

Tobacco Retail Licensing Policy:

A Health Equity Impact Assessment

October 2015



A project of Upstream Public Health in collaboration with an expert advisory workgroup. This project was partially funded by a grant from the Knight Cancer Institute Community Partnership Program at Oregon Health & Science University in February 2015, and through a Strategies for Policy and Environmental Change grant awarded to the Multnomah County Health Department in 2014. Contact: 503-284-6390 | Tia Henderson, Research Manager | www.upstreampublichealth.org



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About this Health Equity Impact Assessment

This Health Equity Impact Assessment examines the potential racial, social, environmental and economic health equity effects of a potential tobacco retail policy on Multnomah County communities, using introduced state legislation as a template. This project was partially funded by a grant from the Knight Cancer Institute Community Partnership Program at Oregon Health & Science University in February 2015, and through a Strategies for Policy and Environmental Change grant awarded to the Multnomah County Health Department in 2014. The goals of this project were to:

- Inform the policy decision-making process within the Multnomah County Health Department and, if possible, the Oregon legislature.
- Examine the racial, environmental, social, and economic health equity impacts of tobacco retail license policy through understanding how the policy interacts with health determinants.
- Make recommendations about how to create a balanced policy that prevents youth access to tobacco and nicotine products while supporting small retailer economic vitality and positive mental health in our communities.

The data analysis and health equity impact characterization included in this report is that of Upstream Public Health. Upstream Public Health is wholly responsible for the report's content and any errors are ours. This report does not necessarily reflect the views of funders or others involved in the HEIA process unless attribution is provided. This report is intended for educational and informative purposes. Any mention of companies, policies, individuals, or organizations are included to advance information purposes and do not constitute an endorsement or sponsorship.

Tobacco Retail Licensing Policy: A Health Equity Impact Assessment Executive Summary

Why a Tobacco Retail Licensing Policy?

Oregon has the highest illegal sales of tobacco to minors in the nation¹, with one in four retailers in Multnomah County illegally selling tobacco to minors in 2014². Since nine out of ten regular smokers report starting to use tobacco before the age of 18³, it's clear we are not doing enough to prevent future generations of youth from easy access to addictive nicotine and tobacco products.

Oregon and Multnomah County elected officials are considering taking common sense action to help reduce the sales of tobacco and e-cigarettes to minors through a tobacco retail licensing policy. Upstream Public Health (Upstream) collaborated with an advisory team of diverse community members and public health staff (see fourth page for a list of Workgroup members), from April to September of 2015, to conduct a Health Equity Impact Analysis (HEIA) on the impact of a potential tobacco retail licensing policy on Multnomah County communities. The project team and Workgroup reviewed research and data, including information gathered from retailers and youth, to understand TRL health equity impacts. This document summarizes the findings and presents priority recommendations to increase health equity and minimize harm.

Inequities in Tobacco Use Persist

The Health Equity Impact Assessment finds that

tobacco is the number one cause of preventable death and chronic disease in Oregon⁴. Tobacco companies have historically, and unethically, targeted residents in our most vulnerable neighborhoods by using advertising methods and promotions specifically intended for communities of color and low-income communities – contributing to persistent inequities in tobacco use. For example, more than 1 in 3 people with earnings less than \$15,000 a year still smoke. More than 1 in 3 Native American and African American residents are smokers. Residents with mental health and substance use challenges are nearly twice as likely to smoke. Tobacco use contributes to health inequities in heart disease rates, stroke, type 2 diabetes, and various types of cancer⁵. It exacerbates lung disease, cardiovascular and respiratory illness, and can increase the risk of reproductive and developmental health outcomes like premature births and low birth weights¹².

Youth are Vulnerable to New Products and Tobacco Retail Licensing Can Prevent Future Inequities

Initiation of smoking behavior is related to easy access to tobacco retailers and the exposure to tobacco advertising that accompanies them⁶⁻¹³. In Multnomah County, more than 1 in 3 tobacco retailers are located within 1000 feet of schools¹⁴. There are many neighborhoods where children live with a higher than average number of retailers nearby (see Map 1). There are also more tobacco

retailers per capita in neighborhoods where more people of color live, which reflect national trends¹⁴.

The tobacco industry has effectively advertised and promoted small cigars, electronic cigarettes, and smokeless tobacco to youth³. Many cheap non-cigarette products are being sold in bright packages in candy-like flavors that are attractive to



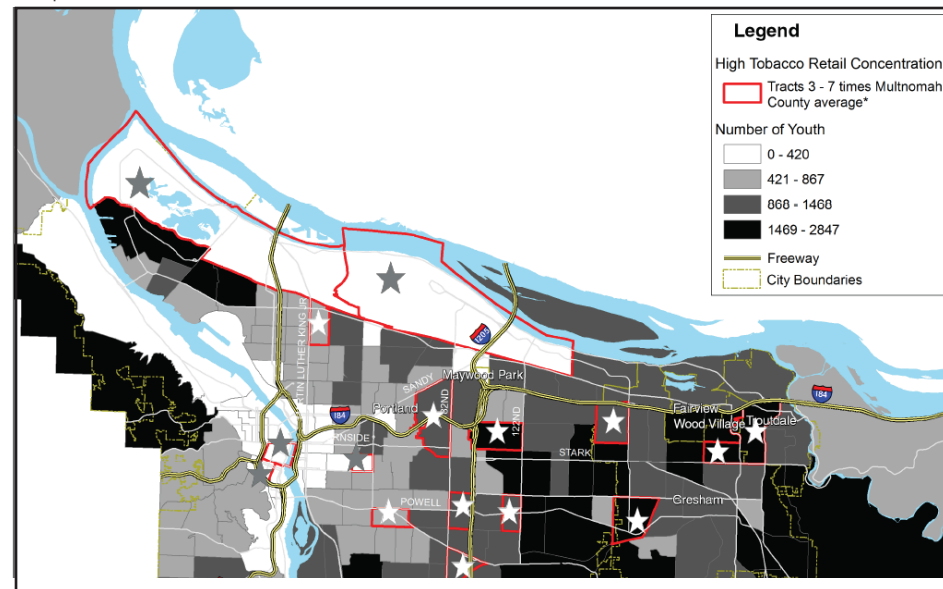
A tobacco retail licensing policy that includes inhalant delivery systems (e-cigarettes) requires retail owners who sell tobacco and/or electronic cigarettes to purchase a license (paying a license "fee"), similar to when they sell alcohol or food. Licensing systems have penalties when retailers sell to minors.

youth^{15,16}. Oregon teens more than tripled their use of all non-cigarette products, including e-cigs, from 7% in 2011 to 17.8% in 2013^{17,18}. Nicotine can affect adolescent brain development and is addictive^{12,30}; it is critical to educate youth about tobacco industry practices and health consequences of tobacco and nicotine use.

The Latino, Asian, and Pacific Islander communities are relatively young – with at least 1 in 3 under the age of 18^{20,21} – increasing the risk of a new generation of youth using nicotine and tobacco. Given the disproportionate focus the tobacco industry has had on communities of color and youth^{3,16,22–25}, a well-implemented TRL policy could prevent tobacco initiation rates among youth of color. Currently, 1 in 10 youth in Oregon, ages 12-17 are smokers. If Oregon's 9.4% youth smoking rate were reduced just a small amount to 7.5% of youth smoking, that would mean 27,690 fewer children growing up with chronic disease related to tobacco, 9,700 lives saved and \$484.6 million in health care costs saved²⁶.

Tobacco retail licensing policy (TRL) has emerged as an effective strategy to reduce rates of tobacco sales to minors^{27–29}. The most effective licensing systems involve a sustainable funding source, such as an annual fee, to maintain the licensing program and include the option to suspend or revoke a license. With these elements in place, retailers are more likely to ask for identification, and sales to minors fall^{27,30–33}.

Map 1: Tobacco Retailers in Relation to Youth



* Multnomah County average is (3) tobacco retailers per census tract. ** Retailer Data Source: Tobacco Retail Assessment 2014 - a collaboration among Multnomah County Health Department, Upstream Public Health and the Oregon Health Equity Alliance (OHEA); Population Source: American Community Survey 5-year estimate 2009-2013.

Effective Retail Licensing Requires Sustainable Funding and Needs to Avoid Burdening Our Smallest Retailers

Workgroup participants were concerned that independently owned small retailers would have a difficult time paying for the cost of a license. They were also concerned that clerks – especially those who do not speak English as a primary language – may not be adequately educated about the new laws and could be fined for selling to minors. While two studies indicate that a tobacco retail license does not impact business revenue^{34,35}, two of the retailers we interviewed explained that tobacco brings customers through the door who then buy other items. Three retailers we interviewed, who each reported tobacco making up between 5 and 12% of

their total sales said they would raise the costs of products for a \$300 licensing fee. A fourth retailer, whose tobacco related sales were about 2% of net profits, said they would likely stop selling tobacco at any tobacco licensing fee level. This aligns with a trend of retailers voluntarily stopping sales of tobacco^{36,37}. Public agencies need to create financial economic development supports, such as incentives, to assist smaller businesses that want to stop selling tobacco and serve healthier products that are less profitable than tobacco.

The Workgroup was also concerned that small retailers of color, or those that serve communities of color, might be targeted for enforcement more than their white counterparts. Studies show that enforcement officers have engaged in racial

profiling on drug related arrests in Portland³⁸ and across the nation in relation to youth possession of tobacco³⁹⁻⁴¹, which provide reason for concern and preventive action. The Workgroup feels that small corner stores are more than a place to buy tobacco – they are a place to meet friends and purchase everyday goods like food or laundry detergent; considering the important role small corner stores can have in a community, the Workgroup feels these retailers need to be protected from potential targeting. A well-implemented TRL policy should acknowledge, and work to prevent, the possibility of racial profiling of both youth and retailers.

Smokers Who Want to Quit Need More Support Beyond a Tobacco Retail License

A TRL policy has a mixed impact on people who are addicted to nicotine and want to quit smoking. On one hand, studies show that if retailers decide to stop selling tobacco and there are fewer retailers located near a smoker's home, this can support a smoker's decision to stop^{42,43}. Studies also show that, for many people, an increased price of tobacco discourages smoking^{44,45}. On the other hand, there is a gap in understanding of how increased prices affect those who have a hard time quitting in research on smoking cessation⁴⁶. In addition, people who do not have phones, do not have homes, or may not speak a language that is offered by the Quit Line cannot access cessation programs that fit their needs. The CDC recommends that Oregon invest \$39.3 million in tobacco prevention and cessation program funds. Oregon only spends

\$9.9 million – just over 1/4th of the recommended amount, and this primarily covers prevention programming, not cessation²⁶. While a traditional TRL policy may be effective at reducing underage youth access to tobacco products, youth and adults already experiencing tobacco and nicotine addiction will still need increased access to culturally responsive tobacco cessation programs.

Priority Recommendations

Based on the existing conditions data, literature review, key informant interviews, and the advisory Workgroup's focus to prevent a widening set of racial and social inequities in the future, the Workgroup and HEIA project team developed nearly 40 recommendations to maximize health equity in relation to how our neighborhood access to tobacco may change based on a tobacco retail licensing policy. **Here, we summarize eight priorities:**

Use retail licensing fees for enforcement, education, and training for community members. Elected officials who bring forward a TRL should set the price of the license fee high enough to cover the enforcement of the licensing system, including education, training, and monitoring.

Implement a strong enforcement system. The TRL system should have the ability to suspend and revoke the license within a specific timeframe, which should be determined with input from small retailers, including retailers of

color, during rule making.

Ensure retail owners, not clerks, are responsible for paying fines and fees. TRL needs to be written in a way that makes owners, not clerks, responsible for fees and fines.

Retail owner trainings on tobacco licensing rules should be culturally and linguistically accessible. All agencies that do tobacco related compliance checks should develop a universal training on retail laws related to sales to minors for retailers that is culturally responsive, free, and can support clerks, managers, and owners in meeting law requirements and ensure all staff are aware of laws.

Support small business owners who decide to top selling tobacco. Public agencies should provide economic development strategies to support businesses who want to shift away from selling tobacco. Ideas include grants, tax credits, trainings, or access to lower-cost financing options.

Prioritize continued involvement of impacted communities. Elected officials who pass a TRL policy should fund a commission to participate in the rule making process and to monitor how tobacco retail licensing is impacting communities. The commission should include at least 1/3 of the seats representing individuals most impacted by the policy – including small retailers, retailers of color, youth, and people of color – to help build power and capacity with

community residents most impacted by this issue. Participants should receive a stipend to sustain and support their engagement.

Provide youth and other impacted groups with education about the harms of tobacco. Public agencies that implement TRL should develop education to youth, immigrant groups, youth of color, and other impacted groups about potential harms and show how the industry is currently marketing to youth with flavors and prices.

Ensure equitable enforcement of the TRL policy. Elected officials who pass a TRL policy should identify sources of data that can help track unintended consequences such as inequitable enforcement that could affect small retailers, people of color, and youth.

Rationale for a Health Equity Impact Assessment:

Upstream Public Health, a public health nonprofit, focuses much of its work on developing innovative strategies to remove barriers that prevent people from attaining equity in health outcomes. Upstream is on the steering committee of the Oregon Health Equity Alliance (OHEA). OHEA, a statewide partnership of diverse health equity advocates, public health entities, and organizations that serve constituents facing health inequities, made tobacco prevention a major focus of their five-year plan. As part of this effort, members of OHEA worked with Multnomah County Health Department to conduct a tobacco retail assessment and understand what was being sold and where in our communities. During the retail assessment, Upstream and partners learned of multiple state bills to introduce a tobacco retail license. Upstream and partners wanted a better understanding of what a policy could mean in terms of health equity for our Multnomah County communities. Upstream received a grant from the Oregon Health and Science University Knight Cancer Institute Community Partnership Program to conduct this HEIA.

Upstream convened a workgroup whose members represented, or work with, many of the groups the tobacco industry has long targeted to maintain an addiction to tobacco and nicotine products. The Workgroup was therefore in a unique position to deeply examine a potential licensing policy and its health equity impacts on their own communities. Their voices and perspectives have been critical to our process and final recommendations to create a balanced policy that prevents youth access to tobacco and nicotine products, while supporting small retailer economic vitality and positive mental health in our communities. Non-public agency members of the Workgroup received a stipend to participate. The project team and Workgroup co-developed over 40 questions related to the policy's potential racial, social, environmental, and economic health equity impacts. They looked at a range of issues, from how the policy might impact youth use of tobacco and nicotine products, to mental health impacts and how we can avoid potential harms on the smallest businesses – especially those owned by people of color.

Advisory Workgroup Members

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Overview

All Multnomah County residents deserve safe places to grow and prosper. Upstream Public Health recognizes that health starts in our communities, homes, and schools. We want the features of these places, including our neighborhoods and stores, to support our health by offering healthy options and job opportunities. To create this health equity impact assessment (HEIA)¹, the project team used a Health Impact Assessment (HIA)² methodology while applying the Multnomah County's Equity and Empowerment lens³ to understand the potential health equity impacts a tobacco retail license (TRL) policy could have in Multnomah County (see definitions).

This project systematically looked at current data, published evidence, and collected perspectives from structured interviews with youth and retailers. Member of the stakeholder advisory workgroup (the Workgroup) were selected based on their expertise from working with tobacco - impacted communities in Multnomah County and their equity perspective. For a definition of the communities the Workgroup viewed as the most impacted and vulnerable in this HEIA, see Appendix 1. The Workgroup guided the project; they met in six 1.5 - hour meetings over the course of April to September 2015 to review information, develop the scope of the assessment, develop and prioritize recommendations based on the findings, and provide general guidance. Members of the Workgroup received a stipend provided by a grant from the Knight Cancer Institute if they would not otherwise have been

able to participate. This report presents a summary of current data and evidence about the potential impacts of a TRL policy in Multnomah County. The project team and Workgroup co-developed assessment questions related to how a TRL policy could most directly impact tobacco use by youth and people of color, economic stability for small retailers, and social equity. The Workgroup prioritized these questions to help the project team focus their efforts. For more information on HEIA methods, see Appendix 1.

This report provides recommendations to maximize health equity benefits and minimize harm. The Introduction provides background on tobacco retail licensing and inhalant delivery devices. The Existing Conditions section reviews current data on tobacco use, tobacco availability in Multnomah County, tobacco retailers, and the history of tobacco industry targeting different groups. The Assessment section reviews evidence and connects the dots to assess potential health equity impacts of a tobacco retail license. The Recommendations section provides suggestions on how to maximize health and minimize harm from a tobacco retail license based on the assessment and information from interviews and Workgroup participants. Appendix 1 has additional methods related to how the HEIA determined potential health effects and developed priority recommendations. Appendix 2 reviews existing tobacco inspection programs in Oregon. Appendix 3 provides a list of cessation resources in Multnomah County.

Health Equity: Attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and healthcare disparities⁴.

Health Inequities: Differences in health that are avoidable, unfair, and unjust⁵.

Determinants of Health: The range of personal, social, economic, and environmental factors that determine the health status of individuals or populations⁶, also called health factors in this report.

Health Impact Assessment (HIA): A systematic process that uses multiple methods and data sources, including input from stakeholder to determine the potential effects of a proposal on the health of a population and the distribution of those effects. HIA provides recommendations for monitoring and managing those effects².

Health Equity Impact Assessment is a tool to analyze a new proposal's potential to impact health disparities and/or impacts on health disadvantaged populations (see Appendix 1 for a definition of impacted or vulnerable groups). It is an adaptation of HIA with an explicit focus on equity¹.

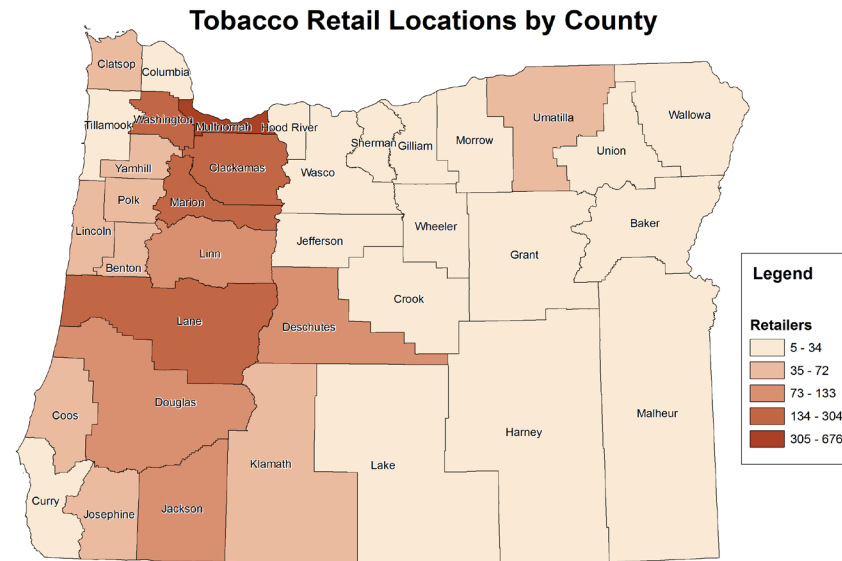
Introduction

Oregon received some good news in the last decade: our communities have steadily reduced our use of cigarettes. Adult cigarette smoking fell 22% between 1996 and 2012, and tobacco sales fell 52% in the same time span⁷. This success is in part from collective efforts of health authorities in local counties, cities, and tribes to create more smoke-free environments and establish new policies and programs to reduce how much tobacco is around us⁸.

Despite the average declining trend in tobacco use, some Oregonians are more affected by tobacco and nicotine addiction than others and need further support. The national Synar Program, sponsored by the Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Prevention, collects data from random inspections of retailers who sell tobacco to minors. The 2013 report indicated that Oregon was leading the nation in illegal sales to minors⁹. The most recent Synar inspections from 2013-2014 indicated that Multnomah County's sales to minors were at 31.9%; in other words, one in three stores visited for Synar inspections sold to a youth under the age of 18¹⁰.

These numbers sounded the alarms for two reasons. First, the Surgeon General's recent report found that most smokers, nine in ten, started under the age of 18¹¹. Second, if this number from the Annual Synar Report does not decline enough to bring Oregon into compliance with federal rules

Figure 1: Oregon Map of Tobacco Retailers



*Oregon Health Authority, Public Health Division Health Promotion and Chronic Disease Prevention section. (March 2015). Oregon tobacco retailers geodatabase. Unpublished data.

(we cannot have more than 20% of retailers found selling tobacco to minors), Oregon could be subject to a penalty of losing 40% of the federal Substance Abuse Prevention and Treatment Block Grant funding (approximately \$8 million per year)¹². The loss of those funds could have further equity impacts beyond tobacco-related health burdens. In the fall of 2014, members of the Oregon Health Equity Alliance and the Multnomah County Health Department, with a grant from the Oregon Health Authority Tobacco Education and Prevention Program, conducted a tobacco retail assessment

to understand what is sold in Multnomah County communities. Oregon elected officials during the 2015 legislative session brought forward three different tobacco retail license bills¹³⁻¹⁵ at the same time as the retail assessment was underway. Multnomah County Commissioners also went on record saying that they support a state tobacco and inhalant delivery system retail license policy and that they would implement a local policy if the state did not¹⁶. This potential policy, and concerns about any consequences it could have, are the rationale for this HEIA.

Tobacco Retail Licensing and Inhalant Delivery Device Overview

“Tobacco Retail License” (TRL) policy is widely used across the United States at the state, county and city levels to ensure compliance with local business standards and as a method to reduce youth access to tobacco products. Oregon is one of 13 states without a tobacco retail license policy in some form (some licenses only cover vending machines)¹⁷. Tobacco retail licensing policy requires retail owners who sell tobacco to purchase a license (paying a license “fee”), the way they would to sell alcohol or food. Depending on how the policy is written, if retailers are caught selling tobacco or electronic cigarettes to minors, regulators can then fine them (a penalty “fine”), and if it happens frequently, suspend or revoke that license. Tobacco retail licensing with fees set at an amount sufficient to pay for an enforcement program have been effective in many communities across the nation at reducing tobacco sales to youth¹⁸⁻²². A handful of cities (Corvallis, Ashland, Eugene, Philomath, Central Point, Salem, Silverton, and Springfield) and counties (unincorporated Lane county and Benton county) in Oregon require businesses to purchase a license to sell tobacco. These policies have set a low license fee and therefore do not have funds to adequately enforce the license rules²³. These areas do not include regions of the state with the largest concentration of retailers, such as most counties along the Willamette Valley, including Multnomah County (see figure 1).

Requiring tobacco sellers to have a license is a response to changing efforts of tobacco industries to keep a youth tobacco market since 1998. In 1998 the Tobacco Master

Settlement Agreement required the five largest tobacco companies in America to pay states funds intended for tobacco prevention efforts, and the Settlement also forbid the same tobacco companies from directly or indirectly advertising to youth²⁴. Based on this agreement, tobacco companies have shifted most of the promotional efforts for tobacco sales to retail locations – or the “point of sale.” At the same time, in the last few years, the sales of electronic cigarettes, or e-cigarettes, has flourished^{25,26}. E-cigarettes deliver nicotine through inhalant delivery device systems that rely on a battery, or other electronic-operated heating of a liquid to a vapor, instead of combustion. The nicotine in the e-cigarette liquid can come from tobacco or other sources^{27,28}. Electronic cigarettes, also called “e-cigs” or “vape,” are a relatively new smokeless nicotine product (see figure 2). Across the country, this new product is relatively unregulated, without many policies preventing minors from purchasing the product^{29,30}. In the 2015 legislative session, Oregon included all “inhalant delivery systems,” which include e-cigarettes, in its Indoor Clean Air Act policy³¹. On January 1, 2016 Oregonians will not be able to use e-cigarettes in workplaces, restaurants, bars, and other indoor public spaces. In March of 2015, Multnomah County Commissioners passed an ordinance banning retailers from selling inhalant delivery systems, such as e-cigarettes or vape pens, to minors. The law will take effect on April 5 of 2015³².

In early 2015 the Oregon Legislature introduced several bills (SB 417, SB 663, HB 3534) that would have required

Figure 2: E-cigarette description²⁷.

What are electronic cigarettes?
Electronic cigarettes, also known as e-cigarettes, are battery-operated products designed to deliver nicotine, flavor, and other chemicals. They turn ingredients into an aerosol that is inhaled by the user.



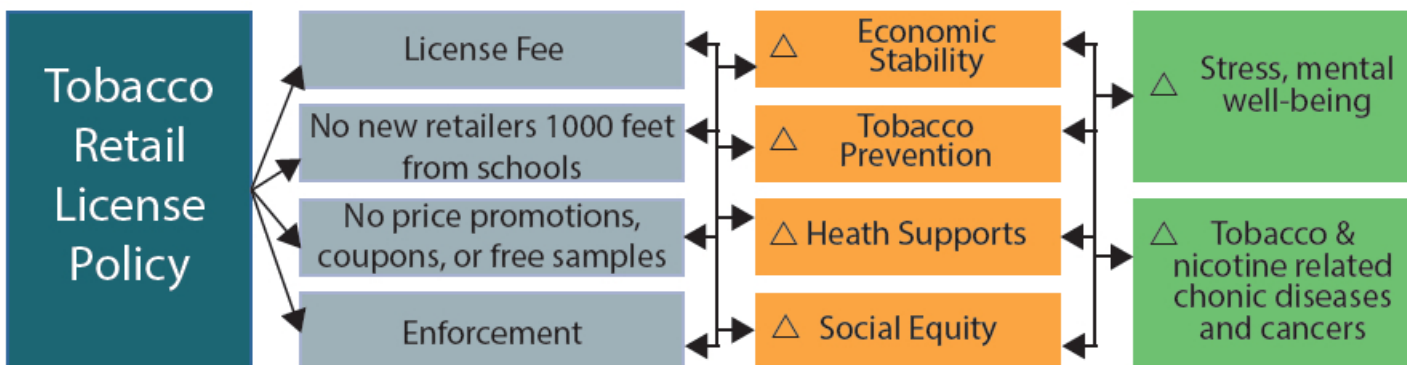
“Why the [tobacco] license? We have the OLCC [alcohol] license, we have a food license, and a business license. So why if we are a business do we have to pay so much? If we sell alcohol it is a \$480 fine, then we can lose the license.”

— Owner, retailer with 8-12% of profits from tobacco products, mid-county

all Oregon businesses who sell tobacco products and items that use an inhalant delivery device to purchase a license. None of the tobacco licensing bills passed through the Oregon legislature in the 2015 session due to a lack of agreement on the provisions. The different bills had elements added to a basic tobacco retail license requirement. For example, Senate Bill 417 added that retailers could not be located 1000 feet from a school, retailers could not be mobile, and retailers could not offer price promotions, coupons, or free samples¹⁴. This Health Equity Impact Assessment examined the potential health equity impacts of elements of Senate Bill 417 (SB 417) on Multnomah County communities because it was the first bill to be introduced, and had the most provisions. This HEIA used elements (see figure 4) from SB 417 as a template, starting point, and guide for understanding future tobacco retail licensing policies. See Appendix 1 for a description of limitations related to this approach.

We will provide this report to legislators who introduce TRL policies in the future. The policy recommendations in this report are focused on tobacco retail license structure and the additional elements brought forward in SB 417 including: enforcement (ability to suspend and revoke); a fee structure; who pays penalty fines; how a fund is used from fees; prohibiting retailers within 1000 feet of schools; limiting mobile retailers; and limiting price promotions, coupons, and free samples. The HEIA does not go further into all possible additions to a tobacco retail licensing system. It also does not examine the use of marijuana in inhalant delivery devices, as this is beyond the scope of this project. The HEIA used existing data on current conditions, a literature review, interviews with youth and retailers, and analysis of tobacco retail policies in other regions. In the Scoping step of this HEIA, the Workgroup determined that a policy with similar components as SB 417 could cause increases or decreases

Figure 3: Tobacco retail license policy summary health pathway diagram



The HEIA begins with elements of a tobacco retail license policy template to the far left. The first column to the right of the policy includes short-term, direct impacts. These immediate impacts contribute to intermediate impacts in the third column. The last column on the right are long-term health outcomes resulting from the interaction of the policy and other health factors.

in health factors or health outcomes such as stress, mental well-being, and tobacco-related chronic illness like cancers, cardiovascular disease, and respiratory illness (see the health pathway diagram in figure 3).

Current Tobacco Inspection Systems in Oregon

As context for understanding a tobacco and inhalant delivery device retail license system, it is helpful to know about other tobacco retail inspection systems in place. There are currently three different tobacco-related inspections programs that affect tobacco retailers in Oregon. The federally funded Synar program is based on a federal law, the Synar Amendment to the Alcohol, Drug Abuse, and Mental Health Administration Reorganization Act passed by Congress in 1992. The Amendment requires states that receive block grant funds for Substance Abuse Prevention and Treatment to: 1) have laws that prohibit the sale and distribution of tobacco products to youth under the age of 18, and 2) to conduct annual, unannounced inspections of retail outlets accessible to minors in order to enforce this law (see Appendix 2). There are no penalties or fines issued to retailers for selling to minors under the Synar program. Separate from Synar, Oregon conducts its own compliance inspections to enforce state laws prohibiting sales of tobacco products to minors. In this inspections program, any individual, including clerks or employees, can be written a citation of up to \$2,000. Both the Synar and Oregon compliance inspections are conducted by the Oregon State Police²³. A third

set of inspections are conducted by contractors with the Food and Drug Administration, independent of Oregon agencies. These inspections are part of the implementation of the federal Tobacco Control Act. These inspections can result in a warning letter, and retailers or merchants - not clerks - are fined for breaking the law. For more details on these three programs, see Appendix 2. In the four interviews we conducted with small tobacco retailers, we learned that three of the four individuals felt the pressure of multiple visits from multiple agencies for various licenses.

Image 1: Tobacco retail display



Figure 4: Example Tobacco Retail License Policy Elements Based on Oregon Senate Bill 417²⁸:

Tobacco Retail Licensing Example Senate Bill 417 Introduced Version

License Fee – Retailers required to purchase license for sales of tobacco or inhalant delivery systems (e-cigs).

Enforcement – Oregon Liquor Control Commission (OLCC) sets fee, can issue penalties, and suspend and revoke license. In the introduced version clerks could be responsible for paying penalties for breaking laws, although this was later removed in subsequent versions, and only owners would have been responsible.

Fund for Enforcement – Fees from licenses are deposited into a fund and used for conducting license inspections, and enforcement.

Other Provisions and Limitations – No retailers allowed within 1,000 feet from schools, retailers cannot be mobile, and retailers cannot offer price promotions, coupons or free samples.

Existing Conditions Related to a Tobacco Retail License

“People struggling with stress and less resources turn to tobacco and other things for comfort, it helps to cope.”

— Workgroup member

Figure 5: Multnomah County Adult Smoking Rates³⁴:

42.2%	American Indians/ Alaska Natives (non-Latino)
29.9%	Black/African American (non- Latino)
27.0%	Latino
20.4%	White (Non- Latino)
12.4%	Asian/Pacific Islander (non- Latino)*

* Interpret cautiously

A: Adult Tobacco Use

In Multnomah County, cigarette smoking continues to be a source of health inequities for American Indian, Alaskan Native, Black, African American, and Latino populations who have a higher rate of use than White, Asian, and Pacific Islander groups, see figure 5³⁴. The rate of smoking among Asian and Pacific Islander communities should be interpreted cautiously. Members of the advisory Workgroup noted that when Asian and Pacific Islander data is presented in aggregate, disparities are hidden among different heritage groups. For example, among Medicaid recipients, smoking rates for Pacific Islanders when compared to other Asian communities were more than twice as high³⁵. An equity report released by Multnomah County on the Pacific Islander community shows that consistently, across multiple outcomes, this community faces higher disparities than White, non-Latino peers³⁶. These disparities do not show up when this group is merged with all other Asians. The Asian Pacific American Network of Oregon, along with other partners, has continually advocated for data on health outcomes and health determinants to be disaggregated.

In Oregon, tobacco is the number one cause of preventable chronic disease and death, and contributes to health inequities^{8,37,38}. For example tobacco use contributes to heart disease, stroke, type 2 diabetes, and various types of cancer³⁹. It worsens lung disease and cardiovascular and respiratory illness and can increase the risk of reproductive and developmental health outcomes, such as premature births and low

birth weights³⁹. Communities of color and low-income populations carry a larger burden of chronic illness, both throughout Oregon and in Multnomah County^{34,40}.

Fortunately, adult cigarette smoking fell 22% between 1996 and 2012⁷. About two in ten Oregonians continue to use tobacco including either smokeless types or cigarettes, based on 2010-2013 data⁷. While this is great progress, many groups in Oregon continue to bear the burden of higher tobacco use than their peers (see Appendix 1). Since we do not have county numbers, we reviewed the state-wide context, see Appendix 1 for more data.

- Tobacco use disproportionately affects many communities of color. For example, more than one in three Black and American Indian and Alaskan Native Oregonians continue to smoke. These numbers are even higher among Medicaid participants who are American Indian and Alaskan Natives, Pacific Islanders, and White, non-Latino (see Appendix 1)³⁵.
- Adults experiencing economic hardship are also disproportionately impacted. Nearly one in three Oregonians who make less than \$15,000 a year smoke compared to one in ten who make \$50,000 or more⁴¹.
- Members of the Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ) community have a higher use of tobacco: nearly one in four for gay or lesbians and nearly one in three for bisexuals, compared to fewer than one in five among heterosexual counterparts⁴¹.

- Persons with mental health and substance abuse challenges are nearly twice as likely to smoke. Nationally, more than one in three adults with a mental illness smoke cigarettes, compared with about one in five adults without mental illness^{42,43}.

The statistics reveal that the communities most impacted by tobacco use are also the same communities burdened with other social, environmental, and physical burdens. For example, members of the LGBTQ community are more likely to experience other mental and physical health issues⁴⁴, those experiencing mental illness are less likely to have health insurance or other health supports⁴⁵, and people of color along with LGBTQ and mentally ill communities may experience chronic stress from discrimination in their daily life⁴⁶⁻⁴⁸.

It is unclear the extent to which different refugee and recent immigrant populations currently use tobacco. The Oregon State Department of Human Services reports that 62,677 refugees have resettled in Oregon since 1975⁴⁹. Many residents - between 20% and 45% in North, South East, East Portland, and Gresham census tracts (e.g. Cully, Lents, and Centennial) - have relocated from other countries according to the 2009-2013 American Community Survey. Workgroup members are concerned that newly relocated immigrant and refugees could potentially also be located in areas with a high number of tobacco retailers and may lack support in managing the trauma and stress related to relocation.

B: Youth Tobacco and E-cigarette Use

In Oregon and Multnomah County, nearly all (96%) residents agree that it's important to prevent tobacco sales to minors⁷. We want to prevent the next generation of youth from being burdened with tobacco use and its related illnesses. In Multnomah County, about one in three (37.2%) Latinos, and Asian and Pacific Islanders (29%) are also under the age of 18, an indication of changing demographics⁵⁰. More than one in three Latino adults in Multnomah County currently smoke. This current data is a concern when we consider that nine in ten adults began smoking when they were under the age of 18³⁹. A higher rate of smoking among the Latino community is concerning, because it indicates that a very young community may be affected by tobacco access and use in the future^{50,51}. It is important to prevent and minimize youth access to tobacco as much as possible.

Different data sources report slightly different numbers for youth tobacco use in Oregon.

- 1 in 10 youth ages 12-17 is a current smoker (not separated by race or ethnicity)^{7,54}.
- More than 3 in 10 young adults ages 18-25 smoke (not separated by race or ethnicity)^{7,54}.
- The rate of cigarette smoking is decreasing among 8th graders (4.3% in 2013 from 8.2% in 2010)^{7,54}.
- The rate of non-cigarette use (smokeless tobacco, cigars, hookah tobacco, dissolvable tobacco, or electronic smoking devices) among 11th graders is increasing since 2011 (17.8% in 2013 from 7% in 2011)^{7,54}.

“My community is so young that preventing their future tobacco and nicotine use is a concern of mine.”

— Workgroup member

Figure 6: Where do youth get tobacco?^{7,54}

- In Oregon, of youth already using tobacco, 6.4% of 8th graders and 16.8% of 11th graders get them from stores or gas stations. Most Oregon youth who smoke get cigarettes from friends who are 18 or older (36.7% of 8th graders and 53.1% of 11th graders).
- In Multnomah County, 1.6% of youth say they get cigarettes from a store or gas station; we do not have data on smokeless tobacco or e-cigarette sources.

“I would choose e-cigarettes over tobacco because there’s no second hand smoke. Also it has a better smell. The negative impact on the body is a little less.”

— Interviewed youth1, age 18, non-smoker

Figure 6: E-cigarette Safety

Current use of e-cigarettes among 11th graders in Oregon almost tripled between 2011 (1.8%) and 2013 (5.2%)^{7,54}. Analysis of nationally representative Youth Tobacco Surveys indicate adolescent use of e-cigarettes is associated with a future intention to smoke regular cigarettes⁵⁵.

Cigar use is also a concern. Cigars are not taxed⁵⁶ the way cigarettes are, which means a person can buy three for a dollar in sweet smelling flavors - such as pineapple and cherry. Nationally, flavored cigar use has increased among adolescents^{57,58}. Table 1 shows a high cigar use for those who identified with multiple races on a Youth Risk Behavior Survey implemented by Multnomah County’s Community Wellness and Prevention program in 2010 and 2012.

E-cigarettes are commonly marketed with claims of being

healthier than traditional cigarettes and not producing secondhand smoke⁵⁹. E-cigarettes come in unflavored, menthol, and a variety of fruit flavors^{25,60}. The numerous flavors and smell sweet make them enticing to children. In 2014, U.S. poison control centers received 3,783 calls regarding e-cigarettes and liquid nicotine⁶¹. Locally, Multnomah County is leading the state in reported poisonings related to e-cigarettes. In 2012 Multnomah County had one reported case; by December of 2014 that number grew to 24, nearly one-third of all e-cigarette related cases in the state⁶².

Youth use of e-cigarettes has been rising. In 2015, the National Youth Tobacco Survey found that youth use of e-cigarettes had tripled between 2013 and 2014 and that current use of e-cigarettes surpassed use of all other nicotine and tobacco related products among high school

Table 1: Multnomah County High School Tobacco Use⁴⁹

	Multiple Races	Black, non-Hispanic	Latino	White, non-Hispanic	American Indian, Alaskan Native, Asian, Native Hawaiian, Other Pacific Islander
HS Cigarette Smoking	8.5%	3.1%	7.5%	6.1%	4.8%
HS Smokeless tobacco use	3.6%	6.8%	5.4%	2.7%	2.9%
HS Cigar use	17.4%	7.3%	6.6%	6.9%	4.9%

students⁶³. “In 2013, E-cigarettes were the most used tobacco product for non-Hispanic whites, Hispanics, and non-Hispanic other races while cigars were the most commonly used product among non-Hispanic blacks⁶³.” Nationwide, the current use of e-cigarettes and hookah appears to be displacing traditional cigarettes, cigars, and other types of products⁶³.

In Multnomah County, the use of e-cigarettes almost tripled between 2011 and 2013, even as cigarette use fell⁶⁴. Among 11th graders surveyed about their use of e-cigarettes in the past month, 1.8% reported use in 2011, and the number increased to 5.2% in 2013. Among Multnomah County high school students in 2012, one in ten (10.1%) had ever used an e-cigarette, and 3.9% were currently using e-cigarettes⁶⁴.

Among the ten youth between the ages of 18 and 25 that we interviewed, eight perceived e-cigarettes as being healthier than cigarettes. Two were unsure and thought both e-cigarettes and cigarettes are bad for you. Six of the ten would choose e-cigarettes over regular cigarettes because of their smell, a perception that the taste would be better because of the flavors, and because there is no smoke. Two current smokers tried e-cigarettes in order to quit and found that e-cigs were not as satisfying because of the “mouth feel” on inhalation. This feedback mirrors a qualitative study in Connecticut where youth from 18 focus groups reported that the primary reason cigarette smokers who tried e-cigarettes discontinued their use was because they were not as satisfying⁶⁵. One person switched to e-cigarettes, and finds that he prefers them because e-cigs are less irritating to his throat. See Appendix 1 for a summary of youth interviews.

What are the differential health impacts of tobacco vs. e-cigs (i.e. “inhalant delivery devices”)? Can smokers use them to quit?

The health risks from smoking are related to both the addictive aspect of nicotine and from inhaling tar and other chemicals combusted during smoking^{11,39}. While e-cigarettes may reduce a person’s exposure to compounds related to combustion, they are not risk-free.

Research on e-cigarettes is mixed about their use as a method to quit smoking. Two systematic reviews and an additional recent analysis showed e-cigs deliver less nicotine per puff than traditional cigarette smoke, and they still deliver enough to maintain nicotine dependence⁶⁸⁻⁷⁰. Two studies indicate e-cigs could be used as harm reduction strategy if it were possible to develop devices that provide standard nicotine levels per puff^{27,68,69}. Right now the way a person inhales and the type of e-cigarette they use determines nicotine delivery and uptake, which varies from person to person and device to device⁶⁶. In one study, results of sample tested cartridges and refill nicotine solutions found that nicotine amounts in 9 out of 20 of the analyzed cartridges differed by more than 20% from values declared by their manufacturers^{28,69}. Three studies could not confirm the long-term benefit of using e-cigarettes for the general population^{28,66,71}.

E-cigarettes have risks. Nicotine is an addictive substance when it is inhaled^{27,28,39,66,67}. It is possible that e-cigarettes can be used for harm reduction to avoid tar and some carcinogens inhaled through traditional smoking of cigarettes⁷². Researchers have found multiple carcinogens in e-cig vapor and fluid that can end up in indoor air

“I would probably choose vapor only because the smell isn’t attached to it. It would feel more pure if I were to go that route.”

— Interviewed youth, age 21, non-smoker

Figure 7: Tobacco Price Discounts



Image from Multnomah County Tobacco Retail Assessment, 2015

“A special effort should be launched to enlist the support of the many minority-owned ‘mom and pop’ retail stores . . .”

— (Eagle Alliance Special Markets Team, RJ Reynolds)

when exhaled⁶⁶. These compounds (e.g. propylene glycol, glycerin, nicotine, 1,2-propanediol, aluminum, 7 polycyclic aromatic hydrocarbons) relate to eye and respiratory irritation and can affect the nervous system, development, and spleen^{27,66,68,69,71,73}. Research also finds they are related to injuries and illness (i.e. explosions, fire) and the chemicals are a concern for pregnant mothers^{27,66,68,69,71,73}. One study indicates that chemicals used to flavor foods, which have not been approved for inhalation, are used in electronic cigarettes⁷³.

C: Tobacco and E-cigarette Promotions and Availability

Tobacco companies focus specifically on youth as future consumers of tobacco^{11,39}. Tobacco companies have used flavored products to attract younger smokers and people of color^{11,74,75}. Menthol and other flavorings attract youth to use tobacco, and some studies indicate that starting cigarette use with menthol encourages long term smoking use and nicotine dependence⁷⁶. As recently as 2010, according to a national study, smokers using menthols were more likely to continue using it, compared to non-menthol users even as other types of cigarette use has declined⁷⁷.

Advertising tobacco also encourages its use among youth. Reviews of studies find that adolescents are influenced by tobacco advertising and marketing. Youth exposed to ads for tobacco recognize different products, and those who see more of these ads are more likely to use tobacco⁷⁸⁻⁸².

Starting in 1998, the Tobacco Master Settlement Agreement no longer allows tobacco companies to directly market to youth using cartoon or other youth-

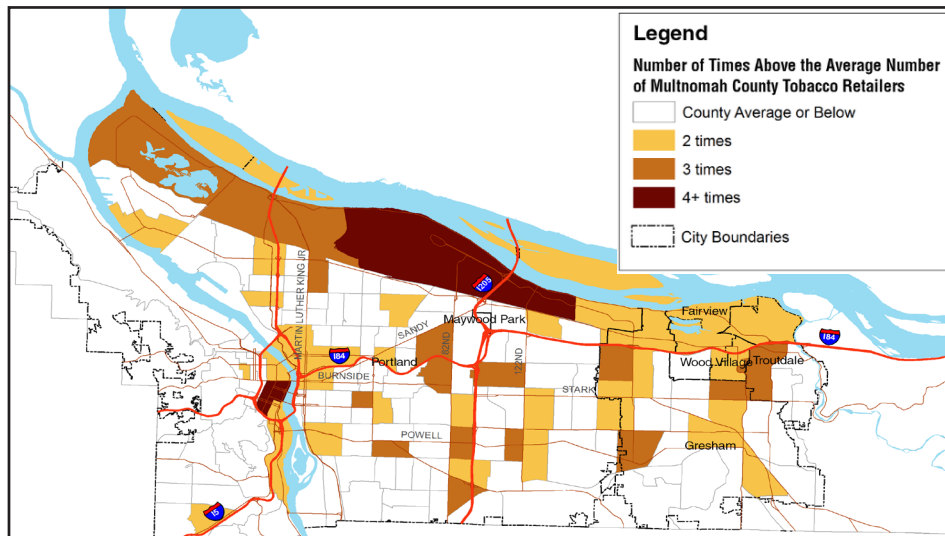
oriented imagery. Tobacco companies now focus their marketing budget on promotions in the retail environment, also called the “point of sale.” Price reduction, presence, placement, and product promotion are the new “4P” strategies tobacco companies can use to sell their product⁸³. In a store selling cigarettes or e-cigarettes, tobacco companies can use tobacco advertising, special displays, place tobacco products at the check-out counter or in other places where they are eye-catching, and arrange products to be near candy or other youth-attractive items⁸⁴⁻⁸⁶. Tobacco companies can enter into a contract with stores where the company offers a discount in order to sell tobacco at a lower price (see figure 7), or the contract can include financial incentives to encourage the retailer to 1) provide a lower price or short-term price promotions, 2) create a display of the product, or 3) use specific advertising and signs .

Tobacco industries use price promotions and discounts to sell their products, which are appealing to youth and individuals who are price sensitive^{80,89-92}. In 2012, the tobacco industry spent \$9.1 billion in advertising and promoting cigarettes⁸⁷. The largest expenditure involved paying retailers to reduce the price of cigarettes through price discounts (85.1% of all cigarette promotion spending)⁸⁷. In the same year, companies spent \$435 million in advertising and promoting smokeless tobacco; and nearly half (48.7%) of that was also spent on price discounts to retailers⁸⁸.

D: Tobacco Retailers in Multnomah County

There are an estimated 2,878 retailers in Oregon and 676 located in Multnomah County, based on existing data;

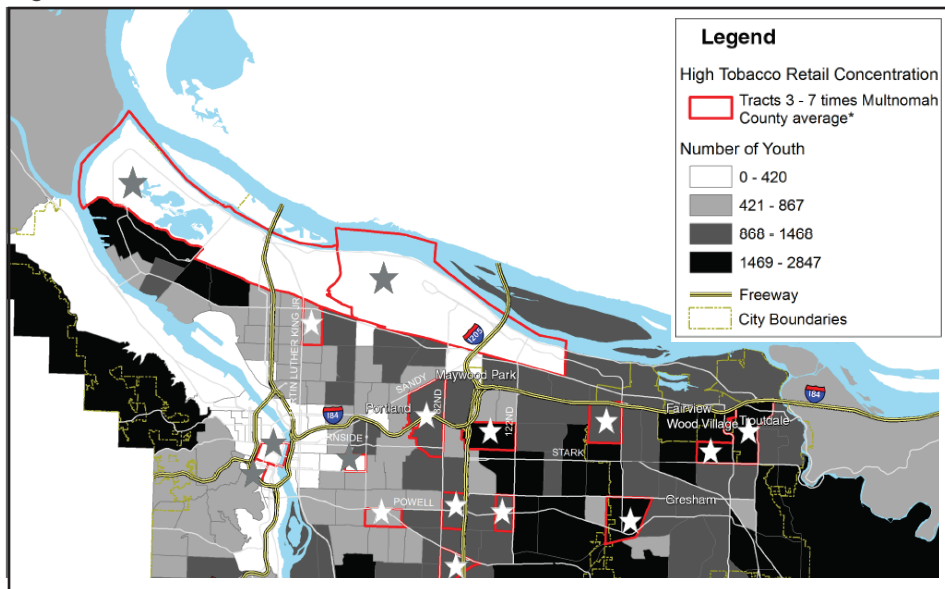
Figure 8: Concentration of Tobacco Retail



Retailer Data Source: Tobacco Retail Assessment 2014 - a collaboration among Multnomah County Health Department, Upstream Public Health and the Oregon Health Equity Alliance (OHEA); Population Source: American Community Survey 5-year estimate 2009-2013.

although this is likely an undercount⁹³. A recent FDA inspections database indicates that there are more than 1,000 retailers in the City of Portland alone⁹⁴. In a recent retail assessment, more than half (66%) of tobacco retailers included were a type of convenience store⁹⁵. More than three out of every four (77%) tobacco retailers in the assessment offered price promotions on at least one tobacco product⁹⁵. Of those who sold menthol cigarettes, six in ten (62%) offered price discounts for menthols⁹⁵. In Multnomah County, among assessed retailers that sold electronic cigarettes, about 3% offered price promotions⁹⁵.

Figure 9: Tobacco Retailers in Census Tracts Near Youth



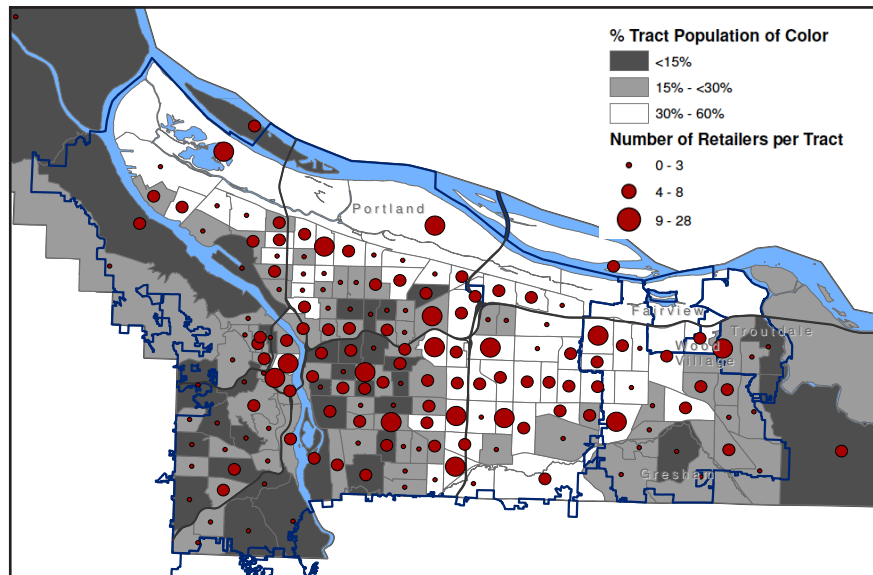
Multnomah County average is (3) tobacco retailers per census tract. Retailer Data Source: Tobacco Retail Assessment 2014 - a collaboration among Multnomah County Health Department, Upstream Public Health and the Oregon Health Equity Alliance (OHEA); Population Source: American Community Survey 5-year estimate 2009-2013.

Based on the tobacco retail assessment, the average number of retailers in each census tract in Multnomah County is three, and nine in ten retailers are located in the City of Portland (91%)⁹⁵. More than one in three (37%) of tobacco retailers are currently located within 1000 feet of a private or public school.

Are there currently more tobacco retailers in neighborhoods where more children live?

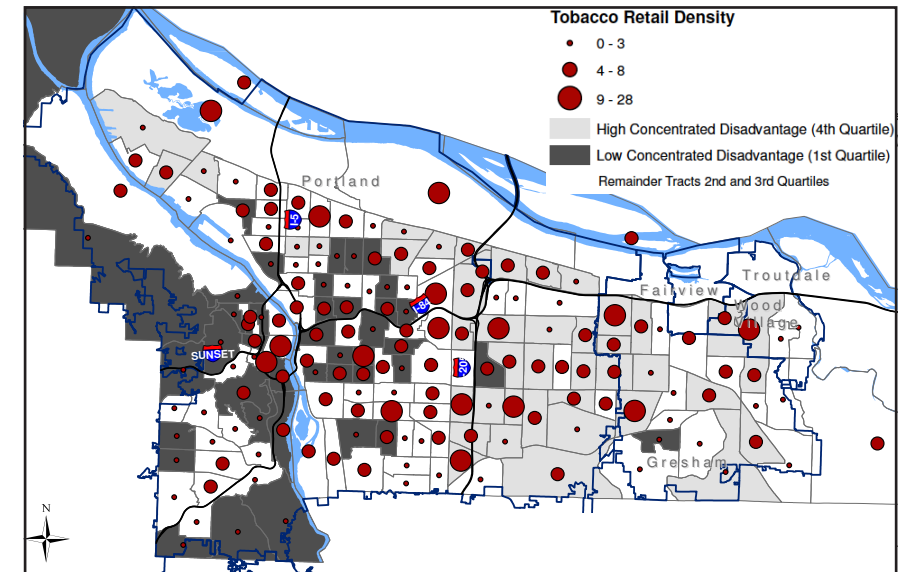
Figure 8 shows that some census tracts have more than the average number of tobacco retailers in the county. In figure 9 we can see that some of these census tracts overlap with neighborhoods where more children live. This amounts to a handful of “hot spots” across the region where youth have more access to tobacco and more exposure to tobacco and nicotine product advertising. As the population continues to grow, and Portland residents are pushed further east in the County^{96,97},

Figure 10: Tobacco Retailer Density in Relation to People of Color



Retailer Data Source (Figures 10 & 11): Tobacco Retail Assessment 2014 - a collaboration among Multnomah County Health Department, Upstream Public Health and the Oregon Health Equity Alliance (OHEA); Population Source: American Community Survey 5-year estimate 2009-2013.

Figure 11: Tobacco Retailer Density, Multnomah County: Association of Maternal & Child Health Programs Life Course Concentrated Disadvantage Indicator. Includes: poverty level, income assistance, female-headed households, unemployed, <18 years of age.



a tobacco retail license policy limiting new retailers near schools may help prevent continued access to tobacco for youth.

Are there currently more tobacco retailers in neighborhoods where more communities of color and people experiencing economic hardship live?

To explore the answer to this question, we used information from the recent Multnomah County Tobacco Retail Assessment⁹⁵ that involved a random, representative sample of tobacco retailers in the county. Using a geographic information

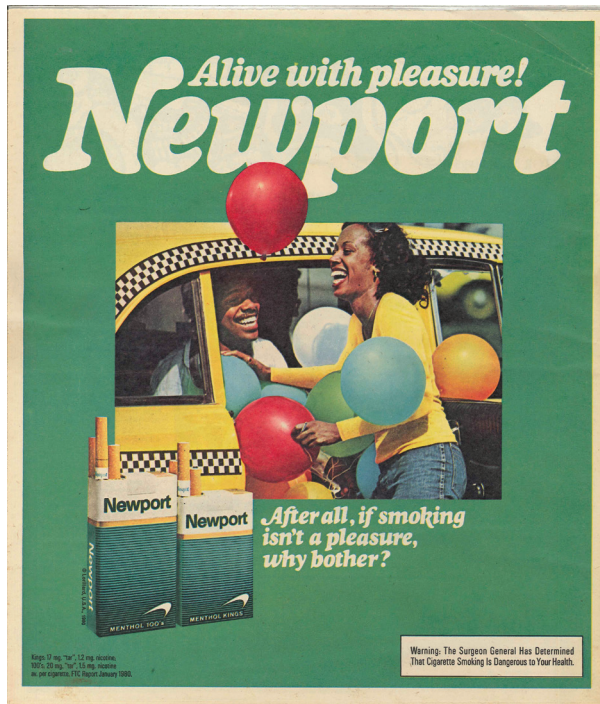
systems analysis to plot retailer location by census tract, the retail assessment found that there are more tobacco retailers per capita in areas with higher populations of color⁹⁵.

- There are 7.8 retailers per 10,000 people in areas where there are less than 15% of residents are people of color.
- There are 8.9 retailers per 10,000 people in areas where between 15 and 30% of residents are people of color.
- There are 11.0 retailers per 10,000 people in

areas where between 30 and 60% of residents are people of color.

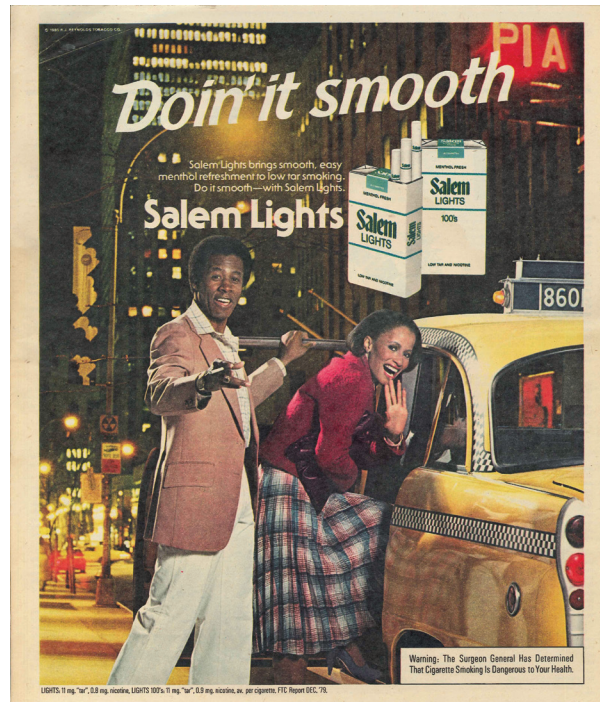
Many of these neighborhoods where more communities of color live also have higher numbers of families experiencing concentrated disadvantage (see figure 11). Concentrated disadvantages is an index that Multnomah County Health Department uses to show how families may be impacted by multiple factors of economic hardship (see description below the map in figure 11). This concentration of retailers in areas where people of color live exists even with recent demographic changes. People of color are being displaced from

Figure 12: Advertising Example



Images from The Portland Observer, 1983

Figure 13: Advertising Example



"These pictures... this is me. This is my community that was impacted".

— Workgroup member

North Portland, an area where more Black residents lived during the 1980s and 1990s, and being forced to move to mid and east-county to homes that are more affordable^{96,97}.

This current state of the tobacco environment mirrors national trends. Studies from cities across the nation indicate that the legacy of industry promotions and financial encouragement of retailers contributed to more tobacco retailers

located in economically under-resourced neighborhoods and in areas where people of color live^{47,98–108}. For example, one study in New York found that census tracts with lower median incomes and higher percentages of African Americans and Hispanics had a higher density of tobacco retailers, placing these communities at greater risk for tobacco related health problems compared to more advantaged communities¹⁰⁴.

What groups in Multnomah County have historically been burdened with tobacco use?

Multiple reviews of tobacco industry documents released in the Tobacco Master Settlement Agreement show that tobacco companies targeted many socially and economically disadvantaged groups across the country—including communities of color, immigrant populations, women, children, Native tribes, the homeless, and LGBT

“This unique combination of ‘Indian’ and ‘Natural’ gives us, and you, a solid competitive edge... an exclusive line of authentic reproductions of Native American pipes, snuff, containers, tobacco pouches, and other natural tobacco implements”.

— Santa Fe Natural Tobacco Company

“They took our cultural traditions and co-opted them, used our images to sell tobacco.”

— Workgroup Member

“Asian smokers appear to be a key market [for tobacco industry] to focus on - since, according to Philip Morris International, smoking incidence in most Asian countries is considerably higher than that of the U.S.”

— Rodriguez Y. 1993

communities - with carefully tailored advertising, marketing, and promotion strategies^{11,39,47,75,100,108-115}. While changes in tobacco advertising and policies to increase the price of tobacco have helped reduce the total number of people smoking,³⁹ many ethnic and culturally specific groups continue to be burdened with tobacco use, as we can see in both Oregon and Multnomah County.

How were groups who now carry tobacco burdens historically targeted?

The tobacco industry historically targeted specific communities as consumer markets, using price promotions, advertising, and flavored products. They also used: comics; culturally specific stories and images; mobile vans; free products at large public events (e.g. music concerts, powwows, rodeos); give-aways in stores, on the street, and in homeless shelters; and other methods^{47,75,108,109,112,116}.

Researchers have not explored industry documents as extensively on practices related to immigrants. A few of the major companies focused on geographic location, assimilation level, and smoking patterns of countries of origin for Asian and Latino or Hispanic immigrants^{109,111}. Tobacco companies conducted psychological profiling, studied community cultures, and used a variety of methods to attract new smokers including youth, men, women, children, soldiers, and particularly socially and economically disadvantaged people^{47,108-110,112-114,116-119}. Tobacco companies were especially interested in African American consumers for their “down” markets including the “younger, less educated, lower in income, urban, [and smoking full-flavor and menthol cigarettes, p. 5628]”¹⁰⁸. To determine specific boundaries of target neighborhoods

within these markets, the Reynolds tobacco company conducted interviews in ZIP code areas pre-defined as inner city, at least 50% African American, and with yearly household incomes under \$20,000¹⁰⁸.

In the 1980s and 1990s tobacco companies undertook the “menthol wars” to gain the largest market share of African American smokers¹⁰⁸. In exploring neighborhood newspapers of Portland in the 1970s through the 1980s, it is clear that industry paid for advertising in newspapers circulated in Portland¹²⁰. Menthol was used to cover the bad taste of tobacco, and add a “cooling” effect, that in the 1940s the tobacco industry claimed had health benefits^{39,121}. Research indicates menthols are more

80% of smokers in Oregon want to quit.

addictive, as people have a lower quit rate with this type of cigarette¹²².

What supports currently exist to help people stop smoking?

Oregon and Multnomah County communities are aware of the risks of tobacco use and are taking steps to quit smoking. In Oregon, eight in ten smokers want to quit⁷. In Multnomah County between 2010-2013, more than half (55.1%) of smokers tried to quit¹²³. There are multiple web-based, telephone, and community-based cessation resources available in Oregon, although Workgroup members indicated that these may not be culturally responsive (see Appendix 3). For example, Oregon has a free Tobacco Quit Line, and web-based supports through

its SmokeFree Oregon site. People experiencing economic hardship, people without phones, those who do not speak English or the other languages the Quit Line offers, individuals with mental illness who are not comfortable with the phone, or those without shelter, may not have the ability to use these services.

The Oregon Division of Medical Assistance programs reimburse American Indian and Alaskan Native providers for tobacco-cessation services¹²⁴. Oregon law requires that health benefit plans purchased after January 1, 2010 provide at least \$500 in payment, coverage, or reimbursement for tobacco-use-cessation programs for enrollees 15 years of age or older¹²⁴. However, this does not include people on Medicaid, Medicare, disability income, short-term health insurance, or student insurance plans. For Medicaid clients covered under the Oregon Health Plan, they may receive basic, intensive, or telephone tobacco-cessation treatment¹²⁴. Under the basic treatment a clinician is supposed to follow the 5 A's: Ask if people smoke, Advise a person to stop smoking, Assess the person's willingness to quit in 30 days, Assist with behavioral counseling or other method, and Arrange for follow up for more intensive treatments if this does

not work (ORS-410-130-0190). Despite this, multiple Workgroup members who have smoked indicated that clinicians may only be covering the first two A's and not providing the others. This may be because in the Oregon statute, the basic treatment that involves discussing client concerns and providing support is only supposed to last six (6) minutes without additional billing (ORS-410-130-0190).

Historically, government agencies and health insurers have not invested sufficient resources in terms of health care, tobacco prevention, and cessation program funds as described in Table 2¹²⁵. Community organizations in Multnomah County-including the African American Health Network, other members of the Action Communities for Health Innovation, and Environmental Change (ACHIEVE) coalition - have focused on, advocated for, and increased funding for tobacco cessation for decades (Personal Communication, ACHIEVE Meeting, Feb 4, 2015).

"Cigarettes are so bad for you. I hate the smell of cigarettes, we used to sell more of them until we were broken into and that is the first thing they [thieves] stole."

— Interviewed store manager who sells tobacco, mid-county

Table 2: CDC recommended tobacco prevention and cessation program funding for Oregon and actual funding¹¹⁵

FY 2015 Current Annual Funding (Millions)	CDC Annual Recommendations (Millions)	FY 2015 Percent of CDC's Recommendations	Current Rank in the Nation
\$9.9	\$39.3	25.2%	19 th

Assessment of Health Equity Impacts of Tobacco Retail Licensing

“Those other places (points to a tobacco shack) only sell tobacco, why do we have to get a license too? Those places have too much advertising, there used to be a limit, now there are too many signs.”

— Owner, retailer with 8-12% of profits from tobacco products, mid-county

In Oregon, the top five tobacco companies in the U.S. spend about \$108.4 million on marketing, compared to \$9.9 million the state spends on programs preventing tobacco use and treatment for tobacco cessation¹²⁵.

This section presents a summary of evidence on assessment questions put forward and prioritized by the Workgroup. The section also includes a summary of health equity predictions based on existing conditions and the result of the literature review. These potential impacts reflect how potential tobacco retail licensing policy could affect health equity factors and health equity outcomes related to changes in the tobacco environment. The data and predictions are then the basis for recommendations at the end of each section.

A: Potential Tobacco Environment and Access Health Equity Impacts

Would the policy reduce price promotions and advertising that encourages youth use of tobacco and e-cigarettes?

If a tobacco retail license policy requires that retailers no longer offer price promotions and advertising, then this would reduce promotions that encourage youth to use tobacco. If a tobacco retail license policy does not restrict price promotions and advertising, it is unlikely the policy will reduce promotional materials that attract youth to smoke. In Oregon, the top five tobacco companies in the U.S. spend about \$108.4 million on marketing, compared to \$9.9 million the state spends on programs preventing tobacco use and treatment for tobacco cessation¹²⁵. In interviews, one retailer expressed a desire for there to be a limit on tobacco advertising.

Tobacco contracts are managed by industry Trade Marketing Managers who build relationships with

retailers. A Trade Marketing Manager will visit a store regularly and offer an ongoing financial incentive payment to the store in exchange for advertising and price discounts. The tobacco company can then change marketing regularly in a store, and this often results in a doubling or tripling of sales of tobacco in a contracted store⁸³. Tobacco is the most profitable item sold in stores, and tobacco price discounts increase sales⁸³. Since retailers do not have funds to provide discounts, tobacco companies pay the stores to cover the cost of the discount. Contracts since 2004 involve paying chain stores a low monthly “rent”(up to about \$200 a month) and all independent retailers are offered “per carton incentives,” or funds to sell a certain number of a specific tobacco product at a lower price. An example would be the tobacco company paying a store \$2.00 for every carton of a specific brand sold in a week. If the store sells 100 cartons, they receive \$200 that week. A tobacco company may also “buy down” the price of a tobacco product by paying a retailer funds to lower the price of a product, often as a way to reduce tobacco prices when there is a tobacco tax⁸³. One study in 2004 in 15 states found that retailers who received \$3,000 or more in cash in the last three months had 19.5 advertising materials compared to those who received no funds and had 8.2 promotional materials¹²⁶.

Among the retailers we interviewed, two had current tobacco contracts, and the other two had contracts in the past. One participant estimated a current contract provided only \$200 a year in reimbursement funds from

a tobacco company for sales. Another participant shared they received up to \$300 a month to sell a specific product at a specific price when they had a contract. These two responses indicate that the amount of money earned from any contract varies widely based on how many cartons retailers sell.

Would tobacco retail policy change the number of retailers located in different neighborhoods?

It is possible that a tobacco retail licensing policy would affect the number of retailers in different neighborhoods, although it is not clear to what degree. Tobacco retail licensing usually includes a fee a business pays to buy the license to sell tobacco¹⁸⁻²⁰. The fee can be used to pay for enforcement of laws that make it illegal to sell tobacco to youth under the age of 18. Retailers who do not earn a significant proportion of their annual profits from tobacco may decide paying a fee to buy a business license is not worth it and may stop selling tobacco^{127,128}. It is also possible that if a retail licensing system has a provision that no new retailers can be located 1000 feet from schools, neighborhoods near schools would eventually have a lower concentration of retailers over time. See the Economic Equity section for more on this topic.

We asked retailers what they would do at three different possible annual fee levels, which we estimated based on the potential of a county and state licensing fee together. In interviews, one retailer mentioned they would stop selling tobacco at a \$300 annual fee level. Two retailers said they would raise the price at \$300, \$500, or \$1000 fee

levels. One retailer would raise the price of tobacco at the lower fee levels and stop selling at \$1000 a year. It is possible that a tobacco retail licensing fee of \$500 or more could reduce the total number of retailers selling tobacco, but we cannot determine which ones would stop and where they are located.

Can this policy reduce the rate of sales to youth under the age of 18 (minors)?

Reviews of existing studies suggest that requiring a license to sell tobacco, with specific policy elements in place to enforce the licensing system, does help reduce youth access to cigarettes through commercial sources^{21,90,129-139}. One study compared youth adolescent smoking in communities with local retail licensing to control communities without the commercial policies. The study found that not only did the law impact youth reported rates of smoking within the first few years of implementation, but the low rates continued even after five years¹³⁹. Studies indicate that when a licensing system involves an annual fee that is high enough to cover regular compliance checks, and the structure provides the option to suspend or revoke a license, the likelihood a retailer will ask for identification increases, and sales to minors fall^{18,21,90,137,140}.

Reviews indicate that a licensing policy that does not include the ability to enforce the license and related tobacco regulations with visits to retailers and does not include the ability to revoke the license, leads to mixed results and limited effectiveness^{18,21,90,101,129,136,137,140}. Four studies indicate

that as youth find it harder to buy tobacco from stores, they obtain them from other sources, such as older siblings, peers, adults, and underground markets^{129,130,136,138}. These studies and current data (see table #) showing youth primarily obtain tobacco from non-retail sources demonstrate the need, in addition to a potential tobacco retail licensing policy, community supports or other policies that encourage young adults to stop purchasing tobacco for their younger peers¹¹.

Would the policy reduce youth use of tobacco and nicotine products?

Some areas of Multnomah County have a concentration of more families with children combined with a higher than average number of tobacco retailers, and evidence indicates that a higher density of retailers near youth results in youth being more likely to try tobacco^{95,104,141-145}. It is possible that a tobacco retail policy with a reduction in price promotions and fewer retailers near schools could, in combination with other recent policies, reduce use of flavored tobacco products and e-cigs.

Consistently, numerous studies find that advertising, price, and promotions to youth impact youth's experimentation with and perception of tobacco products^{11,80,89,146,147}. If retailers stopped using price promotions, this could affect youth use of tobacco products. Research on youth use of tobacco related to the number of retailers in their neighborhood indicates that when youth have more opportunities to obtain tobacco and

“I prefer menthol cigarettes. I like Swisher Sweets [little cigar] and for ceremonial purposes loose leaf or Native American Spirits. I tried e-cigs and didn’t like them. I don’t know. I hear a lot of different things. That e-cigs are good for you, better. Others say it’s worse for you because of the chemicals. I just don’t know. They get expensive fast because you have to buy the pen, the liquid, etc. Accessories are costly.”

— Interviewed Youth,
Age 21, smoker

they see more tobacco advertising, they are more likely to smoke. For example, in one study the prevalence of current smoking was 3.2 percentage points higher at schools in neighborhoods with 5 or more retailers than in neighborhoods without any tobacco retailers. The density of retail cigarette advertising in school neighborhoods was similarly associated with smoking prevalence in high schools^{21,132}. Another study in California found that for stores within walking distance to high school schools, for each 10 percentage point increase in the proportion of Black students, the proportion of menthol advertising increased, without a similar change in non menthol promotions⁹². In Multnomah County, 37% of retailers are located 1,000 feet from a school, based on analysis of tobacco retail assessment data⁹⁵. Research on tobacco retail outlet density near schools indicates that concentrated tobacco retailers can have an encouraging effect on youth initiation and experimentation with smoking^{141,143}. While a tobacco retail licensing policy may affect the number of retailers in the future located near schools, few studies indicate that youth attitudes or perception of tobacco changes from tobacco retail licensing²¹.

Because tobacco retail licensing is intended to help reduce the number of sales to youth, it is possible that with more retailers in an area there are more opportunities to attempt a sale. A licensing policy can help reduce this potential, especially in neighborhoods with more retailers.

Can this policy help protect youth from other unregulated products as they emerge?

A licensing system helps the public know who sells

tobacco and nicotine products and where they are located, and a licensing system establishes a culture that selling to minors is not okay¹⁴⁵. At the moment, Oregon officials use lists of retailers from federal inspection systems, such as Synar, to know where tobacco retailers are located. While tobacco distributors have complete lists, they are not available to the public. Not knowing who sells tobacco or nicotine products is a barrier to educating retailers about existing laws and new laws on emerging products such as electronic cigarettes. We do not know if a tobacco retail license would help protect youth from other unregulated products like e-cigarettes, however, it would ensure we know where all retailers are in the state, which can support educating retailers about new product health risks.

Earlier in 2015, the state legislature included electronic cigarettes in the Indoor Clean Air Act, making it illegal to use them indoors in public. Recently in 2015, the Multnomah County Board of Health also made 18 the legal age limit for using e-cigarettes; many retailers may not know about this new law. It is certain that a licensing system for tobacco and inhalant delivery devices will support tobacco educators in reaching retailers and informing them of existing and new laws about these products.

Would the policy affect people who want to quit smoking? How?

Research indicates a tobacco retail licensing policy can help decrease the number of retailers located near a smoker’s home, supporting people who want to quit smoking^{130,148–150}. If more retailers decided to stop selling tobacco, or there were fewer retailers near

schools, this could result in fewer tobacco retailers in some neighborhoods. Reducing availability of tobacco products is part of a three-part strategy to help smoking cessation, along with reducing exposure to secondhand smoke and countering pro-tobacco advertising. Banning sampling and price promotions can support a smoker in quitting^{151,152}.

Research on tobacco retail density indicates that having a high number of tobacco retailers near the home prevents people from being successful in their attempts to quit smoking. One study found that a higher concentration of tobacco retail outlets within walking distance of one's home may reduce cessation activity among non-treatment seeking smokers, and that impact may be most detrimental for cessation among smokers in higher poverty areas¹⁵⁰. In high poverty areas, smokers living between approximately 500 meters (~1600 feet) and 1.9 kilometers (1.2 miles) from a retailer were more than twice as likely to abstain for at least 30 days, compared with those living less than 500 meters from an outlet. Another study of economically disadvantaged smokers enrolled in a cessation program found that those living within one mile of a tobacco retail outlet had stronger urges to smoke compared to those who lived greater than a mile from an outlet¹⁴⁸. A third study found that participants who lived within a shorter walking distance (less than 500 meters) of a tobacco retailer were less likely to abstain from smoking compared to those who lived farther from an outlet, and the strength of this relationship increased the closer the person lived (less than 250 meters) to the closest outlet¹⁴⁹.

Will this policy lessen the existing health inequities and burdens on tobacco and nicotine related chronic conditions? Is this policy more effective at helping to reduce existing tobacco disease inequities for some groups over others?

Cigarette smoking relates to additional inequities related to who experiences stroke, any type of cancer, lung cancer, and colorectal cancer¹⁵³. Black/African American residents in Multnomah County are disproportionately impacted by each of these conditions¹⁵³. Native American, Pacific Islander and Latino populations in Multnomah County also bear a greater burden than their White, non-Latino peers of one or more of these conditions¹⁵³.

The TRL policy is prevention focused – aiming to stop new tobacco use before it starts. Three reviews examined the equity impacts of tobacco policies (over other interventions) on reducing smoking-related inequalities among groups most impacted by smoking^{154–156}. Two reviews determined that laws, such as TRL, that involve restricting young people's access to tobacco products reduced illegal age sales, but the findings were mixed about whether these policies reduce actual smoking behavior^{154,155}. If the policy prevents youth of color from beginning to use tobacco, then the policy could reduce tobacco-related health inequities, because more people of color would be free of this risk factor in the future.

Will the policy reduce the state costs for treating smoking related chronic conditions?

In Oregon, the current youth smoking rate is 9.4%¹²⁵. If that rate were reduced to 7.5% - which is Florida's rate, the lowest in the nation - this small decline would mean 27,690 fewer children growing up with chronic disease

"There needs to be a recommendation about how those who continue to smoke are also in stressful situations, and it's not fair to force them to stop smoking without supports when they may live in unsafe areas, without access to parks, without job opportunities, without health care."

— Workgroup member

"Personally I feel like the taste and strength of a drag is stronger with a cigarettes, not e-cigs. If there wasn't any nicotine in cigarettes I wouldn't smoke as much. I would still smoke because I like the experience, the nicotine gets me going. My partner bought me a refillable e-cigarette and I freaked at the cold feel of the electricity. It was electric, and felt strange."

— Interviewed Youth, age 25, smoker

“So many immigrant community members become small business owners. They work so hard; I want to be sure that they are not targeted based on how they look. It is really important that any new policy be very clear and that education and training be in an understandable, straightforward way.”

— Workgroup member

related to tobacco and nicotine use, 9,700 lives saved, and \$484.6 million in health care costs saved (page 10 of Broken Promises report)¹²⁵. We do not have similar numbers for Multnomah County available.

Potential Tobacco Environment and Access Changes Summary

Table 3 describes the predicted impacts that a tobacco retail licensing policy, as outlined earlier in this report, could have on the tobacco environment. This summary table is based on examining the current conditions, the research literature on each topic, and the potential interactions between the policy and these factors^{157–159}. The current data on who uses tobacco combined with research on historical industry practices shows that people of color, people experiencing economic hardship, people with chronic mental health and substance use challenges, and LGBTQ community members continue to carry the burden of tobacco use. For a description of how each outcome relates to policy recommendations, see Appendix 1.

Based on the information reviewed so far, and the need to prevent a widening set of racial and social inequities in the future, the workgroup and HEIA analysis suggest a series of recommendations to maximize health equity in relation to how our neighborhood access to tobacco may change based on a tobacco retail licensing policy. These are described in Conclusions section.

B: Potential Economic Health Equity Impacts

A central factor that contributes to life long health is employment and income security^{160–162}. The workgroup wanted to understand the impact of a tobacco retail license fee on small, independently owned retailers who

may not have access to as many financial resources or supports as larger corporate peers. Further, workgroup members wanted to understand how the price of the tobacco retail licensing fee could impact the cost of tobacco products.

Who is most impacted by the retail license fee? What is the impact of \$300 to \$500 annual license fee on a small retailer's bottom line? Would the retail license fee be passed on to customers?

In order to understand how a license fee would affect retailers and the price of tobacco products, we start with current sales, costs, and the impact of the licensing fee. Nationally, cigarettes were the number one product in sales for convenience stores in 2012, with other tobacco products the fourth best seller according to an industry report¹⁶³. Nationally, average cigarette sales for a store in 2012 were \$622,248. We do not have a way to calculate average sales of cigarettes in Oregon, because we do not have an up-to-date list of retailers with associated sales levels. However, after talking with retailers, we expect that the businesses that are most sensitive to a license fee are those for whom tobacco is a secondary market - meaning not their primary source of profits.

There is very little published research on the impact of tobacco, or even liquor, retail license fees on sales for small retailers. One Australian study found that when the government increased a tobacco retail-licensing fee 15-fold (from \$12.90 to \$200 a year), the number of license applications fell by 23.7% in a three-year time span after the increase¹²⁸. The researcher found that during the same time period, the number of gaming and liquor licenses increased each year, and there was no significant change in reported business revenue after the implementation of

Table 3: Predicted Environment and Access Health Impacts of Tobacco Retail License Policy

Potential Tobacco Environment and Access Health Equity Impacts				
Health Determinant or Health Outcome	Likelihood	Direction of Impact	Impacted & Most Vulnerable Groups	Equity Harms or Benefits
Youth’s tobacco purchases from stores	Very Likely , with \$ for enforcement and ability to suspend/revoke	Decrease	Youth, youth of color, youth experiencing economic hardship, LGBTQ youth	Benefits
Youth’s ongoing use of tobacco and e-cigs based on store proximity	Uncertain to mixed for existing users Possible to prevent, decrease new users	Mixed	Youth, youth of color, Youth experiencing economic hardship, LGBTQ youth	Benefits
Youth’s experimentation with tobacco and e-cigs	Possible to Likely	Decrease	Youth, youth of color, Youth experiencing economic hardship, LGBTQ youth	Benefits
Youth’s positive impressions about tobacco and e-cigs	Uncertain to Possible	Decrease	Youth, youth of color, Youth experiencing economic hardship, LGBTQ youth	Benefits
Retailer proximity to schools	Likely to Certain if policy includes limiting new stores near schools	Decrease	Youth, youth of color, Youth experiencing economic hardship, LGBTQ youth	Benefits if have supports in place
Number of retailers who choose to stop selling tobacco and switch to other items	Uncertain to Possible	Increase	People of color, current smokers, people experiencing economic hardship	Benefits if new items do no harm
People who want to stop smoking supported by retail environment	Uncertain to Possible	Mixed	Current smokers	Mixed
Tobacco and nicotine related chronic conditions	Likely	Decrease	Youth and young adults	Benefits
State costs of health care for tobacco and nicotine related chronic conditions	Likely	Decrease	Youth, young adults, current smokers	Benefits
Harms = Disproportionate harms: The decision will result in disproportionate adverse effects to populations defined by demographics, culture, or geography		Benefits = Disproportionate benefits: The decision will result in disproportionate beneficial effects to populations defined by demographics, culture, or geography		

a smoke-free pubs and clubs law during the same time^{128,164}. The author concludes that retailers who do not have a strong demand from consumers for tobacco will stop selling it at a higher fee level¹²⁸. The Oregon Liquor Control Commission estimated in a fiscal analysis of a tobacco retail licensing bill (Senate Bill 0633) that a \$300 annual fee would be needed to implement licensing checks¹⁶⁵.

One way a retailer can handle the cost of a license fee is to pass the cost on to consumers. Analysis on the impact of tobacco retailer licensing fees indicates that for smaller retailers who have an annual volume of sales of \$25,000 (i.e., a little more than 4,100 packs sold a year, or about a dozen packs per day), a \$200 licensing fee would raise the price of a pack of cigarettes by five cents. A \$500 retail licensing fee would raise the price of a pack of cigarettes by twelve cents (see table 4)¹⁶⁶. Oregon’s average price of cigarettes is about \$1.30 less the national average of \$6 a pack. The analysis of the impact of the licensing fee started with the higher \$6 a pack average. Therefore, in Oregon, the number could be about a penny higher. We conclude that if the license fee is set at \$300 or less a year, retailers may raise the price of cigarettes by about eight cents a pack.

This estimated price increase of less than a dime per pack from a retail license should be considered relative to the current cost of tobacco products. Oregon has some of the lowest tobacco taxes in the country, and therefore our prices on tobacco are lower¹⁶⁷. For example, Oregon’s tax on cigarettes

was \$1.31 in 2015, while Washington’s was \$3.025¹⁶⁷. The average lowest prices of tobacco and e-cigarettes in Multnomah County are listed in table 59⁹⁵.

Extensive research covered in a 2012 systematic literature review indicates that when prices of cigarettes increase to a high enough level, people—especially youth and young adults—buy and use less tobacco¹⁶⁸. Specifically, a 20% increase in the unit price of tobacco is associated with a median reduction of 7.4% of demand among adults and 14.8% median demand reduction among young people¹⁶⁸. Other research indicates smoking can decline by 4% with a 10% increase in prices^{169–171}. To see these changes, the price of cigarettes would have to rise by at least \$0.50 to \$1.00 a pack. A change between five and fifteen cents would not reduce the

sales or use of tobacco. However, youth and people experiencing economic hardship who are sensitive to price changes might be impacted. A recent study calls this into question as new data from the 2007 – 2013 Youth Risk Behavior Survey finds that youth are becoming less responsive to cigarette taxes¹⁷². This study does not take into account that there are cheaper tobacco product options available, such as flavored little cigars. More than one young person we interviewed indicated that the high price of tobacco makes smoking difficult, and some continue regardless of prices.

Table 4: The potential impact of tobacco retailer license fees upon the additional costs of a pack of cigarettes¹⁶⁶

Annual sales volume for cigarettes	Number of packs sold *	Annual license fee						
		\$ 50	\$ 100	\$ 200	\$ 500	\$ 1,000	\$ 2,500	\$ 5,000
\$ 25,000	4,167	\$ 0.01	\$ 0.02	\$ 0.05	\$ 0.12	\$ 0.24	\$ 0.60	\$ 1.20
\$ 100,000 ^a	16,667	\$ -	\$ -	\$ 0.01	\$ 0.03	\$ 0.06	\$ 0.15	\$ 0.30
\$ 300,000 ^b	50,000	\$ -	\$ -	\$ -	\$ 0.01	\$ 0.02	\$ 0.05	\$ 0.10
\$ 500,000	83,333	\$ -	\$ -	\$ -	\$ 0.01	\$ 0.01	\$ 0.03	\$ 0.06
\$ 1,000,000	166,667	\$ -	\$ -	\$ -	\$ -	\$ 0.01	\$ 0.02	\$ 0.03
\$ 2,500,000 ^c	416,667	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 0.01	\$ 0.01

* Assumes a \$6.00 per pack average price (national average= %5.95, 11/1/2010 - Tax Burden on Tobacco)

^a Supermarket ^b Gas w/convenience store

^c Warehouse club. The prices that are highlighted are the ones that are more likely to have an impact. The other amounts, such as a potential \$.01 price hike, are very negligible.

Some researchers argue that raising the price of tobacco negatively disproportionately impacts people experiencing economic hardship who do not have as many supports to help them quit smoking, in comparison to those with more resources¹⁷³⁻¹⁷⁵. One study calculated that in New York, which has some of the highest tobacco taxes in the nation, in 2010-2011 the lowest income group of smokers spent 23.6% of annual household income on cigarettes, a significant financial burden¹⁷⁶. Further, one review found that there is a lack of evidence about the impact of increasing cigarette prices on smoking behavior in heavy/long-term smokers, persons with a dual mental health and substance use diagnosis, and Aboriginals¹⁷⁷. Others argue that tobacco use has such a heavy health toll that it is important to consider raising tobacco prices to

reduce how attractive cigarettes are^{175,178}. From a health equity perspective, if tobacco prices increase, it is crucial to support persons who are addicted and want to quit. This can happen through funding and providing trauma-informed, culturally responsive, targeted, smoking cessation efforts because of the extensive health burdens tobacco brings^{154,156,174,175,177}.

Have other TRL programs used education as part of their enforcement efforts, what kind and for whom? Has any of it been culturally competent for retailers? And how was it done?

The Assessment team did not find culturally responsive tobacco programming for retailers. However, the state of Michigan has a robust training program for retailers that includes linking retailer staff to tobacco cessation

“This is adding another small fee to smaller retailers. It’s not even that expensive for an alcohol license (\$100 I think). I don’t know what the law on e-cigarettes is but I see them everywhere. We don’t even sell lighters to underage kids.”

— Manager, retailer with tobacco sales 2% of profits, mid-county

Table 5: Multnomah County Tobacco Retail Tobacco Prices

Item	Average Lowest Price	Price Range
Cigarettes, single pack	\$4.70	\$1.99 - \$11.99
Newport menthol hard pack	\$6.52	\$5.65 - \$11.99
Blu disposable e-cigarette	\$9.86	\$7.99 - \$12.99
Single flavored little cigar	\$1.00	\$0.50 - \$8.99
One can chewing tobacco	\$4.94	\$0.99 - \$7.99

programs, as many staff are smokers¹⁷⁹. Michigan also put into place a “We Check to Protect” program connect to a new law supported by a broad coalition that changed all government issued identification to clearly label in red the legal age when a person can purchase tobacco and alcohol¹⁷⁹. Michigan has a Youth Access to Tobacco Workgroup that put forward a set of best practice recommendations for tobacco vendor education¹⁸⁰. Based on this the Workgroup and project team developed recommendations for any tobacco retail licensing system to work with existing tobacco inspections programs, retailers, and community organizations to develop culturally responsive future training materials in different formats for retailers, especially those who speak English as a second language.

Who could pay the fines for breaking the sales to minor laws? What is the risk of a clerk losing their job?

If a policy does not place the responsibility for fees and fines on owners, it is likely that clerks would be disproportionately harmed. Senate Bill 417 initially placed the burden of any penalty fines on clerks. The Workgroup is concerned, because the current Oregon tobacco inspections system can result in fines to clerks who are likely paid minimum wage and unable to afford higher fines. If a clerk is not trained in new tobacco control laws and is issued a fine based on this lack of training, then a tobacco retail licensing law could create inequitable burdens. The amended version of a similar retail licensing bill, SB 663, requires that owners of the

retail license pay the license fee and the penalties for selling to minors¹⁸¹. There has been a growth in businesses owned by recent immigrants,^{51,182,183} and different areas of Portland may have retail staff for whom English is not the primary language spoken in the home. Out of the four retailers we interviewed, three spoke a language other than English in the home, and the fourth spoke another native language in addition to English. The Workgroup developed recommendations to address potential inequities based on language or culture, citing concern about the existing tobacco inspection program and the impacts of burdening lower paid workers with a potentially unaffordable fee. Many Workgroup participants are concerned about the potential for convenience store staff members to lose their jobs if they made a mistake in selling to a minor without being aware of new laws. To avoid this outcome, Workgroup participants want to ensure convenience store staff members are well educated and trained in all laws related to sales to minors, in a way that is relevant to their cultural backgrounds and language. See the recommendations in the next section for more on this topic.

In places that have these laws do owners help prevent youth access beyond the law?

There has been an increase in the number of retailers who have voluntarily stopped selling tobacco products, regardless of the presence of tobacco retail license laws^{127,184,185}. Most of the people interviewed in these studies indicate ethical reasons for stopping sales—for example a pharmacy

not wanting to sell tobacco alongside drugs that help manage tobacco-related illness^{184,185}. Other business reasons retailers gave are that the sales of tobacco have declined so much that it became easier to shift away from it, and that selling tobacco did not fit with the store’s image¹²⁷. In Multnomah County, La Amistad, a small market in Portland, decided when they first opened that they would not sell tobacco¹⁸⁶.

Are there existing policies that support economic development for retailers who limit their tobacco and nicotine sales?

Workgroup members in the assessment were concerned that for some smaller retailers the license fee would be difficult to cover. We learned in our interviews with small retailers that tobacco brings customers in to purchase other things, and even if tobacco is a relatively small percentage of sales, a few considered it important enough to keep at multiple levels of a retailer fee. The four retailers we interviewed told us that between 2% and 12% of sales profits are directly tobacco and related products. Out of the four key informant interviews, three retailers said they would raise the price of tobacco in order to cover the cost of a retail license at a \$300, \$500, or \$1000 level. One retailer we interviewed said she would stop selling tobacco at any level of an annual retail-licensing fee, because the cost of the license was not worth the value of keeping the product in the store. This retailer estimated that about 2% of her annual profits came from tobacco sales. Another said that he would raise the price of products to cover the fee at \$300

or \$500 and stop selling at \$1000. To determine the example fee levels, we reviewed local licensing fees in areas across the country where cities or counties have local fees in addition to a state required licensing fee¹⁸⁷. The Workgroup was concerned that it may be difficult for retailers interested in stopping tobacco sales to transition away from tobacco in a short period of time financially, even if a retailer is interested in this option. This could add stress to small retailers with fewer resources. Providing methods to transition from tobacco is one of the Center for Disease Control's recommended health equity practices when implementing point of sale strategies (page 48)¹⁸⁸.

There are very few studies on how to best provide economic supports related to tobacco point of sale strategies. The Center for Disease Control and Prevention recommends supporting retailers to sell healthy items, such as nutrient rich foods, through healthy food financing or healthy corner store initiatives¹⁸⁸. Some small retail owners can qualify for traditional micro-financing programs such as Individual Development Accounts (IDA) (a matched savings account), smaller interest loans, and business trainings for incubating new ideas (Personal Communication, Rebecca Bodonyi, September 2, 2015).

One study in Oklahoma found that some tobacco retailers were willing to remove non-contractual tobacco advertising for six months in exchange for free advertising about their store¹⁸⁹. In New York City, City Councilors created a series of zoning

incentives in the FRESH program. These incentives provides financial benefits to retailers who offer more fresh produce and hire local workers on a limited basis as part of a healthy food initiative¹⁹⁰. The program is a result of multiple agencies working together to provide the financial supports. These incentives include:

- Real estate tax reductions through land taxes and building taxes,
- Sales tax exemption on materials to construct or equip new facilities,
- A one time deferral of a mortgage related to a project's financing,
- Additional development rights to add onto a building in mixed residential area relative to the size of the original grocery store,
- A reduction in required parking,
- Additional space in certain districts, and
- Eligibility to apply for loan and grant financing incentives related to selling more foods¹⁹⁰.

Workgroup members recommend that County and City elected officials explore developing incentives like these, or tax credits, for retailers who stop selling tobacco. Further, there are other strategies, such as help with revising a business plan and market research to determine a feasible replacement product (such as food or coffee), which can support existing or expanded profits.

Potential Economic Health Equity Impacts of a Tobacco Retail License Policy

Table 6 describes the predicted impacts of pieces of a tobacco retail licensing policy on different aspects of economic stability. This summary table is based on examining the current conditions, the research literature on each topic, and the potential interactions between the policy and these factors¹⁵⁷⁻¹⁵⁹. The main focus of this health equity factor is to protect the potential for smaller retailers for whom tobacco is a secondary market to stay financially stable. The HEIA report suggests multiple recommendations, particularly focused on supporting small businesses that decide they want to sell something other than tobacco, in the Recommendations section.

Table 6: Predicted Economic Health Equity Impacts of Tobacco Retail License Policy

Potential Economic Health Equity Impacts				
Health Determinant or Outcome	Likelihood	Direction of Impact	Impacted & Most Vulnerable Groups	Equity Harms or Benefits
Small retailer tobacco sales of tobacco products	Likely to Certain	Decrease	Youth, people of color, people experiencing economic hardship, LGBTQ, those with mental illness, houseless, small retailers	Benefits to some, Harms to small retailers
Clerks pay fines for TRL, potentially lose jobs if they sell to minors	Likely to Certain	Increase	Clerks in retail stores, people who do not speak English as a first language	Harms unless supports in place
Prices of tobacco products	Possible	Small Increase	Existing tobacco users experiencing economic hardship	Benefits for some, Harms for others
Retailer stress related to license fee or business change	Uncertain to Possible	Increase	Small retailers who rely on tobacco as secondary market, retailers who do not speak English as a first language	Harms unless supports in place
Harms = Disproportionate harms: The decision will result in disproportionate adverse effects to populations defined by demographics, culture, or geography			Benefits = Disproportionate benefits: The decision will result in disproportionate beneficial effects to populations defined by demographics, culture, or geography	

C: Potential Social Health Equity Impacts

Social health equity is related to creating environments that support positive mental health. Mental health is different from mental illness. The two are related; as positive mental health decreases as the chance of developing mental illness increases^{191,192}. Supporting positive mental health is about making sure people have the material resources they need, have a sense of control over their lives, and have the ability to participate in important decisions that impact their lives. Many Workgroup members were concerned that the enforcement component of tobacco retail licensing, which helps keep retailers in compliance with all laws related to sales to minors, would be inequitably enforced – either through profiling some retailers based on the clientele they serve, or not adequately enforcing the laws for the same reason. They were also concerned that any new policy needs to be clearly explained to the people impacted. The Workgroup wanted a better understanding of how youth are currently treated in relation to possession of tobacco or e-cigarettes. This section also explores potential education strategies that can be aligned with enforcement to support retail owners, managers, and staff for whom English is not the first language spoken at home. As described earlier, those who experience discrimination from belonging to a social group outside of the dominant norm – for example because of race, ethnicity, age, disability, or sexual orientation – often experience health inequities including higher cortisol levels

from constant stress, violence, lack of economic opportunity, and poor mental health^{4,46,48,193–195}.

To what extent is tobacco use and possession currently used as a reason enforcement offers stop, detain, and question youth? Other groups? What are the consequences of youth tobacco possession? What impact could a TRL policy have on youth?

Oregon and many other states across the nation have laws that make it illegal for a person under the age of 18 to buy, obtain, or possess tobacco without the consent of a minor's parent or guardian in their own home¹⁹⁶. In Oregon, the consequence of youth possession based on ORS 176.400 provisions is that the first time, a youth can be required to participate in a tobacco education program, a tobacco cessation program, or community service that is associated with tobacco related diseases. If there is a second violation, the person can lose their driving privileges, and the right to apply for driving privileges can be suspended for a period up to a year (ORS 167.401). Our analysis of all three state tobacco retail license policies indicates that none of them would aim to give fees or penalize youth purchasing tobacco.

The project team could not find literature related to tobacco retail licensing point of sale policies and racial profiling. The team found studies indicating that minor youth possession laws are ineffective at preventing youth access to tobacco and that youth of color experience racial profiling in relation to minor use and possession laws in other states from

enforcement officers (MUPs)^{133,197–203}. For example in Texas, African American and Hispanic youth had a higher probability of being cited for possessing tobacco than their peers²⁰². In 2015, both the Oregon State Legislature and Multnomah County made it illegal for minors to buy e-cigarettes^{31,32}. In conversations with school-based police officers in two Multnomah County school districts, the project team learned that officers might stop youth who are using electronic cigarettes, because the tools can be reconfigured to vaporize marijuana. Interviews with youth similarly described that enforcement officials for tobacco have not personally stopped youth between the ages of 18 and 25. However, one youth mentioned they have been stopped when enforcement officers thought a hand-rolled cigarette was a marijuana joint. While marijuana is beyond the scope of this analysis, tobacco retail licensing that encompasses inhalant delivery devices could potentially limit youth access to electronic devices.

Will this policy increase the likelihood of fines, suspension, and license loss for retail owners of color who speak a different primary language other than English?

In order to answer this question we would need to understand if existing retailers of color are already profiled in some way. There is currently a lack of data on which businesses are owned by people of color in Multnomah County, therefore we do not know if specific tobacco retail owners may be targeted based on their appearance or the clientele

“My friends that smoke frequently get tobacco or e-cigarettes from stores or gas stations, they started when they were younger and got them from for free from relatives and friends.”

— Interviewed youth, age 18

they serve (see Appendix 1 for a discussion of data sources we reviewed). The state of Oregon does not record race or ethnicity when people apply for business licenses. Indirectly, there is evidence of other types of racial profiling and harassment that indicates this remains a concern. Research on drug arrests in other cities, including Seattle, indicates that racial bias results in more people of color being disproportionately arrested²⁰⁴. City of Portland stop and search traffic violation data from 2004 to 2008 in 94 neighborhoods indicate that Black and Hispanic drivers were overrepresented in traffic stops²⁰⁵. For example, during this time period, 17% of total traffic stops involved African American drivers, who were just 6% of the population aged 15 and older²⁰⁵. Members of the Workgroup have had experiences of being stopped by police. The findings in studies that show racial profiling has occurred in other parts of the nation in relation to youth possession of tobacco provide reason for concern and preventive action. This concern, paired with Oregon’s history of racial exclusion laws²⁰⁶ and the presence of disproportionate youth discipline by race in Oregon schools²⁰⁷⁻²⁰⁹, led the workgroup to develop recommendations to prevent further harm for both youth of color and for retailers who serve communities of color (see the Recommendations section).

Potential Social Health Equity Impacts of a Tobacco Retail License Policy

Table 7 summarizes the predicted impacts of pieces of a tobacco retail licensing policy on different aspects of social equity. Based on the literature

review and limited current data, it is possible that enforcement officers could profile youth of color for electronic inhalant devices, even though they may not target youth with tobacco (a mixed possible impact). Similarly, indirect literature related to racial profiling and data on other enforcement activities in the region also indicates that it is possible for profiling to increase in some areas and decline in others. As described in the section on environmental health equity related to tobacco access, we predict that it is likely for a policy to address historical tobacco burdens if culturally responsive tobacco cessation programs are in place and if retailers are provided with options for economic development if they choose to stop selling tobacco. This summary table is based on examining the current conditions, the research literature on each topic, and the potential interactions between the policy and these factors¹⁵⁷⁻¹⁵⁹.

Table 7: Potential Social Health Equity Impacts of TRL

Potential Social Health Equity Impacts				
Health Determinant or Outcome	Likelihood	Direction of Impact	Impacted & Most Vulnerable Groups	Equity Harms or Benefits
Enforcement officers stopping youth for tobacco possession	Possible	Mixed	Youth, youth of color, youth experiencing economic hardship, LGBTQ youth	Harm unless prevented
Licensing inspections inequitably applied	Possible	Mixed	Retailers of color, neighborhoods where people experiencing economic hardship or people of color live	Potential Harm
Address historical tobacco related inequities through prevention of tobacco related illness	Likely to Certain	Increase	People of color, people experiencing economic hardship, mentally ill, immigrant groups	Benefits if supports in place (see Economic and Access sections)
<p>Harms = Disproportionate harms: The decision will result in disproportionate adverse effects to populations defined by demographics, culture, or geography</p>			<p>Benefits = Disproportionate benefits: The decision will result in disproportionate beneficial effects to populations defined by demographics, culture, or geography</p>	

Recommendations, Discussion, and Conclusions

This assessment focused on the way tobacco retail licensing policy, based on elements of an introduced state bill SB 417, could affect health equity. The HEIA concludes that a well-designed state or local tobacco retail policy with additional program and policy supports can help support improved health equity conditions in Multnomah County. This assessment predicts that health equity benefits would likely result from a TRL primarily through the potential to reduce tobacco and nicotine product sales to youth and youth of color in our neighborhoods. Reduced sales to youth can contribute to less initial access and experimentation with tobacco and nicotine at the age when most people start smoking. Reduced access and experimentation could create health and health cost savings for youth and reduced health care costs for Multnomah County for tobacco and nicotine related chronic conditions over a lifetime. The Workgroup developed recommendations to maximize this potential benefit and to minimize potential harms to small retailers, clerks, and people who currently use tobacco and want to quit. This section summarizes our priority recommendations (see table 8) and provides an overview of our detailed lists of recommendations in tables 9-11.

Protect Youth by Designing a Strong Licensing System

We want to make the potential to protect youth health as strong as possible through ensuring our

neighborhood environments do less to encourage youth tobacco and nicotine use. Through examining research on TRL policies in other areas, we learned that an effective licensing system is one where the licensing enforcement system has a sustainable funding source^{18,139,187}. One way to do this is to set a licensing fee high enough to ensure that agencies can educate retailers, conduct retailer inspections, and monitor its implementation (see table 8). A strong TRL system is also most effective when there is the ability to suspend or revoke a license^{18,139,187}. The Workgroup recommended that the decision about how to structure such a system needs to be developed with advice and guidance of community members who are most impacted by the decision—including small retailers, retailers of color, community members who smoke, youth of color, members of the LGBTQ community, and those with mental illness. Based on trends related to e-cigs and tobacco products other than regular cigarettes, we also recommend that public agencies that implement TRL develop tobacco education to youth, youth of color, communities who have recently immigrated to the U.S. (including refugees), and other impacted groups—which includes descriptions of industry advertising methods to youth and the health risks of tobacco and nicotine.

A recommendation that supports healthy environments, economic equity, and social equity involves agencies implementing TRL systems to

monitor and evaluate the process to ensure retailers and neighborhoods are not under- or over-visited. The Workgroup was unable to come to consensus on the best way to do this, in part because of the lack of racial and ethnic background data of retailers, and in part because of the ongoing shift in neighborhood demographics thanks to rapid gentrification and displacement of communities of color out of central and northern Portland^{96,97}. Despite a random selection of retailers already in place with existing tobacco inspection systems, when one of our analysts visited the FDA's website, she found that one retailer in Portland was visited five times in the space of two months. This may be the result of a random system, but for that retailer it may seem like a targeted system. There is a need to explore how to implement a TRL equitably and in alignment with existing state inspection systems.

Some health factors and outcomes will require other supports to address health equity, please see Appendix 1 for a table showing the predictions and potential recommendations. The current literature and existing conditions indicates that youth who already smoke will not necessarily stop smoking tobacco with a TRL policy in place. A basic TRL system also does not reduce the amount of tobacco advertising in retail outlets, which shape youth perceptions of tobacco and nicotine products. Based on both of these predictions, we recommend decision makers explore raising the age limit to buy tobacco to 21, thereby aligning

Table 8: Summary Priority TRL Recommendations

Recommendation	Environmental Equity	Economic Equity	Social Equity
Elected officials who bring forward a TRL set the price of the license fee to cover the enforcement of the licensing system, including education, training, and monitoring.	✓		✓
Elected officials who bring forward a TRL include the ability to suspend and revoke a license for sales to minors within a specific timeframe determined in a rule making process with input from small retailers and retailers of color.	✓	✓	✓
Public agencies that implement TRL develop education to youth, immigrant groups, youth of color, and other impacted groups about tobacco and e-cigarette potential harms and show how the industry is currently marketing to youth with flavors and prices.	✓		✓
Multnomah County, Oregon Health Authority, Coordinated Care Organizations (CCOs), local clinics, and public health advocacy organizations work collectively to increase funding for culturally responsive smoking cessation programs.	✓		✓
Elected officials who bring forward a TRL require owners, not clerks, to be responsible for annual license fees and penalty fines.	✓	✓	✓
All agencies that implement tobacco related compliance checks develop a universal training on retail laws related to sales to minors for retailers. This training needs to be culturally responsive, free, and can support clerks, managers, and owners in meeting law requirements and ensuring staff is aware of laws.		✓	✓
Elected officials who pass a TRL policy establish a rule making process that includes at least 1/3 of the seats occupied by individuals most impacted by the policy—including small retailers, retailers of color, youth, and people of color—to help build power and capacity with community residents most impacted by this issue. People who could not otherwise participate should be offered a stipend.		✓	✓
Agencies implementing a TRL develop an evaluation and monitoring system to ensure equitable implementation of the policy, with input from an advisory group that includes groups most impacted by tobacco use—especially small retailers and retailers of color.	✓	✓	✓
Agencies implementing a TRL research and develop economic program supports for small retailers who choose to stop selling tobacco.		✓	✓

it to the age to purchase alcohol. Based on data indicating the rise in youth use of flavored non-cigarette tobacco products earlier in this report, we think policies that reduce flavored products²¹⁰ and a zoning ordinance that lowers the total percentage of all types of advertising would help reduce youth exposure to tobacco and tobacco-related advertising. Reduced advertising would also reduce visual blight from too much signage, a complaint of one retailer interviewed²¹¹.

Protect the Economic Stability of Our Smallest Retailers

Information about profits gained from sales of tobacco and the tobacco industry's incentives to retailers leads to the conclusion that the smallest retailers, who sell below \$25,000 in annual sales for cigarettes, may be the ones most likely to 1) pass the cost of the license fee on to the customer and 2) be unable to afford the fee if their sales levels are very low. For these reasons, we recommend that public agencies that implement tobacco retail licensing explore financial incentives for retailers, and develop economic programs that can give retailers who choose to stop selling tobacco a means to continue earning profits from alternative products. We recommend a TRL structure that requires retailer owners maintain the responsibility of the retail license fee and any penalties associated with sales to minors. This is because clerks are paid minimum wage, and an owner may not inform or require staff be trained in current tobacco laws without this element in place. The analysis of current conditions, existing research, and talking

with youth and retailers suggests that to effectively support social and economic equity through a TRL policy, we need to provide free tobacco related education to retailers in a culturally responsive way. Then owners can ensure their staff understands current laws, especially as new laws are passed related to e-cigarettes.

Members of the Workgroup determined that the rule making process—decisions about implementing a TRL policy related to fees, penalties, enforcement, and compliance checks—can have significant equity impacts. For this reason, several recommendations involve any agency putting forth a TRL to include members of the most impacted community members in a process – especially small retailers and retailers of color. In discussions, two Workgroup members brought up the concept that a complaint driven process – where community members report if they see people selling tobacco to youth – is useful to ensure the public is part of the solution. However, members of the Workgroup who were part of the tobacco retail assessment heard from retailers that as the neighborhoods gentrify and communities move around, at least one retailer mentioned being harassed by complaints from people who are new to the area. This raises the concern again of people being profiled or targeted based on their race, or the people they serve. For this reason we put forward a recommendation related to proactive education and trainings about new laws for retailers.

We explored the possibility of recommending that elected officials create a graduated fee structure based on the volume of tobacco sold, considering the possibility that if retailers who sold less tobacco paid a lower fine, it would be a smaller burden and one that was proportional to their profit margins. Unfortunately, we learned this recommendation is not feasible because 1) the cost of training, inspections, and education is consistent across all retailers, regardless of the sales volume and 2) we also learned that any fee structured in a graduated way is considered a tax, and Oregon state law pre-empts any further tobacco related taxes beyond what the legislature has already established¹²⁴. While this recommendation is not feasible, we did learn that there are other economic development efforts available to smaller retailers, including low cost or free support for revising a business plan and market research to understand the relative profitability of, for example, sales of prepared foods or coffee drinks.

Protect People Most Impacted by Tobacco Use

We have a collective obligation to prevent future generations from becoming addicted to tobacco and nicotine. At the same time, TRL does not change larger social systems that may exclude and minimize the voice of impacted groups who currently struggle with tobacco and nicotine use. Tobacco retail licensing policies and other policies that aim to reduce the attractiveness of tobacco, especially to youth, may add a secondary, unintended consequence of making tobacco more expensive or harder to get without simultaneously

providing tobacco cessation supports to those who desire and need them.

In reviewing the information covered in this HEIA, the Workgroup brought forward a series of concerns related to the double burden felt by community members who are now addicted to tobacco and nicotine products. There is a strong relationship between the stress a person experiences in their life circumstances and the use of tobacco. The daily harassment, discrimination, and institutionalized racism that affects people of color, people experiencing economic hardship, those with mental illness, and members of the LGBTQ community is well established in the public health research base^{75,175,193,194,212–221}. The Workgroup felt strongly that institutional history has resulted in fewer public dollars spent related to education, health care access, and tobacco cessation in specific communities to mitigate efforts of the tobacco industry.

Further, the era in which we conducted this HEIA took place at the same time as news stories of multiple deaths of unarmed people of color, particularly African Americans, at the hands of police officers in different cities across the nation. Family members, and loved ones of the Workgroup, were also impacted by similar abusive situations that did not appear in newspapers. These incidents catalyzed the Black Lives Matter movement and contributed to national conversations on race, systems of oppression, the excessive use of force by police officers,²²⁵ and police militarization²²⁶. While

the circumstances of these injuries and deaths are not addressed by a Tobacco Retail Licensing policy, the Workgroup and project team wanted to ensure that any new policies, especially those that are intended to promote people's health and wellbeing, do not increase the chances that a person of color - especially youth of color - might be stopped in relation to tobacco and generate situations that can escalate.

Nicotine is addictive; and tobacco contributes to multiple life-threatening diseases, including cancer^{39,67}. Communities of color, people experiencing economic hardship, members of the LGBTQ community, and those with chronic mental illness continue to use tobacco even as the rate of tobacco use among white, heterosexual people has declined. The disproportionate health burden borne by impacted communities, created in part through focused efforts of the tobacco industry, is a pressing equity issue that must be addressed. The Workgroup agreed that implementation of this policy must protect people's health through increased access to culturally responsive tobacco cessation programs. One of the Workgroup's initial recommendations was to require that Coordinated Care Organizations create and track metrics related to tobacco use to encourage them to be accountable to providing cessation services to their clients. During the project, we learned that this is already underway and that in 2016 CCOs will be required to track tobacco use as an incentive to encourage Medicaid participants to quit²²².

This HEIA examined an evidence-based public health strategy, tobacco retail licensing, from a racial, social, environmental, and economic equity perspective. The World Health Organization defines public health as "all organized measures (whether public or private) to prevent disease, promote health, and prolong life among the population as a whole²²³." Research on social health determinants, or the factors that shape our health beyond our personal behaviors, tells us that many factors can promote – or negatively impact – our health^{218,219,224}. It is helpful to consider how population-wide public health policies connect to other settings and systems, such as enforcement and local economies. One author of this report concludes that the history of making decisions about education, law enforcement, and health care separate from one another has not helped prevent health inequities. Instead, this separation is complicit in creating health inequities, including the ones we have now related to tobacco use. It will continue to take a concerted, collective effort to support groups to end the pattern of some groups being more burdened by tobacco use than others. We want all people, regardless of background, to be free of harms from tobacco and nicotine addiction.

Table 9: Tobacco Access and Environment Health Equity Recommendations

<p>Tobacco Retail License Policy:</p> <ul style="list-style-type: none"> • Elected officials who bring forward a TRL set the price of the license fee to cover the enforcement of the licensing system including education, training, and monitoring. • Elected officials who bring forward a TRL include the ability to suspend and revoke a license for sales to minors within a specific timeframe determined in a rule making process with input from retailers of color. • Elected officials who bring forward a TRL limit price promotions and discounts to reduce attractiveness of tobacco to youth and develop programmatic supports to make cessation programming culturally accessible to different groups most impacted by tobacco use. • Elected officials who bring forward a TRL limit new retailers located 1,000 feet from schools to reduce the number of retailers near youth in the future as the region increases in population. • Agencies implementing a TRL develop an evaluation and monitoring system to ensure equitable implementation of the policy, with input from an advisory group that includes groups most impacted by tobacco use—especially small retailers and retailers of color. 	<p>Funding and Programs:</p> <ul style="list-style-type: none"> • Multnomah County, Oregon Health Authority, Coordinated Care Organizations (CCOs), local clinics, and public health advocacy organizations work collectively to increase funding for culturally responsive smoking cessation programs to support people who want to quit. This could include the following: <ul style="list-style-type: none"> ◦ CCOs ensure Medicaid recipients receive cessation support without limits to cessation counseling or other culturally responsive supports. ◦ Consider Tobacco Master Settlement Agreement dollars to support culturally relevant tobacco cessation programming if other sources are not available. • Local foundations, community based organizations, and local funders support and hire community health workers to develop and implement tobacco cessations efforts for people without health insurance, including immigrant and refugee communities. 	<ul style="list-style-type: none"> • Any tobacco cessation program is developed and implemented with a trauma-informed lens, especially with immigrant and refugee populations. • Community organizations and local clinics work with stakeholders to develop these cessation efforts for people without health insurance. • Agencies implementing a TRL also support the new policy with other changes to the environment. Examples include providing incentives to stores to reduce the total tobacco and nicotine product advertising to address historical burdens and help reduce youth attraction to tobacco/nicotine products. • Make tobacco reduction a top priority in future Multnomah County Community Health Improvement Plans. • Public agencies and elected officials who implement TRL develop economic support programs for small retailers who want to transition away from tobacco sales (see Economic Equity).
	<p>Data:</p> <ul style="list-style-type: none"> • State universities and health agency researchers study e-cigarettes use among youth in the future. • State and local agencies disaggregate data on sub-groups among Latino, API, and others to identify sub-groups most burdened by tobacco use; develop policies and programs to support these groups. • The Equity Atlas (previously of the Coalition for a Livable Future) includes tobacco retailers in its list of health determinants when TRL makes data publicly available. 	<p>Education:</p> <ul style="list-style-type: none"> • Public agencies that implement TRL develop education to youth, immigrant groups, youth of color, and other impacted groups about potential harms of tobacco and e-cigarette and show how the industry is currently marketing to youth with flavors and prices. • Public agencies that implement TRL hire community health workers to deliver education and trainings to retailers in enforcement process as proactive approach.

Figure 10: Economic Stability Recommendations

<p>Tobacco Retail License Policy:</p> <ul style="list-style-type: none"> • Elected officials who bring forward a TRL require owners, not clerks, to be responsible for annual license fees and penalty fines. • Write TRL policy so that training and education is mandatory or incentivized to support clerks and retailers in understanding new tobacco regulations. 	<p>Programs:</p> <ul style="list-style-type: none"> • Agencies that pass and implement a TRL research the feasibility of a financial incentive, such as a tax credit for retailers who voluntarily choose to not sell tobacco. • City, County, and State authorities work with Community Development Corporations to develop microenterprise strategies and program for retailers who want to switch away from selling tobacco. <ul style="list-style-type: none"> ○ Many stores who do not accept Women, Infants and Children (WIC) and Supplemental Nutrition Assistance Program (SNAP) benefits could receive a training to encourage more small retailers to start. ○ Community college free supports to small businesses, public agency small business development programs, and other existing community organization-based economic development programs can help stores develop and implement a new business plan. • State agencies responsible for providing tobacco prevention grants should explore funding applicants who implement economic development pilot strategies, to support retailers who want to switch from selling tobacco (including researching other products, development of a new business plan, etc.). • Community Development Corporations work with financial organizations (i.e. banks) to develop lower-cost financing options for small business loans to support retailers who want to switch from tobacco. • Community Development Corporations work with financial organizations (i.e. banks) to offer Individual Development Account support for retailers who want to switch from tobacco. • Local foundations support retailers who choose to stop selling tobacco with grants that increase advertising and visibility to increase overall sales, as part of larger strategy to support local business and wellness in our communities.
<p>Education:</p> <ul style="list-style-type: none"> • All agencies that implement tobacco related compliance checks or inspections align efforts to prevent multiple visits to the same retailers. • All agencies that implement tobacco related compliance checks develop a universal training on retail laws related to sales to minors for retailers. This training should be culturally responsive, free, and can support clerks, managers, and owners in meeting law requirements and ensuring staff is aware of laws. 	

“We have one foot in, we don’t earn very much. Everyone comes in to check in on us – it’s too much, [multiple fees] discourage running a convenience store.”
 — Interviewed store owner who sells tobacco, mid-county

Table 11: Social Health Equity Recommendations

<p>Tobacco Retail License Policy:</p> <ul style="list-style-type: none"> • Elected officials who pass a TRL policy declare that the rationale for tobacco retail licensing is to protect our most vulnerable members of our communities against predatory practices. The policy recognizes that many members of communities of color continue to bear the burden of historical targeting by the tobacco industry, and this is one policy to prevent that from happening to our next generation of youth. • Elected officials who pass a TRL policy establish a rule making process that includes at least 1/3 of the seats occupied by individuals most impacted by the policy—including small retailers, retailers of color, youth, and people of color—to help build power and capacity with community residents most impacted by this issue. People who could not otherwise participate should be offered a stipend. • Elected officials who pass a TRL policy require rule making for TRL to use key questions of the Equity and Empowerment Lens (see Appendix 1). • The TRL policy should require all owners to make education and training on tobacco retail licensing mandatory and a requirement for license renewal. • The TRL policy should require all retailers to publicly display that they have a tobacco retail license. 	<p>Education:</p> <ul style="list-style-type: none"> • Multnomah County Health Department and enforcement agencies work with Oregon Health Authority Synar coordinator and Federal Drug Administration program to develop education and training that is available online, is free, is available in multiple languages, is developed to be culturally relevant, and is held at regular time periods in-person at community accessible sites such as community centers. 	<p>Enforcement and Monitoring of TRL:</p> <ul style="list-style-type: none"> • All agencies that implement state, federal, and local tobacco related compliance checks or inspections align efforts to prevent multiple visits by different groups to the same retailers to minimize burdens. • Agencies implementing a TRL develop an evaluation and monitoring system to ensure equitable implementation of the policy, with input from an advisory group that includes groups most impacted by tobacco use—especially small retailers and retailers of color. • Agencies who implement a TRL policy track what has been happening in City of Portland with the training and education for the recent City of Portland Tobacco-Free Parks Policy. Align Tobacco Retail Licensing (TRL) enforcement efforts with Racial and Ethnic Approaches to Community Health (REACH) training input or improve on it at the county level to ensure the license is equitably enforced. • Agencies who implement a TRL policy work with culturally-specific groups to monitor citations of youth for tobacco and e-cigarettes.
	<p>Data:</p> <ul style="list-style-type: none"> • Elected officials who pass a TRL policy identify sources of data to help track unintended consequences, such as inequitable enforcement. • Any public data and information about a TRL policy be available in easy to understand brochures or one-page briefs for community members—both on related agency websites and available in multiple languages in print. 	

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Appendix 1: Practitioner Methods

Tobacco Retail License Policy Health Equity Impact Assessment

Title: Oregon Tobacco Retail License Policy Health Equity Impact Assessment

Timeline: HEIA screened in December of 2014; reporting completed by December of 2015

Geographic Focus: Multnomah County, Oregon

Funding: This project was supported in part by a grant from the Knight Cancer Institute Community Partnership Program at Oregon Health and Science University and the racial equity analysis portion of the HEIA was partially supported by a Strategies for Policy and Environmental Change (SPaRC) grant awarded to the Multnomah County Health Department from the Oregon Health Authority

Sector(s): Business licensing, public health tobacco chronic disease prevention

HIA type: Decision support, intermediate scope

A) Overview

This appendix is for anyone interested in the methods and process used in this Health Equity Impact Assessment (HEIA). The name “Health Equity Impact Assessment,” reflects the use of Health Impact Assessment (HIA) methods and the use of an Equity and Empowerment (EE lens) to conduct each stage of the HIA. This appendix describes how this HEIA meets the Minimum Elements of HIA established by the North American HIA Practice Standards Working Group of the Society of Practitioners of HIA (SOPHIA)¹. The appendix also describes the use of Multnomah County’s Equity and Empowerment Lens in this HIA². The term “project team” includes Upstream staff members Tia Henderson (Research Manager, project lead), Claudia Arana Colen (Equity Coordinator, analyst), Nafisa Fai (Tobacco and Oral Health Manager, workgroup member), and consultants Jamie Jones (analyst), and Scotty Ellis (Coalition of a Livable future, analyst).

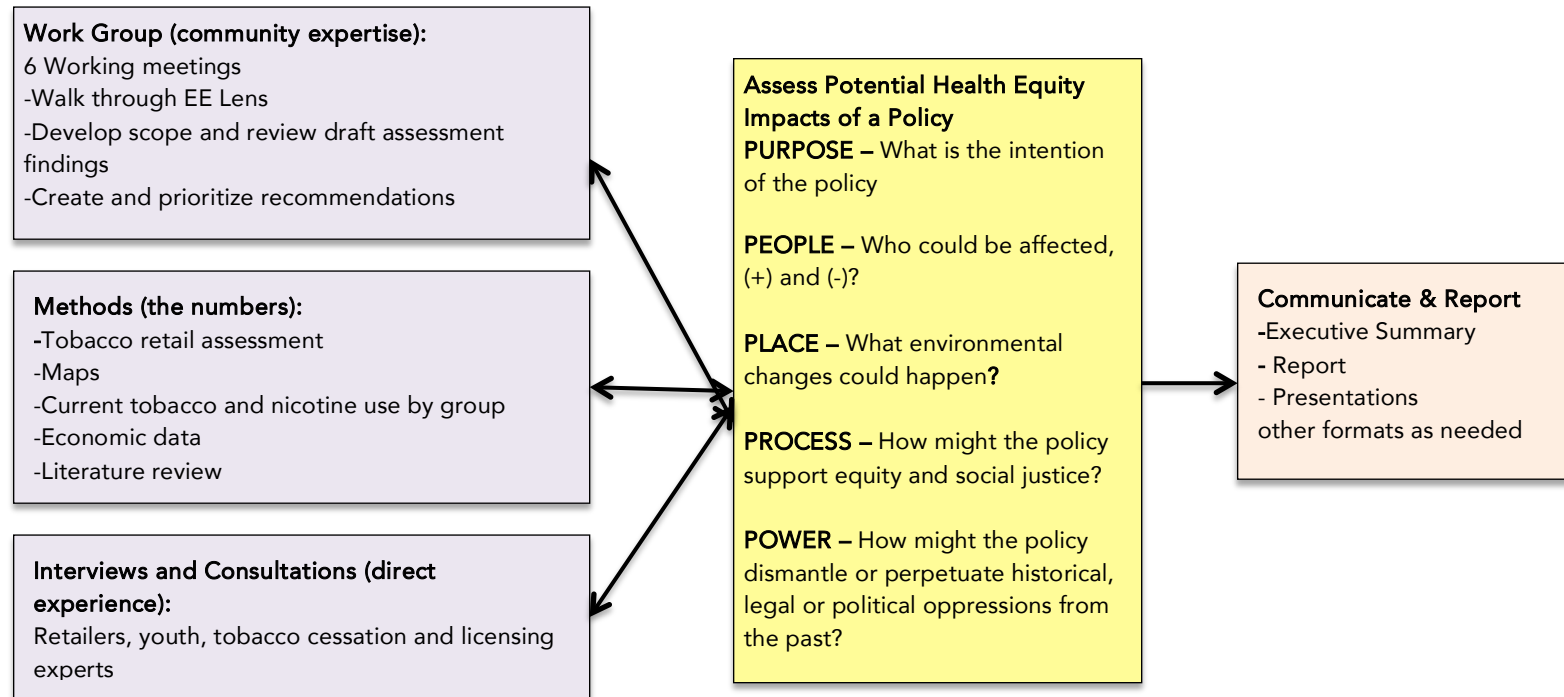
A.1) Predicting Health Equity Impacts of Tobacco Retail Licensing

This project analyzed potential health equity impacts of tobacco retail licensing (TRL) policy following the six steps of a Health Impact Assessment (HIA) (see figure 1). In this project, the analysts worked with an advisory Workgroup to develop a scope, define and prioritize assessment questions, review findings, and develop recommendations on the potential social, economic, and environmental health equity impacts of a state tobacco retail licensing policy on Multnomah County communities. Like many HIAs, this project also used mixed methods that included a literature review, key informant interviews with youth and retailers, and guiding information from the advisory Workgroup (see figure 2).

Figure 1: HIA Steps

1. **SCREENING** determines the need for and value of an HIA.
2. **SCOPING** develops a plan and timeline for the HIA that defines research questions, health outcomes and vulnerable populations.
3. **ASSESSMENT** involves using existing data, expertise and experience to profile existing conditions, evaluate the direction and magnitude of potential health impacts, and make policy recommendations.
4. **RECOMMENDATIONS** advocate in the most effective way possible actions that will improve health outcomes of the policy.
5. **REPORTING** communicates the HIA findings and recommendations.
6. **MONITORING AND EVALUATION** tracks the impact of the HIA on the decision making process.

Figure 2: HIA process merged with an EE lens in this HEIA



A.2) Screening and Decision Context

Four factors led to the decision to conduct an HEIA on the potential health equity impacts of a tobacco retail license policy on Multnomah County communities. First, several state tobacco retail license policies were introduced in the state legislature³⁻⁵ during the 2015 legislative session, and Multnomah County Commissioners had mentioned being willing to take action if the state policy did not pass⁶. Second, there was new information available to help understand how the policy might impact people and their neighborhoods. In 2014, the Multnomah County Health Department and a set of community organizations within the Oregon Health Equity Alliance (OHEA) were awarded a *Strategies for Policy and Environmental Change (SPArC) – Tobacco Free* grant from the Oregon Health Authority; these groups conducted a county tobacco retail assessment, providing information about which tobacco and nicotine items are being sold in Multnomah County. Third, public health advocates were concerned about a growing use of e-cigarettes among youth and about the legacy of tobacco use and related chronic illness and cancers disproportionately impacting people of color. Finally, jurisdictions and small businesses had expressed concern about the impact a licensing system could have on economic stability.

The goals of this HEIA follow:

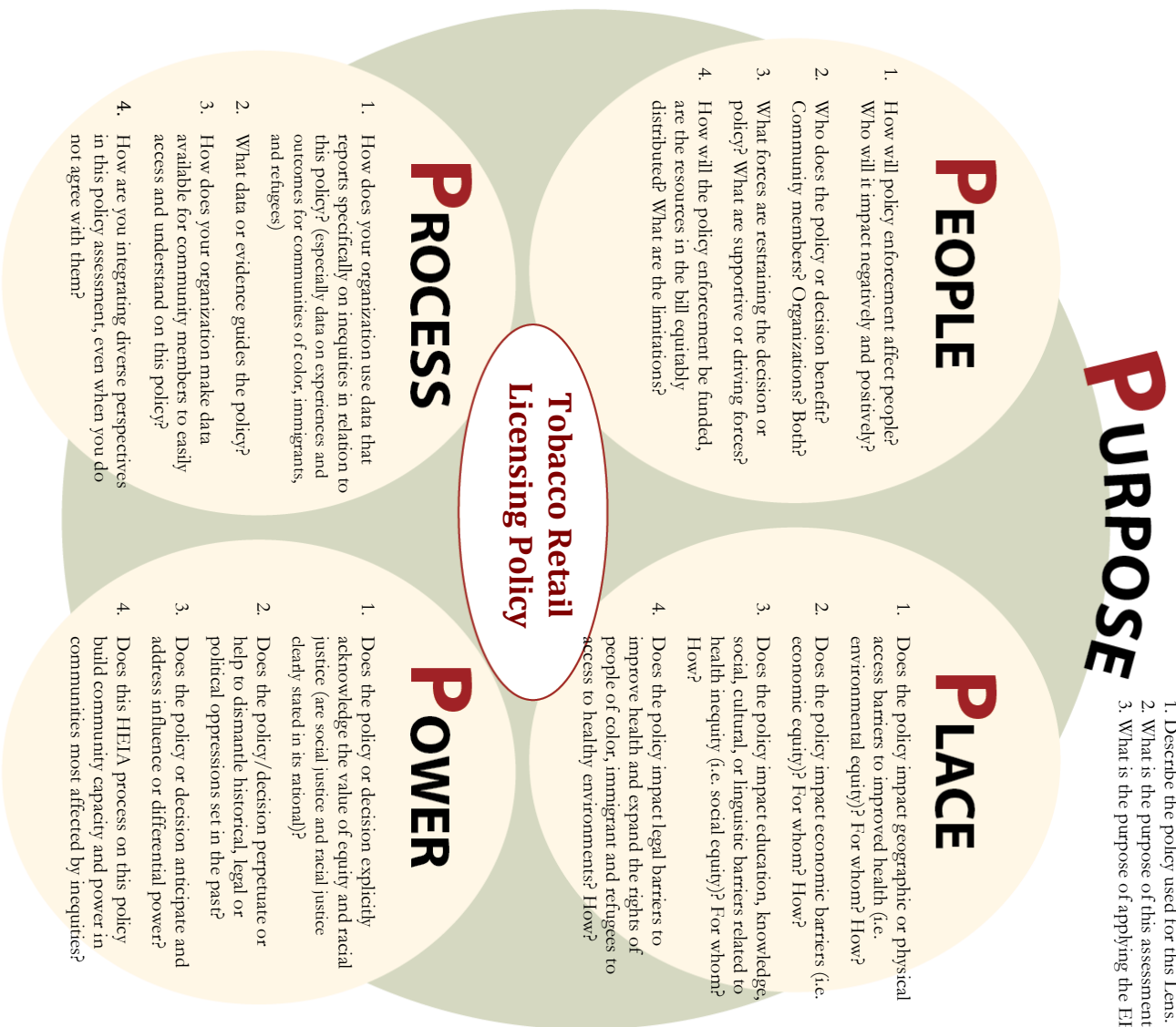
- Inform the policy decision-making process within the Multnomah County Health Department and, if possible, the Oregon legislature.
- Examine the racial, environmental, social, and economic health equity impacts of tobacco retail license policy through understanding how the policy interacts with health determinants.
- Make recommendations about how to create a balanced policy that prevents youth access to tobacco and nicotine products while supporting small retailer economic vitality and positive mental health in our communities.

Although public health considerations, namely preventing youth access to tobacco and nicotine to avoid chronic disease and cancer, were already part of public discussions about tobacco retail licensing including inhalant delivery devices, a broad health determinant and equity perspective beyond tobacco-related illness was not part of the discussions about the policy. A recent health equity report from the Centers for Disease Control and prevention noted the possibility of inequitable impacts to economic stability and inequitable enforcement⁷. Because of these concerns, and a desire to inform the a state or county decision making process, Upstream Public Health decided to work on an HEIA to examine how elements of a state bill or a comparable policy at the local level would affect Multnomah County communities. Upstream wanted to determine the potential positive and negative impacts and identify ways to prevent harm and maximize benefits.

A.3) Use of Equity and Empowerment Tool

In screening this decision, Upstream staff determined that there was the potential for inequitably distributed impacts, and that there was sufficient time and resources to develop an HIA to inform decision making – specifically the administrative rule making process. Further, Upstream had wanted to apply the Multnomah County’s Equity and Empowerment Lens to public health policy decisions as a way to make social equity efforts more explicit in HIA practice. Because this policy had the potential to also impact broader health determinants, such as economic stability of small retailers and the use of enforcement officers in neighborhoods where people of color reside, Upstream staff determined this was an appropriate policy for an HIA using an intentional racial equity perspective. Upstream’s Research Manager, Upstream’s Tobacco and Chronic Disease Specialist, and Upstream’s Equity Coordinator reviewed the existing Equity and Empowerment Lens tools for policy and for organizations².

The project lead consulted with the EE Lens Senior Policy Advisor, Sonali Bajalee, for feedback. The Upstream project team selected questions from both the EE lens policy and general tool and inserted them in the 5 P template the County provided to create a tobacco retail-licensing version. This document is on the previous page. The project lead used the tool during the Scoping, Assessment, and Reporting stages of the HIA to ensure that the EE Lens guided all the Assessment questions, input from stakeholders, data gathering processes, and communication of findings. The project lead also structured Advisory meetings 1-5 using the EE Lens to develop the HEIA Assessment questions and other procedures needed to conduct the HEIA. The group used the People and Place questions in the first two meetings and covered the Power and Process in the third and fourth meetings.



Equity and Empowerment Lens

A.4) Stakeholder Engagement

The project lead conducted a stakeholder analysis with input from Upstream staff to identify potential advisory Workgroup members in the Screening phase. The criteria for involvement in the Workgroup were: 1) at least one representative from County and State health agencies to ensure these participants would share relevant information from the HEIA with elected officials if it was requested, 2) at least one representative from organizations that serve and work with each of the most tobacco burdened communities in Multnomah County, including Native American, African American, Latino and Asian Pacific Islander groups, people experiencing economic hardship, and the mentally ill (with preferably at least one person being a community health worker), and 3) at least one representative of a small independently owned retailer who sells tobacco who can share the realities of small business operations. The project team identified organizations that serve Multnomah County populations and sent invitation emails until a final group of twelve members agreed to be involved. Members who were unable to participate without financial compensation received a stipend paid for by the OHSU Knight Cancer Institute Community Partnership Program grant. The public agency representatives did not accept a stipend. The final Workgroup included one state Oregon Health Authority representative, three County health department representatives who work on three different focus areas (tobacco, chronic disease, and Racial and Ethnic Approaches to Community Health or REACH programming), multiple representatives from organizations that serve and work with culturally and racially specific communities (including one person who works as a community health worker), and one tobacco retailer who sent two managers. The front pages of the HEIA report list each Workgroup member and their affiliation.

B) HEIA Scope

Workgroup members and the analyst team initially used the Senate Bill 417 structure as a template. The Workgroup used their collective expertise in tobacco policy and tobacco use in communities and guiding questions from the Equity and Empowerment lens tool to develop the HEIA scope and assessment questions. The project lead tracked other state tobacco retail licensing bills during the 2015 legislative session. As different state tobacco retail license policies were introduced in the legislature, the project lead provided updates related to content of the HEIA to make sure the Advisory Workgroup had sufficient information about different possible tobacco retail license policy elements to provide guidance on the HEIA.

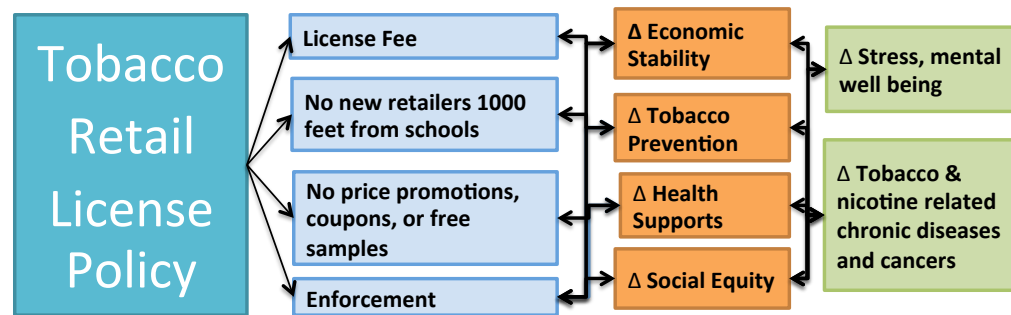
B.1) Health Determinant Pathways and Impacted Groups

The Workgroup determined that a policy with similar components as SB 417 could affect changes, either positive or negative, to health outcomes such as stress, mental well-being, and tobacco-related chronic illness like cancers and respiratory illness (see the health pathway diagram in figure 3). The analyst team conducted an integrated literature review, examined data from existing sources, spoke with experts in Oregon and neighboring states, and interviewed young adults and retailers in order to answer the priority assessment questions. For this project, “vulnerable or most impacted people” included the following:

- Children, youth, youth of color, youth in low-income families
- People of color
- People with persistent mental illness

- People living with economic hardship
- People who identify as Lesbian, Gay, Bisexual, Transgender or Queer (LGBTQ)
- People living in stressful neighborhoods (i.e. violence)
- People with other substance abuse challenges
- People with existing chronic conditions such as respiratory or heart problems
- People who want to stop using tobacco or nicotine
- Retail owners, clerks, managers for whom English is not their language of origin
- Retailers of color, or retailers who serve people of color

Figure 3: Tobacco retail license policy HEIA summary pathway diagram



B.2) Scope of Assessment Questions

Based on a discussion of the introduced SB 417 policy and background on tobacco sales and current conditions, the Advisory Workgroup developed research questions and suggested exploring linkages between the TRL policy and three core health determinant areas: environmental changes and access to tobacco, economic stability, and social equity related to enforcement. The Workgroup members prioritized the breadth of the Scope and the Assessment questions based on the extent to which each one helped determine the potential health equity impact of the TRL policy on a) the most number of people and b) the most vulnerable people. In the tables below, stars indicate the level of priority among the Workgroup and the initials "WG" indicates that workgroup members developed the questions during discussions. The project team brought other research questions forward as a starting point. The summary pathway diagram is in Figure 3 and tables 1-3 describe the Assessment questions.

Table 1: Tobacco environment and access health equity impact assessment questions (★ is a Workgroup priority and multiple stars indicates multiple Workgroup votes as a priority, “WG” are questions developed by WG members)

Context Questions	Current Condition Questions	Impact Questions
(WG) Is this the most effective way to address sales to minors?	What is current rate of illegal sales to minors in Oregon and Multnomah County? What is the youth reported rate of youth purchases of tobacco products from retailers?	★★Will the policy reduce the rate of sales to minors? ★★Can this policy help protect youth from unregulated products like e-cigs as they emerge?
(WG) Is this the most effective way to address tobacco/nicotine use in burdened communities?	What is the current federal \$ Oregon and Multco receives for addiction and mental health services based on keeping sales to minors below the federal thresholds?	★If we *don't* have this policy, will we lose federal \$ for tobacco prevention? Will the TRL impact these funds?
What is the relationship between tobacco retailer density and youth use of tobacco and nicotine products?	Where are retailers currently selling tobacco and e-cigs?	In places that have these laws do owners help prevent youth access? ★(WG) In places that have these laws do owners help prevent youth access?
What is the relationship between tobacco retailer density, tobacco marketing, and youth use of tobacco?	What is reported use of tobacco products and e cig products in Multnomah county for youth and adults?	★★Would this policy impact advertising to youth? Would this impact price promotions and how?
What is the relationship between retail density and smoking cessation behaviors?	What is the current level of people in Multnomah County who report wanting to quit smoking?	★★★★Would the policy support people who want to quit smoking? How? ★★ (WG) Would this policy impact people who are already smoking? How?
★(WG) What are the differential health impacts of tobacco vs. e-cigs (i.e. “inhalant devices”)?	What is the current prevalence of youth tobacco users and e-cig users?	★★★★Would the policy reduce youth use of tobacco and nicotine products? What is the likely impact of this policy on youth use of e-cigs vs. tobacco?
How are products, or how have they been, marketed or promoted through price to youth and communities of color? How is the retail space a primary outlet for marketing to youth, low income, and communities of color?	★★★★★What groups have historically been burdened with tobacco use in Oregon? How have these groups been targeted?	★★Will the policy reduce existing inequity of tobacco/nicotine burdened communities? How? What would be the saved \$ health costs of less youth using tobacco? Will this policy impact those with chronic mental illness?
	What are the current chronic health conditions that are tobacco related among Multnomah county residents? Who is disproportionately burdened?	★★★What chronic health conditions would this prevent and by how much?
What is the distribution of tobacco retailers in Multnomah County?	★★★★ (WG) Are there currently more tobacco retailers in low income/communities of color neighborhoods?	★★★★ If so, would this policy change that? How?

Table 2: Economic stability health equity impact assessment questions (★ is a Workgroup priority and multiple stars indicates multiple Workgroup votes as a priority, “WG” are questions developed by WG members)

Context	Current Conditions	Impact Questions
★★★★★★ (WG) Have other TRL programs used education as part of their enforcement efforts? What kind and for whom? Has any of it been culturally competent for retailers? And how was it done?	What current training programs are available to retailers related to age-specific laws?	<i>(context and current conditions related to potential WG recommendation developed early in the Assessment)</i>
	★★Who pays the fees and fines if for breaking laws?	If it is clerks, what is the risk that this could cost them their job? ★★★★★★ (WG) Will this policy increase the likelihood of fines, suspension, and license loss for owners of color who speak a different language?
What has been the trend in CA, OR, and WA related to tobacco retail policies in terms of price and policy components? Is there a relationship between tobacco retail licensing and business decline (i.e. fewer retailers) in other areas?	What is the likely range of licensing fees based on existing local policies in OR and WA?	★★What is the impact of ~\$500 annual license fee on small retailers’ bottom lines? What is the threshold that puts them beyond the “price of business”? ★★Would the retail license fee be passed on to customers? How? ★If there was a price increase on items, how large is it, and would it affect people’s purchases? ★★★★Are there existing policies that support economic development for retailers who decide to stop their tobacco/nicotine sales?
		Is there risk of business loss or the need to transfer away from selling tobacco? Does this impact mental health and stress? For whom? If there is a risk of job loss for clerks, what does this mean for their health?
	How would a limit on retailers 1000 feet from schools work?	(WG) In the license renewal process, would a business potentially have to relocate or lose ability to do business near schools? Or stop selling tobacco?

Table 3: Social health equity impact assessment questions (★ is a Workgroup priority and multiple stars indicates multiple Workgroup votes as a priority, “WG” are questions developed by WG members)

Context Questions	Current Conditions Questions	Impact Questions
★★★★★★ (WG) How have other states enforced this law, and do we see inequities affecting some communities vs. others? What inequities? Who is negatively impacted?	Current level of retailers in Multnomah County posting the notice about illegal sales to minors?	★Will this policy increase any inequities related to legal enforcement? For whom?
	★★★★★To what extent is tobacco use and possession currently used as a reason enforcement offers stop, detain, and question youth? Other groups?	(WG) Would enforcement use the new law to increase how often it stops youth with tobacco? Would TRL change enforcement of existing laws

Context Questions	Current Conditions Questions	Impact Questions
	*****What are the consequences of youth possession?	restricting sales to minors? ***If tobacco is a reason youth are stopped by enforcement, what impact does this have on stress or other mental health outcomes?
	*(AC) Have other TRL programs used education as part of their enforcement efforts? What kind and for whom? And how was it done? – duplicate of Economic Q	(WG) Will this policy increase mental stress for owners of color who speak a different language? – Duplicate in Economic Q
*****Is this policy more effective at reducing existing tobacco disease inequities for some groups over others? Which folks? – Overlaps w/Tobacco Access Q	What are existing health inequities/burdens for tobacco related chronic conditions? For whom? – overlaps with Tobacco Access Q	*****Will this policy lessen the existing health inequities and burdens on tobacco related chronic conditions? For whom? - overlaps with Tobacco Access Q

C) Assessment Methods and Source(s) of Evidence

C.1) Literature Review Methods

This HIA relied on an integrative^{8,9} review of empirical literature. Project team members examined content-specific literature databases for peer reviewed literature and supplemented this with grey literature through searches on Google Scholar, reference lists, and backward searching. The project team used the following databases: PubMed, BioMed Central, BMJ Clinical Evidence, Ebsco host, Academic Search Premier, and Google Scholar. The project team used integrative review on impact questions in order to evaluate the presence of existing evidence. The project team evaluated incoming articles and rejected from use any articles with serious inconsistencies, imprecise or sparse data, a high probability of reporting bias based on industry funding the research, important inconsistencies, or other serious study limitations; the team noted gaps where possible.

The HIA Research Team conducted literature reviews on impact questions from each of the three health determinant pathways showing in figure 3, using an excel spreadsheet to keep track of research question, databases searched, search terms used, relevant articles found, and articles kept and why or why not. The project team used different combinations of search terms in table 5 on Google Scholar first, then in other databases as needed. The project team entered all documents into a Zotero reference manager. All other context provided in the report, such as institutional racism’s role in generating health inequities, involved a simple search for existing reviews or recent articles from a trustworthy source (i.e. the US Surgeon General report) on the topics. The project team lead chose the most current reviews or meta-analyses from the most reliable sources possible.

Table 4: Literature Search Criteria

Inclusion	Exclusion
Research is directly related to tobacco retail licensing policy and related issues such as profiling of youth for tobacco use.	Research is more than three degrees of separation away from this topic.
Research reviews, meta-analysis, or provides original data using sound experimental or observational design or is a relevant case study.	Research uses faulty or questionable methods (e.g. poor response rates, bad inclusion criteria).
Research connects health outcomes findings to relevant populations (e.g. tobacco use and depression).	Research is on a non-relevant population (e.g. developing countries).
Research occurs within the past fifteen years.	Literature is theoretical or an opinion piece and does not present original findings.
When current research is unavailable, used research older than 15 years.	
Research is from the US unless current research on a similar topic is not available. Only English language articles were used.	

Table 5: Search terms by HEIA health determinant pathway

Pathway	Search Terms
Tobacco retail licensing and tobacco environment and access	Oregon, tobacco, history, Black, African American, Native American, women, marketing, minority, prevention, cost, monetary costs, value, equity impact review, tobacco license equity impact, tobacco policy impact review, tobacco policy meta-analysis, nicotine addictive review, youth tobacco access, tobacco retailer density, tobacco access, electronic cigarette health, electronic cigarette youth, electronic cigarette sales, electronic cigarette flavors, tobacco point of sale, tobacco advertising, tobacco promotion, prevent youth access, tobacco retailers, vape, tobacco marketing minority, monetary costs preventing tobacco related death, communities of color, vulnerable populations, tobacco retail neighborhoods, smoking behavior
Tobacco retail licensing & social equity	tobacco retail licensing, tobacco youth enforcement, education, cultural sensitivity, cultural competence, retailer, racial profiling, tobacco policy equity impact, inequality, US, tobacco laws arrests, culturally responsive law enforcement, culturally sensitive law enforcement, tobacco enforcement, minority, youth, Oregon tobacco history, tobacco industry minorities target, institutional racism and health, racism and smoking
Tobacco retail licensing & economic equity	Tobacco retail licensing impact, small business, minority owned retailer, tobacco sale limits, price elasticity tobacco, enforcement, education, cultural sensitivity, retailers, clerks, cultural competence, microenterprise, economic development, food access, tobacco policies impact small business, tobacco sale limits

Figure 4: Oregon adult smoking by race and ethnicity summary^{14,15}

<p>1 in 3 Black and Native persons smoke</p> <ul style="list-style-type: none"> • 33.3% African American, non-Latino • 35.3% American Indian and Alaska Native, non-Latino • 21.4% White, non-Latino • 20.8% Latino • 14.1% Asian / Pacific Islander, non-Latino <p>Smoking by household income – Impacts those with least finances</p> <ul style="list-style-type: none"> • 31.4% Less than \$15,000 • 26.4% make between \$15,000 - \$24,999 • 19.7% \$25,000 - \$49,999 • 11.0% \$50,000 or more <p>Smoking by sexual orientation – LGBT persons more likely to smoke</p> <ul style="list-style-type: none"> • 22.4% Gay or Lesbian smoke • 37.9% Bisexual • 18.1% Not gay, lesbian or bisexual <p>Smoking during pregnancy – Impacts the youngest moms</p> <ul style="list-style-type: none"> • 13.9% who used tobacco during their pregnancy were less than 18 years old • 19.2% 18-19 years old • 18.6% 20-24 years old • 10.6% 25-29 years old • 5.2% 30 years old and older <p>Tobacco use among Medicaid recipients</p> <ul style="list-style-type: none"> • 41.1% American Indian & Alaska Native, non-Latino • 36.8% White, non-Latino • 33.8% Pacific Islander • 31.1% African American, non-Latino • 14.1% Asian (non-Pacific Islander) • 9.9% Latino or Hispanic

C.2) Current Conditions Data – Relevant Information

This HEIA examined existing secondary data sources, where feasible, to understand current conditions that might be impacted by a tobacco retail license policy. Data sources are cited where relevant in the report. This section includes a more detailed summary data of adult smoking descriptive numbers in Oregon, an explanation of the sources for different maps, calculations derived from Geographic Information Systems in the report, other data sources, and identified data gaps. The maps in the HEIA report come from the recent tobacco retail assessment unless otherwise described. Either Claire Smith at Multnomah County Health Department or Scotty Ellis at the Coalition for a Livable Future created each map.

Concentration of tobacco retail in areas with youth (Ages 0 – 17)

The average concentration of tobacco retailers for a census tract in Multnomah County is three. This average was identified using data from the Tobacco Retail Assessment 2014 – a collaboration between Multnomah County Health Department, Upstream Public Health, and the Oregon Health Equity Alliance. Youth numbers for each census tract were obtained from the 2010 U.S. Census, and the distribution of the data categories was found using Natural Breaks, a method of manual data classification that seeks to partition data into classes based on natural groups in the data distribution.

Concentration of tobacco retail in areas with People of Color

The concentration of retailers per capita is the number of retailers, divided by the total population, multiplied by 10,000. For example, the county per capita of 9.5 comes from the calculation: (730 retailers/766,135 population) x10,000. Multiplying the result by 10,000 makes that rate comparable to areas with differing population sizes. In the <15% areas of color the calculation is: (94 retailers/120,147 population) x 10,000. The 15-<30% areas of color

the calculation is: (286 retailers/319,650 population) x 10,000. The 30% or greater areas of color the calculation is: (339 retailers/307,842 population) x 10,000. We used the 2013 American Community Survey county population estimates.

Concentration of tobacco retail

The average concentration of tobacco retailers for a census tract in Multnomah County is three. This average was identified using data from the Tobacco Retail Assessment 2014 – a collaboration between Multnomah County Health Department, Upstream Public Health, and the Oregon Health Equity Alliance.

Portland area historical tobacco advertising

In reviewing the history of tobacco industry practices in the U.S., the project team learned that the larger tobacco companies targeted different racial and cultural groups across the country. The current conditions also indicated that current retail distribution, based on the tobacco retail assessment, showed more retailers located in neighborhoods with more families of color. The Workgroup wanted an understanding of if and how the tobacco industry targeted populations in Portland in similar ways as other metropolitan areas around the country, through marketing and promoting of tobacco products. The project lead conducted a content analysis scan, guided by information from reviews of industry documents, to look for ads targeting African Americans in local north Portland newspapers. The project lead examined one dozen papers from different local news outlets for each of the following decades: 1950s, 1960s, 1970s, and 1980s. The project lead examined the frequency of full page tobacco ads in each paper for each decade. Based on this cursory scan, tobacco advertising did not show up until the early 1980s, and at that point the tobacco industry used full-page color ads featuring African American models, often to advertise menthol cigarettes. The ads included in the HEIA report are from the Portland Observer in 1982 and 1983 from the Verdell Burdin and Otto G. Rutherford Family Collection at the Portland State University Library Special Collections.

C.3) Interviews and Expert Consultations

The project team contacted experts in Oregon, California, and Washington to help answer context or current condition questions where feasible. The project team also met with Multnomah County commissioners to ask what information would be most useful from the HEIA to hear in an executive summary and briefing during the Reporting phase in September. These expert consultations were not included in the Human Subjects approval process through Oregon Health and Sciences University.

The project lead developed a protocol to complete short interviews with youth and retailers and submitted this and all supporting documents to the Institutional Review Board at Oregon Health and Sciences University. The project team used a purposive sample to identify youth and retailers using existing relationships with youth and retailer representatives on the HEIA's Advisory Workgroup. The project lead provided all interview participants with \$25 gift cards at the end of each interview.

Youth key informant interviews

The project lead conducted a convenience sample of approximately 20 youth and aimed for a final sample size of 12, including both users of tobacco and non-users who have tried tobacco. Project team members contacted organizations identified by Workgroup members as working with youth of color, LGBTQ youth, and youth without homes. These youth were the focus, because Workgroup members felt that these youth would be most impacted by tobacco and electronic cigarette use based on the assessment findings. The project lead did not collect identifying information, and all potential subjects were informed that their participation was confidential. The lead determined age first; people under 18 years were excluded. The project lead provided participants with a \$25 gift card upon completion. Questions included how they identify their cultural or ethnic background and gender, what their personal experience has been with tobacco products of any kind including e-cigarettes, why they choose tobacco over e-cigarettes or visa versa if they use these products, where they and/or their peers get them most frequently, how often their peers purchase them from stores or gas stations, and whether or not they/peers have ever been stopped by police or other authorities for using tobacco or e-cigarettes. The project lead completed a total of 10 interviews.

Table 6: Youth demographics summary

	Ages	Race or Ethnicity	Sexual Orientation	Gender Identity
Of 10 Youth	<ul style="list-style-type: none"> • Ages 18-21 (8) • Ages 22-25 (2) 	<ul style="list-style-type: none"> • Asian or Pacific Islander (3) • African American (2) • Latino/Hispanic (3) • White (1) • Native American (1) • Multiple Races (2) <p>Additional responses included above: Jewish/African American, Mexican American, Colombian</p>	<ul style="list-style-type: none"> • Heterosexual (6) • Declined (1) • Queer & Pansexual (1) • Pansexual (1) • Questioning (1) 	<ul style="list-style-type: none"> • Female (6) • Male (2) • Gender Queer, non-conforming (1) • A Gender, he/ they (1)

Table 7: Youth experience with police and tobacco questions summary

	% Ever Stopped by Police for Tobacco	% Frequently See Peers Stopped by Police for Tobacco
Of 10 Youth	<ul style="list-style-type: none"> • Yes (1) • No (9) 	<ul style="list-style-type: none"> • Never (7) • Often (1) • See cops who say they are checking youth for marijuana (2)

Table 8: Youth tobacco questions summary

	Experience with Tobacco Products	Experience with E-cigs	How Most Friends Get Tobacco or E-cigs	How Often Friends Get Tobacco or E-cigs from Stores or Gas Stations	What Would You Choose: Either Tobacco or E-cigs and Why?
Of 10 Youth	<ul style="list-style-type: none"> • Never tried tobacco products (4) • Have tried them, but don't currently use (1) • Have tried them; sometimes still use (2) • Regularly use a tobacco product (3) 	<ul style="list-style-type: none"> • Have never tried them/ no interest (4) • Tried them (6) <p><u>Of these:</u></p> <ul style="list-style-type: none"> ○ Tried them and now use them (1) ○ Tried them and don't use them (5) 	<ul style="list-style-type: none"> • No answer/ don't use (5) • Gas stations only (2) • Chain stores only (1) • Gas, chain, or independent (2) 	<ul style="list-style-type: none"> • Often, 1-2 times/week (9) • Not Very Often (1) 	<ul style="list-style-type: none"> • Would choose e-cigs (6) • Would choose tobacco cigarettes (3) • Not sure (1) <p>Why reasons: E-cigs because no smoke, flavors, smells better, doesn't hurt throat or lungs. Cigarettes because more nicotine, e-cigs still have chemicals, don't like feel of e-cig electricity, e-cigs don't hit the spot</p>

Retailer key informant interviews

The project lead identified small, independently owned convenience store retailers using data from the Tobacco Retail Assessment, which Upstream Public Health co-owns. These retailers were the focus, because Workgroup members were most concerned that a retail license fee would affect them. The project lead developed a list of 26 convenience stores, with six located near schools. The goal was to obtain interviews with at least six stores and two near schools. The project lead or another team member conducted initial phone calls to find out when a manager or owner would be in. The project lead visited retailers to drop off a packet of the interview and consent forms and ask permission to conduct the interview. The team lead explained the purpose of the interview, project funding, and that those willing to be interviewed would be offered a \$25 gift certificate for their confidential responses upon completion. The lead did not collect identifying information. The project lead went over the consent form with all participants. Questions included the primary language spoken at home, cultural or ethnic background, gender identification, role in the store, estimates of tobacco sales, opinions about the effect of varying levels (i.e. \$300, \$500, \$100) of annual TRL license fee costs on business practices (i.e. stop selling tobacco, sell more tobacco, raise the price of tobacco, start a contract with a tobacco distributors, close the shop, other), effect on retailers near schools of mandating a 1000 foot boundary from schools for tobacco sales, willingness to participate in training on the new policy, and under what conditions would they send staff to a training. The project lead completed four interviews, and none were near schools. Most contacted retailers declined to participate based on being too busy.

Table 9: Retailer Demographic Interview Summary

	Language Spoken at Home	Race or Ethnicity	Gender	Role in Store
Of 4 Retailers	English (1) Spanish (2) Amharic (1)	English Korean (1) Hispanic (2) Black American (1)	Female (3) Male (1)	Owner (3) Manager (1)

Table 10: Retailer Response to Tobacco Questions

	Current Tobacco Contract	% Estimate of Total Profits from Tobacco and Related Products	Response to TRL Fee at \$300	Response to TRL Fee at \$500	Response to TRL Fee at \$1000	Willing to send managers and clerks to training?
Of 4 Retailers	Yes (2) No (2)	One each of the following responses: 2% 8-12% 10% 12%	Raise price of tobacco (3) Stop selling tobacco (1)	Raise price of tobacco (3) Stop selling tobacco (1)	Raise price of tobacco (2) Stop selling tobacco (2)	Yes (4) All said it needs to be free If there is an incentive (1) If it is mandatory (1) Don't think needed (1)

C.4) Assessment Limitations

This HEIA has several imitations readers should consider when applying its findings and recommendations. First, the project did not have an introduced policy it was directly seeking to inform. While we used SB 417 as an initial template, the 2015 legislative session saw three different bills, with a variety of approaches introduced in different committees. For example, SB 417 directed the Oregon Liquor Control Commission (OLCC) to manage the licensing system. A second bill, HB 3534 included the Oregon Health Authority, in an intergovernmental agreement with the OLCC, enforcing the licensing system. A third bill, SB 633, directed the Oregon Department of Revenue to manage a licensing system. Assessing the potential impacts of elements of each bill was beyond the scope of the HEIA. Multnomah County commissioners or Oregon legislators could bring forward a new TRL policy with different provisions that this HEIA did not examine. Many of the health factors and health outcomes this HEIA examined are impacted by a host of other variables beyond a tobacco retail license, and therefore direct causality between a TRL and outcomes would require further study.

We sought information from Workgroup participants, youth, and retailers to provide perspectives from those who might be most impacted by a TRL policy. Many retailers did not agree to be interviewed. It is likely we did not capture a representative sample of all experiences in this HEIA process. For example, in hearings related to state TRL policies, many opponents of the policies provided testimony about the licensing fee impacting their bottom line. We intentionally met with the smallest retailers who we thought would be least able to afford a licensing fee, however some larger retailers may have a different set of experiences to share.

The literature review and existing data had limitations based on sparse literature or non-existent data. While the retail assessment is limited because it did not include all retailers in the County, based on FDA data, it reflects a representative sample¹⁰. For example, we were unable to find literature directly concerning culturally relevant training provided for tobacco retailers related to any kind of license. This information gap remains, although indirect literature about culturally relevant smoking cessation training can be used by agencies implementing a tobacco retail licensing system. Much of the literature reviewed is from other locations and may not be representative of how Oregon or Multnomah County communities could respond in similar circumstances. We may have missed literature or analyses in our searches.

The project team was unable to answer multiple current conditions questions, given existing data gaps. The following are areas where the project team, often with help from staff from public agencies, could not find usable information readily available to address HEIA assessment questions.

- Questions about TRL Impacts to Small Minority Owned Retailers: Data on the number of people of color-owned businesses is outdated in Multnomah County. The most recent data are from the 2007 U.S. Economic Census, which pre-dates extensive displacement and gentrification underway between Portland and neighboring cities¹¹. Existing business associations and chambers of commerce are open to anyone, even when they may focus their services for one ethnic or racially specific group. Data on minority-owned businesses does not classify business type, so we were unable to identify the number of small tobacco retailers who are likely to be most impacted (beyond an understanding that they exist). We also could not find data on the average sales of tobacco and related products for retailers in Oregon, in Multnomah County, or by retailer size.
- Questions about TRL Impacts to Youth of Color: Police and other enforcement officers do not record the number of stops of youth, the reasons they are stopped, or the race and ethnicity of those they stop. Citation records are available from different city enforcement agencies of Multnomah County. We were unable to determine the degree to which youth are stopped for possession or use of tobacco products from secondary data. Instead, we relied on information provided from school based police officers in two school districts in Multnomah County, obtained from Multnomah County staff (Personal Communication, Inga Suneson, June 2, 2015), youth responses to interview questions related to this topic, and impressions from colleagues in Seattle, WA related to this topic. Our impression, with this limited set of data, is that enforcement agencies like the police currently stop youth if they are using hand rolled tobacco or e-cigarettes, under the impression that the items could include marijuana. Existing literature related to other tobacco possession laws indicates that in other jurisdictions around the country, law enforcement has a pattern of racially profiling youth of color.
- School districts have policies related to tobacco possession and discipline. They also keep records of discipline actions for youth under the age of 18, and these are available from the Oregon Department of Education (ODE). However, youth can be brought in for up to three discipline infractions at a time, and the primary reason they are disciplined is not described (Personal Communication, Wes Mouw, June 15, 2015). For example, a youth who is fighting with another person may be stopped for fighting, and if they also have cigarettes in their possession this will be included in the discipline action, even if the primary reason they are brought in is for fighting (Personal Communication, Wes Mouw, June 15, 2015). The data ODE provided indicated that between 2010-11 and 2013-14, for all students in districts in Multnomah County, the number of Hispanic/Latino students brought in for any tobacco-related incident among other incidents

went from 8 to 19, while the number of other youth of color brought in for any tobacco incident (with or without other incidents) declined or remained unchanged in the same time period. The project team and some Workgroup members felt that the data was not reliable enough to draw conclusions about whether tobacco is a reason youth are brought in in schools.

- Questions about Culturally Responsive TRL Training: We were unable to find data nation-wide on the number of states or local jurisdictions that use culturally responsive methodology in their trainings for tobacco retail licensing or related tobacco trainings for retailers. We only found that smoking cessation programs recognize, and often employ, the use of a culturally responsive lens.
- Questions about Current Burden of Tobacco Use and Conditions: We found very limited county-level data on the use of tobacco and e-cigarettes among different populations, especially for youth and people of color who are from different countries of origin such as African, Latin American, South American, and East Asian regions. We also do not have good data for Asian and Pacific Islander communities where inequities across groups are hidden by aggregate data.
- Questions on Tobacco Cessation and Use: It was challenging to understand and describe what is available in terms of smoking cessation options for different groups, because the smoking cessation program is often based on insurance or lack of insurance coverage in Multnomah County¹².

C.5) Characterization of Impacts

The analyst team initially judged potential predicted impacts following the Minimum Elements of a Health Impact Assessment¹. The analysts used existing conditions data and the literature review to characterize predicted health equity impacts in this report¹³. The project lead selected a set of categories that would be as straightforward as possible and still meet the Minimum Elements. For each health factor or health outcome, the project lead assessed a separate prediction, based on what we predict looking at a TRL policy structure and the literature, looking at what we would predict from existing conditions with a policy in place, and the perspectives or concerns of Workgroup participants including interview results. The overall prediction is based only on the relationship between a potential policy and the existing data and literature. The interview and stakeholder perspectives were used to develop recommendations. Interview results were used to revise policy recommendations and address concerns based on data gaps. For example, the Workgroup was concerned that different enforcement agencies were racially profiling youth of color for tobacco use and, that if the TRL encouraged enforcement of existing minor possession laws, we could see more of this in the future. With the lack of data on this topic, youth interviews helped us get a general impression that this is not perceived as happening widely for general tobacco products. However youth do perceive racial profiling occurring in relation to possessing electronic cigarettes because of the link between use of the inhalant systems and marijuana. In a series of Workgroup meetings, the project lead presented initial characterizations based on the existing conditions data and the literature review, and the Workgroup provided feedback. See Table # at the end of this appendix for a summary.

Table 11: Potential impacts of a TRL policy on tobacco and environment access on health equity outcomes

Health Factor or Outcome	Literature Review	Existing Data	Stakeholder Perspectives, Interviews	Based on Literature and Data				Recommendations and Comments
				Overall Prediction	Likelihood	Most Impacted	Equity Impact	
Youth's tobacco purchases from stores	Decrease	Decrease	Mixed	Decrease	Very Likely with \$ for enforcement and ability to suspend/revoke	Youth, youth of color, youth experiencing economic hardship, LGBTQ youth	Benefits	TRL fee needs to cover enforcement and ability to suspend and revoke license to maximize this impact
Youth's ongoing use of tobacco and e-cigs based on store proximity	Mixed	Uncertain	Mixed	Mixed	Uncertain for existing users Possible to prevent new users	Youth, youth of color, Youth experiencing economic hardship, LGBTQ youth	Benefits	Increasing the age limit to 21 would have a greater impact on this outcome than TRL alone
Youth's experimentation with tobacco and e-cigs	Decrease	Uncertain	Mixed	Decrease	Possible to Likely	Youth, youth of color, youth experiencing economic hardship, LGBTQ youth	Benefits	Increasing the age limit to 21, reduction in advertising and marketing of products, and decrease in flavored products would affect this beyond TRL
Youth's positive impressions about tobacco and e-cigs	Decrease	Decrease	Decrease	Decrease	Uncertain to Possible	Youth, youth of color, youth experiencing economic hardship, LGBTQ youth	Benefits	Reduction in advertising and marketing of products and a counter nicotine and tobacco effort would affect this beyond TRL

Table 11 continued

Health Factor or Outcome	Literature Review	Existing Data	Stakeholder Perspectives, Interviews	Based on Literature and Data				Recommendations and Comments
				Overall Prediction	Likelihood	Most Impacted	Equity Impact	
Retailer proximity to schools*	Decrease	Decrease	Decrease	Decrease	Likely to Certain if policy includes limiting new stores near schools	Youth, youth of color, youth experiencing economic hardship, LGBTQ youth	Benefits if have supports in place	Adding TRL element where no new retailers locate 1000 feet from schools would support this as populations grow in areas with kids
Number of retailers who choose to stop selling tobacco and switch to other items	Increase	Uncertain	Increase	Increase	Uncertain to Possible	People of color, current smokers, people experiencing economic hardship	Benefits*	See economic stability section
People who want to stop smoking supported by retail environment	Mixed	Uncertain	Mixed	Mixed	Uncertain to Possible	Current smokers	Mixed	Need more tobacco cessation funds and programs to support current smokers
Tobacco and nicotine related chronic conditions	Decrease	Decrease	Decrease	Decrease	Likely	Youth, young adults	Benefits	TRL needs fee that can support enforcement, suspension of license and ability to revoke
State costs of tobacco and nicotine related chronic conditions	Decrease	Decrease	Uncertain	Decrease	Likely	Youth, young adults, current smokers	Benefits	TRL needs fee that can support enforcement, suspension of license and ability to revoke, Funds need for smoking cessation programs, Trauma informed smoking cessation

Table 12: Potential impacts of a TRL policy on economic stability health equity outcomes

Health Factor or Outcome	Literature Review	Existing Data	Stakeholder Perspectives	Based on Literature and Data				Recommendations
				Overall Prediction	Likelihood	Who is Most Impacted	Equity Impact	
Small retailer tobacco sales of tobacco products	Decrease	Uncertain	Mixed	Decrease	Likely to Certain	Youth, people of color, people experiencing economic hardship, LGBTQ, those with mental illness, small retailers, houseless	Benefits for some Harms to small retailers	Economic development efforts support retailers who want to stop selling tobacco
Clerks pay fines for TRL, potentially lose jobs if sell to minors	Increase	Uncertain	Increase	Increase	Likely to Certain	Clerks	Harms unless supports in place	TRL must be written so that owners are responsible for fees and fines; Training on rules needs to be mandatory and culturally responsive
Prices of tobacco products	Uncertain	Small Increase	Mixed	Small Increase	Possible	Existing tobacco users with economic hardship	Benefits for some Harms for others	Need more tobacco cessation funds and programs to support current smokers
Retailer stress related to license fee or business change	Increase	Uncertain	Increase	Increase	Uncertain to Possible	Small retailers that rely on tobacco as secondary market	Harms unless supports in place	Training on rules needs to be mandatory and culturally responsive; Economic development efforts support retailers who want to stop selling tobacco

Table 13: Potential impacts of a TRL policy on social health equity outcomes

Health Factor or Outcome	Literature Review	Existing Data	Stakeholder Perspectives	Based on Literature and Data				Recommendations
				Overall Prediction	Likelihood	Who is Most Impacted	Equity Impact	
Enforcement officers stopping youth for tobacco possession	Increase if enforce minor possession laws	Uncertain	Workgroup concerned increase profiling, Interviews indicate happening with e-cigs only	Mixed	Possible	Youth, youth of color, youth experiencing economic hardship, LGBTQ youth	Harm unless prevented	Administrative rules developed with oversight committee; Enforcement applied with EE lens
Licensing inspections inequitable applied	Uncertain	Mixed	Workgroup concerned increase profiling	Mixed	Possible	Retailers of color, neighborhoods where people experiencing economic hardship or people of color live	Potential Harm	Administrative rules developed with oversight committee; Enforcement applied with EE lens
Address historical tobacco related inequities through prevention	Likely to Certain	Increase	Increase	Increase	Possible to Likely	People of color, people experiencing economic hardship, mentally ill, immigrant groups	Benefits if supports in place (see Economic and Access sections)	TRL with adequate fee for enforcement, ability revoke and suspend license, focus on owner responsibility, and funding cessation programs

D) Recommendations Development

After reviewing preliminary findings from the literature and existing conditions data, the project lead and Workgroup members developed an initial draft of recommendations at the second Workgroup meeting. This initial recommendations development process led the Workgroup to request further information from the project team. The Workgroup revised the recommendations several times through the third and sixth meetings and while reviewing the first draft of the report.

The project lead met with members of the Workgroup who attended last session of meetings. Alongside the project lead, some Workgroup members initially reviewed the health effects characterization table (included in this appendix) to identify the recommendations that occurred multiple times relative to different health factors or health outcomes based on the literature review and current condition data. This became the first set of recommendations that other Workgroup members revised and clarified in the last meeting. Workgroup members put forward a final set of priority recommendations, featured in the executive summary, and based on those they felt would have the most impact on preventing harm or maximizing health.

E) Report Review Process

Workgroup members had the opportunity to review different drafts of the report as it progressed. The project lead also asked external experts, including staff at the Multnomah County Health Department and the author of the tobacco retail assessment report, to review the report for clarity and accuracy. Upstream Public Health is planning to share the report on its website, with Workgroup members, with partners in the Oregon Health Equity Alliance, and with the ACHIEVE and REACH groups and others who have requested hearing more. Upstream will also share the report findings with Multnomah County Commissioners and Oregon legislative staff if a tobacco retail license is introduced at either level of government.

F) Evaluation and Monitoring

This HEIA will use an internal process evaluation. The project lead will ask Workgroup participants to fill out an online survey regarding their experience of the HEIA process, including lessons learned and suggestions for improvement. The project lead's self-assessment of the HIA process in relation to the HIA minimum elements is listed on the next page (see table 14). In the final Workgroup meeting, participants described the following elements as new information they gathered from being involved in the HEIA:

- How much tobacco has impacted different groups over time, and I lived during that history without realizing the tobacco impacts at the time.
- New learning that retailers depend on tobacco for other sales.
- Retailer's potential threshold for a licensing fee and about when a retailer shifts to not selling tobacco.
- How much I care about businesses staying afloat; I want the policy to help reduce sales to youth, without hurting retailers.
- Struck by youth interview results that those who did not smoke, most of them had family members that smoked with health consequences, so then youth decided not to smoke.
- Multnomah County is putting a lot of effort in preventing youth from using tobacco; they care about the youth and about overall health of community.
- One person wants businesses to be accountable, feels strongly that tobacco burdens lower income people and people of color, and retailers have a role to improve the health of the community, how do we find a middle ground?

The project lead will monitor the impact of this HEIA on any TRL policy that emerges from Multnomah County or the State of Oregon level following the publication of the report. This includes inclusion of recommendations for the HEIA in any TRL legislation, elected official or

public agency’s references to the report or project, and changes to the content of the TRL discussion—comparing the information in the 2015 state legislative hearings to future ones.

Table 14: How this HEIA addressed the HIA Minimum Elements 2014 version

HIA Minimum Elements	How Addressed
HIA is conducted to assess the potential health consequences of a proposed program, policy, project, or plan under consideration by decision-makers, and is conducted in advance of the decision in question.	This HEIA was a hybrid, because the project team was uncertain if a state policy would pass and wanted to be certain to inform a county policy in the absence of state action. It looked at the potential impacts of the state policy and began before the policy was passed. The HEIA continued in order to inform Multnomah County commissioners in advance of their developing a TRL policy at the local level.
HIA involves and engages stakeholders affected by the proposal, particularly vulnerable populations.	This HEIA involved a workgroup whose members work with people of color and other groups most impacted by tobacco use in Multnomah County. It also involved a small retailer manager to understand the impact of sales on retailers.
HIA systematically considers the full range of potential impacts of the proposal on health determinants, health status, and health equity.	This HEIA systematically reviewed existing grey and peer reviewed literature through searches on Google Scholar and other databases, using search terms defined by the Assessment questions developed by the WG and project team.
HIA provides a profile of existing conditions for the populations affected by the proposal, including their health outcomes, health determinants, and vulnerable sub-groups within the population, relevant to the HIA issues.	This HEIA provides a description of existing conditions for those impacted by tobacco use, availability of tobacco and e-cigarettes, and existing sales of tobacco related to health equity concerns developed in the Scoping process.
HIA characterizes the proposal’s impacts on health, health determinants, and health equity, while documenting data sources and analytic methods, quality of evidence used, methodological assumptions, and limitations.	The HEIA report provides documentation of information sources where available, the evidence used to characterize impacts, and its limitations.
HIA provides recommendations, as needed, on feasible and effective actions to promote the positive health impacts and mitigate the negative health impacts of the decision, identifying, where appropriate, alternatives or modifications to the proposal.	The HEIA report provides recommendations based on Assessment findings to promote positive benefits and address potential negative impacts where possible.
HIA produces a publicly accessible report that includes, at minimum, documentation of the HIA’s purpose, findings, and recommendations, and either documentation of the processes and methods involved, or reference to an external source of documentation for these processes and methods. The report should be shared with decision-makers and other stakeholders.	This HEIA report is being shared with stakeholders and decision makers.
HIA proposes indicators, actions, and responsible parties, where indicated, for a plan to monitor the implementation of recommendations, as well as health effects and outcomes of the proposal.	The HEIA proposes a small set of indicators to monitor the implementation of the recommendations and any potential health effects that could be related to a future TRL policy.

Appendix 1 References

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8. Torraco, R. J. Writing integrative literature reviews: Guidelines and examples. *Human Resource Development Review* **4**, 356–367 (2005).
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12. *Tobacco Cessation Services: 2014 Survey Report Oregon Health Plan (Medicaid)*. (Oregon Health Authority, 2015).
13. Bhatia, R. *A Guide for Health Impact Assessment*. (California Department of Public Health, 2010).
14. *Oregon Tobacco Facts 2013, Oregon Behavioral Risk Factor Surveillance System 2012, Adult Cigarette Smoking*. (Oregon Health Authority, 2013). At <<https://public.health.oregon.gov/PreventionWellness/TobaccoPrevention/Pages/oregon-tobacco-facts.aspx>>
15. *Oregon Behavioral Risk Factor Surveillance System (BRFSS) Race Oversample 2010-2011 See 'Oregon Tobacco Facts Data Sources and Statistical Methods'*. (2012).

	SAMHSA’s Synar Program in Oregon	Oregon’s Tobacco Retailer Compliance Inspections	FDA’s Tobacco Retail Compliance Inspection Contracts														
Who?	Coordinated by Addictions and Mental Health (AMH). Conducted by: Oregon State Police as AMH temporary employees.	Coordinated by Addictions and Mental Health. Conducted by: Oregon State Police through an interagency agreement.	Coordinated by Food and Drug Administration (FDA) Conducted by inspectors commissioned by the FDA.														
What?	<p>The Synar Amendment requires states, as a condition of receiving the Substance Abuse Prevention and Treatment Block Grant to:</p> <ul style="list-style-type: none"> • Have in effect a law prohibiting the sale or distribution of tobacco products to youth under age 18; • Enforce this law; • Conduct annual, unannounced inspections of retail tobacco outlets accessible to minors; • Achieve a noncompliance rate of no more than 20%; and • Submit an annual report detailing activities to enforce its law. <p>No penalties or citations are issued during the Synar inspections. Data is collected and reported annually to the Substance Abuse and Mental Health Services Administration (SAMHSA) in the Annual Synar Report.</p>	<p>State compliance inspections are conducted in order to enforce state laws prohibiting the sale of tobacco products to minors.</p> <p>People found to be in violation of ORS 163.575 (Endangering the Welfare of a Minor) by selling tobacco to a person under the age of 18 are issued a citation with a fine of up to \$2,000. Individual clerks/employees are cited for violations, not retailers/merchants.</p> <p>The Presumptive fine for this violation is \$435.</p>	<p>The Tobacco Control Act authorizes the FDA to contract with states, territories, and tribes to assist with inspections of retail establishments.</p> <p>All compliance check inspections completed under the FDA contracts are for enforcement purposes, and violations may lead to Warning Letters, Civil Money Penalties, or other enforcement options. (Penalties are imposed on retailers/merchants, not individuals.)</p> <table border="1" style="width: 100%; margin-top: 10px;"> <thead> <tr> <th style="width: 60%;">Number of violations</th> <th style="width: 40%;">Civil Money Penalty</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;">1</td> <td style="text-align: center;">\$0.00 with warning letter</td> </tr> <tr> <td style="text-align: center;">2 within a 12 month period</td> <td style="text-align: center;">\$250</td> </tr> <tr> <td style="text-align: center;">3 within a 24 month period</td> <td style="text-align: center;">\$500</td> </tr> <tr> <td style="text-align: center;">4 within a 24 month period</td> <td style="text-align: center;">\$500</td> </tr> <tr> <td style="text-align: center;">5 within a 36 month period</td> <td style="text-align: center;">\$5,000</td> </tr> <tr> <td style="text-align: center;">6 or subsequent within a 48 month period</td> <td style="text-align: center;">\$11,000</td> </tr> </tbody> </table>	Number of violations	Civil Money Penalty	1	\$0.00 with warning letter	2 within a 12 month period	\$250	3 within a 24 month period	\$500	4 within a 24 month period	\$500	5 within a 36 month period	\$5,000	6 or subsequent within a 48 month period	\$11,000
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Appendix 2: Tobacco Retailer Inspections in Oregon

	SAMHSA’s Synar Program in Oregon	Oregon’s Tobacco Retailer Compliance Inspections	FDA’s Tobacco Retail Compliance Inspection Contracts
Where ?	Annual, unannounced inspections of retail tobacco outlets in a way that provides a valid probability sample of tobacco sales outlets accessible to minors. Results of the Synar Survey are reported annually to SAMHSA, resulting in Oregon’s Retailer Violation Rate (RVR) as reported in SAMHSA’s Annual Synar Reports.	Annual, unannounced inspections of retail tobacco outlets. Approximately 1,500 of the estimated 3,000 tobacco retailers receive a compliance visit during the annual inspection period.	There is no requirement that compliance check inspections conducted under the FDA contracts be conducted at a statistically representative sample of tobacco outlets. The FDA does require its contractors to conduct inspections in a variety of different locations, outlet types, and communities, including minority communities as directed by Section 105 of the Tobacco Control Act.
When?	Random, unannounced inspections	Random, unannounced inspections	Ongoing throughout the year
Why?	The Synar Amendment sets a performance target. States must prove that the retailer violation rate is 20% or less through the statistically valid survey described above. There is an incentive to comply, such as the potential loss of Block Grant funds.	AMH contracts with the Oregon State Police to conduct inspections, as required by ORS 181.428 (State Police Tobacco Law Enforcement Fund) and ORS 181.430 (Department to administer program to enforce laws discouraging use of tobacco products by minors).	The FDA regulation does not include a specific performance target.
Other	www.samhsa.gov/synar Program Contact: Letitia Mack, Synar Coordinator Addictions & Mental Health (503) 945-5765 Letitia.m.mack@state.or.us	www.oregon.gov/oha/amh/Pages/prevention.aspx Program Contact: Letitia Mack, Synar Coordinator Addictions & Mental Health (503) 945-5765 Letitia.m.mack@state.or.us	Compliance information: www.fda.gov/TobaccoProducts/GuidanceComplianceRegulatoryInformation/default.htm Inspection database: http://www.accessdata.fda.gov/scripts/oc/inspections/oc_insp_searching.cfm

Appendix 3: Resources for Quitting Tobacco Use

Phone Based	
Oregon Tobacco Quit Line <ul style="list-style-type: none"> - 24 hours, 7 days a week - 170+ languages - Free services 	1.800.QUIT.NOW (1.800.784.8669) or www.quitnow.net/oregon Spanish Quit Line: 1.855.DEJELO-YA (1.855.335356.92) or www.quitnow.net/oregonsp TTY: 1.877.777.6534
Asian Smokers Quit Line <ul style="list-style-type: none"> - Hours of operation are Monday through Friday from 8am to 9pm, Pacific Time. - Voicemail and recorded messages are available 24 hours a day. 	Chinese (Cantonese and Mandarin): 1-800-838-8917 Korean: 1-800-556-5564 Vietnamese: 1-800-778-8440
SmokeFree Text <ul style="list-style-type: none"> - Free phone text-based cessation program - For teens and young adults (age 13 and up) 	http://smokefree.gov/smokefreetxt
Online	
Become an Ex (American Legacy Foundation)	http://becomeanex.org
You Can Quit Smoking Now (DHHS)	www.smokefree.gov/
Freedom From Smoking (American Lung Association)	www.ffsonline.org
Live Chat with a Quit Counselor (National Cancer Institute)	https://cissecure.nci.nih.gov/livehelp/welcome.asp
TeenQuit <ul style="list-style-type: none"> - For teen tobacco users 	www.teenquit.com
My Last Dip <ul style="list-style-type: none"> - Smokeless tobacco users 	www.mylastdip.com
Ucanquit2 <ul style="list-style-type: none"> - Military members, families and veterans 	www.ucanquit2.org
Community Based	
American Lung Association <ul style="list-style-type: none"> - Standardized curriculum, trained facilitators - Self-help, group program, online options 	www.lungoregon.org/quit/index.html
Nicotine Anonymous <ul style="list-style-type: none"> - Non-profit, 12-step based program 	www.nicotine-anonymous.org
Health Systems	
In 2009, the Oregon Legislature passed Senate Bill 734 requiring private health insurers to offer a tobacco cessation benefit of at least \$500.	Contact your health insurance company to find out what benefits they provide.

WITHIN 20 MINUTES OF QUITTING SMOKING...

YOUR BODY BEGINS A SERIES OF CHANGES THAT CONTINUE FOR YEARS.

