksheet should include each of the following budget categories, as relevant:

- **Salary:** List each position funded by the grant on a separate line. For each position, include the job title, annual salary, FTE as a percentage and the number of months requested for each staff person. The total salary will automatically calculate. Include a narrative for each position, briefly describing their primary responsibilities on the grant.
- **Fringe Benefits:** If applicable, list the fringe rate for each position on a separate line. The total fringe will automatically calculate. Unless otherwise indicated, the general assumption is that the "Base" will be the total salary charged to the contract.
- **Equipment:** Provide a total amount for equipment, as well as a narrative listing planned purchases and brief rationale. Office furniture, equipment and computer/software upgrades are allowed provided they are reasonable expenditures, relate to the Local Project Plan and have not been purchased in the previous three years.
- **Supplies:** Provide a total amount for supplies. Supplies may include office supplies or meeting supplies, including food purchases for partner engagement meetings. Expenditures for educational materials must be for materials approved by TPEP. If expenditures are allocated for educational materials, the narrative must include a justification that describes how such materials are related and essential to specific activities listed in the Workplan.
- **Travel:**
    - **In-state:** Provide a narrative statement describing proposed in-state travel. Include local mileage as well as per diem, lodging and transportation to attend required and requested meetings. Federal per diem rates limit the amount of reimbursement for in-state travel – see U.S. General Services Administration Per Diem Rates at www.gsa.gov/perdiem.
    - **Out-of-state:** Travel to attend out-of-state events or conferences is permitted if content is applicable to the Workplan. Provide a narrative statement that includes the name of the event or conference, and how the proposed travel relates to the Workplan. Include amounts for per diem, lodging, transportation, registration fees and any other expenses. Federal per diem rates limit the amount of reimbursement for out-of-state travel – see U.S. General Services Administration Per Diem Rates at www.gsa.gov/perdiem.
- **Other:** List expenses for items not listed above, such as telephone, rent, copying, printing, postage and mailing that are directly related to grant activities. Smaller honorariums or incentives to support community partner engagement may be listed in this budget category. Connect with your CPL to learn more about how to write in compensation for community partners. Please note expenses such as equipment, supplies, indirect rate, or cost allocation may not be included in the "Other" category if they are included elsewhere in the budget.
- **Contracts:** Grantee's community engagement work can directly support community-based organizations through sub-contracts to center the ideas, expertise, and vision of communities. Pre-approval from HPCDP must be obtained for any subcontracts. List

each proposed subcontracted program activity and the name of the proposed subcontractor (if known) along with the amount of the contract. All activities related to the subcontractor must be clearly specified in the Workplan, and must include: (1) scope of work, including tasks and deliverables; (2) time period of the contract; (3) person in your agency who will supervise or manage the contract; (4) name of the contractor, if known; and (5) what method will be used to select the contractor, such as bids, RFPs, sole-source, etc.

- **Total Direct Costs:** The total direct cost will auto-fill on the worksheet. Confirm that the amount is correct.
- **Cost Allocation and Indirect Rate:** Indicate the cost allocation or indirect rate. The worksheet will auto-fill the total direct costs and multiply the cost allocation or indirect rate against the total direct to calculate the total cost allocation or indirect amount. OHA reserves the right to request additional detail on cost allocation or indirect rates.
- **Totals:** The worksheet will calculate the total budget amount requested. Ensure that the total budget amount is within the range for the applicable Tier (see table on page 27).

F. Reporting

Reports from TPEP Coordinators help HPCDP monitor grant compliance, inform program improvement activities, collect data to maintain secure funding and track successes around the state. Two (2) times per year on the schedule outlined below, LPHAs must complete a progress report and may be asked to compete a follow-up interview with their HPCDP liaison to describe progress made on the approved workplan. Reports will be completed during the following periods:

- January 2024
- July 2024
- January 2025
- July 2025

HPCDP will notify TPEP Coordinators to complete the online reporting form at least two weeks prior to the due date. TPEP Coordinators will use the approved Workplan form to report on activities. Local TPEP must complete 75% or more of the planned activities in the approved plan within the anticipated timeframe and/or explain barriers to planned activities and describe the alternative activities conducted to continue advancing the strategy. Local TPEP is required to submit copies of policies adopted or modified during the reporting period as well as additional documentation, if relevant, such as success stories and earned media.

After reporting forms are complete, HPCDP liaisons may request follow up reporting interviews. LPHA leadership is requested to attend the reporting interview. HPCDP liaisons will send a follow-up communication with HPCDP feedback and resources.

III. APPLICATION SUBMISSION

A. Application Deadline and Delivery

One (1) electronic copy each of the cover letter, budget, workplan and communications plan must be received via email no later than 11:59 p.m., May 5, 2023. The application must be submitted in the original Microsoft Word and Microsoft Excel formats. Please consider labeling each file with your LPHA name, the grant year, and the name of the form, as in these examples:

- LPHAName.2023-25.CoverLetter.docx
- LPHAName.2023-25.Budget.xlsx
- LPHAName.2023-25.Workplan.docx
- LPHAName.2023-25.CommunicationsPlan.docx

Email applications to HPCDP.Community@odhsoha.oregon.gov. Completed submissions will receive a notification of receipt.

B. Application Requirements

Applications must address all requirements included in this RFA. An application missing any item listed below will be considered incomplete. Include the following application materials:

1. Application Cover Sheet
2. Workplan Template
3. Line-Item Budget and Narrative Worksheet
4. Tier 3 Prerequisites – *Tier 3 Only*
5. Communications Approval

C. Application Cover Sheet

Complete all sections of the Application Cover Sheet (Attachment 1).

Applicants must disclose all direct and indirect organizational or business relationships between the applicant or its subcontractors, including its owners, parent company or subsidiaries and companies involved in any way in the production, processing, distribution, promotion, sale or use of tobacco or tobacco-related products.

D. Applying as a Consortium

If applying as a consortium of LPHAs, submit an integrated application including one Workplan, one budget for each year (clearly indicating funding that will be allocated to each LPHA) and one communications plan rather than separate documents for each county in the consortium. Within the Workplan, indicate whether a particular strategy or initiative is consortium-wide or will be primarily undertaken by one member of the consortium. If the latter is the case, indicate

which consortium member is undertaking the strategy or initiative and describe partnership coordination activities among the consortium members.

IV. APPLICATION REVIEW PROCESS

A. Application Timeline

RFA opens	March 16, 2023
Question submission deadline	4:00 p.m., March 31, 2023
Questions & Answers and any Amendments to the RFA posted to website	April 7, 2023
Budgets[†], Cover Letters, Workplans and Communication Plans due	11:59 p.m., May 5, 2023
Initial Notification of Approval of submitted application materials (Workplan, Budget and Communications Plan) and/or request for revisions	By June 1, 2023
Revision Period	June 1-13th, 2023
All TPEP Work Plans and Budgets finalized	By June 15, 2023
Start/end date for Bridge Funding	July 1, 2023 – September 30, 2023
Start/end date for Grant Period	Oct 1, 2023 – June 30, 2025

B. Award Notice

Applicants will be notified by June 1, 2023 about the status of their application as:

- Accepted as submitted
- Accepted with required changes

[†] Extensions for budget submission may be granted on a case-by-case basis. Contact your assigned HPCDP liaison to discuss.

- Requiring re-submission

OHA may negotiate a modification of the Local Project Plan and budget, and award funds only after such modification has been agreed upon by OHA. Final determination of funding within the selected Tier will be determined by several variables, including proposed strategies, planned activities, incorporation of a health equity lens, population, and average number of ICAA complaints. All funds awarded under this RFA will be included in the Intergovernmental Financial Assistance Agreement between OHA and LPHAs.

- Please note: All budgets for 90-day bridge funding will be submitted on or before April 16th to be included in the July 2023 amendment cycle. Counties moving from ICAA Response Only into a higher tier will submit a 90-day budget for approval on or before April 16th. Final budgets for the 2023-2025 biennium will be included in the following LPHA amendment cycle.

At CLHO's request, approved work plans will be shared with other funded TPEP throughout the state via the TPEP Portal.

Guidance for Workplan and Budget Revisions

The purpose of a workplan is to develop a shared vision and create a road map of what needs to be accomplished for success. Workplans are a shared agreement between HPCDP and the partner on the work that will take place. Workplans are a living document and may change. HPCDP expects the most that a partner would change their workplan would be two or three times per biennium.

HPCDP recognizes that policy and systems change work is dynamic and workplan activities and strategies may shift throughout the biennium. Throughout the 2023-2025 biennium, all requested changes to approved workplans and budgets must be submitted in writing to HPCDP for approval. Minor shifts in activities can be described in reporting forms if there are no shifts to the overall strategy or approach. Local programs should contact their assigned HPCDP Community Programs Liaison to discuss more significant changes to the approved workplan and/or budget to determine whether revised documents should be submitted for approval. *Changes to any budget line of 10% or more require submission of a revised budget for approval.*

Please refer to the examples below for guidance on whether Workplan revisions are needed:

EXAMPLE: No Workplan Revisions Needed

A workplan that would not require formal changes would be if a TPEP coordinator planned to pass a smoke-free parks policy to make all the parks in one town in their county smoke-free. If the TPEP coordinator was unable to work with the town that they originally planned on but ended up working with another town to pass a smoke-free parks policy, the TPEP coordinator would not have to change their workplan. They would write about this and the reason for these changes in their quarterly report.

EXAMPLE: Workplan Revisions Needed

A workplan would require formal changes if a TPEP coordinator determined there was a lack of community readiness to pass a smoke-free parks policy, and instead decided to work on restricting outlet density where commercial tobacco products were sold through zoning or distance requirements. Because the TPEP coordinator significantly changed their strategy and approach - and would likely change their activities and engaged partners - this would require workplan revisions to be submitted to HPCDP for approval. This example might also require budget changes.

C. Reservation of Oregon Health Authority Rights

Oregon Health Authority reserves all rights regarding this RFA, including, without limitation, the right to:

1. Amend or cancel this RFA without liability if it is in the best interest of the public to do so;
2. Reject any and all applications received by reason of this request upon finding that it is in the best interest of the public to do so;
3. Waive any minor irregularity, informality or non-conformance with the provisions or procedures of this RFA, and to seek clarification from the applicant, if required;
4. Reject any application that fails to substantially comply with all prescribed solicitation procedures and requirements;
5. Negotiate a final grant within the scope of work described in this RFA and to negotiate separately in any manner necessary to serve the best interest of the public;
6. Amend or replace any grants that are a result of this RFA; such amendments or new grants may be for additional periods of time, for changes in payment rates for services, or to add or delete any terms and conditions of such grants which are within the scope of this RFA;
7. To extend any grants that are a result of this RFA or to enter new grants within the scope of this RFA without an additional solicitation process. Workplans and budgets will continue to be subject to OHA approval during any subsequent periods.

D. Questions

This RFA is non-competitive. Therefore, applicants are encouraged to contact assigned HPCDP liaisons and staff for technical assistance or by submitting questions in writing to HPCDP.Community@odhsoha.oregon.gov.

Questions submitted in writing by 4:00 p.m., March 31, 2023, will be posted in Q&A format to the TPEP RFA section of HPCDP Connection, on April 7, 2023.

Virtual office hours with HPCDP staff via Zoom will be available to discuss the application, including any questions about Workplans and budgets. Communications regarding the dates, times and links of these meetings will be shared shortly after the application is released.

If you have questions during the application process, please reach out to your assigned HPCDP liaisons (see table below).

Counties/LPHAs	**Assigned HPCDP Liaison and Email**
Coos, Crook, Curry, Deschutes, Douglas, Jackson, Jefferson, Josephine, Klamath	Kari Swoboda Kari.l.Swoboda@dhsoha.state.or.us
Benton, Lane, Lincoln, Linn, Marion, Polk, Yamhill	Annie Dillon Annie.Dillon@dhsoha.state.or.us
Baker, Gilliam, Grant, Harney, Lake, Malheur, Morrow, Umatilla, Union, Wallowa, Wheeler	Jacob Melson Jacob.Melson@dhsoha.state.or.us
Clackamas, Clatsop, Columbia, Hood River, Multnomah, North Central (Wasco, Sherman), Tillamook, Washington	Laura Perdue Laura.Perdue@dhsoha.state.or.us