Oregon Health Authority

AGENDA

PUBLIC HEALTH ADVISORY BOARD
Incentives and Funding Subcommittee

September 22, 2017
1:00-2:00 pm
Portland State Office Building, 800 NE Oregon St., Conference Room 710, Portland, OR 97232

Webinar: https://global.gotomeeting.com/join/929512805
Conference line: (877) 873-8017
Access code: 767068

Subcommittee Members: Jeff Luck, Alejandro Queral, and Akiko Saito

Meeting Objectives

- Develop tobacco prevention funding recommendation for consideration by the full Public Health Advisory Board.

1:00-1:05 pm	**Welcome and introductions**	Cara Biddlecom, Oregon Health Authority
1:05-1:50 pm	**Tobacco Prevention and Education Program funding for 2017-19** • Review background and purpose for this agenda item • Discuss Tobacco Prevention and Education Program funding concepts • Develop funding recommendation for the full Public Health Advisory Board	Kirsten Aird, Karen Girard, and Luci Longoria, Oregon Health Authority
1:50-2:00 pm	**Public comment**	
2:00 pm	**Adjourn**	Cara Biddlecom, Oregon Health Authority

Executive Summary

Tobacco use is the single most preventable cause of disease, disability, and death in the United States. Nearly one-half million Americans still die prematurely from tobacco use each year, and more than 16 million Americans suffer from a disease caused by smoking. Despite these risks, approximately 42.1 million U.S. adults currently smoke cigarettes. And the harmful effects of smoking do not end with the smoker. Secondhand smoke exposure causes serious disease and death, and even brief exposure can be harmful to health. Each year, primarily because of exposure to secondhand smoke, an estimated 7,330 nonsmoking Americans die of lung cancer and more than 33,900 die of heart disease. Coupled with this enormous health toll is the significant economic burden. Economic costs attributable to smoking and exposure to secondhand smoke now approach $300 billion annually.

Fifty years have passed since the 1964 Surgeon General's report on smoking and health concluded: "Cigarette smoking is a health hazard of sufficient importance in the United States to warrant appropriate remedial action." There now is a robust evidence base for effective tobacco control interventions. Yet, despite this progress, the United States is not currently on track to achieve the *Healthy People 2020* objective to reduce cigarette smoking among adults to 12% or less by the year 2020. A 2007 Institute of Medicine (IOM) report presented a blueprint for action to "reduce smoking so substantially that it is no longer a public health problem for our nation." The two-pronged strategy for achieving this goal includes: 1) strengthening and fully implementing currently proven tobacco control measures; and 2) changing the regulatory landscape to permit policy innovations. Foremost among the IOM recommendations is that each state should fund a comprehensive tobacco control program at the level that the Centers for Disease Control and Prevention (CDC) recommends.

Evidence-based, statewide tobacco control programs that are comprehensive, sustained, and accountable have been shown to reduce smoking rates, as well as tobacco-related diseases and deaths. A comprehensive statewide tobacco control program is a coordinated effort to establish smokefree policies and social norms, to promote and assist tobacco users to quit, and to prevent initiation of tobacco use. This comprehensive approach combines educational, clinical, regulatory, economic, and social strategies. Research has documented the effectiveness of laws and policies in a comprehensive tobacco control effort to protect the public from secondhand smoke exposure, promote cessation, and prevent initiation, including: increasing the unit price of tobacco products; implementing comprehensive smokefree laws that prohibit smoking in all indoor areas of worksites, restaurants, and bars, and encouraging smokefree private settings such as multiunit housing; providing insurance coverage of evidence-based tobacco cessation treatments; and limiting minors' access to tobacco products. Additionally, research has shown greater effectiveness with multicomponent interventional efforts that integrate the implementation of programmatic and policy initiatives to influence social norms, systems, and networks.

CDC's *Best Practices for Comprehensive Tobacco Control Programs—2014* is an evidence-based guide to help states plan and establish comprehensive tobacco control programs. This edition updates *Best Practices for Comprehensive Tobacco Control Programs—2007*. The 2014 edition describes an integrated programmatic structure for implementing interventions proven to be effective and provides the recommended level of state investment to reach these goals and to reduce tobacco use in each state.

These individual components are most effective when they work together to produce the synergistic effects of a comprehensive statewide tobacco control program. On the basis of evidence of effectiveness documented in the scientific literature and the experiences of state and local programs, the most effective population-based approaches have been defined within the following overarching components.

I. State and Community Interventions

State and community interventions include supporting and implementing programs and policies to influence societal organizations, systems, and networks that encourage and support individuals to make behavior choices consistent with tobacco-free norms. The social norm change model presumes that lasting change occurs through shifts in the social environment — initially or ultimately — at the grassroots level across local communities. State and community interventions unite a range of integrated activities, including local and statewide policies and programs, as well as initiatives to eliminate tobacco-related disparities.

The most effective state and community interventions are those in which specific strategies for promoting tobacco use cessation, preventing tobacco use initiation, and eliminating exposure to secondhand smoke are combined with mass-reach health communication interventions and other initiatives to mobilize communities and to integrate these strategies into synergistic and multicomponent efforts.

II. Mass-Reach Health Communication Interventions

An effective state-level, mass-reach health communication intervention delivers strategic, culturally appropriate, and high-impact messages through sustained and adequately funded campaigns that are integrated into a comprehensive state tobacco control program. Typically, effective health communication interventions and countermarketing strategies employ a wide range of paid and earned media, including: television, radio, out-of-home (e.g., billboards, transit), print, and digital advertising at the state and local levels; promotion through public relations/earned media efforts, including press releases/conferences, social media, and local events; health promotion activities, such as working with health care professionals and other partners, promoting quitlines, and offering free nicotine replacement therapy; and efforts to reduce or replace tobacco industry sponsorship and promotions.

Innovations in health communication interventions include the ability to target and engage specific audiences through multiple communication channels, such as online video, mobile Web, and smartphone and tablet applications (apps). Social media platforms, such as Twitter and Facebook, have facilitated improvements in how messages are developed, fostered, and disseminated in order to better communicate with target audiences and allow for relevant, credible messages to be shared more broadly within the target audiences' social circles.

III. Cessation Interventions

Comprehensive state tobacco control program cessation activities can focus on three broad goals: (1) promoting health systems change; (2) expanding insurance coverage of proven cessation treatments; and (3) supporting state quitline capacity.

Health systems change involves institutionalizing cessation interventions in health care systems and seamlessly integrating these interventions into routine clinical care. These actions increase the likelihood that health care providers will consistently screen patients for tobacco use and intervene with patients who use tobacco, thus increasing cessation. Expanding cessation insurance coverage removes cost and administrative barriers that prevent smokers from accessing cessation counseling and medications, and increases the number of smokers who use evidence-based cessation treatments and who successfully quit. Expanding cessation insurance coverage also has the potential to reduce tobacco-related population disparities.

Quitlines potentially have broad reach, are effective with and can be tailored to diverse populations, and increase quit rates. Because state quitline services are free, remove time and transportation barriers, and are confidential, they are one of the most accessible cessation resources. Optimally, quitline counseling should be made available to all tobacco users willing to access the service.

IV. Surveillance and Evaluation

Surveillance is the process of continuously monitoring attitudes, behaviors, and health outcomes over time. Statewide surveillance is important for monitoring the achievement of overall program goals. Evaluation is used to assess the implementation and outcomes of a program, increase efficiency and impact over time, and demonstrate accountability.

Publicly financed programs need to have accountability and demonstrate effectiveness, as well as have access to timely data that can be used for program improvement and decision making. Therefore, a critical infrastructural component of any comprehensive tobacco control program is a surveillance and evaluation system that can monitor and document key short-term, intermediate, and long-term outcomes within populations. Data from surveillance and evaluation systems can be used to inform program and policy directions, demonstrate program effectiveness, monitor progress on reducing health disparities, ensure accountability to those with fiscal oversight, and engage stakeholders.

V. Infrastructure, Administration, and Management

A comprehensive tobacco control program requires considerable funding to implement. Therefore, a fully functioning infrastructure must be in place in order to achieve the capacity to implement effective interventions. Sufficient capacity is essential for program sustainability, efficacy, and efficiency, and it enables programs to plan their strategic efforts, provide strong leadership, and foster collaboration among the state and local tobacco control communities.

An adequate number of skilled staff is also necessary to provide or facilitate program oversight, technical assistance, and training.

The primary objectives of the recommended statewide comprehensive tobacco control program are to reduce tobacco use and the personal and societal burdens of tobacco-related disease and death. Research shows that the more states spend on comprehensive tobacco control programs, the greater the reductions in smoking. The longer states invest in such programs, the greater and quicker the impact.

Implementing comprehensive tobacco control programs at the levels of investment outlined in this report would have a substantial impact. As a result, millions of fewer people in the United States would smoke and hundreds of thousands of premature tobacco-related deaths would be prevented. Long-term investments would have even greater effects.

We know what works to effectively reduce tobacco use, and if we were to fully invest in and implement these proven strategies, we could significantly reduce the staggering toll that tobacco takes on our families and in our communities. We could accelerate the declines in cardiovascular mortality, reduce chronic obstructive pulmonary disease, and make lung cancer a rare disease. With sustained implementation of state tobacco control programs and policies, the *Healthy People 2020* objective of reducing adult smoking prevalence to 12% or less by 2020 could be attainable.

Tobacco Prevention and Education

Expanding our reach for a healthier Oregon

Program Report 2015–2017

Oregon Health Authority

This report provides a snapshot of current TPEP accomplishments. It also looks ahead to show how state support will further reduce Oregon's burden of tobacco-related diseases and make our communities healthier and safer.

TPEP: 20 years of success

2017 marks the 20th year of the Oregon Tobacco Prevention and Education Program (TPEP). The program was started by Oregonians for Oregonians with the passage of Measure 44, which raised the price of tobacco and dedicated a portion of the increase to tobacco prevention and education. Since TPEP started, cigarette consumption in Oregon has declined by more than 50 percent.

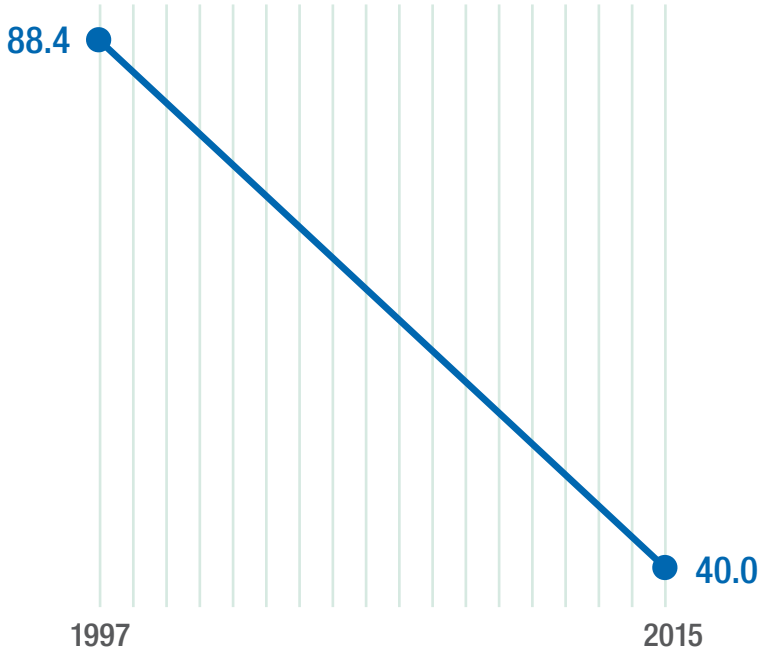
Despite this good news, tobacco use remains Oregon's number-one preventable cause of death and disease. It is responsible for more than 7,000 deaths in our state each year. Secondhand smoke causes an additional 625 deaths.* As a result, TPEP's work continues to be vital to Oregonians' health.

Goals

TPEP's four goals for making Oregon communities safer and healthier:

1. Eliminate exposure to secondhand smoke
2. Prevent youth from initiating tobacco use
3. Identify and eliminate tobacco-related disparities in all populations
4. Help smokers quit

Per capita cigarette pack sales in Oregon, 1997 and 2015



Since TPEP started, Oregon's per capita cigarette pack sales have declined by more than 50%.

* This number is an estimate from the 7,270 Oregon deaths in 2014 from tobacco (see Oregon death certificates) and updated data on number of tobacco-related deaths and deaths from secondhand smoke from chapter 12 of the latest surgeon general report (http://www.surgeongeneral.gov/library/reports/50-years-of-progress/).

How TPEP works

The Tobacco Prevention and Education Program partners with local public health authorities, tribes and regional health equity coalitions to prevent and reduce tobacco-related deaths in every Oregon community. More than 85 percent of Oregon's TPEP funding flows directly into communities working to reduce tobacco-related illness and death across the state.

TPEP supports proven strategies to reduce tobacco use, including:

- Increasing the price of tobacco
- Promoting smoke-free environments
- Improving access to affordable and effective cessation services
- Warning of tobacco's dangers
- Reducing youth exposure to tobacco marketing

The cost of tobacco use

Tobacco use is a major risk factor for developing asthma, lung, liver, colorectal and other forms of cancer, arthritis, heart disease, stroke and diabetes. Tobacco use also worsens symptoms for people already living with chronic diseases.

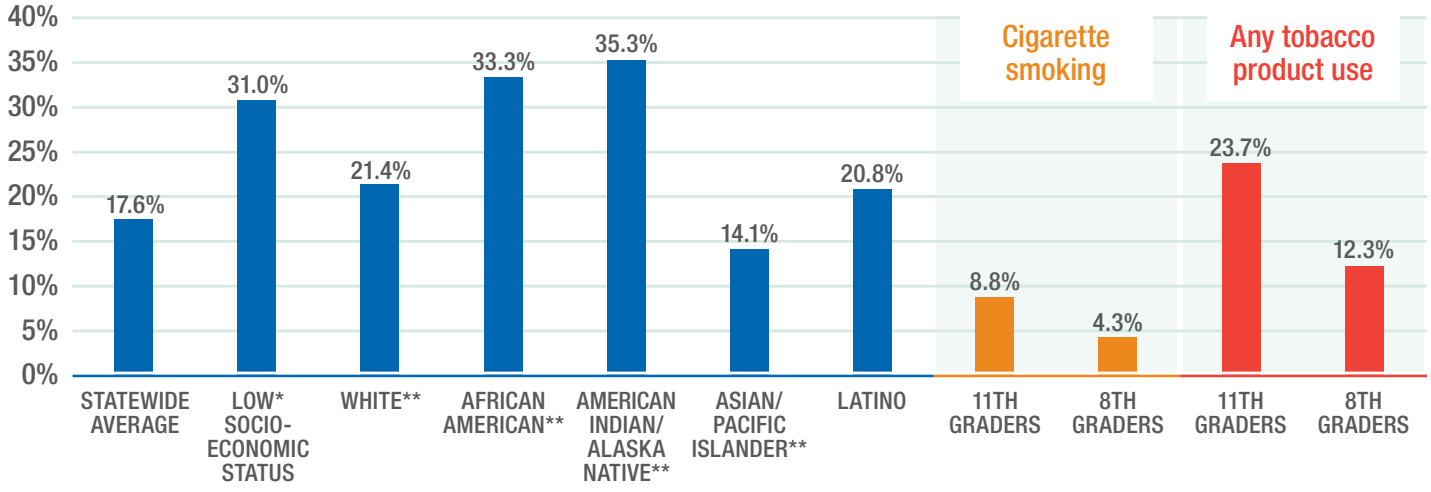
This burden falls hardest on lower-income Oregonians and certain racial and ethnic communities that use tobacco at higher rates and experience the harshest consequences.

All people in Oregon pay the price of tobacco use. Medical expenses and lost wages that result from tobacco-related disease and premature death cost Oregon $2.5 billion each year, or $1,600 for every Oregon household in our state.

Most TPEP funding comes from state taxes on tobacco products. However, in 2013, for the first time, the Legislature allocated funds from the Tobacco Master Settlement Agreement to support tobacco prevention efforts.

TPEP reduces tobacco's harm to Oregonians

Percentage of adult Oregonians who smoke, among selected groups; and teen smoking rates



Source: Oregon Behavioral Risk Factor Surveillance System (2015). BRFSS race-oversample (2010–2011), Oregon Healthy Teens (2015).

Note: Estimates are age-adjusted.

* Low socio-economic status includes having less than a high school education or being at 100% or less of the federal poverty level.

** Non-Latino

TPEP budget | 2015–2017

TPEP delivers comprehensive, evidence-based tobacco prevention and education programs to all people in Oregon.

More than two-thirds of TPEP's $19.86 million biennial budget supports public and private organizations' programs and services.

Funds support local public health authorities, tribes and community-based and not-for-profit organizations.

More than $10 million of TPEP's budget goes to communities across the state.

Community programs

TPEP provides funding to:

- All 34 of Oregon's local public health authorities;
- All nine federally recognized tribes; and
- Six coalitions of community-based organizations that represent people who are traditionally underserved and experience health disparities.

Communities use these funds to reduce tobacco use where people live, work, play and learn.

Public awareness and education

TPEP's statewide education campaigns include advertising on television, radio, digital and social media and in newspapers across Oregon.

TPEP also promotes news stories and editorials to raise Oregonians' awareness of the dangers of secondhand smoke and the benefits of quitting tobacco.

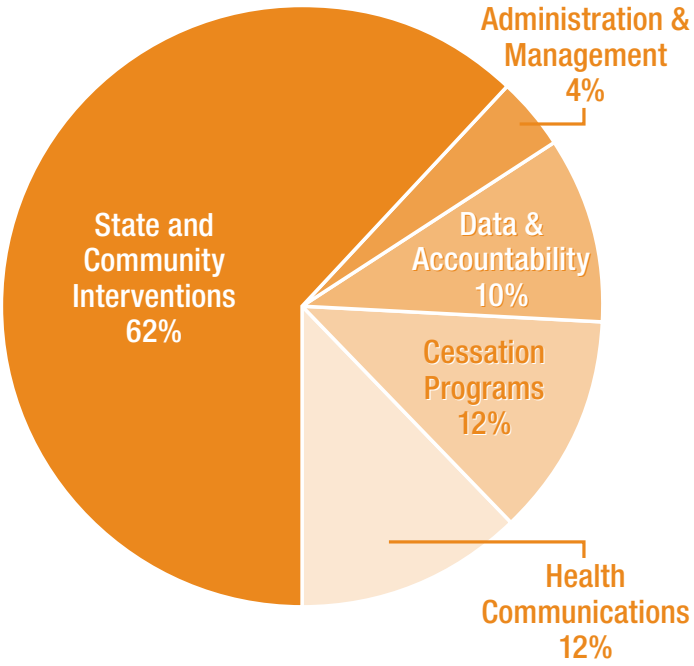
Oregon Tobacco Quit Line

The Oregon Tobacco Quit Line gives free help and coaching to all people in Oregon who want to quit using tobacco. It is also available to their friends, family and health care providers.

Data and accountability

TPEP tracks, measures and analyzes tobacco-related data on Oregon adults and youth to ensure programs are appropriate and effective.

TPEP measures effectiveness by comparing national and Oregon data and trends during the same period.



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Tobacco Prevention and Education Program (TPEP)
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You can get this document in other languages, large print, braille or a format you prefer. Contact the Public Health Division at 971-673-0372. We accept all relay calls or you can dial 711.

OHA 9809 (12/16)

Tobacco Use Reduction Account Biennium Comparison Summary

	State-Community		Health Communication		Cessation		Surveillance-Evaluation		Administration-Management		TOTAL	
BIENNIUM	2015-2017	2017-2019	2015-2017	2017-2019	2015-2017	2017-2019	2015-2017	2017-2019	2015-2017	2017-2019	2015-2017	2017-2019
TOTAL TURA BUDGET TARGET											$ 19,686,000	**$ 16,300,000**
LESS TOTAL COST ALLOCATION EXPENSES: 16.41%											$ 2,924,825	**$ 2,297,766**
TOTAL BUDGET FOR DIRECT SERVICES		$ 8,681,385		$ 1,540,246		$ 1,680,268		$ 1,260,201		$ 840,134	$ 16,761,175	**$ 14,002,234**
Targeted Percent of Total Direct Budget	62%	62%	11%	11%	12%	12%	6%	9%	9%	6%	100%	**100%**
Actual Percent of Total Direct Budget		66%		11%		11%		9%		5%		**102%**
PERSONNEL	**$ 906,986**	**$ 844,055**	**$ 486,107**	**$ 449,785**	**$ -**	**$ -**	**$ 555,015**	**$ 436,939**	**$ 437,142**	**$ 377,246**	**$ 2,385,250**	**$ 2,108,025**
TRAVEL	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
SUPPLIES	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 55,000**	**$ -**	**$ 55,000**
COMMUNITY GRANTS & CONTRACTS												
Community Grants	$ 10,000,000	$ 8,200,000	$ -	$ -	$ -	$ 80,000	$ -	$ -	$ -	$ -	$ 10,000,000	**$ 8,280,000**
Contracts	$ 1,116,400	$ 254,000	$ 1,816,500	$ 1,136,835	$ 1,850,000	$ 1,397,932	$ 1,035,000	$ 755,000	$ 34,000	$ -	$ 5,851,900	**$ 3,543,767**
Total Community Grants & Contracts	**$ 11,116,400**	**$ 8,454,000**	**$ 1,816,500**	**$ 1,136,835**	**$ 1,850,000**	**$ 1,477,932**	**$ 1,035,000**	**$ 755,000**	**$ 34,000**	**$ -**	**$ 15,851,900**	**$ 11,823,767**
OTHER												
Administration Fees (Facilities, Information Technology, Insurance, State Government Service Charges, Telecommunications)	$ -	$ -		$ -	$ -	$ -	$ -	$ -	$ -	$ 200,498	$ -	**$ 200,498**
Database Administration	$ -	$ -		$ -	$ -	$ -	$ -	$ -	$ 100,000	$ 50,000	$ 100,000	**$ 50,000**
Legal Fees	$ -	$ -		$ -	$ -	$ -	$ -	$ -	$ 30,000	$ 50,000	$ 30,000	**$ 50,000**
Total Other	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 130,000**	**$ 300,498**	**$ 130,000**	**$ 300,498**
TOTAL BUDGET	**$ 12,023,386**	**$ 9,298,055**	**$ 2,302,607**	**$ 1,586,620**	**$ 1,850,000**	**$ 1,477,932**	**$ 1,590,015**	**$ 1,191,939**	**$ 601,142**	**$ 732,744**	**$ 18,367,150**	**$ 14,287,290**

Tobacco Use Reduction Account 2017-2019 Budget Summary All Interventions							
	State-Community	**Health Communication**	**Cessation**	**Surveillance-Evaluation**	**Administration-Management**	**TOTAL**	**Notes/Descriptions:**
TOTAL TURA BUDGET TARGET						**$ 16,300,000**	
LESS TOTAL COST ALLOCATION EXPENSES: 16.41%						**$ 2,297,766**	
TOTAL BUDGET FOR DIRECT SERVICES	$ 8,681,385	$ 1,540,246	$ 1,680,268	$ 1,260,201	$ 840,134	**$ 14,002,234**	
Targeted Percent of Total Direct Budget	62%	11%	12%	9%	6%	**100%**	
Actual Percent of Total Direct Budget	66%	11%	11%	9%	5%	**102%**	
PERSONNEL	**$ 844,055**	**$ 449,785**	**$ -**	**$ 436,939**	**$ 377,246**	**$ 2,108,025**	
TRAVEL	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	
SUPPLIES	**$ -**	**$ -**	**$ -**	**$ -**	**$ 55,000**	**$ 55,000**	
COMMUNITY GRANTS & CONTRACTS							
Community Grants	$ 8,200,000	$ -	$ 80,000	$ -	$ -	**$ 8,280,000**	
Contracts	$ 254,000	$ 1,136,835	$ 1,397,932	$ 755,000	$ -	**$ 3,543,767**	
Total Community Grants & Contracts	**$ 8,454,000**	**$ 1,136,835**	**$ 1,477,932**	**$ 755,000**	**$ -**	**$ 11,823,767**	
OTHER							
Administration Fees (Facilities, Information Technology, Insurance, State Government Service Charges, Telecommunications)	$ -	$ -	$ -	$ -	$ 200,498	**$ 200,498**	
Database Administration	$ -	$ -	$ -	$ -	$ 50,000	**$ 50,000**	
Legal Fees	$ -	$ -	$ -	$ -	$ 50,000	**$ 50,000**	
Total Other	**$ -**	**$ -**	**$ -**	**$ -**	**$ 300,498**	**$ 300,498**	
TOTAL BUDGET	**$ 9,298,055**	**$ 1,586,620**	**$ 1,477,932**	**$ 1,191,939**	**$ 732,744**	**$ 14,287,290**	

State & Community Interventions

Tobacco Use Reduction Account 2017-2019	**$**	**16,300,000**
Cost Allocation 16.41%	**$**	**2,297,766**
Budget Available for Allocation	**$**	**14,002,234**

CDC Recommendation for State & Community Interventions: (Percent)		**62%**
CDC Recommendation for State & Community Interventions: (Amount)	**$**	**8,681,385**
TPEP Allocation (Percent)		**66%**
TPEP Allocation (Amount)	**$**	**9,298,055**

PERSONNEL	**$**	**844,055**

TRAVEL	**$**	**-**

SUPPLIES TOTALS	**$**	**-**

COMMUNITY GRANTS:		
1) County TPEP - Community programs to increase smoke and tobacco-free areas, limit the tobacco industry's influence in the retail environment, educate decision makers about the harms of tobacco, address the price of tobacco, and make cessation services available and accessible.	$	6,900,000
2) Tribal TPEP - Grants to tribes for infrastructure to reduce commercial tobacco use in tribal communities.	$	1,000,000
5) Regional Health Equity Coalitions- Grants to regional partners focused on policy, system and environmental solutions to address tobacco-related disparities.	$	300,000
CONTRACTS:		
1) Tribal Tobacco Prevention Support - Culturally-relevant training and technical assistance to Tribal TPEP Programs in alignment with statewide TPEP strategic goals.	$	64,000
2) Regional Health Equity Coalition Technical Assistance - Technical assistance to Regional Health Equity Coalitions to build capacity for policy advancement through a lens of health equity.	$	50,000
3) Event Logistics Contractor - Logistics and costs related to planning and hosting two Grantees and Contractors Meetings and one Place Matters Conference.	$	90,000
4) Grantee training series- Training and technical assistance to support County TPEP in defending and strengthening the Indoor Clean Air Act.	$	50,000
COMMUNITY GRANTS/CONTRACTS TOTALS	**$**	**8,454,000**

OTHER COSTS	**$ -**

State-Community Intervention Total	**$ 9,298,055**

Health Communications Interventions

Tobacco Use Reduction Account 2017-2019	**$**	**16,300,000**
Cost Allocation 16.41%	**$**	**2,297,766**
Budget Available for Allocation	**$**	**14,002,234**

CDC Recommendation for Health Communications Interventions: (Percent)		**11%**
CDC Recommendation for Health Communications Interventions: (Amount)	**$**	**1,540,246**
TPEP Allocation (Percent)		**11%**
TPEP Allocation (Amount)	**$**	**1,586,620**

PERSONNEL	**$**	**449,785**
TRAVEL	**$**	**-**
SUPPLIES TOTALS	**$**	**-**
COMMUNITY GRANTS:		
CONTRACTS:		
1) **Cessation Campaign-** Identify and test existing cessation campaigns for effectiveness among Oregon tobacco users.	$	100,000
2) **Prevention Campaign**- Conduct audience research, develop messages, test messages and implement a statewide media campaign.	$	946,835
3) **Campaign Implementation Technical Support-** Technical assistance to Coordinated Care Organizations to implement the Prevention or Cessation campaigns in their service area. Technical assistance consists of engaging a media contractor to plan the purchase and placement of the campaign in the local service area.	$	90,000
COMMUNITY GRANTS/CONTRACTS TOTALS	**$**	**1,136,835**
OTHER COSTS	**$**	**-**
Health Communications Intervention Total	**$**	**1,586,620**

Cessation Interventions

Tobacco Use Reduction Account 2017-2019	**$**	**16,300,000**
Cost Allocation 16.41%	**$**	**2,297,766**
Budget Available for Allocation	**$**	**14,002,234**

CDC Recommendation for Cessation Interventions: (Percent)		**12%**
CDC Recommendation for Cessation Interventions: (Amount)	**$**	**1,680,268**
TPEP Allocation (Percent)		**11%**
TPEP Allocation (Amount)	**$**	**1,477,932**

PERSONNEL	**$**	**-**

TRAVEL	**$**	**-**

SUPPLIES TOTALS	**$**	**-**

COMMUNITY GRANTS:		
1) Sustainable Relationships for Community Health (SRCH) - Competitive grants to communities for implementing, spreading and sustaining tobacco cessation screening and referral systems. (Total funding for SRCH is $480,000; see State & Community Intervention for balance of funds.)	$	80,000

CONTRACTS:		
1) Technical assistance to Coordinated Care Organizations (CCO) for tobacco prevalence incentive metric implementation- Technical assistance to support **i**mplementation of Health Evidence Review Commission guidance on the tobacco prevalence incentive metric including: ensuring implementation of comprehensive cessation benefits, and implementation of tobacco prevention and cessation media campaigns. **Sustainable Relationships for Community Health (SRCH) Institutes** - Technical assistance and logistics support to Coordinated Care Organizations for Sustainable Relationships for Community Health Institutes to ensure implementation, spread and sustainability for tobacco cessation screening and referral systems.	$	350,000

2) Clinic Support in Rural Communities - Funding to Oregon Primary Care Association and Oregon Rural Practice-based Research Network to support implementation of tobacco cessation policies and procedures in clinics to decrease tobacco use among rural populations.	$	162,000
3) Technical assistance to Coordinated Care Organziations (CCO) for delivery of tobacco cessation Services for American Indian/Alaska Native populations- Funding to Oregon Community Health Worker Association, Northwest Portland Area Indian Health Board and tribal partners to identify opportunities for Coordinated Care Organizations to ensure culturally appropriate services for tobacco cessation with the American Indian/Alaska Native population and ensuring use of cessation benefits.	$	75,000
4) Quit Line - Call services and nicotine replacement therapy to help uninsured and insured Oregonians quit tobacco. Approximately 1-2% of tobacco users in Oregon access Quit Line services. Services include evidence-based telephonic cessation counseling and medication for all uninsured Oregonians. Insured Oregonians receive a coaching intake call and a referral to other quit support services.	$	604,702
5) American Indian/Alaska Native Quit Coach Pilot Project: Funding for Quit Line contractor to hire American Indian/Alaska Native Quit Line coaches to provide culturally-specific services to support quitting among the American Indian/Alaska Native population.	$	100,000
6) Technology updates- Text/mobile options for Quit Line services: Provide funding to Quit Line contractor to implement evidence-based text messaging for Quit Line participants to connect with their Quit Coach, interact with a Web Coach, use medications correctly, manage urges, and avoid relapse – all from mobile phones.	$	76,230
7) Electronic health record system- Buildouts for e-referrals to the Quit Line: Improvements to the Oregon Tobacco Quit Line to allow e-referrals.	$	30,000
COMMUNITY GRANTS/CONTRACTS TOTALS	**$**	**1,477,932**

OTHER COSTS	**$**	**-**

Cessation Intervention Total	**$**	**1,477,932**

Surveillance & Evaluation Interventions

Tobacco Use Reduction Account 2017-2019	**$**	**16,300,000**
Cost Allocation 16.41%	**$**	**2,297,766**
Budget Available for Allocation	**$**	**14,002,234**

CDC Recommendation for Surveillance & Evaluation Interventions: (Percent)		**9%**
CDC Recommendation for Surveillance & Evaluation Interventions: (Amount)	**$**	**1,260,201**
TPEP Allocation (Percent)		**9%**
TPEP Allocation (Amount)	**$**	**1,191,939**

PERSONNEL	**$**	**436,939**

TRAVEL	**$**	**-**

SUPPLIES TOTALS	**$**	**-**

COMMUNITY GRANTS:		

CONTRACTS:		
Surveillance-		
1) Behavioral Risk Factor Surveillance System Survey (BRFSS): An ongoing telephone survey to collect data on tobacco product use among Oregon adults.	$	210,000
2) Youth survey: A school based survey of 6th, 8th and 11th graders to collect data on tobacco product use among Oregon youth.	$	120,000
3) Panel surveys: A bi-annual web survey to collect data on tobacco-related opinions and attitudes among Oregon adults.	$	75,000
4) Targeted population survey: Explore options for administering a respondent-driven survey to collect tobacco-related data among targeted, hard-to-reach populations (e.g., American Indian/Alaska Natives, African Americans, and sexual minority populations). These populations typically have higher rates of tobacco use, but low representation on other population surveys.	$	50,000
Evaluation-		
1) Statewide retail/Strategies for Policy and Environmental Change (SPArC) Tobacco Free evaluation: An evaluation of the advancement of tobacco prevention policies in the retail environment for County TPEP and Strategies for Policy and Environmental Change (SPArC) communities.	$	125,000

2) Indoor Clean Air Act (ICAA) expansion evaluation: An evaluation of Indoor Clean Air Act policy expansion work among communities related to smoke shops and cigar bars.	$	75,000
3) Prevention campaign evaluation: An evaluation of the Prevention media campaign.	$	50,000
4) Tobacco 21 evaluation: An evaluation of the effects of SB754, which raises the minimum age to purchase tobacco from 18 to 21.	$	50,000
COMMUNITY GRANTS/CONTRACTS TOTALS	**$**	**755,000**

OTHER COSTS	**$**	**-**

Surveillance & Evaluation Interventions Total	**$**	**1,191,939**

Administration & Management

Tobacco Use Reduction Account 2017-2019	**$**	**16,300,000**
Cost Allocation 16.41%	**$**	**2,297,766**
Budget Available for Allocation	**$**	**14,002,234**

CDC Recommendation for Administration & Management: (Percent)		**6%**
CDC Recommendation for Administration & Management: (Amount)	**$**	**840,134**
TPEP Allocation (Percent)		**5%**
TPEP Allocation (Amount)	**$**	**732,744**

PERSONNEL	**$**	**377,246**

TRAVEL	**$**	**-**

SUPPLIES TOTALS	**$**	**55,000**

COMMUNITY GRANTS:		

CONTRACTS:		
COMMUNITY GRANTS/CONTRACTS TOTALS	**$**	**-**

OTHER COSTS	**$**	**-**
Administration fees (Facilities, Information Technology, Insurance, State Government Service Charges, Telecommunications)	$	200,498
Database administration	$	50,000
Legal fees	$	50,000
OTHER COSTS TOTALS	**$**	**300,498**
Administration & Management Interventions Total	**$**	**732,744**

Scenario 1: Statewide Public Health Modernization Funding Model to Reduce Tobacco Use

Program	Description	Funding	Pros	Cons
Basic Infrastructure	Awardees will focus on developing infrastructure and identifying regional strategies for tobacco control and future policy advancement, including enforcement of the Indoor Clean Air Act. Tiered requirements will be based on the funding amount. Every LPHA will receive this funding for the 17-19 biennium.	$3,690,000 Modernization base funding	• Provides flexibility for strengthening the entire public health system by making funding available for every county, based on each county's (or region's) unique policy environment. • Continues progress on a statewide movement to achieve policies that result in health equity for all communities in Oregon, regardless of the local policy environment. • Funds can be leveraged to support the development of regional public health infrastructure and new partnerships to reduce tobacco use. • Reinforces the use of proven interventions to implement policy, systems and environmental change strategies and multi-sector interventions to reduce tobacco use. • Strong likelihood of more policy and systems changes to prevent and reduce tobacco use and exposure. • Greater probability of achieving outcomes and reducing tobacco use. • Funding model aligns with Public Health Advisory Board (PHAB) and Conference of Local Health Officials (CLHO) approved modernization formula.	• Uncertain funding may make retention and recruitment of staff more challenging. • First time the Public Health Modernization Base funding formula will be implemented. • Counties experiencing barriers to cross-jurisdictional sharing may be at a disadvantage. • Potential for Basic Infrastructure LPHAs to decrease emphasis on policy outcomes. • Requires an additional reduction to cessation resources directed towards helping uninsured people quit.
Enhanced Implementation	In addition to basic infrastructure, LPHAs or regional partnerships demonstrating leadership engagement and commitment to tobacco control initiatives will receive additional funds to advance policy and systems changes in TPEP's focus areas. Focus areas include: • Raising the price of tobacco • Funding for tobacco prevention • Retail strategies • Expanding the ICAA • Health System/CCO leadership collaborations The number and type of TPEP focus areas addressed, and proposed population reach will influence the amount of additional resources provided to each LPHA.	$3,210,000		
TOTAL amount for July 2017 through June 2019		**$6,900,000**		

Scenario 3-Revised: Redistribute county TPEP non-competitive grant funding based on current CLHO funding formula; maintain competitive policy grant program; eliminate competitive CCO/LPHA collaboration grant program

Program	Description	Funding Amt.	Pros	Cons
County base + Current TPEP formula	Distributed through current CLHO base formula.	$3,705,000	• Reinforces the use of proven interventions through competitive grants to implement policy, systems and environmental change strategies and multi-sector interventions to reduce tobacco use. • Allows counties flexibility to apply for and receive additional funding based on each county's unique policy environment. • Redistributes funding for county TPEP non-competitive grant programs to address health equity by using the modernization formula.	• This scenario eliminates competitive grant funding for SRCH, which has been proven to build sustainable cross-sector partnerships, referral protocols and community-clinical linkages. • Eliminating TPEP funding for SRCH will result in fewer high-level productive partnerships with health systems to achieve reductions in tobacco use at the local level. • Counties with larger populations will have larger cuts to their budgets. • Resources continue to be distributed to counties regardless of policy feasibility or prioritization of tobacco prevention. • Requires an additional reduction to cessation resources directed towards helping uninsured people quit.
	TPEP Per Capita Formula	$2,195,000		
Strategies for Policy and Environmental Change (SPArC)	Competitive grants to local communities to advance tobacco prevention policies	$1,000,000		
Sustainable Relationships for Community Health (SRCH)	Competitive grants to implement, spread and sustaining tobacco cessation screening and referral systems In eliminating the SRCH competitive grant opportunities, the current requirements for county TPEP grant funding will be updated to require a commitment of the LPHA administrator/Health Officer to meet and collaborate with their CCO(s)' leadership to ensure a community-based approach to the CCO tobacco incentive metric.	Eliminated		
TOTAL		**$6,900,000**		

Proposed timeline and key decision

TPEP Budget Discussions and Recommendations
(July-October 2017)

- CLHO meeting, September 21
- TRAC meeting, September 22
- PHAB Incentives & Funding Subcommittee, September 22
- PHAB meeting, October 19

CLHO and PHD collaborate on transition plan
(Oct.-Dec. 2017)

- Review and revise Program Element 13 as needed.
- Design and implement simple budget amendment process.
- Verify we can ensure statewide coverage for tobacco prevention.
- Identify what can support LPHAs in their transition to a new budget and work plan.

LPHAs implement updated work plans and budgets
(By January 31, 2018)

- Identify appropriate venue for regular communication with PHD and CLHO to review and discuss implementation. (The new CLHO Health Promotion Committee?)
- For the 17-19 biennium, evaluate modernization funding structure for ensuring statewide coverage of tobacco prevention and progress toward outcomes.

Important discussion points for PHD and CLHO:

Budget transition

OHA-PHD is committed to ensuring local programs have a transition period between the current funding structure and the reduced funding structure to be implemented in January 2018. Currently, all 34 LPHAs have a Program Element 13 approved budget.

- The total amount of the approved budget for the first 6 months of the biennium is $1,750,000. The remaining 18 month budget allocation varies depending on the scenario selected.
    - Scenario 1: The total budget amount for county programs for the biennium is $6.9 Million. Thus, the total budget amount available for the last 18 months of the biennium is $5,150,000, if county program spending for the first 6 months of the biennium keeps pace.
    - Scenario 3: The total budget amount for county programs for the biennium is $6.9 million. However $1 million is available for competitive funding, leaving $5,900,000 for county TPEP. Thus, the 18 month biennium budget for TPEP counties is $4,150,000, if county program spending for the first 6 months of the biennium keeps pace.
- What are recommendations for how to apply the first 6 month LPHA budget expenditures across the entire budget? Historically, the first 6 months of a fiscal year are underspent. Should under-expenditures from the first 6 months be directed to the last 18 months, and if so, how?
- What supports can help accelerate transition among counties that are ready to shift? This could help lessen the impact of the budget cut on the remaining 18 months of the biennium.
- A subcommittee would be helpful for the Program Element and work plan transition process. Volunteers should be familiar with and have decision-making experience for county public health budgets. Who can volunteer for this and obtain appropriate approvals from their agency leadership to do so?

Tobacco Prevention Assurances for All Oregonians

- What if an LPHA (county) opts not to apply for TPEP funds? Should those funds be made available to other local entities (community based agencies or neighboring counties) to deliver tobacco prevention services? Or, should the funds and responsibility for tobacco prevention services be returned to PHD? Should a ranked order of priority for recipients of these funds be established?
- At Basic Infrastructure the ICAA must be enforced, including training and outreach with businesses. Data including population size, number of businesses, and history of enforcement complaints can be used to determine what additional work should be required with basic infrastructure funding. Are there other variables that should be considered?

Training and technical assistance

- What shared learning opportunities and venues can be accessed for state and LPHAs to support communications, transition support, and regional planning options? (Place Matters, Grantees and Contractors, Communities of Practice, Regional Support Networks, etc.)?
- What modernization activities, resources and tools can be enlisted to help LPHAs that want to move from Basic Infrastructure to Enhanced Implementation?
- What else can OHA-PHD do to support LPHAs?