Oregon Tobacco Prevention and Education Program (TPEP)

Local Public Health Authority Grants

2021-2023 Request for Applications

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I. INTRODUCTION AND ELIGIBILITY

A. Purpose

The Oregon Tobacco Prevention and Education Program (TPEP) 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 (LPHAs) to implement community tobacco prevention and education programs that are grounded in best practices for tobacco control and seek to make sustainable policy, systems and environmental changes.

Fifty years of 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 on communities from cigarettes, smokeless tobacco and other tobacco products, as well as from e-cigarettes or vape pens that contain nicotine. This approach leads to better health, better care, and lower health care costs for all Oregonians. TPEP's priorities for comprehensive tobacco use reduction in Oregon are:

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

Identifying and eliminating tobacco-related disparities is a cross-cutting goal to be addressed within each of the goals listed above. Additionally, the strategic priorities outlined by the Centers for Disease Control and Prevention (CDC) and currently being promoted by TPEP are:

- State and Community Interventions
- Mass-Reach Health Communication Interventions
- Tobacco Use and Dependence Treatment Interventions
- Surveillance and Evaluation

B. Burden of Tobacco in Oregon

Today in Oregon, fundamental components of health such as nutritious food, spaces to play and be active and smoke-free places are out of reach for too many people. Certain populations in Oregon bear a greater burden of chronic disease than others. These health disparities are fueled by inequities that exist in physical places, such as our homes, schools, neighborhoods,

and workplaces; and in the social conditions that shape our lives, like different education and income levels, and discrimination and racism.

Tobacco smoke is toxic and contributes to deaths of smokers and non-smokers alike. There is no safe level of exposure to tobacco smoke. It can cause heart disease and cancer and worsen respiratory conditions such as asthma. Certain populations including pregnant women, children, older adults, and people with chronic illness are especially vulnerable. Additionally, high youth use of other tobacco products such as, e-cigarettes remains a public health concern. There is strong evidence to suggest that these products increase youth nicotine addiction and youth initiation of conventional tobacco products. In addition, smoking and the use of other tobacco products, including e-cigarettes, in public places can normalize smoking behavior.

- Tobacco use is the number one cause of preventable death in Oregon.
- Tobacco use contributes to thousands of deaths in Oregon each year and costs billions in direct medical costs, lost productivity, and early death.
- Tobacco-related deaths are almost always due to one of three causes: cardiovascular diseases, cancers, and respiratory disease.
- The tobacco industry spends more than $100 million a year marketing to people in Oregon.

For additional tobacco data, please see 2020 Oregon Tobacco Facts at https://public.health.oregon.gov/PreventionWellness/TobaccoPrevention/Pages/oregon-tobacco-facts.aspx

While cigarette use in Oregon continues to decline overall, groups that historically have been targeted by the tobacco industry continue to use tobacco at higher rates, including people with lower incomes; certain racial and ethnic groups including Native Americans/Alaskan Natives, Black and Pacific Islander communities; members of lesbian, gay, bisexual, transgender, queer/questioning, two-spirit (LGBTQ2S) communities; people with disabilities; people living with mental illness; Oregon Health Plan members; people with less than a high school degree; and people living with addiction to alcohol and other drugs. Because these communities use tobacco at higher rates, they experience the harshest health consequences, including higher rates of heart disease and other tobacco-related problems.

The severe impacts of COVID-19 on tobacco users is another stark reminder of the importance of comprehensive tobacco prevention policies and programs. Reducing the burden of tobacco helps prevent chronic disease and reduce health disparities that are exacerbated by infectious

disease outbreaks like COVID-19. Now more than ever, we see the critical role our work plays in creating more resilient communities.

Chronic diseases like asthma, diabetes, arthritis, cardiovascular disease and cancer are caused or worsened by tobacco use and exposure to secondhand smoke. These diseases are a tremendous cost to Oregonians in both lives and dollars. TPEP is part of a comprehensive public health approach to chronic disease prevention and health promotion.

All Oregonians deserve convenient access to activities and spaces that help them live better, regardless of their income, education, or ethnicity. Healthy environments where people live, learn, work and play should be the norm in every community.

C. Commitment to Equity

Health equity needs to be the foundation of every aspect of tobacco prevention – from how we gather and interpret data, to community engagement, to communication and education, to how we measure and evaluate results. Local programs, Tribes, Regional Health Equity Coalitions, health system partners, community-based organizations, and OHA can all work together to improve health equity and address disproportionate rates of commercial tobacco use in specific communities. Dedicated culturally and tribal specific prevention and nicotine addiction treatment programs will help community members quit, prevent youth from starting, and reduce tobacco-related death and disease. Together we all have the opportunity to advance the vision of eliminating racial and other health inequities by 2030.

D. Background on TPEP Tiered Funding Model

Guided by shared tobacco prevention values, a tiered funding model was developed in partnership with the Conference of Local Health Officials (CLHO) to advance tobacco prevention policy and systems change initiatives in communities with attention and focus on getting to outcomes for reducing tobacco-related health disparities.

The TPEP tiered funding model was developed with careful consideration of the 2018-2019 CLHO TPEP Funding Formula Workgroup recommendations, the Public Health Advisory Board funding principles, and the CLHO Funding Formula Checklist. The model offers the flexibility to nimbly deliver resources to LPHAs based on total tobacco prevention funding made available to OHA. The tiered funding model allows LPHAs to opt in at the level of outcomes they can achieve. The model incorporates policy and systems change approaches that have traditionally been funded through competitive grants.

The model aligns with TPEP Program Element 13. Each tier has a defined scope of work and includes example activities. Funding ranges are provided within tiers, and final awards will be determined based on proposed strategies, incorporation of a health equity lens, population, and average number of Oregon Indoor Clean Air Act (ICAA) complaints. Tier 3 award amounts will also be determined based on demonstrated success and capacity for advancement of tobacco policy, systems, and environmental change strategies. Additionally, OHA has received feedback from several LPHAs that local tobacco prevention policy change proves challenging given organizational or political hurdles. In response, the tiered proposal includes a fourth category, the ICAA Response Tier, to ensure that LPHAs that opt out of expanded funding for tobacco prevention can still fulfill local duties and activities related to enforcing the ICAA as required by Oregon law.

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

OHA acknowledges that this RFA is released amid the COVID-19 pandemic. We recognize that the timeline for re-openings, social distancing procedures, etc. is uncertain. Therefore, use your best judgment to design a proposal that fits the most likely scenario for your population and setting. Programs are encouraged to resume or maintain the groundwork that has been laid during the 2019-21 biennium. OHA understands that some previous strategies and activities may need to be repeated.

The information throughout this document is also collected for quick reference in Appendix A: Local TPEP Tiered Model. In addition, 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 tiers, and confirmation is contingent on OHA's approval of a submitted Program Plan (Attachment 3) and Budget (Attachment 2). The following is a description of each tier and its scope of work:

Tier 1: Foundational Tobacco Prevention & Capacity Building

Tier 1 provides funding to conduct local duties and activities related to enforcement of the Oregon Indoor Clean Air Act (ICAA) and to engage in basic tobacco prevention education and advocacy. Tier 1 is a bridge to full engagement in policy and systems

change processes. LPHAs that select Tier 1 include those that have not yet demonstrated support from executive leadership and/or elected officials to pass tobacco prevention policies but want to maintain a tobacco prevention program that builds local capacity.

Scope of work: Programs in this tier are expected to develop and maintain foundational partnerships with community partners, health systems, and other sectors and stakeholders. Programs understand, follow, and recommend best practices to partners, decision-makers, and internal leadership. Programs in Tier 1 are expected to build capacity towards passage of tobacco prevention policies and implementation of health systems change initiatives, and assist partners with resources and information, as requested.

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.

LPHAs in Tier 1 are also required to advance **at least one of the following health systems change initiatives** in collaboration with health systems:

Health Systems 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 include but are 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.

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 change strategies, as well as relationships in place with health system partners to implement health systems change initiatives.

Scope of work: Tier 2 provides funding to advance **at least two priority policy strategy areas,** selected by local program from a menu of options listed below. Programs must choose at least one policy strategy from Categories A and/or B below. The program must also choose **at least one health systems change initiative described in Tier 1**. LPHAs have the flexibility to select relevant policy options based on political and community readiness.

Policy and Program Strategies

Tier 2 Programs are **required to advance two policy and program strategies** (see list below). Programs must choose at least one policy strategy from Category A and/or B below.

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. price promotion prohibitions)
- 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)
- 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 smoking beyond the current 10 foot from entrances, exits, or windows
- 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.
- 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 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 your 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 your 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 ask your intern to 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 known to allow advertising and sponsorship from tobacco industry.
- Another important approach that your community feels will make a difference and support a tobacco-free world. We may not be familiar with the idea, so please be sure to explain it with the greatest possible detail!

Tier 3: Accelerating Tobacco Prevention Outcomes

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

Scope of work: Tier 3 programs implement **three policy or program strategies described above.** Programs must choose at least two policy strategies from Categories A and/or B. Tier 3 programs must also select **at least one health systems change initiative** for tobacco prevention in collaboration with health system partners. LPHAs are encouraged to propose community-tailored strategies.

Eligibility for Tier 3: LPHAs must have completed at least **six of the ten** following prerequisites to qualify for Tier 3. Documentation should be submitted with the TPEP funding application (Attachment 5). The timeframe for the following prerequisites is within the previous two biennial funding cycles unless otherwise stated below:

Tier 3 prerequisites

- ☐ Required: 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.)
- ☐ Leveraged funding commitment from CCO, federal grant or foundation partner for tobacco prevention and cessation activities
- ☐ 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)
- ☐ Comprehensive county tobacco-free policy in place
- ☐ Demonstrated current health system partnerships (e.g., memorandum of understanding in place, funding agreement, current initiative) for tobacco prevention
- ☐ Evidence of convening and/or funding partners representing communities most burdened by tobacco in pursuit of priority tobacco prevention strategies (commitment to health equity)
- ☐ Demonstrated implementation of communications strategy, including earned media, to support tobacco prevention strategy(s) in the previous biennium (2019-2021)
- ☐ Evidence of shared regional strategy and collaboration in pursuit of priority tobacco prevention strategies
- ☐ Evidence of local public health accreditation
- ☐ 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)

ICAA Response Tier

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

Scope of work: The ICAA Response Tier provides funding for maintaining an open line of communication with OHA, complete all required ICAA trainings, and conducting local duties and activities related to the enforcement of the ICAA. Programs in this tier are not expected to advance policies, systems, or environmental change initiatives or to engage in tobacco prevention education and advocacy.

II. DESCRIPTION OF PROGRAM SERVICES BY TIER

A. Oregon Indoor Clean Air Act Compliance Activities

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

Local Public Health Authorities must participate in enforcement of the Oregon Indoor Clean Air Act, as outlined in the Delegation Agreement for the Oregon Indoor Clean Air Act (see Appendix C). 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 Indoor Clean Air Act enforcement (OAR 333-015-0025 and 333-015-0090). LPHAs are responsible for responding to complaints of violation, for assisting businesses in achieving compliance and for coordinating with OHA for training and enforcement cases. 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 Indoor Clear Air Act (ICAA) Enforcement Toolkit on HPCDP Connection at https://www.oregon.gov/oha/PH/DISEASESCONDITIONS/CHRONICDISEASE/HPCDPCONNECTION/TOBACCO/Pages/ICAAToolkit.aspx.

LPHAs must carry out the Delegation Agreement in order to be in compliance with both the standard LPHA Financial Assistance Agreement and with Program Element 13 (see Appendix D). LPHAs must maintain an open line of communication with OHA, complete all required ICAA trainings, an conducting local duties and activities related to the enforcement of the ICAA.

B. Program Components by Tier

HPCDP, in collaboration with CLHO, has identified the core program components LPHAs awarded funds for local TPEP must include. These components are described below and are divided into the following categories:

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. Health systems change initiative	Tiers 1-3
6. Policy	Tiers 2-3

1. MONITORING AND EVALUATION

Monitoring and evaluating tobacco prevention policies and interventions are essential to a comprehensive tobacco prevention program. Data and information gathered can be used to identify priorities, inform, and engage decision-makers, identify local community champions, guide and improve efforts, and demonstrate effectiveness. Sharing this information gives stakeholders a clearer picture of the tobacco epidemic and what can be done to implement and strengthen policies, systems and environmental changes that reduce the harms of tobacco and nicotine inhalant delivery systems.

In addition, state laws, policies and executive orders are in place that call for LPHAs to have active roles and responsibilities for successful policy implementation, including but not limited to the ICAA.

Participation in the following 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 C).
- Maintain diligent communication with OHA on citations and other enforcement activities, particularly as cases of violation escalate.
- Follow public health modernization requirements that support ICAA enforcement,

including maintaining a public-facing website with updates to content, such as contact information, made no less than annually; being a reputable source of health information; and adapting or customizing communications products provided by PHD related to the ICAA. For more information on public health modernization, see the public health modernization manual here: https://www.oregon.gov/oha/PH/ABOUT/TASKFORCE/Documents/public_health_modernization_manual.pdf.

- 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

- Participate in Local Program Plan review of progress and lessons learned with state TPEP. This includes check-ins with State program liaison, site visits, and reporting requirements, including two reports and interviews per year.
- Share experiences and successes locally and with regional and statewide TPEP partners. Submit at least (1) one success story per year. (See Appendix E for guidance.)
- As applicable, share local policies with state TPEP to be included in the HPCDP policy tracking system.
- Use tools and recommendations from the Policy Change Process Model and the Systems Change Process Model.
- Participate in statewide coordinated evaluation activities related to the TPEP Tiered Model, the tobacco retail environment and any other statewide tobacco prevention evaluations planned for the biennium.
- 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.
- As applicable, support monitoring, evaluation and implementation of OHA Tobacco Free Facilities and Services Policy by responding to requests from HPCDP or local residential addictions and mental health treatment facilities.
- As requested, conduct or facilitate tobacco retail assessments in coordination with

HPCDP, including advising on content, participating in trainings, coordinating assessors and submitting assessments for analysis.

- Participate in TPEP triennial reviews, as required per the global OHA-PHD intergovernmental agreement (IGA).

2. TRAINING AND TECHNICAL ASSISTANCE

The following describes required training and technical assistance by tier and is followed by additional opportunities (required and optional). HPCDP understands that during the beginning of the biennium, training and technical assistance hours may be reduced. This will allow more time and space for grantees to respond to the COVID-19 pandemic, if necessary. Additionally, training and technical assistance learning opportunities will be offered remotely until it is safe to resume meeting in person. Trainings will be focused on current and emerging priority areas and will support networking and collaboration with peers, including sharing lessons learned and successful strategies.

ICAA Response Tier and Tiers 1-3

The 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), are **required** to attend the following trainings and technical assistance opportunities:

Type	Description	Timing
In-person or webinar trainings	Webinars or online meetings focusing on support for local duties and activities related to ICAA enforcement.	At least annually and as new information is available

Tiers 1-3 (optional for ICAA Response Tier)

Trainings and technical assistance opportunities are focused on current and emerging priorities and are intended to develop and enhance skills necessary to effectively advance policy and health systems change. Trainings support networking and collaboration with peers and provide opportunities to share lessons learned. HPCDP requires participation in capacity-building and collaboration opportunities in the form of trainings and online meetings, webinars, and conference calls. The trainings and requirements by tier are outlined in the charts below.

The local TPEP main point of contact and any staff funded 0.5 FTE or more by TPEP are **required** to complete the following training and technical assistance opportunities. Please note that HPCDP reserves the right to require other TPEP-funded staff to attend trainings or meetings, determined on a case-by-case basis.

Type	Description	Timing
Self-guided e-learning module	Appropriate Use of Public Funds	January 2022 January 2023
Regional Support Network (RSN) meetings	Regional meetings convening all HPCDP grantees within a specific geographic area (defined as one of six regions under HPCDP's technical assistance support model) to leverage funding within the region in support of policy, systems, and environmental change goals. RSN meetings are opportunities for information sharing and training that aligns with regional needs. The RSN meetings provide a forum for building mutual support and collaboration on strategies to advance progress within the region and build statewide movement on policy strategies. Each RSN is supported by a team of HPCDP staff who answer questions, clarify requirements for grants, support RSN meeting planning and connect RSN members to other HPCDP resources as needed. RSNs typically meet via web-based meeting for 1.5 hours every other month. Once safe to do so, RSN members may decide to meet in-person for a quarterly 3-hour meeting instead or determine a different pattern and frequency. RSN members are responsible for the costs of any in-person gathering, including travel, meeting rooms and other costs.	Recurrence and frequency to be determined by RSN members. Please note: These meetings may shift focus to better support communities. Please stay tuned for future conversations in the new biennium.
New Coordinator orientation	Remote orientation to TPEP, HPCDP, best practices and strategies 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.	Within 4 weeks of starting position

Tiers 2-3 (optional for other tiers)

Type	Description	Timing
Tobacco Prevention Policy Calls	Updates on national, state, and local tobacco policy initiatives. 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, program plans, lessons learned and successes.	Every 4th Tuesday, 11am-12pm PST Additional 2nd Tuesday calls are available during legislative session (January – June, 11 – 11:30am PST)
Technical assistance and strategic communications	Consulting and strategic planning support are provided by HPCDP staff and contractors, who are available to consult on local TPEP development and implementation of policy and systems change strategies or support strategic communications planning. Topics to be agreed on by local TPEP staff and HPCDP.	This consulting will occur at a frequency agreed on by HPCDP and local TPEP staff
In-person or webinar trainings	Webinars or online meetings focusing on specific content areas, strategies in local Program Plans, new statewide campaigns, dissemination of surveillance data, and timely information about new state or federal regulations that impact local programs.	TBD – Based on strategic needs or identified opportunities for capacity-building and alignment

Optional for all tiers

Type	Description	Timing
Mentoring *(Optional)*	Grantees are encouraged to participate in mentoring activities. Tier 3 grantees may be required to participate as part of statewide leadership activities; these will be determined on a case-by-case basis and will align with approved program plans and planned activities. Examples of possible mentoring activities include delivering a training or working one-on-one	Throughout the biennium

Type	Description	Timing
	with local TPEP in other counties within a defined timeframe. Mentoring activities can be suggested by Tier 2 and 3 applicants in the submitted program plan.	
Community Policy Leadership Institutes (CPLIs) *(Optional)*	Grantees identified as having significant readiness and leadership commitment to policy and systems change initiatives have the option to apply to participate in institutes over the course of the biennium to support their progress. The goal of the CPLIs is to support local policy alignment with attention to principles of equity and inclusion. LPHAs sharing regions with Regional Health Equity Coalitions are encouraged to participate together.	Fall 2021 Spring 2022
Communities of Practice *(Optional)*	Online peer learning communities related to a specific policy area or systems change strategy. Grantees with a common strategic priority meet regularly in an online forum to learn, share ideas, build innovation, and develop solutions.	TBD - Based on strategic needs or identified opportunities for capacity-building and alignment

Budgeting for Training

Grantees may choose to reserve some funding in the budget for anticipated travel costs for attending in-person trainings. Please note that training and technical assistance learning 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 2021-23. However, If you expect to apply to participate in the upcoming Community Policy Leadership Institutes (potentially in-person at a TBD location in the state) or non-HPCDP training opportunities, be sure to budget to cover estimated costs for participation in those training events.

3. COMMUNITY ENGAGEMENT AND ALIGNMENT

Community Engagement

Building collaborative partnerships is important for increasing capacity, amplifying the community's 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. It is a shared-leadership approach where communities are involved and actively engaged in decision-making processes from the beginning, and their values, strengths, resources, and input shape development of work that will affect their health.

We encourage TPEP grantees to authentically engage and work with community organizations and members. This work involves actively supporting community members and partners to take the next steps to support policy and prevention efforts. Some partnerships may include forming advisory groups comprised of community members to inform activity and strategic planning while others may mobilize active community-or youth-led coalitions.

Community engagement also includes specifically engaging communities disproportionately affected by tobacco disparities to actively participate in 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 within the community 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 strokes. Grantee's community engagement work can directly support community partners through contracting, resources, and language access to center the ideas, expertise, and vision of communities.

Although there is variability in the ways to operationalize community engagement, the following principles from the Annie E. Casey Foundation should consistently guide your work:

- Value and prioritize lived experience and community voice
- Commit to full transparency and accountability
- Acknowledge that there are institutional, systemic, and structural barriers that perpetuate inequity which has silenced the voice of the community over time
- Commit to partnership in the co-creation and co-ownership of solutions

Community Alignment

Many organizations, including community-based organizations, Tribes, cities, other county programs, schools, health systems, and Coordinated Care Organizations, are actively working towards improving health and quality of life for people across Oregon. Community alignment

allows for organizations with multiple perspectives to work together towards solving common problems and increases the likelihood that collective efforts will bring about change.

TPEP grantees are encouraged to work with diverse stakeholders 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 in partnership with their community.

Community alignment can vary across different communities and grantees. A natural alignment point may be with the county Alcohol and Drug Prevention Education Program (ADPEP), as leveraged coalition partners and county preventionists can tackle community priorities more efficiently. Community alignment work may also include bridging Community Health Improvement Plan (CHIP) priorities with tobacco prevention and cessation efforts to work with CCOs on shared tobacco cessation strategies. For example, you may work to connect a CHIP strategy related to inclusion and access for people with disabilities with a specific activity to engage an organizational partner working with people with disabilities on a clean indoor air policy or culturally specific cessation project. Another example is to align and support work with your Maternal Child Health partners who may be interested in developing a closed loop referral process to ensure ample quit resources for pregnant or parenting women accessing services. There is a myriad of possibilities for community alignment within tobacco control and prevention.

4. COMMUNICATIONS STRATEGIES

The purpose of communications for tobacco prevention and cessation is to:

- Equip individuals and organizations with what they need to influence policies, systems, and environmental change in their communities;
- Increase awareness and skills of individuals and communities through culturally relevant education; and
- Engage community members in the conversation and solutions for developing healthier communities, environments, and policies.

Tobacco companies spend billions annually on tobacco advertising to keep tobacco products front and center where people will see them every day. Tobacco advertising and promotions make tobacco more affordable, attractive, and appealing – especially to young people. Health communications in tobacco control can help counter these efforts by accelerating environmental, systems and policy changes that reduce tobacco use. In addition, health

communications are an area to collaborate with health systems, community-based organizations, and other partners with shared values to support tobacco cessation and prevention policies and programs. As part of a comprehensive tobacco control program, health communications can:

- Reduce tobacco-related disparities;
- Reduce tobacco use and secondhand smoke exposure;
- Counter the industry's extensive advertising and promotion efforts;
- Support tobacco control policy and program efforts; and
- Shift social norms around tobacco use.

The CDC Best Practices User Guide: Health Communications in Tobacco Prevention and Control identifies the key components of a successful communications strategy. These are:

- **Program Communications**
- **Owned and Social Media**
- **Earned Media**
- **Paid Media**

Programs may reference the CDC Best Practices User Guide for additional information about these communications components. Local TPEP in Tiers 1 through 3 will develop a communications plan that leverages each of these channels to further their program plan goals. The number of channels and scope of activities within each channel will be dependent on funding tier.

Applicants should **complete the communications plan template** (Attachment 4) that describes strategic communications objectives, audiences, and tactics. A communications plan draft should be submitted with the application packet and align with activities in the program plan (Attachment 3). The submitted communications plan will be a living document that grantees adapt to emerging opportunities and program plan changes. HPCDP staff and OHA contractor, the Metropolitan Group are available for consulting and technical assistance as applicants complete the communications plan. ***For support with your TPEP Communications Plan, please contact Olivia Stone at ostone@metgroup.com***.

The communications plan should **include the following four key components**:

Program Communications

Program communications means the coordinated system a program uses to achieve communications goals. This includes defining roles and responsibilities for TPEP-funded staff and identifying key people in other departments who will provide expertise,

guidance, and support. Program communications also includes community engagement and stakeholder communications, for example, informational meetings and presentations that advance program plan activities.

Tiers 1-3

- Develop and document an approval process for external communications with your program leadership. This process is meant to encourage team conversations about staff roles and how the program would like to share timely, accurate, culturally responsive, and proactive tobacco prevention and cessation information, news, and program updates.
- Use outreach materials from statewide communications initiatives, such as Smokefree Oregon, throughout the grant period. For example, the program may use Smokefree Oregon materials such as fact sheets, social media posts, and campaign ads in their outreach.

Tiers 2-3

- Identify internal and external spokespeople for tobacco prevention and cessation initiatives in the communications plan.
- Present to a leadership body or members of that body at least once yearly about the program's policy goals. This may be demonstrated during reporting through a public meeting agenda or similar document.

Tier 3

- Share communications best practices and lessons learned with Tier 1 and/or Tier 2 grantees, in coordination with OHA.
- Present to a leadership body or members of that body at least twice yearly about the program's policy goals. This may be demonstrated during reporting through public meeting agendas or similar document.

Owned and Social Media

Owned media refers to communications platforms that a program controls directly. These may be digital platforms, such as websites, blogs, and listservs, or social media platforms such as Facebook and Twitter. Digital communications are an important way to share health information and data, share best practice strategies, and outline program goals. Social media posts can also be helpful as a short, visual way to convey messages.

Tier 1

- Develop a process to share tobacco-related information on the organization's website and social media channels, if available. This may be included in the approval process for external communications described under Program Communications above.
- Include messages from the Smokefree Oregon social media calendar in the program's communications plan as they align with the program's communications objectives. HPCDP may request post metrics as part of communications campaign monitoring and evaluation.

Tier 2

- Develop a process to share tobacco-related information on the organization's website and social media channels, if available. This may be included in the approval process for external communications described under Program Communications above.
- Include messages from the Smokefree Oregon social media calendar in the program's communications plan as they align with the program's communications objectives. HPCDP may request post metrics as part of communications campaign monitoring and evaluation.
- Maintain channels for regular program updates to external partners, for example, a listserv or blog, and include these channels in the program's communications plan.
- Post tobacco-related content on the organization's social media site at least **quarterly,** including at least one post from a Smokefree Oregon social media calendar. HPCDP may request post metrics as part of communications campaign monitoring and evaluation.

Tier 3

- Develop a process to share tobacco-related information on the organization's website and social media channels, if available. This may be included in the approval process for external communications described under Program Communications above.
- Include messages from the Smokefree Oregon social media calendar in the program's communications plan as they align with the program's communications objectives. HPCDP may request post metrics as part of communications campaign monitoring and evaluation.

- Maintain channels for regular program updates to external partners, for example, a listserv or blog, and include these channels in the program's communications plan.

- Post tobacco-related content on the organization's social media site at least **monthly,** including at least one post from a Smokefree Oregon social media calendar. HPCDP may request post metrics as part of communications campaign monitoring and evaluation.

- Develop and maintain a process such that individuals interested in learning more about the program are provided with opportunities to engage in local tobacco prevention or cessation work (i.e. cultivating champions)

Earned Media

Earned media refers to stories about a program's work that are published in outlets that the program does not control directly. It can reach new community members and increase the credibility of a program's message. Outreach to media outlets, or earned media "pitches," offers reporters what they need: compelling, important information to share with their audience. There are many ways to generate earned media, including building relationships with journalists, letters to the editor, press releases, pitching stories to reporters, and hosting an earned media event. HPCDP will provide earned media templates, such as customizable news releases, sample Letters to the Editor, or sample Op-Ed to all grantees. HPCDP or media contractor staff are also available to help grantees develop their own earned media pitches.

Tier 1

- Work to secure at least one earned media piece yearly. This may include using at least one earned media template, such as a draft press release, provided by Smokefree Oregon to leverage a statewide cessation campaign.

Tier 2

- Work to secure at least one earned media piece in the first grant year and two earned media pieces in the second grant year. This may be demonstrated through links or other documentation during reporting.
- Use at least one earned media template provided by Smokefree Oregon in the first grant year and two earned media templates in the second year to leverage

statewide cessation and prevention campaigns. These activities may count toward working to secure earned media.

Tier 3

- Work to secure at least one earned media piece in the first grant year and two earned media pieces in the second grant year. This may be demonstrated through links or other documentation during reporting.
- Use at least one earned media template provided by Smokefree Oregon in the first grant year and two earned media templates in the second year to leverage statewide cessation and prevention campaigns. These activities may count toward working to secure earned media.
- Host one earned media event yearly. An "earned media event" is defined as any event that generates media to further the program's health systems or policy objectives. This may include a special event hosted by the program's organization, an event hosted by a community partner, or another event with opportunities for media advocacy. This may be demonstrated through evidence of earned media or other documentation during reporting.

Paid Media

Paid media refers to spending money to market a message on TV, radio, billboards, or other locations in the program's service area. Paid media allows for control over key messages and the timing of those messages. In addition, it can be segmented by audience, giving programs the ability to reach narrower audience segments. HPCDP uses paid media for statewide Smokefree Oregon campaigns and all grantees have access to resources for those campaigns.

Grantees are encouraged to leverage HPCDP's paid campaigns to garner local earned media, for example, by issuing a press release that aligns with a statewide paid cessation campaign. Since state media campaigns are developed to be leveraged in communities, local TPEP grant funding is not intended for purchase of media without prior approval from HPCDP (For more information about restrictions on the use of TPEP funds, see page 35.)

Tiers 1- 3

- Leverage statewide paid media campaigns to promote the Oregon Tobacco Quit Line, for example, by using cessation media tools such as social media posts, newsletters, email blasts, ads, and fact sheets available on Smokefree Oregon.

Tiers 2- 3

- Leverage statewide paid media campaigns to promote the Smokefree Oregon prevention campaign, for example, by using prevention media tools such as social media posts, newsletters, email blasts, ads, and fact sheets available on Smokefree Oregon.

Tier 3

- Work toward getting local Coordinated Care Organization(s) to invest in evidence-based tobacco prevention and cessation paid media (advertising) campaigns, in collaboration with statewide media campaigns.

- If relevant, evaluate local paid media campaigns in collaboration with HPCDP to measure total investment, number of impressions, partner engagement, and campaign effectiveness.

5. HEALTH SYSTEMS CHANGE INITIATIVES

Applicants in Tiers 1-3 are **required to work on at least one health systems change initiative**. These initiatives fall into one of two strategic categories: improving tobacco cessation in clinical settings and engaging healthcare partners in community-based interventions. Background on each strategy is provided below, followed by a description of the requirements and options for each tier and a list of resources. 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 Susan Kerosky at Susan@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 and health-related services, such as organizations employing Community Health Workers (CHWs) and organizations that provide services to people experiencing homelessness, the elderly, or people with disabilities.

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 tobacco users 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. 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 addition, LPHAs can support CCOs and other healthcare partners identify and remove systemic barriers to accessing cessation services.

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 multisector intervention statement on tobacco which outlines evidence-based interventions at the community level. The goal of the statement is to provide CCOs the information they need to reduce cigarette smoking prevalence in their memberships and broader communities and to encourage CCOs to play a role in implementing evidence-based, community-level strategies alongside their local public health counterparts. LPHAs can use the HERC guidance to educate and engage CCOs and other healthcare partners in community interventions.

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.

Menu of Health Systems Change Initiatives

TPEP's role 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 above in this section and the Health Systems Resources Appendix F 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. While TPEP funds cannot be used to deliver direct cessation services, including providing counseling and medication, local TPEP can help identify the culturally appropriate resources for investment by healthcare partners. 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.)

Tiers 1-3

All programs in Tiers 1-3 are required to work on at least one health systems change initiative:

- 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 CCO(s) to implement at least one HERC-recommended multisector approach for tobacco prevention, which include but are not limited to:
    - CCO leadership 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 eliminate tobacco-related disparities.
- 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.

Additional Required Activities

In addition to the health systems change initiative above, programs in Tiers 1-3 are also

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.

6. POLICY & PROGRAM STRATEGIES

Background

Establishing smoke and tobacco-free places creates a healthy environment and promotes social norms that support wellness. Local jurisdictions can enact comprehensive local ordinances prohibiting smoking and vaping of tobacco and cannabis products in all indoor and outdoor workplaces and public places to limit exposure to the community or employees, for example in certified smoke shops, cigar bars or in potential cannabis-use establishments and at temporary events.

Tobacco retail license policies could reduce the number of Oregon youth and young adults who become addicted to tobacco, help people who use tobacco quit and reduce health care costs. Oregon is one of only nine states without tobacco retail licensure. Effective, basic tobacco retail licensure means having meaningful fees and penalties that fully cover all program costs (e.g. administrative and enforcement costs), and escalating penalties that include the ability to suspend or revoke licenses for violations. It also includes enforcement of the policy. Tobacco retail licensure makes it easier to enforce laws prohibiting sales to people under age 21. It also creates opportunities to limit density of tobacco retailers, including locations near youth-oriented locations, and provides an opportunity to pursue other prevention policies.

Oregon jurisdictions have authority to pass local policies. Expansion of smoke-free policies and interventions in the tobacco retail environment are foundational to supporting local and statewide public health protections.

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.

LPHAs in **Tier 2** are **required to advance at least two** policy and program strategies from the following list. Programs must choose at least one policy strategy from categories A or B below.

LPHAs in **Tier 3** are **required to advance at least three** policy strategies from the following list, two of which must come from categories A and/or B. Tier 3 applicants must also meet the prerequisites described on page 13 of this document and in Attachment 5.

Menu of Policy & Program Strategies

Tiers 2 and 3

Strategy Area A: Reduce the Availability of Tobacco Products

- Effective, basic* tobacco retail licensure
- Prohibit the sale of flavored tobacco products and inhalant delivery systems (IDS), (including menthol)
- Increase the cost of tobacco through non-tax approaches (e.g. price promotion prohibitions)
- 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)
- Increase promotion of healthy products, while decreasing the advertising and prominence of alcohol and tobacco products.
- Other proposed strategies

Strategy Area B: Reduce Exposure to Secondhand Smoke:

- 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

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

- 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 smoking beyond the current 10 foot from entrances, exits, or windows
- 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 inhalant delivery systems.
- Other proposed strategies

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 district to ensure possession of tobacco products and/or use of these products does not result in missing educational opportunity, and instead provides the necessary support to young people to quit..
- Build a cohort program of youth advocates to be involved in peer education, to participate in youth tobacco sale surveys and to support TARA 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 your program 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 tobacco retail mapping project.
- 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.
- 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. 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 ask intern to develop a tobacco 101 educational series. Create a presentation and sharing plan to utilize this material for new coalition members or LPHA staff onboarding and to share with allied partner coalitions.

- Develop non-tobacco sponsorship policies for major events such as rodeos and concert venues known to allow advertising and sponsorship from tobacco industry.
- Another important approach that your community feels will make a difference and support a tobacco-free world. We may not be familiar with the idea, so please be sure to explain it with greatest possible detail!

D. Staffing and Budget

Staffing is a budget priority for program resources. To ensure adequate staffing and accountability for completion of the local program plan, the majority of 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 local program plan. HPCDP understands the need for flexibility during the COVID 19 pandemic, and we recognize that TPEP staff may be providing LPHA COVID 19 support during the first part of the biennium. Although, TPEP funding is not allowed to directly support the local COVID 19 response, the budget may reflect an approach to ramp up TPEP staffing throughout the first year, if necessary.

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

Tier	**Biennial funding range**	**Minimum staffing**
Tier 1	Varies by program	At least .5 FTE required*
Tier 2	$100,000 - $250,000	At least .75 FTE recommended*
Tier 3	$250,000 - $850,000	At least 1.5 FTE recommended*
ICAA Response Tier	$15,000 (fewer than 10 complaints per year based on 3-year average) $35,000 (more than 10 average complaints per year based on 3-year average)	No requirement

*FTE to support leadership and program administration is allowed. Staffing proposals should be commensurate with proposed program plan. All staff funded through TPEP PE 13 must be identified with associated activities in the approved program plan, including leadership and administration.

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 local program plan. For LPHAs with multiple program staff, the TPEP Coordinator also ensures that other program staff members conduct the activities in the local program plan.

E. Line Item Budget and Narrative

LPHAs determine the amount requested in the budget based on activities in the program 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 24month budget for the fiscal period July 1, 2021 – June 30, 2023, using the required Line Item Budget and Narrative Worksheets (Attachment 2). 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 hold events and trainings at tobacco-free locales and follow the HPCDP Nutrition Protocol and the DHS/OHA Healthy Meetings, Conferences, and Events policy and guidelines. These documents are available on the Healthy Meetings and Events page on HPCDP Connection at https://www.oregon.gov/oha/PH/DISEASESCONDITIONS/CHRONICDISEASE/HPCDPCONNECTION/NUTRITION/Pages/HealthyMeetings.aspx.

Restrictions

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

- To purchase nicotine replacement therapy or other cessation medication;
- To support staff time providing tobacco cessation client services, such as classes, coaching or counseling;
- To provide 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;
- For purchasing media or media campaign materials without prior approval from HPCDP;

- To cover staffing to support local COVID 19 response.

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 Program 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 Local Program Plan. Funds may not be used for clinical cessation services, treatment, or medications.
    - If a grantee includes training supplies in the budget, ensure it describes how the trainings support Program Plan strategies. Hosting of community meetings can include costs for refreshments. If food or drinks are served, grantees must follow the HPCDP Nutrition Protocol and the DHS/OHA Healthy Meetings, Conferences and Events Policy. These documents are available on the Healthy Meetings and Events page on HPCDP Connection at https://www.oregon.gov/oha/PH/DISEASESCONDITIONS/CHRONICDISEASE/HPCDPCONNECTION/NUTRITION/Pages/HealthyMeetings.aspx
- **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 Local Program Plan. Provide a narrative statement that includes the name of the event or conference, and how the proposed travel relates to the Local Program Plan. 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. 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 Local Program Plan, 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 X).

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 local program plan. Reports will be completed during the following periods:

- January 2022
- July 2022
- January 2023
- July 2023

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 local program plan 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 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 of the budget and cover letter must be received via email no later than 11:59 p.m., April 12, 2021. An electronic copy of the program plan and communications plan must be received via email no later than 11:49 p.m., April 26, 2021. The application must be submitted in the original Microsoft Word and Microsoft Excel formats. Label each file with the LPHA name, the grant year, and the name of the form as in these examples:

- LPHAName.2021-23.CoverLetter.docx
- LPHAName.2021-23.Budget.xlsx

- LPHAName.2021-23.ProgramPlan.docx
- LPHAName.2021-23.CommunicationsPlan.docx

Email applications to your assigned HPCDP liaisons or to Leah Festa at Leah.Festa2@dhsoha.state.or.us.

. 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:

- Application Cover Sheet (Attachment 1)
- Line Item Budget and Narrative Worksheet (Attachment 2)
- Local Program Plan Form (Attachment 3)
- Communications Planning Template (Attachment 4)
- Tier 3 Prerequisites – *Tier 3 Only* (Attachment 5)

C. Application Cover Sheet

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

Applicants must disclose any and 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 Local Program Plan, 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 Local Program Plan, 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, 2021
Question submission deadline	4:00 p.m., March 26, 2021
Questions and answers posted to website	April 5, 2021
Amendments to the RFA (if any) posted to website	April 9, 2021
Budgets[†] and Cover Letters due	11:59 p.m., April 12, 2021
Program Plan and Communications Plan due	11:59 p.m., April 26, 2021
Initial notification of approval of TPEP budgets and/or request for revisions	April 13th - April 16th, 2021 (Please note that HPCDP may notify LPHAs of approval earlier than these dates, if budgets are submitted earlier than the deadline.)
Initial Notification of TPEP Program Plan (and any remaining Budget) approval and/or request for revisions	May 20th, 2021
All TPEP Program Plans and Budgets finalized	June 15, 2021
Start/end date for Grant Period	July 1, 2021 – June 30, 2023

B. Award Notice

Applicants will be notified in May/June 2021 about the status of their application as:

- Accepted as submitted

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

- Accepted with required changes
- Requiring re-submission

OHA may negotiate a modification of the Local Program 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 approved on or before April 16th will be included in the July 2021 amendment cycle. If required revisions are not able to be made by this date, then final awards will be included in the next LPHA amendment cycle with the opportunity for LPHAs to submit expenditures from July 1, 2021.

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

Please note: HPCDP recognizes that policy and systems change work is dynamic and program plan activities and strategies may shift throughout the biennium. Throughout the 2021- 2023 biennium, all LPHA-requested changes to approved budgets and program plans 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 liaison to discuss more significant changes to the approved program plan 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.

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 into new grants within the scope of this RFA without an additional solicitation process. Local Program Plans 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 Leah Festa at Leah.Festa2@dhsoha.state.or.us.

Questions submitted in writing by 4:00 p.m., March 26, 2021, will be posted in Q&A format to the TPEP RFA section of HPCDP Connection, https://www.oregon.gov/oha/PH/DISEASESCONDITIONS/CHRONICDISEASE/HPCDPCONNECTION/Pages/RFAs.aspx on April 5, 2021.