Maryland Tobacco Control and Prevention Program Interim Evaluation

June 13, 2018

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Maryland Tobacco Control Program Interim Evaluation

Submitted to

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About the Schaefer Center for Public Policy

Established in 1985 with a mission to bring the University of Baltimore's academic expertise to bear in solving problems faced by government and nonprofit organizations, the Schaefer Center has grown into one of Maryland's preeminent policy centers offering invaluable assistance in support of Maryland's public sector.

Housed in the University of Baltimore's College of Public Affairs, the Schaefer Center is able to complement its professional staff by drawing upon the expertise of faculty and students in its three schools Criminal Justice, Health and Human Services, Public and International Affairs in its research, consulting, and professional development work.

The Center offers program evaluation, policy analysis, survey research, strategic planning, workload studies, opinion research, management consulting, and professional development services. It is through the Schaefer Center that the University of Baltimore and the College of Public Affairs meet a central component of the University's mission of applied research and public service to the Baltimore metropolitan area and to the State of Maryland.

Since its creation more than 30 years ago, the Schaefer Center has completed hundreds of research and professional development projects for various local, state and federal agencies, as well as nonprofit organizations.

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Executive Summary

The Center for Tobacco Prevention and Control (CTPC) at the Maryland Department of Health (MDH or the Department) contracted with the Schaefer Center for Public Policy at the University of Baltimore, College of Public Affairs to conduct an evaluation of Maryland's Tobacco Control Program (MTCP). The evaluation contract is in place from June 2017 through June 2019, and will examine the program activities covering July 1, 2014 through June 30, 2017 (FY 2015 through FY 2017). This is the first of two reports being produced through this research. Findings from this report, as well as strategic planning and additional analysis, will guide development of the second report.

Utilizing process and outcome evaluation frameworks, this Maryland Tobacco Control Program Interim Evaluation Report assesses the progress Maryland is making toward achieving its goals and objectives around reducing the prevalence of cigarette smoking among adults; reducing the prevalence of tobacco use among youth; decreasing youth access to tobacco in the retail environment; reducing exposure of youth to secondhand smoke (SHS); and decreasing exposure to secondhand smoke among Maryland residents by increasing the voluntary household no-smoking rules. This report also examines the activities undertaken by CTPC, local health departments (LHDs), and grantees to achieve these objectives while following the Maryland Cancer Control Plan as the current strategic plan.

In completing this evaluation, the research team conducted an extensive review of documents from the Maryland Department of Health and other sources; analyzed secondary data from a wide variety of sources such as the Behavioral Risk Factor Surveillance System (BRFSS) and the Youth Risk Behavior Survey/Youth Tobacco Survey (YRBS/YTS); conducted interviews with representatives from each of the 24 Maryland LHDs, grantees, and CTPC staff; and conducted focus groups with representatives from the 24 Maryland LHDs. Additionally, the research team conducted a formal stakeholder survey to capture perceptions regarding the evaluation plan, research questions, and data collection efforts.

Funding for this project was provided through the Maryland Cigarette Restitution Fund.

Program Outcomes

As documented in this report, CTPC has achieved considerable progress across the four Maryland Tobacco Control programmatic goals: 1) prevent initiation of tobacco among youth and young adults; 2) promote quitting among adults and youth; 3) eliminate exposure to secondhand smoke; and 4) identify and eliminate tobacco-related disparities among population groups.

Specific achievements include:

- Reducing the tobacco retailer non-compliance rate (13.9% in 2017), well below the national target of 20%;
- Reducing the prevalence of current cigarette smoking for all adults (13.7% in 2016) below the state 2020 target of 15.6%;
- Reducing the prevalence of all tobacco use among high school students (14.4% in 2016) and minority high school students (13.0% in 2016) below the state 2020 target of 16.1%;
- Increasing the number of youth who self-report not being exposed to secondhand smoke at home (for high school youth, 74.2% in 2016 from 37.5% in 2000; for middle school youth, 81.7% in 2016 from 52.9% in 2000); and
- Sustaining Comprehensive Tobacco Control Programming for two decades, with programming and infrastructure that aligns with CDC Best Practices.

Summary of Recommendations

CTPC has achieved considerable progress across the four programmatic goals for the tobacco control program in Maryland. Specific achievements include reducing the tobacco retailer non-compliance rate, reducing the prevalence of current cigarette smoking adults, and reducing the prevalence of all tobacco use among high school students (overall and those self-identified as minority). In addition, Maryland residents have increased protection from SHS exposure. These outcomes point to evidence that several strategies are working within the structure of the current CTPC program.

This interim evaluation also identified opportunities to improve programming and achieve even greater outcomes. These include areas such as data collection and reporting, sharing resources and knowledge, and local challenges related to targeting specific populations. With these in mind, this report offers three administrative recommendations to CTPC.

1. **Statewide Planning for Comprehensive Improvements for Data Collection:** The first recommendation is to conduct a strategic review of data collection processes. This recommendation stems from observations about effectively utilizing currently collected administrative data and the ability for LHDs to play a greater role in understanding how their data contribute to statewide accomplishments. This process should include important key stakeholders, including LHD staff, to develop a sense of where data collection efforts could be improved. Results of such a review could reveal opportunities for a centralized electronic data collection and reporting system or enhancement to the current system to be more standardized across jurisdictions. In addition to addressing the performance management challenges of the existing system, the impact of such a review would provide benefits for LHDs, stakeholders in the communities, other partners, and CTPC staff.

2. **Continue Investing in Areas that Work and Strategically Invest in Areas of Need:** The second recommendation is to better target and invest in areas of need across the state, particularly the large differences in performance between jurisdictions. Examples of large differences in performance across jurisdictions include tobacco use among minority youth (state average is 13.0%; difference between the jurisdictions with the highest and lowest rates is 36.2% in 2016) and rates of smoking among pregnant women (state average 5.9%; difference between the jurisdictions with the highest and lowest rates is 22.9% in 2016). The benefit of strategically investing resources is two-fold: first, there are improvements in health at the local level for the groups benefiting from more targeted interventions; second, the statewide average also sees improvement as the high levels of tobacco use come into better alignment with their peers. Strategic investment is a win-win scenario.

3. **Formalize Knowledge Sharing by Creating a Resource Repository:** The third recommendation is to develop a formalized system for the sharing of programmatic knowledge and resources. Throughout the data collection, LHDs reported that they do not receive enough communication from CTPC about program priorities, program guidelines, and the work of other LHDs. Further, the interviews and focus groups also revealed that LHDs want an opportunity to learn from each other and to share resources like media materials and successful strategies. Participants suggested the development of an operational manual would be helpful, as well as a centralized repository to house certain resources such as standard operating procedures, FAQs, and technology solutions. The importance of improved communication cannot be overstated. Participants extensively noted the need for more trust and transparency, both of which stem from improving formal communication efforts, such as a formalized knowledge sharing system. A formalized system of resources, operating procedures, and state strategies would increase transparency, formalize operations, and create additional opportunities for communication.

Dissemination Plans and Next Steps

This interim evaluation report is the first outcome in a multi-year evaluation and strategic planning partnership with the Schaefer Center. Following the submission of this report to the Centers for Disease Control and Prevention, the findings from this interim evaluation will be shared with stakeholders, including LHDs, grant-funded partners, advisory boards, coalition members, and other interested parties.

Facilitated strategic planning sessions with CTPC and stakeholders will be held in the fall/winter of 2018. These discussions will review the evaluation findings in greater detail, and inform the direction and focus of the Maryland Tobacco Control Program moving forward. Research evaluation questions will be discussed and adjusted for future evaluations, as needed. These discussions will inform an update to the statewide strategic plan and guide sustainability for the Maryland Tobacco Control Program.

Introduction

The Maryland Department of Health, Center for Tobacco Prevention and Control has provided oversight of the statewide Maryland Tobacco Control Program for over 18 years. Due to comprehensive statewide programming, strong policies, cessation support services, and a vast network of partners and stakeholders, tobacco use among youth and adults in Maryland has decreased drastically since 2000.

Despite the many successes Maryland has experienced, there are still significant concerns to address. While there have been drastic decreases in cigarette use among youth, other tobacco products have become more prevalent. Populations that are harder to reach, such as those of lower socio-economic status (SES), behavioral health, LGBT, and pregnant smokers, still have higher smoking rates than the general population. Within Maryland, youth attitudes are favorable towards tobacco use, and decreasing youth access via retail purchases remains a priority. Smoking in public places is prohibited; however, there remain opportunities for reducing secondhand smoke exposure within homes, especially among those of lower SES.

The Maryland Tobacco Control Program infrastructure consists of networked partnerships and managed resources; employs responsive planning and engaged data; and uses multi-level leadership structures (Appendix 3). Ensuring these components remain viable is important to sustaining the success of reducing tobacco-related death and disease among Maryland residents.

This evaluation will assist the Center for Tobacco Prevention and Control in identifying strengths and areas of opportunity to utilize dollars and resources effectively in reaching its goals to protect residents from the harms of tobacco use, leading to a healthier Maryland.

Maryland Tobacco Control Program Description

In 1999, the State tobacco control program staff took the lead role in providing expertise to the *Task Force to End Smoking in Maryland*, established by the former Governor. The Task Force recommended instituting a comprehensive state tobacco control program model based on the 1999 CDC Best Practices. The Center for Tobacco Prevention and Control (CTPC) within the Maryland Department of Health (MDH) oversees and implements the many components of the Maryland Tobacco Control Program (MTCP). Consistent with the Centers for Disease Control and Prevention Best Practices for Tobacco Control Programs (Centers for Disease Control and Prevention, 2014a), the Program's approach focuses on: state and community interventions; cessation interventions; mass-reach health communications interventions; surveillance and evaluation; and infrastructure, administration, and management.

CTPC maintains 16 individuals on staff. Eight of these positions are federally-funded, and eight are state-funded. Many staff, including the Center director and three division chiefs, have been with the Center for more than ten years, demonstrating a continuity of programming and

institutional knowledge. CTPC has staff and works with those within the Administration who fulfill the necessary roles outlined in the CDC Best Practices to ensure a successful statewide program:

- Program Director
- Policy Coordinator
- Communications Specialist
- Cessation Coordinator
- Survey and Evaluation staff
- Fiscal management staff
- Administration Staff

State funding is provided to all 24 Local Health Departments, which each have their own tobacco control programs that address school- and community-based programs, cessation, and enforcement activities.

Additional components that comprise the MTCP include:

- Two statewide resource centers:
  - Legal Resource Center for Public Health Policy (LRC)
  - Maryland Resource Center for Quitting Use and Initiation of Tobacco (MDQuit)
- The Maryland Tobacco Quitline, 1-800-QUIT NOW
- Local coalitions within each of Maryland's 24 major political jurisdictions that represent the diverse demographics of its respective jurisdiction
- Community-based programming, including funding to organizations who reach vulnerable and underserved populations
- Health communications grantees
- Partnerships with other MDH entities (Centers for Cancer Prevention, Chronic Disease, and Oral Health programs, Maternal Child Health, WIC, Office of Minority Health and Health Disparities, Environmental Health, Medicaid and Behavioral Health Administration)
- Health Systems grantees
- Statewide Advisory Board
- Statewide Tobacco Control Coalition

The overall goals of CTPC and its partners are to:

- Prevent youth and young adults from initiating use of tobacco products;
- Provide resources to assist residents in quitting tobacco use;
- Eliminate exposure to secondhand smoke; and
- Identify and eliminate health disparities among population groups disproportionately affected by tobacco-related death and disease (The Center for Tobacco Prevention and Control, n.d.).

CTPC priorities focus on:

- Reducing youth access to tobacco products within retail environments.
- Reducing tobacco use among pregnant women and women of childbearing age and among those with behavioral health conditions, i.e., mental health and substance abuse.
- Reducing secondhand smoke exposure through efforts addressing smoke-free multi-unit housing, parks, beaches, college campuses, and other outdoor areas.
- Implementing health communications to educate residents on the dangers of tobacco use and exposure to secondhand smoke, the benefits of quitting, and resources available.
- Incorporating tobacco use cessation into health systems (Maryland Department of Health and Mental Hygiene, 2017).

CTPC currently utilizes four distinct funding streams in support of tobacco control activities: State General Fund, CDC OSH Core Grant, federal Prevention and Public Health funding (Quitline capacity), and State Cigarette Restitution Funds (Master Settlement Agreement [MSA] dollars). The majority of the funds for the statewide program come from CRF dollars. CRF funds are tied to a framework and operations governed by a statute adopted in 2000. More detail is provided in Appendix 2, as statutory restrictions and mandates impact Maryland's overall tobacco control efforts, work plans, and budgets.

The Maryland MSA net payment was reported to be $147 million in 2017 (National Association of Attorneys General, 2018). As with most states, MSA dollars are not required to go to tobacco control activities, and go towards Medicaid programs, cancer screening, and other non-health programs. Maryland also receives an average of $360 million in cigarette taxes; however, these dollars go into the state General Fund, and not directly to the statewide tobacco control program. Over the past 18 years, funding levels to the MTCP have fluctuated, with a high of $21 million in 2000 to a current level of over $11 million (from state and federal funding combined). Table 1 shows the variation of funding to MTCP over the past several years, and also in relation to CDC Best Practice recommendations. The funding level in Maryland falls significantly short of the CDC recommendation for the state. Table 2 presents the total appropriations for CTPC for FY 2016 – FY 2018. Of note, in FY 2017, there was a $2 million increase in state dollars to the statewide program; these additional dollars are dedicated to enforcement activities.

Table 1: Expenditures as a Percentage of CDC Recommended Levels[1]

Year	Total Amount for Maryland	Total Per Capita	CDC Best Practices Recommended Amount	Total Expenditures as a % of CDC Recommended Level
2011	$6,020,000	$1.04	$63,300,000	9.5%
2012	$6,147,000	$1.04	$63,300,000	9.7%
2013	$5,816,000	$0.98	$63,300,000	9.2%
2014	$10,295,000	$1.72	$48,000,000	21.4%
2015	$8,500,000	$1.97	$48,000,000	17.7%

(Centers for Disease Control and Prevention, 2018)

Table 2: Total Appropriations for CTPC

Year	State Appropriations[2]	Federal Appropriations[3]	Total
FY 2016	$8,600,000	$1,200,000	$9,800,000
FY 2017	$10,600,000	$1,200,000	$11,800,000
FY 2018	$10,600,000	$1,200,000	$11,800,000

(Tobacco Free Kids, 2018; Centers for Disease Control and Prevention, 2018)

Logic Model

The CTPC logic model (see Figure 1 and Figure 2) provides an overview of the program's resources, activities, outputs, as well as the planned outcomes.

The long-term outcomes align with the four goals of the tobacco control program and are in keeping with CDC guidelines. The model is used to inform and guide planning and evaluation. The model will be used to draw linkages between the program goals, indicators of success in reaching those goals, and in establishing performance measures.

[1] Data were derived from Bridging the Gap/ImpacTeen Project, University of Illinois at Chicago Health Policy Center (UIC) for the State Tobacco Activities Tracking and Evaluations (STATE) system. Expenditures from 2008 to 2014 are compared against 2007 CDC Best Practices Recommendations; expenditures from 2015 are compared against 2014 CDC Best Practices Recommendations. These data are not adjusted for inflation. "Total Amount" refers to total funds allocated for tobacco control programs, summed from state, federal, American Legacy Foundation (if applicable), and Robert Wood Johnson Foundation (if applicable) funding sources. These totals may not match other estimates due to how the variables are defined. Definitions for data values can be obtained here: https://chronicdata.cdc.gov/Funding/University-of-Illinois-at-Chicago-Health-Policy-Ce/68zh-tyt3.

[2] This include cigarette restitution fund and general appropriation dollars, as well as additional dollars allocated by the governor or other special appropriation measures.

[3] Figures provided under this column are rounded to reflect consistency across data sources.

Figure 1: Logic Model: Resources and Activities (Part 1)

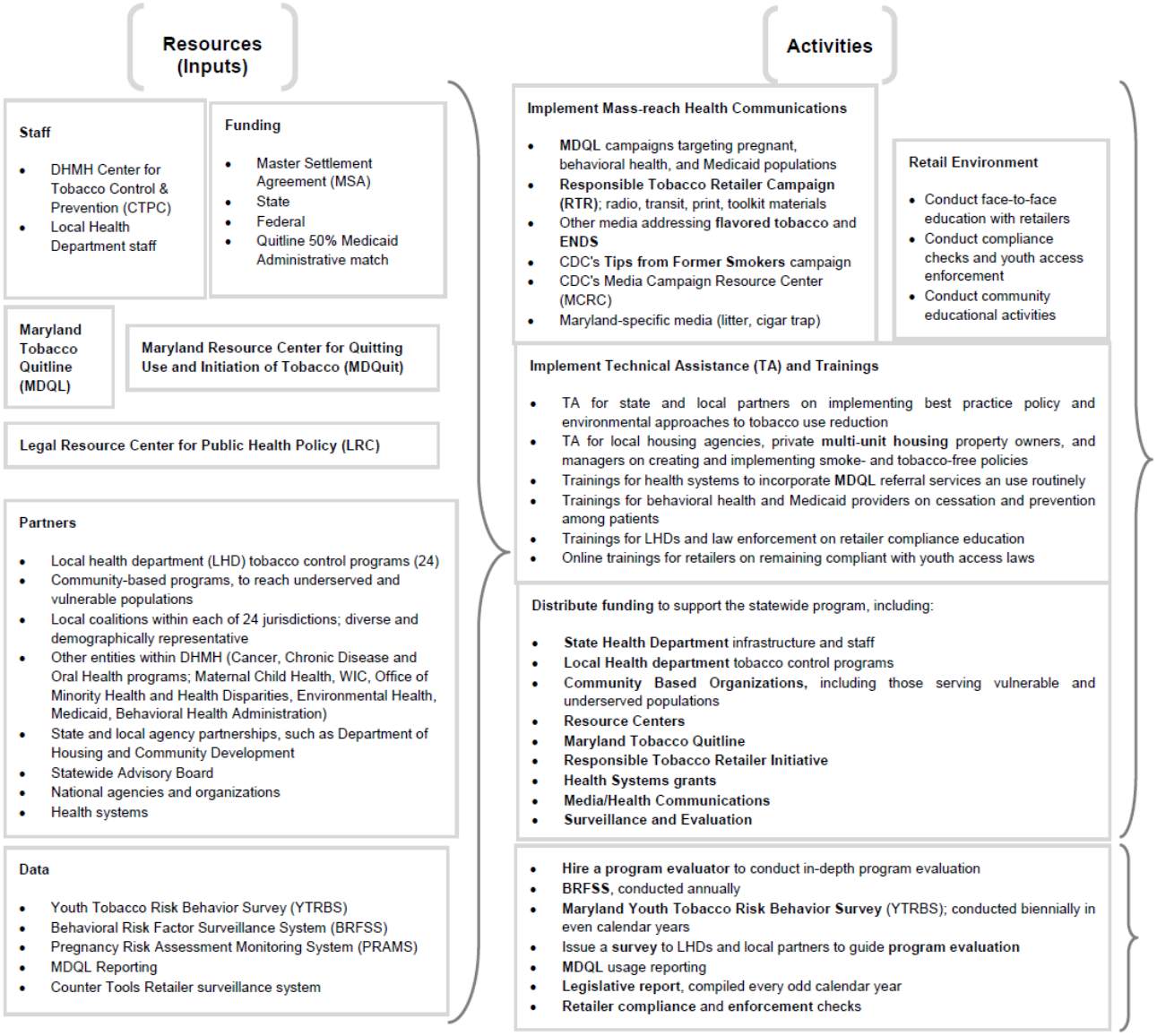
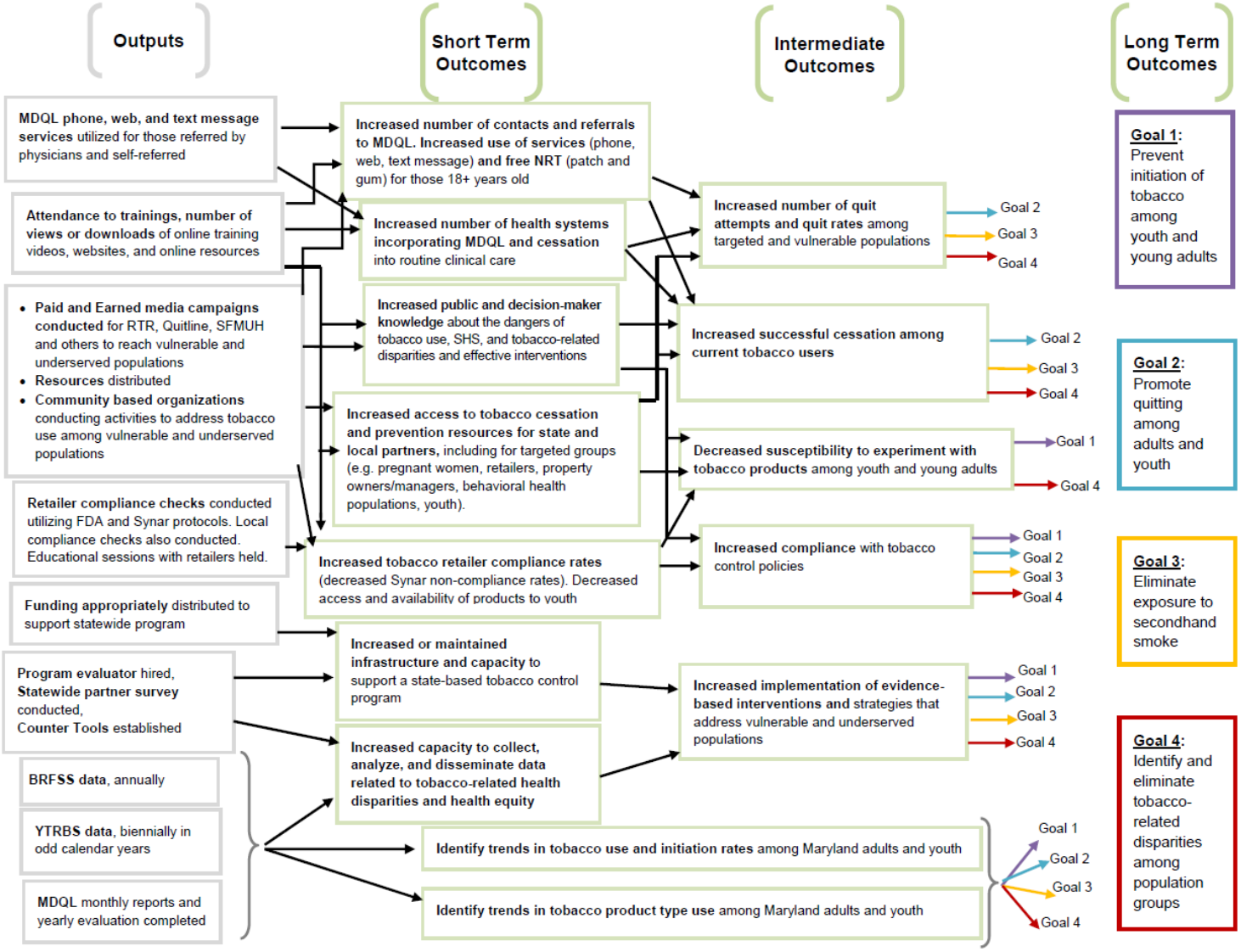


Figure 2: Logic Model Continued: Outputs and Outcomes (Part 2)



Evaluation Methodology

This evaluation employed a four-part methodology for collecting and analyzing data that included: (1) stakeholder engagement; (2) document and data review; (3) interviews; and (4) focus groups. The evaluation data collection protocol was ruled exempt by the Institutional Review Boards at the University of Baltimore on March 1, 2017 and at MDH on July 10, 2017. The subsequent pages provide an overview of the methodology.

Stakeholder Engagement Process

CTPC stakeholders' buy-in is critical to the success of the process and the ultimate utility of the evaluation. CTPC supported two core activities to engage stakeholders in the evaluation process: sharing the evaluation with individuals through presentations as well as utilizing a formal stakeholder survey to capture perceptions regarding the evaluation plan, research questions, and data collection efforts.

Stakeholder Presentations

The research team delivered three presentations to stakeholders to inform them of the evaluation process and research activities that would be taking place. Presentations typically consisted of an overview of the evaluation plan and an opportunity to ask the research team questions.

June 28, 2017: The Schaefer Center attended a Local Health Department Tobacco Control Program Coordinator in-person meeting to introduce coordinators to the project. Coordinators were given the opportunity to sign up for an interview about their tobacco control work.

July 13, 2017: The MDH CTPC hosted a Tobacco Control webinar for local health departments. The webinar included updates and overviews of grantees from the CTPC Health Systems Cessation Grants. CTPC discussed a summary of the evaluation and upcoming research activities. The meeting was attended by members of the Schaefer Center, CTPC Health Systems grantees, and LHDs staff.

October 26, 2017: The Schaefer Center research team attended the MD Quit Advisory Board Meeting at the UMBC campus in Baltimore. An overview of the evaluation plan, including details on the data collection process, was provided.

Stakeholder Survey

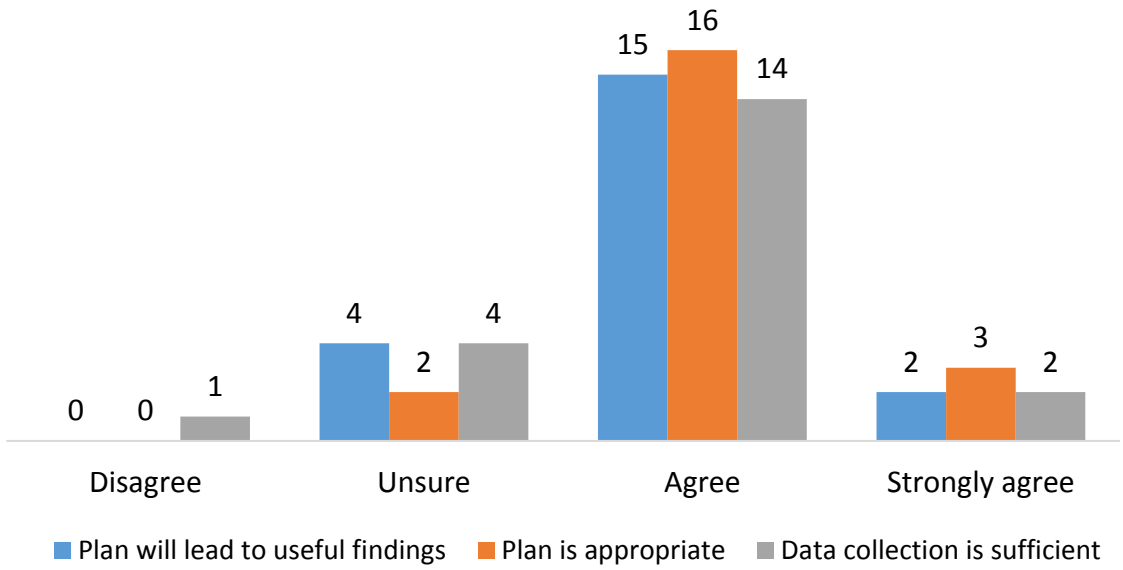
On December 1, 2017, a stakeholder survey was emailed to CTPC evaluation stakeholders. Additional distributions included an anonymous link to Statewide Tobacco Coalition members. Because the survey was shared both by email (controlled access) and an anonymous link (open access), it is not possible to determine how many individuals were offered it and a response rate

cannot be calculated. The number of responses varied by question (n=21-34); the survey did not include forced responses.

The purpose of the survey was to gauge stakeholder perceptions about the research plan, questions, and methods. It included questions about stakeholders' perceived utility of answers to the research questions. The results found that 74% (n=23) of survey respondents reported that they are satisfied the research questions would yield useful information.

Additional questions sought to understand stakeholder perceptions about the expected utility of the findings based on the evaluation plan, the appropriateness of the data collection efforts, and the sufficiency of the data collection plan. Figure 3 shows that for survey respondents who answered this question (n=21), a majority agree with utility of findings (71%, n= 15) as well as the appropriateness (76%, n=16) and sufficiency of data collection (71%, n=14).

Figure 3: Response Rates for Utility, Appropriateness, and Sufficiency



The buy-in and knowledge-sharing that occurred during the stakeholder engagement processes has been valuable for connecting the research team to staff at the local health departments and providing a unified message about the purpose of the evaluation. This bears out in the results of the survey, which suggest stakeholders are satisfied with the evaluation plan.

Document and Data Review

In addition to participating in stakeholder engagement, this project relied heavily on the review of documents and analysis of secondary data. The documents included legislation, CDC grants and guidelines, CTPC partner grant applications, CTPC partner grant reports, and prior evaluations of CTPC and/or partners.

While most of the administrative files were formal reports, a portion of the files included administrative data compiled through the reporting and monitoring activities of CTPC. This included data reported in progress and final reports of grantees, as well as compiled administrative data that is submitted annually to the Maryland Department of Budget and Management (DBM). When possible, this report relied on reports of administrative data submitted to DBM over the individual LHD reports. All administrative data from the LHD reports that is utilized here has been validated and corrected for inclusion.

INTERVIEWS

Researchers performed semi-structured interviews of three groups associated with the CTPC: 1) the local health department (LHD) staff, 2) CTPC grantees, and 3) CTPC staff. These interviews complemented the focus groups, document review, and data analysis.

LHD Staff

LHD interviews began on July 20, 2017 and concluded on September 20, 2017. Twenty-four local health department jurisdictions were invited to participate. They were identified by CTPC staff and a contact list was provided to the Schaefer Center for Public Policy to schedule the interviews. Half of the counties had two contacts, one being the Tobacco Sales Compliance Coordinator (TSCC) and one the Cigarette Restitution Fund Program Coordinator (CRFPC). The other half had one contact filling both positions. Interviewees were contacted by email, with follow-up phone calls to schedule the interviews. Notice about the interviews and evaluation was provided to local health officers. The interviews had a 100% (n=24) participation rate.

Each jurisdiction's interview was attended by at least one representative from the local health department. The average attendance was two staff members, and the maximum was 12. Each interview lasted one to two hours and transcripts were created. Together, there were approximately 40 hours of interviews, which generated 1,055 pages of transcripts.

Interviews were semi-structured. They covered five topics: overview of their local health department; data and reporting; sustainability of local programs; successes and challenges of implementation; and target populations served by local programs. The coding structure developed for this project was derived from thematic and descriptive content covered in the interviews. The research team used manual and text searches to assign codes to interview content using NVivo 11 or Windows. Interrater reliability was conducted in an iterative and ongoing fashion through the data collection.

CTPC Grantees

CTPC grantee interviews began on October 4, 2017 and concluded on October 30, 2017. Ten CTPC grantees were invited to participate. Participants were identified by CTPC staff who provided a list of potential interviewees and the Schaefer Center for Public Policy scheduled the interviews.

Interviewees were contacted by email with follow-up phone calls taking place to schedule the interviews. Grantees received a notice about the interview and evaluation. The interviews had a 100% (n=10) participation rate.

Each interview was attended by at least one representative from the organization, an average of two staff members, and as many as four. Each interview lasted one to two hours and a transcript was generated. Together, the interviews lasted approximately ten hours and produced 208 pages of transcripts.

The interviews were semi-structured. The interviews covered four topics: overview of their organization and CTPC grant-funded programming; data and reporting related to their grant-funded programming; sustainability of their grant-funded programs; and successes and challenges of their grant-funded work.

CTPC Staff

These interviews began on November 1, 2017 and concluded on December 4, 2017. Nine CTPC staff members were invited to participate. Participants were identified by CTPC leadership who provided the research team with an interviewee contact list. Interviewees were contacted by email with follow-up phone calls to schedule interviews. The interviews had a 100% (n=9) participation rate. Each interview lasted one to two hours and a transcript was generated. Together, the interviews lasted approximately 12 hours and generated 274 pages of transcripts.

The interviews were semi-structured. The interviews covered four topics: overview of each interviewees work portfolio; data and reporting; sustainability of CTPC programs; and the successes and challenges of CTPC work.

FOCUS GROUPS

Focus groups were another primary data collection activity. Four focus groups were conducted with local health department staff across Maryland. They complemented the interviews and the document and data review.

The focus groups began on November 6, 2017 and concluded on November 8, 2017. Twenty-four individuals, one from each local health department, were invited to participate and the focus groups had an 80% (n=19) participation rate. The discussions covered local tobacco control programs with a specific emphasis on the support received, barriers encountered, and what is required to implement these programs. The focus groups lasted 7.75 hours and produced 104 pages of transcripts.

Program Goals, Objectives, Strategies and Evaluation Research Questions

At the core of every evaluation are questions which guide the work to be accomplished. For this project, the research team used three guiding frameworks that relate to strategic mechanisms established by MDH. First, CTPC is guided by four goals that strategically drive its work. Second, there are program objectives, which reflect performance goals established in the state strategic plan and the CDC Core work plan. Third, research questions, articulated in the CTPC evaluation plan (Center for Tobacco Prevention and Control, 2015), which are connected to the goals and objectives of the program. Each of these will be discussed in the following section.

CTPC Goals, Objectives, and Strategies

The CTPC program goals continue to follow CDC Best Practices regarding comprehensive structures for tobacco control programs. In addition, the goals align with the overall long-term outcomes that CTPC aspires to achieve, as previously detailed in the logic model. The goals form the underlying direction of the Tobacco Control Program in Maryland while CTPC's strategic objectives guide decisions about programming, funding, and strategy. These objectives are established as part of the state strategic plan/Maryland Comprehensive Cancer Plan and the CDC CORE work plan. The four goal areas, five objectives, and strategies for the Tobacco Control Program in Maryland are provided in Table 3.

Table 3: List of Tobacco Control Program Goals, Objectives, and Strategies

Goal 1: Prevent initiation of tobacco among youth and young adults	**Objectives**: 2. By 2020, reduce the prevalence of tobacco use among high school youth by 5% to reach the following targets: Cigarette use – 11.3% (2013 baseline of 11.9%); Cigar use – 8% (2013 baseline of 12.5%); Smokeless tobacco – 6.9% (2013 baseline of 7.4%); All tobacco use – 16.1% (2013 baseline of 16.9%). 3. By 2020, decrease the retailer non-compliance rates for Synar inspections to 20% from a 2014 baseline of 24%.
	Strategies: • Restrict and enforce minors' access to tobacco products • Educate and inform stakeholders and decision-makers about evidence-based policies and programs to prevent initiation of tobacco use • Implement evidence-based, mass-reach health communication interventions to prevent initiation • Provide on-going training and technical assistance • Develop and maintain managed resources including adequate staffing, funding, sub-recipient grants and contracts • Disseminate and use of surveillance data to inform planning and program implementation
Goal 2: Promote quitting among adults and youth	**Objectives**: 1. By 2020, reduce the prevalence of current cigarette smoking among adults by 5% to 15.6% from a 2013 baseline of 16.4%. 2. By 2020, reduce the prevalence of tobacco use among high school youth by 5% to reach the following targets: Cigarette use – 11.3% (2013 baseline of 11.9%); Cigar use – 8% (2013 baseline of 12.5%); Smokeless tobacco – 6.9% (2013 baseline of 7.4%); All tobacco use – 16.1% (2013 baseline of 16.9%).
	Strategies: • Maintain capacity for the Maryland Tobacco Quitline • Increase engagement of health care providers and systems to expand utilization of proven cessation methods • Implement evidence-based, mass-reach health communication interventions to promote cessation and support the Maryland Tobacco Quitline • Provide on-going training and technical assistance

Goal 3: Eliminate exposure to secondhand smoke	**Objectives:** 4. By 2020, reduce exposure of high school youth to secondhand smoke by 5% to 30.1% from a 2013 baseline of 31.7%. 5. By 2020, decrease exposure to SHS among Maryland residents by increasing the number of voluntary household no smoking policies from 81.2% to 85%.
	Strategies: • Increase policies for smoke-free multi-unit housing • Implement and enforce policies for tobacco-free public places • Educate and inform stakeholders and decision-makers about evidence-based policies and programs to reduce exposure to secondhand smoke • Implement evidence-based, mass-reach health communication interventions to reduce exposure to secondhand smoke • Provide on-going training and technical assistance • Disseminate and use of surveillance data to inform planning and program implementation
Goal 4: Identify and eliminate tobacco-related disparities among population groups	**Objectives**: 1. By 2020, reduce the prevalence of current cigarette smoking among adults by 5% to 15.6% from a 2013 baseline of 16.4%. 2. By 2020, reduce the prevalence of tobacco use among high school youth by 5% to reach the following targets: Cigarette use – 11.3% (2013 baseline of 11.9%); Cigar use – 8% (2013 baseline of 12.5%); Smokeless tobacco – 6.9% (2013 baseline of 7.4%); All tobacco use – 16.1% (2013 baseline of 16.9%).
	Strategies: • Use data to identify disparate populations and inform public health action • Implement evidence-based, mass-reach health communication interventions to reduce and eliminate tobacco related disparities among population groups • Develop and maintain managed resources including adequate staffing, funding, sub-recipient grants and contracts; including community-based organizations and local coalitions • Provide on-going training and technical assistance to incorporate evidence-based cessation and prevention messages into routine clinical care, including facilities that serve behavioral health, Medicaid, and pregnant populations

Evaluation Research Questions

The purpose of the evaluation is to use a combination of process and outcome measures to determine the effectiveness of the Maryland Tobacco Control Program. Project objectives were reviewed and research question were developed in collaboration with CTPC. Table 4 presents the research questions that informed the content of focus groups, interviews with local health departments and grantees, and interviews with CTPC.

Table 4: List of Evaluation Research Questions

Part A: Responsible Tobacco Retailer Initiative Reducing Youth Access to Tobacco Products	
Research Question 1	Were responsible Tobacco Retailer resources appropriately allocated, developed, and distributed to partners?
Research Question 2	To what extent was needed technical assistance (TA) provided to partners involved with implementing the Responsible Tobacco Retailer Initiative?
Research Question 3	To what extent have CTPC and collaborative partners increased activities designed to increase education and outreach directed at licensed tobacco retailers from 2013-2015?
Research Question 4	To what extent have CTPC and other statewide entities increased enforcement activities from 2013-2015?
Research Question 5	Did the Synar non-compliance rates decrease (from 24% in FFY2014, 31% in FFY in 2015) and to what extent did compliance with tobacco control policies related to youth access increase?
Part B: Maryland Comprehensive Tobacco Control Program Activities	
Research Question 6	To what extent does the Maryland Tobacco Control Program implement the CDC Best Practices model and are the programmatic activities at the state and local level reflective of community needs?
Research Question 7	To what extent has CTPC increased health communication interventions and messages reaching the general population and populations with negative disparities in the use of tobacco products and tobacco-related death and disease (racial/Ethnic groups, low SES, Medicaid, Behavioral Health, LGBT, & youth)?
Research Question 8	To what extent has CTPC and partners increased the number of implemented evidence-based interventions and strategies that address vulnerable and underserved populations?
Research Question 9	To what extent has the Tobacco Program and its partners increased the demand for tobacco cessation and increased quit attempts?
Research Question 10	To what extent did the use of tobacco products decrease since 2014?
Research Question 11	To what extent did the prevalence of tobacco use decrease among targeted high-risk populations?

Evaluation results will help CTPC and its partners assess several elements. First, they will allow CTPC to determine the program components that have been effective in reducing tobacco use and changing retailer behaviors. Second, the results will allow CTPC to know what should be expanded and replicated to continue the success of the program. Third, they will provide guidance to CTPC on where funds should be spent. Lastly, the evaluation will allow CTPC to more fully grasp the current environment and resources available to strategically plan for a sustainable future. As a result of this evaluation, CTPC will be better positioned to make changes to state strategies. These changes will result in a better alignment between local strategies and statewide program goals.

Linking Goals, Objectives, and Research Questions

While the program goals, objectives, and evaluation research questions have been presented as separate concepts, this evaluation recognizes the linkages between them. In several instances, more than one objective is relevant for a specific program goal, and in all instances, multiple research questions relate the overall program goal. This reflects the interdependent nature of CTPC's work. Table 5 shows how the program goals, objectives, and evaluation research questions relate to one another.

Table 5: High Level Mapping of Outcomes, Objectives, and Research Questions

Long Term Program Outcomes (Goals)	Project Objectives	Research Questions
Goal 1: Prevent the initiation of tobacco among youth and young adults	O 2, 3	RQ 1, 2, 3, 4, 5, 6, 9, 10
Goal 2: Promote quitting among adults and youth	O 1, 2	RQ 6, 9, 10
Goal 3. Eliminate exposure to secondhand smoke	O 4, 5	RQ 6, 10
Goal 4: Identify and eliminate tobacco-related disparities among population groups	O 1, 2	RQ 6, 7, 8, 11

Evaluation Findings

The following section presents the findings of this evaluation across three areas. The first section discusses the findings from this evaluation across the four goal areas of CTPC. The second section presents findings for the research questions related to the Tobacco Retailer Initiative. The third section presents findings for the research questions related to the Maryland Comprehensive Tobacco Control Program Activities.

Findings for CTPC Goal Areas

The following is a high-level discussion about the progress being made on the four different goal areas of CTPC. Several performance measures are included below in the discussion of the goals and discussed in detail in the sections that address the evaluation research question.

Goal 1. Prevent initiation of tobacco among youth and young adults.

Trends among Maryland middle and high school students have largely indicated decreasing initiation of smoking cigarettes and cigars from 2000 to 2016. However, Electronic Smoking Device (ESDs, e-cigarette, 'vape') use is still very high for this group, meaning there is still work to do to drive down initiation.

To that end, Maryland engages in extensive tobacco retailer compliance and education programming as part of the strategy to prevent tobacco initiation among youth and young adults. In FY 2015, Maryland launched the Responsible Tobacco Retailer Initiative, a comprehensive statewide initiative, to reduce retailer noncompliance with youth tobacco sales laws. A major component of this effort was providing funding and technical assistance to LHDs so they could increase compliance checks, education, and other enforcement activities within their jurisdictions. CTPC contracted with the Legal Resource Center to provide training and technical assistance to LHDs, retailers, CTPC, law enforcement, and others to ensure that retailers know the law and those responsible for compliance monitoring have the information and tools they need to carry out their duties. Statewide media and resources were also placed and developed to provide additional education to retailers and partners.

The Responsible Tobacco Retailer Initiative has achieved significant success with reducing the tobacco retailer noncompliance from a high of 31% in FFY 2015 to 13.9% in FFY 2018, well below the national target of 20%. However, Maryland's rate in 2017 is still much higher than the national 2014 noncompliance rate of 9.8% (the most recent year for which data are available). This implies that more can be done to further reduce the noncompliance rate.

GOAL 2. PROMOTE QUITTING AMONG ADULTS AND YOUTH.

CTPC has made progress on promoting quitting among adults and youth, overall. There have been steady declines in tobacco product use and cigarette smoking rates for adults, as well as declines in tobacco product use for youth. Specifically, CTPC has been successful in achieving its 2020 goal to reduce the prevalence of current cigarette smoking for adults to 15.6%. In 2016, the rate was 13.7%. In addition, CTPC has been successful in achieving their 2020 goal to reduce the prevalence of all tobacco use among high school students to 16.1%. In 2016, the rate was 14.4%.

The state of Maryland has mixed results regarding increasing the demand for tobacco cessation. The findings show that while trends at the LHD are declining, usage of the Quitline has increased. This suggests that more work is needed to continue to increase participation in cessation efforts, through better targeting for those individuals with a desire to quit but do not seek out assistance. To this end, CTPC is engaging in important statewide strategies, as discussed in the following sections.

GOAL 3. ELIMINATE EXPOSURE TO SECONDHAND SMOKE.

CTPC has also made progress on eliminating exposure to secondhand smoke. Between Fall 2000 and Fall 2016, the proportion of middle school and high school youth reporting that they had not been exposed to secondhand smoke indoors during the seven days before being surveyed increased from 52.9% to 81.7% among public middle school youth, and from 37.5% to 74.2% among public high school youth (Maryland Department of Health, 2018). In addition, in 2016, adults reported that 87.0% of Maryland households prohibited all smoking inside the residence (81.9% among those with no college education, 85.0% among those with some college, and 93.5% among college graduates) (ibid). Middle school student responses showed a similar trend in smoking rules inside the home.

Since 2006, when rules about smoking inside residences were first assessed, Maryland high school youth have reported a steady increase in smoking bans inside their homes, whether or not there is resident adult smoker present (Maryland Department of Health, 2018). The data from 2016 is not comparable to previous years as it included an additional response option. However, 2016 data do show that even among smokers, over 63% never allow smoking in their homes (ibid).

GOAL 4. IDENTIFY AND ELIMINATE TOBACCO-RELATED DISPARITIES AMONG POPULATION GROUPS.

CTPC has made progress in identifying trends for tobacco related disparities for population groups, with documented success in some areas and not in others. In regard to racial and ethnic population groups, CTPC has been successful in reducing the prevalence of tobacco use among minority adult populations in line with their program objective. Another population group that has been targeted are minority youth. CTPC has been successful in achieving their 2020 goal to

reduce the prevalence of tobacco use among minority high school students to 16.1%. In 2016, the rate was 13.0%. There are mixed results for addressing the extent to which CTPC and its partners have increased demand for tobacco cessation and increased quit attempts for different racial and ethnic groups. At the LHD level, cessation participation rates have declined for all racial and ethnic groups.

While these population groups have clear benchmarks and data to support observations on this goal, more work can be done to expand trend data collection related to other important population groups. These include populations such as individuals of different sexual orientation, socio-economic status, and mental health, as well as capturing data on these groups over time. Without this expanded data collection, conclusions cannot be made about progress on eliminating tobacco-related disparities for these groups in Maryland.

Findings for Part A: Responsible Tobacco Retailer Initiative – Reducing Youth Access To Tobacco Products

Retailer compliance and youth enforcement efforts in Maryland are conducted via three different, but related efforts: LHD inspections; FDA inspections; and Synar inspections. The latter two are conducted by the MDH Behavioral Health Administration (BHA). Using data collected from these inspections, MDH monitors retailer compliance with State, Federal, and local laws that restrict the sale of tobacco products to youth.

The Synar program, through the Substance Abuse and Mental Health Services Administration (SAMHSA), establishes a maximum tobacco retailer non-compliance rate, currently 20% for every state and the District of Columbia. Each state must conduct random inspections of tobacco retailers, and if the statewide tobacco retailer non-compliance rate exceeds the established maximum, then that state is subject to a penalty (Substance Abuse and Mental Health Services Administration, 2017). SAMHSA penalizes state government, not tobacco retailers, for underage tobacco sales. The standard penalty is 40% of a state's annual Substance Abuse Prevention and Treatment Block Grant (SABG), translating to over $13 million annually for Maryland. SAMHSA also offers an alternate penalty in which states have to find new state dollars to apply to enforcement activities that will lower the non-compliance rate to below 20%. In 2014 and 2015, the Maryland Synar tobacco retailer non-compliance rates were at 24.1% and 31.4% - well above the allowable limit of 20% via Synar standards. Maryland was able to use the alternative penalty, using new state dollars in the amount of $1.4 million (FY 2015) and $3.8 million (FY 2016) for enforcement-related activities and retailer education.

CTPC established and implemented the Responsible Tobacco Retailer Initiative with the goal to increase retailer responsibility and decrease youth access to tobacco. The Initiative includes funding for local health departments to engage community partners to increase education, outreach, and enforcement activities; mass reach health communication initiatives, and partnerships with the Behavioral Health Administration, the Office of the Comptroller, and retailers.

The following questions evaluate the progress made with the Responsible Tobacco Retailer Initiative.

RESEARCH QUESTION 1

Were responsible tobacco retailer resources appropriately allocated, developed, and distributed to partners?

In FY 2015, the Responsible Tobacco Retailer Initiative placed a heavy emphasis on developing educational resources to assist retailers with remaining in compliance with the law. Materials included a guidebook, a quick reference guide, ancillary materials to place in stores (window clings, stickers, magnets, and posters), and an interactive online training. All these materials are housed on the campaign website www.NoTobaccoSalesToMinors.com, along with an online order form for materials (Maryland Department of Health and Mental Hygiene, 2015, p. 44). In the first year, CTPC distributed 8,500 toolkits to all licensed tobacco retailers, sent materials to all LHDs, and sent materials to community-based organizations, including Minority Outreach and Technical Assistance (MOTA) organizations assisting in the education of retailers.

Mass-reach health communications interventions were another part of the Initiative. In the first year, ads were placed on various transit, billboard, and radio (English and Spanish) mediums generating 54 million impressions (Maryland Department of Health, 2018, pp. 58-59). CTPC conducted focus groups with tobacco retailers in 2015 to update creative and get feedback on the most useful materials. Additionally, in 2016, the toolkit materials were translated into nine languages, which were identified by LHDs as prominently spoken by retailers in their jurisdictions.

It is clear that CTPC developed a comprehensive array of resources to support the Responsible Retailer Initiative. CTPC strategically mailed educational materials to retailers periodically throughout the year while providing the same resources to those conducting the educational visits at the retail locations—this allowed for consistent messaging across the state. There was an increase in the number of visits to the campaign website and requests for materials (from LHDs and retailers) after each media placement and mailing, indicating material development and distribution were appropriate. In response to the research question, while no direct causal relationship was examined, the steep decrease in Synar violation rates from FFY 2015 to FFY 2018 indicates the materials were appropriately allocated, developed, and distributed to partners and target audiences (See Figure 5 under Research Question 5).

RESEARCH QUESTION 2

To what extent was needed technical assistance provided to partners involved with implementing the Responsible Tobacco Retailer Initiative?

As indicated above, Maryland placed an increased focus on tobacco retailer compliance with youth access laws starting in FY 2015. It became evident that providing additional technical assistance to support the Initiative was a necessity early on. To provide the required technical

assistance, CTPC contracted with the University of Maryland Baltimore, Legal Resource Center for Public Health Policy (LRC) starting on October 15, 2016 to support the expanded retailer education and enforcement efforts (Legal Resource Center for Health Policy, 2016). Prior to FY 2015, there were no specific statewide trainings for retailers or those conducting retail compliance checks at the local level.

As summarized in their final report for FY 2016, the LRC's work included training, education, and assisting local authorities with adopting, implementing, and enforcing laws regarding tobacco sales to minors (Legal Resource Center for Health Policy, 2016). LRC provided extensive technical assistance to partners involved with the Responsible Retailer Initiative (Maryland Department of Health and Mental Hygiene, 2016). The Legal Resource Center responded to 200 technical assistance requests; all 24 jurisdictions received assistance. The LRC created and disseminated more than 100 resource documents, presented at over 75 events, and educated retailers in 10 counties. CTPC continues to contract with the LRC to provide ongoing technical assistance on youth tobacco laws, the proper way to conduct retailer compliance checks, and tactics for educating the public and retailers about youth tobacco state laws. In response to the evaluation research question, this demonstrates the extent to which technical assistance.

Research Question 3

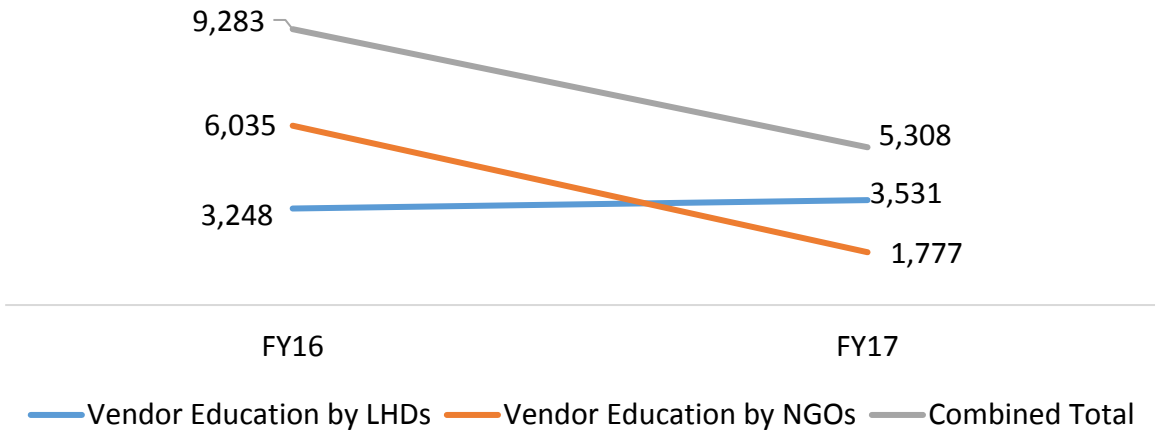
To what extent have CTPC and collaborative partners increased activities designed to increase education and outreach directed at licensed tobacco retailers from 2013-2015?

As mentioned previously, in FY 2015 and FY 2016, CTPC had to apply a significant amount of new state dollars to enforcement activities due to being out of compliance with Synar retailer non-compliance rates ($1.4 million and $3.8 million, respectively). As the retailer violation rate decreased to well below 20%, a penalty was no longer applied to Maryland. To sustain progress and avoid future penalties, the Governor allocated $2 million to the state program for enforcement activities. While this amount was lower than the $3.8 million in FY 2016, funding was provided to sustain program activities.

While significant activity to reach out to licensed tobacco retailers occurred during FY 2015, the wording of the performance measures changed in FY 2016 in response to grantee feedback, and as a result, the performance measures for FY 2015 are not comparable to those of FY 2016 and FY 2017. Since the Responsible Tobacco Retailer Initiative did not exist in 2013, the number of activities designed to educate and reach out to licensed tobacco retailers increased from 2013 through 2015. For example, in FY 2015, the number of sub-vendors (NGOs and MOTA groups) funded to conduct face-to-face education with retailers in FY 2015 was 51; this number was zero in 2013 (Maryland Department of Health and Mental Hygiene, 2013; 2014).

Despite the progression of the program from 2013, administrative data reviewed show mixed results as funding has fluctuated over time. LHD grantee reports between FY 2016 and FY 2017, show a decline in the numbers of retailers educated at the local level. See Figure 4 for a visualization of these trends. Given the recent changes made to the definition of the performance measures, a comparison cannot be made prior to FY 2016[4]. The total number of retailers educated in FY 2017 (5,308) is below the rate in FY 2016 (9,283). This coincides with decreased funding levels for this initiative ($3.8 million in FY 2016 and $2 million in FY 2017).

Figure 4: Two-Year Trends on Face-To-Face Retailer Education by NGOs and LHDs



(Maryland Department of Health and Mental Hygiene, 2016; Maryland Department of Health, 2018)

[4] Administrative data available for these programmatic areas do not exist in a comparable way prior to FY16. Future reports should evaluate the trend over time to have a better sense of the direction and extent of change.

CTPC also captures trends in collaborative outreach activities related to the Responsible Tobacco Retailer Initiative. The activities documented in the LHD grantee reports include collaborations with NGOs, schools, coalitions, and faith-based organizations. A portion of those activities are reported to the Maryland Office of Budget and Management. A list of these activities is included in Table 6. Given the recent changes made to performance measures, a direct comparison cannot be made prior to FY 2016. These data are sorted by the percentage change from FY 2016 to FY 2017. This table shows that the numbers for all community-based enforcement activities have declined from FY 2016 to FY 2017. In some cases, the difference is small, but there has been a dramatic reduction in the number of town hall meetings on tobacco use and prevention, for example[5]. This raises important questions about saturation, sustainability, and capacity.

Table 6: Two-Year Trend of Enforcement Partnerships by Local Health Departments

Indicator	FY 2016	FY 2017	Difference	Percent Change
School-based collaborations	79	71	-8	-10%
Tobacco retailer group training sessions	48	42	-6	-13%
Leadership meetings held on tobacco use and prevention	78	49	-29	-37%
Faith-based collaborations	46	23	-23	-50%
Town hall meetings on tobacco use and prevention	81	10	-71	-88%

(Maryland Department of Health and Mental Hygiene, 2016; Maryland Department of Health, 2018)

In response to the research question, since the Responsible Tobacco Retailer Initiative did not exist in 2013, the number of activities designed to educate and reach out to licensed tobacco retailers increased from 2013 through 2015. In addition, the qualitative data from interviews stress the importance of community partnerships in their work, further indicating that activities increased during this time period. Almost every LHD reported that good relationships with local community partners helped them achieve project goals. LHDs said community partners helped them to overcome challenges caused by lack of funds, as well as provided collaborative outreach to better target certain population (such as, minority owned retailers). When the nature of the territory and the characteristics of the jurisdiction were not favorable for LHD enforcement work, partners proved to be indispensable. With this added context, it appears that the decline in enforcement partnerships may be a result of solidifying relationships, rather than a decline in activity. Additional efforts should be made to monitor these levels moving forward to accurately determine a trend over a longer period.

[5] Important to note that the guidance provided to LHDs in FY 17 indicated that town hall meetings were not required because of a reduction in funding for enforcement.

RESEARCH QUESTION 4

To what extent have CTPC and other statewide entities increased enforcement activities from 2013-2015?

In addition to the FDA and Synar inspections (through the MDH Behavioral Health Administration), each jurisdiction monitors illegal tobacco sales to minors by conducting regular inspections of licensed tobacco retailers. State funding was drastically cut in FY 2010, and many local enforcement programs suffered due to lack of resources. In FY 2015 and FY 2016, funds to local health departments were provided to boost compliance/enforcement efforts. Local enforcement programs commonly involve a partnership or contract between the county health department and the county police or sheriff's department.

The LHD grantee reports[6] include data on trends relating to tobacco sales compliance checks and tobacco sales citations. Between FY 2014 and FY 2017, these performance measures changed and are not directly comparable. In order to allow for comparison over time, combined performance measures have been created. Table 7 shows that tobacco sales compliance checks and citations issued saw dramatic increases from FY 2013 to FY 2015. These numbers continued to increase in FY 2016, with a slight decline in FY 2017. For tobacco retailer compliance checks, there was a percentage change of 429% from FY 2013 to FY 2017. For tobacco sales citations issued, there was a percentage change of 374% from FY 2013 to FY 2017.

Table 7: LHD Tobacco Sales Compliance Checks and Enforcement from FY 2013 to FY 2017

Indicator	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	Difference	Percent Change
Tobacco retailer compliance checks[7]	1,229	5,321	3,921	10,419	6,498	5,269	429%
Tobacco sales citations issued[8]	160	255	310	1,291	758	598	374%

(Maryland Department of Health and Mental Hygiene, 2013; 2014; 2015; 2016; Maryland Department of Health, 2018)

[6] LHDs grantee reports are submitted to CTPC at MDH. These are annually tabulated and provided to the Maryland Department of Budget and Management for budget reconciliation. Reports to the Office of Budget and Management also include data on trends relating to tobacco sales compliance checks conducted as reported by local health departments.

[7] In FY16, CTPC modified the compliance check performance measures, making comparisons across time difficult. To resolve this, a combined performance metric has been created here. It combined the following metrics "Tobacco retailer product placement compliance checks", "Tobacco retailer youth access compliance checks", and "Tobacco retailers issued citations for sales to minors" (from FY 2013, FY 2014, and FY 2015) with "Tobacco sales compliance checks" (from FY 16 and FY 17).

[8] In FY16, CTPC modified the sales citations performance measure, making comparisons across time difficult. To resolve this, a combined performance metric has been created here. It combined the following metrics "Tobacco retailers issued citations for sales to minors" (from FY 2013, FY 2014, and FY 2015) with "Tobacco sales citations issued" (from FY 16 and FY 17).

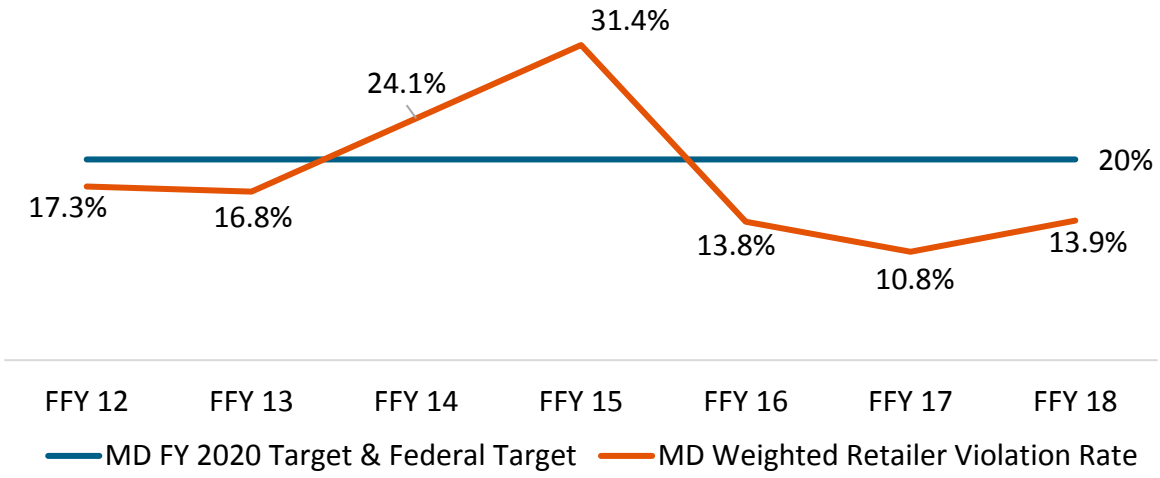
To achieve these results in a short amount of time, notably with the dramatic increase between FY 2015 and FY 2016 for both metrics, CTPC utilized several statewide and local strategies to mobilize resources. In interviews with LHDs and CTPC staff, extensive comments were made around establishing and building community partnerships in order to more effectively target tobacco sales compliance. While this chart focuses on the extent that LHDs increased enforcement activities, the outcomes reflect the successful implementation of a statewide strategy to drive up compliance checks and enforcement. In response to the evaluation research question, the extent of the change is noteworthy, as measured by these performance measures of enforcement activities.

RESEARCH QUESTION 5

Did the Synar non-compliance rates decrease (from 24% in FFY 2014 and 31% in FFY 2015) and to what extent did compliance with tobacco control policies related to youth access increase?

Maryland has achieved significant success with reducing its Synar-related tobacco retailer non-compliance rates from a high of 31.4% in FFY 2015 to 13.9% in FFY 2018, well below the national target of 20%. See Figure 5. To achieve the results, partnerships were developed and/or strengthened between CTPC and the MDH Behavioral Health Administration (BHA), the Comptroller's office, LHDs, MDH leadership, statewide resource centers, community organizations, and the retail community. Maryland's rate in FFY 2018 is higher than the FFY 2017 and FFY 2016 rate.

Figure 5: Synar Violation Rates (Tobacco Sales to Youth) against Federal Target



(Maryland Department of Health, 2014; 2015; 2016; 2017; Substance Abuse and Mental Health Services Administration, 2012)

While progress is being made, the findings for this evaluation research question implies that more can be done to further reduce the non-compliance rate. Related to this, important pieces of legislation were passed to help strengthen youth tobacco prevention efforts. The first requires

retailers who sell Electronic Smoking Devices (ESD) to acquire a license to sell these products and the second allows local health departments to utilize civil citations for tobacco sales to minors' violations. Previously many counties only utilized criminal citations for sales to minors. These both became effective October 1, 2017. CTPC continues to work closely with the Comptroller's Office to establish policies for suspending licenses of retailers who have multiple youth access law violations. In response to the evaluation research question, findings show that the Synar non-compliance rates have decreased.

FINDINGS FOR PART B: MARYLAND COMPREHENSIVE TOBACCO CONTROL PROGRAM ACTIVITIES

The Maryland Tobacco Control Program provides comprehensive programming to address the initiation, usage, cessation, and exposure to tobacco products. The organization of the Maryland Comprehensive Tobacco Control Program aligns with CDC Best Practices for Comprehensive Tobacco Control Programs (2014). The CDC Best Practices includes five core components: state and community interventions; mass-reach health communication interventions; cessation interventions; surveillance and evaluation; and infrastructure, administration, and management (Centers for Disease Control and Prevention, 2014a). Together, the structure of the tobacco control program allows CTPC to achieve its four organizational goals.

The following questions evaluate the progress made with the Maryland Comprehensive Tobacco Control Program Activities.

RESEARCH QUESTION 6

To what extent does the Maryland tobacco control program implement the CDC Best Practices model and are the programmatic activities at the state and local level reflective of community needs?

CTPC continues to follow the CDC Best Practices for Comprehensive Tobacco Control Programs (2014). This includes five core components: state and community interventions; mass-reach health communication interventions; cessation interventions; surveillance and evaluation; and infrastructure, administration, and management (Centers for Disease Control and Prevention, 2014a). Per state statute, the Maryland Tobacco Control Program has related components: Statewide Public Health, Local Public Health, Surveillance and Evaluation, Administrative, and Counter Marketing. Brief descriptions of how Maryland implements the CDC Best Practices are provided in the sections that follow as a response to the evaluation research question.

State and Community Interventions (Statewide Public Health and Local Public Health Components)

State and community interventions include the following: local public health component; state funded tobacco use prevention and cessation resource centers; Responsible Retailer Initiative; and Minority Outreach and Technical Assistance (MOTA) Organizations. Each is discussed below.

Local Public Health Component

All twenty-four Local Health Departments in Maryland receive state-funding for tobacco control initiatives in their respective jurisdictions – 23 counties and Baltimore City. Each local health department must have a local health coalition – representative of their jurisdiction's diverse demographics – that helps plan tobacco control programming based on community needs. Local tobacco control programs cover four components: school-based interventions; community-based interventions; local tobacco-use cessation interventions; and local enforcement of youth access restrictions.

Statewide Public Health Component

State Funded Tobacco Use Prevention and Cessation Resource Centers

There are two state funded tobacco use prevention and cessation resource centers – the Legal Resource Center for Public Health Policy and the Maryland Resource Center for Quitting Use and Initiative of Tobacco (MDQuit).

1. Legal Resource Center for Public Health Policy (LRC) at the University of Maryland, School of Law provides legal technical assistance to community groups, employers, local health departments, residents, and agencies across Maryland on a variety of topics including: implementation of smoke-free multi-unit housing; implementation of smoke-free grounds; implications of electronic cigarettes (e-cigarettes) and smoke-free policies; flavored cigar products; tobacco sales to minors; and tobacco point-of-sale advertising and product placement in retail stores.

2. Maryland Resource Center for Quitting Use and Initiation of Tobacco (MDQuit) at the University of Maryland Baltimore County links tobacco control professionals and healthcare providers to state tobacco initiatives; provides evidence-based resources and tools to local programs; and supports a collaborative network of tobacco prevention and cessation professionals. MDQuit staff provide statewide technical assistance and training on motivational interviewing, Fax-to-Assist programs for referrals to the Maryland Tobacco Quitline, trainings for providers and residency programs on addressing tobacco use and cessation, and train the trainer models to address tobacco use among Medicaid patients, as well as patients with mental health and substance use conditions. CTPC also uses the MDQuit State Advisory Board as a tobacco control program advisory board.

Responsible Tobacco Retailer Initiative

The Responsible Tobacco Retailer Initiative brings together community and state partners to educate retailers on youth tobacco sales laws and increase enforcement of these laws, in order to reduce youth access to tobacco products. Partnerships developed and/or strengthened

because of this Initiative include the MDH Behavioral Health Administration (BHA), the Comptroller's office, LHDs, MDH leadership, statewide resource centers, community organizations, and the retail community.

Key program components include: development and placement of media (radio, transit, and billboard) and a corresponding website (NoTobaccoSalesToMinors.com); development and distribution of educational materials to assist retailers with remaining in compliance with the laws; statewide trainings for LHDs, law enforcement and compliance officers; face-to-face retailer education; and an increased number of compliance checks at the local level.

Minority Outreach and Technical Assistance (MOTA) Organizations

CTPC partners with the Minority Outreach and Technical Assistance (MOTA) Initiative (Maryland Department of Health, 2018a). MOTA was established in 2001 under the provisions of the Cigarette Restitution Fund (CRF) to provide support for MDH efforts to reach vulnerable populations and to help the CRF program to engage minority populations to serve on tobacco and cancer community health coalitions. One MOTA goal is to help the Office of Minority Health and Health Disparities (MHHD) eliminate health disparities by focusing on preventive measures and promoting healthy lifestyles. Targeted minorities include African Americans, Pacific Islanders, Asian Americans, Hispanics/Latinos, and American Indians (Office of Minority Health and Health Disparities, 2018). MOTA grant recipients include faith-based organizations, hospital-based groups, academic institutions, and non-profit grassroots groups.

MOTA organizations play a key role in conducting face-to-face education with retailers at the point of sale location, reaching members of harder to reach communities. The research team interviewed three MOTA vendors to learn about their contributions. Conversations revealed that there are several strengths to this approach. One, MOTA vendors are often small and nimble organizations, able to adjust programs to meet the needs of the state. Second, the staff at MOTA organizations are well-respected, known leaders in their communities. As a result, MOTA vendors can reach individuals that are often left out of more traditional public health services. Finally, MOTA vendors can develop long-term relationships with youth and often do so outside of a school setting. Given the need in Maryland to target minority youth to decrease tobacco use, the MOTA strategy should continue.

Cessation and Health Systems Interventions

The cessation and health systems interventions include the Maryland Tobacco Quitline; LHD cessation programs; health systems change initiatives; and pregnancy and tobacco cessation help (PATCH) programs. Each is discussed below.

Maryland Tobacco Quitline, 1-800-QUIT-NOW

Maryland has a comprehensive tobacco quitline service to provide proactive phone counseling for Maryland residents in English, Spanish, and other languages, and free Nicotine Replacement Therapy (NRT) (patch and/or gum) to callers over 18 years of age. If desired, callers can also be referred to their LHD for in-person cessation counseling and free medications, if eligible. Residents have the option of two levels of service: (1) a brief single call intervention along with support materials mailed to callers; or (2) multiple call (up to four calls) counseling sessions along with mailed support materials. Since 2012, services for the Maryland Tobacco Quitline have expanded to include counselors whom are now available 24/7; services to teens ages 13-17; Web Coach® web support with NRT, and Text2Quit® text support. In addition, the Maryland Tobacco Quitline includes an intensive pregnancy support program, including incentives, to specifically target this population.

The Maryland Tobacco Quitline maintains a 50% Medicaid Administrative Match for callers identifying as Medicaid participants. As an early adopter of this program, the Medicaid Match has strengthened the existing relationships between CTPC and state Medicaid agencies around providing comprehensive cessation benefits for Medicaid population of tobacco users while also building sustainability (North American Quitline Consortium, 2012). Starting in 2014, Maryland Medicaid required managed care programs to cover all FDA-approved tobacco cessation medications (as required by Section 2502 of the Patient Protection and Affordable Care Act) (The Center for Tobacco Prevention and Control, n.d.)

Local Health Department Cessation Programs

Each local health department runs a cessation program ranging from in-person classes to distributing medications and nicotine replacement therapies. The Maryland Tobacco Quitline makes referrals to local programs in order to ensure a multitude of cessation options are available to residents.

Health Systems Change Initiatives

CTPC is continuing pilot programs to incorporate cessation counseling into health systems approaches through grants to:

- MD Health Care Innovations Collaborative (MHCIC) – a partnership between the University of Maryland, School of Medicine, Johns Hopkins Community Physicians, and the Maryland Health Care Commission. The goal of this grant is to increase the number of patients receiving tobacco cessation counseling via e-referrals in Patient Centered Medical Homes.

- Orthopedic Trauma Department at the University of Maryland Baltimore. The goal of this grant is to provide motivational interviewing coupled with a referral to the

Maryland Tobacco Quitline to increase quit rates and attempts among patients from the trauma department.

- Multiple LHDs and hospital-based systems, such as Sheppard Pratt Health Systems, to incorporate cessation into routine client/patient visits—targeting those serving residents who are disproportionately affected by tobacco-related morbidities.

Looking at one of these programs in more detail, the grant-funded partnership with Sheppard Pratt Health Systems has seen great outcomes on expanding cessation services to patients who suffer from mental health and substance abuse disorders. The partnership aims to integrate tobacco dependence treatment into clinical workflows as well as connect patients to evidence-based services. In the fall of 2015, Sheppard Pratt established a smoking cessation program and hired a Tobacco Dependence Treatment Coordinator as part of this program. Specific efforts include: systematically screening patients at admission for tobacco use; educating and training clinicians about treatment services for tobacco dependence and delivering these services to patients; continuing treatment after discharge from a hospital program; updating Electronic Medical Records to document all tobacco dependence treatment services; and evaluating and sustaining the treatment program. Since the program's inception, over 2,500 patients have received smoking cessation services.

Pregnancy and Tobacco Cessation Help (PATCH) Programs

CTPC funds LHDs, MOTA community-based organizations, and hospital-systems to conduct education/trainings to women of childbearing age about the dangers of tobacco/secondhand smoke/nicotine use during pregnancy and educate healthcare providers (including those at FQHCs) and targeted populations about tobacco cessation and prevention services available to pregnant smokers. The PATCH Program works to reduce smoking rates among pregnant and postpartum women, women of child bearing age, and members of their households and social environments. The program also works to establish smoke-free homes and healthy environments for all children and youth.

Mass-Reach Health Communication Interventions

No state funding has been allocated to the Tobacco Counter-Marketing and Media Component of the CRF for years; however, CTPC is able to leverage federal prevention and cessation funding and campaigns, as well as CRF Statewide Public Health dollars, to support these efforts, along with LHD efforts through CRF Local Public Health dollars.

In FY 2016, CTPC entered into a five-year contract with a health communications agency to conduct media development, placement, and strategic planning. The health communications agency has assisted CTPC with strategically placing media to reach those with the highest need.

CTPC has developed innovative TV, radio, out-of-home, print ads, websites and toolkits. Ads have been developed and placed in various mediums to best reach the target population and drive

audiences to the Maryland Tobacco Quitline and campaign websites. The media placement schedules complement the CDC TIPS ads to maximize resources and drive residents to the Maryland Tobacco Quitline. See Research Question 7 for more details.

Surveillance and Evaluation

Maryland conducts middle school, high school, and adult surveys to produce jurisdiction-level and statewide estimates of key short-, intermediate-, and long-term outcomes. Data is used to track tobacco use rates among Maryland youth and adults to guide and support the implementation of statewide comprehensive tobacco program. CTPC works closely with the Maryland Department of Health, Center for Chronic Disease Prevention on assessing and analyzing questions.

YRBS/YTS. Maryland administers the CDC Youth Risk Behavior Survey (YRBS) combined with questions from the CDC Youth Tobacco Survey (YTS) [CDC recognizes it as YRBS as all applicable protocols and procedures are adhered to]. The YRBS/YTS is administered in the fall of even calendar years, with about 85,000 public school students completing surveys each round. MDH has added questions addressing awareness of cessation programs, use of e-cigarettes and vaping devices, and residential smoke-free rules (Prevention and Health Promotion Administration, 2017b).

BRFSS. The MDH Center for Chronic Disease Prevention and Control Maryland administers the Behavioral Risk Factor Surveillance System (BRFSS) annually. The BRFSS contains an enhanced tobacco module; CTPC uses BRFSS in place of the Maryland Adult Tobacco Survey.

Infrastructure, Administration, and Management

Consistent with CDC Best Practices, CTPC supports its programs with a multi-level management approach and a supportive infrastructure. Program infrastructure includes: responsive planning, multi-level leadership, networked partnerships, managed resources, and engaged data (Centers for Disease Control and Prevention, 2017c). In Maryland, the CTPC provides oversight, technical assistance and training to local health departments, grantees, and partners, ensuring that efforts coordinate with program goals and messages. Additionally, the MDQuit Resource Center (University of Maryland, Baltimore County) and the Legal Resource Center for Public Health Policy (University of Maryland, Francis King Carey School of Law) help establish best practices and assistance in legal and policy issues. As part of this evaluation, several of these grantees were interviewed including MDQuit Resource Center, the Legal Resource Center for Public Health Policy, the media contractor, and several health systems grantees.

As mentioned, infrastructure includes not only funding and personnel (aka managed resources), but management structures (e.g., multi-level leadership and networked partnerships), responsive planning and plans (e.g., strategic plan, sustainability plan, etc.), and measurement tools (e.g., engaged data) (Centers for Disease Control and Prevention, 2017c). The Center for

Cancer Prevention and Control oversees the process for development of the Maryland Comprehensive Cancer Control Plan, which CTPC utilizes as its current strategic plan.

The state maintains advisory and collaborative relationships with the MDQuit Advisory Board and the Maryland Tobacco Control Coalition which supports planning and engagement with statewide stakeholders.

State Advisory Board and Coalition

The MDQuit Advisory Board serves as the statewide tobacco control advisory board. The Advisory Board is comprised of multidisciplinary members who have diverse backgrounds and experience in tobacco control. Advisory Board members include smoking cessation counselors, medical directors, professors, lawyers, local tobacco control health department staff, psychiatrists, and national tobacco control leaders. More information and a complete list of Advisory Board members can be found at https://mdquit.org/about-us. The Advisory Board provided comments, feedback, and guidance with respect to the selection of evaluation questions, selection indicators, measures, and dissemination planning.

The Maryland Statewide Tobacco Coalition is comprised of voluntary organizations, such as the American Lung Association, the American Cancer Society, and the American Heart Association, along with health care providers, local health department staff, higher education staff, legal staff, and community representatives. CTPC works with the statewide coalition in a resource capacity. The Statewide Coalition works to push policy initiatives across the state. Members of the coalition provided input on the structure of this evaluation plan and will participate in strategic planning moving forward.

RESEARCH QUESTION 7

To what extent has CTPC increased health communication interventions and messages reaching the general population and populations with negative disparities in the use of tobacco products and tobacco-related death and disease (Racial/Ethnic Groups, Low SES, Medicaid, Behavioral Health, LGBT, & Youth)?

The extent to which CTPC has engaged in health communication interventions for the general and target populations is evidenced by the scope of work which has been undertaken. In the documents reviewed, this evaluation found evidence that CTPC has developed TV, radio, out-of-home, print ads, websites and toolkits. Ads have been placed in various mediums to best reach the target population—such as, point-of-care marketing (within doctor's offices) for pregnant women and Medicaid populations; newspaper, transit, billboard, and digital ads targeting retailers. The following are examples of this work.

- Several campaigns promoting the Maryland Tobacco Quitline services, targeting pregnant women, behavioral health populations, and Medicaid populations. Ads can be viewed at http://www.smokingstopshere.com/media/. For example, CTPC has

executed targeted media campaigns featuring real Marylanders offering testimonials of their positive experiences with the Quitline, including a pregnant smoker who was also a Medicaid beneficiary.

- The toxic tobacco litter awareness campaign aims to educate residents about the negative and detrimental impact of tobacco litter on the environment. The ads show that cigarette toxins can get into "more than just your lungs," and that tobacco litter impacts where we live, work, and play. The campaign's primary audience is those who self-identify as smokers but also aims to reach the general population to encourage healthy communities.

- CTPC developed a media campaign that promoted quitting tobacco use among those recovering from mental illness and addictions. The campaign was also designed to empower behavioral health professionals and family members of those in recovery to encourage quitting tobacco. The campaign included television, transit, and internet ads as well as posters. An accompanying toolkit was sent to behavioral health professionals at over 360 provider sites.

- Responsible Tobacco Retailer ads encourage and promote responsible tobacco retailing in tobacco sales outlets, change community norms, and reinforce that selling tobacco to youth under 18 is in violation of local, state, and federal laws. Materials are also provided to assist retailers with training staff and remaining compliant with all tobacco sales laws. Materials, and an online training, can be found at www.NoTobaccoSalesToMinors.com.

- Smoke-free Multi-Unit Housing toolkits increase awareness among property owners and managers about the benefits of, and ability to, implement smoke-free properties. The toolkit along with other materials can be viewed at www.mdsmokefreeliving.org.

- The Cigar Trap campaign increases awareness among parents about the dangers of youth cigar use, as they are available in enticing fruit/candy flavors, sold as singles with low price points. Ads can be viewed at www.TheCigarTrap.com.

- Youth populations were targeted through numerous media outreach initiatives in FY 2017, including the prevention campaign, "Tobacco Stops With Me."

- CTPC implemented a multi-pronged approach to encourage pregnant smokers and Medicaid participants to call the Quitline. Including TV ads and a point of care (POC) marketing campaign. POC marketing offers patients actionable information on key health conditions and lifestyle changes that directly influences the way they think about their health and encourages them to discuss condition-management with their physician. Combining evidence-based health communication campaigns with health systems change efforts to reach patients at the POC has enabled CTPC to connect with and educate Maryland's Medicaid and pregnant populations where they receive care.

In FY 2017, CTPC entered into a five-year contract with a health communications agency to conduct media development, placement, and strategic planning. The health communications agency will continue to assist CTPC with strategically placing media to reach those with the highest need. In response to the evaluation research question, while a quantitative conclusion cannot be made about the extent to which CTPC increased health communication interventions, the qualitative evidence supports the findings that CTPC has an established record of providing mass-reach health communication interventions that reach the general population and populations with negative disparities in the use of tobacco products and tobacco-related death and disease (such as Racial/Ethnic Groups, Low SES, Medicaid, Behavioral Health, LGBT, & Youth).

RESEARCH QUESTION 8

To what extent has CTPC and partners increased the number of implemented evidence-based interventions and strategies that address vulnerable and underserved populations?

One of the primary goals of CTPC is to reduce tobacco-related health disparities, including tobacco users who are Medicaid participants, pregnant women, behavioral health, and women of child-bearing age. CTPC utilizes multiple avenues to sustain the reach and Quitline utilization among these vulnerable populations. CTPC will continue to provide intensive and tailored messaging and outreach to promote cessation resources and connect pregnant women and Medicaid participants, as well as healthcare providers treating these populations, to free and effective cessation services.

CTPC and LHDs are increasingly leveraging and maximizing resources through collaborations across a variety of organizations and institutions to reach those disproportionately affected by tobacco use. For both state- and community-led efforts, MDH goes to great lengths to develop relevant and appropriate materials reflective of the needs of many different groups. These strategies focus on statewide infrastructure and partnerships related to the tobacco control program. The first are formalized partnerships with local non-governmental organizations associated with the Minority Outreach and Technical Assistance initiative in Maryland. The second are local coalitions organized by the LHDs which mobilize community stakeholders around the tobacco control program. The third are statewide resource centers which provide technical assistance and support to local health departments and other stakeholders. Additionally the PATCH program reaches women smoking while pregnant and youth are educated on tobacco use. These efforts show how the state implements the CDC Best Practices model by maintaining state and local programs that are reflective of community needs. In these campaigns, MDH is trying to reach both the general population and populations with disparities in tobacco-related death and disease. Brief descriptions of how Maryland implements these efforts are provided in the sections that follow as a response to the evaluation research question.

Minority Outreach and Technical Assistance Organizations

CTPC partners with the Minority Outreach and Technical Assistance (MOTA) Initiative (Maryland Department of Health, 2018a). MOTA was established in 2001 under the provisions of the

Cigarette Restitution Fund to provide support for MDH efforts to reach vulnerable populations and to help the CRFP recruit minorities to serve on tobacco and cancer community health coalitions. One MOTA goal is to help the Office of Minority Health and Health Disparities (MHHD) eliminate health disparities by focusing on preventive measures and promoting healthy lifestyles. Targeted minorities include African Americans, Pacific Islanders, Asian Americans, Hispanics/Latinos, and American Indians (Office of Minority Health and Health Disparities, 2018). MOTA grant recipients include faith-based organizations, hospital-based groups, academic institutions, and non-profit grassroots groups.

The research team interviewed three MOTA vendors to learn about their contributions. Conversations revealed that there are several strengths to this approach. One, MOTA vendors are often small and nimble organizations, able to adjust programs to meet the needs of the state. Second, the staff at MOTA organizations are well-respected, known leaders in their communities. As a result, MOTA vendors can reach individuals that are often left out of more traditional public health services. Finally, MOTA vendors can develop long-term relationships with youth and often do so outside of a school setting. Given the need in Maryland to target minority youth to decrease tobacco use, the MOTA strategy should continue.

Local Coalitions Targeting Vulnerable and Underserved Populations

CTPC promotes local partnerships between LHDs and community organizations that serve populations with tobacco-related disparities. These partnerships are intended to prevent initiation of tobacco use and to promote cessation among vulnerable subgroups. Maryland continues to be successful in establishing and sustaining relationships with community organizations that can reach vulnerable populations. All local health departments have formed tobacco coalitions with statewide membership at more than 600 people. These coalitions provide diverse and inclusive participation for tobacco control activities. The demographic composition of the coalitions is 39% African-American, 4% Asian American, 51% Caucasian, 3% Hispanic/Latino, 1% Native American, and 2.3% other. These coalitions provide input to their local health department on the development of comprehensive tobacco control plans (Maryland Department of Health and Mental Hygiene, 2015).

Youth Education

The number of people reached through LHD school-based activities in Maryland is presented in Table 8. Note that the data for this area are sorted by the percent change from FY 2013 to FY 2017[9]. The administrative data reviewed shows that over time, several programmatic areas have seen increases while still other areas have seen a decline. This might suggest that this strategy

[9] Note, in some cases a difference could not be calculated as not data were available for FY 2017 or FY 2013. In two cases, a difference calculation was conducted. For "Students in alternative school settings educated on tobacco use prevention" the difference is between FY 2013 and FY 2016, as no FY 2017 data were provided in the administrative data reports. For "K-12 parents educated on tobacco use prevention", the difference was calculated for FY2015 and FY 2017, as no data were provided in previous years.

ebbs and flows with access to school and the ability to build relationships with students and other partners. This conclusion is supported by information collected through interview with LHD staff.

Table 8: LHD School-Based Element Summary of Activities from FY 2013 to FY 2017

Indicator	FY 2013	FY 2014	FY 2015	FY 2016	FY2017	Difference	Percent Change
College students received tobacco use prevention education on campus	205	379	1,861	13,242	9,616	9,411	4,591%
Students in alternative school settings educated on tobacco use prevention	166	253	431	2,971	n/d	2,805	1,690%
Teachers, nurses, daycare providers, and school administrators trained on available tobacco use prevention and cessation curricula, programs, and strategies	777	1,145	1,202	1,038	1,583	806	104%
K-12 students receiving multiple tobacco use prevention education sessions	74,712	132,476	103,265	141,860	126,894	52,182	70%
Pre-K students receiving multiple tobacco use prevention education sessions	1,163	2,475	1,501	2,170	1,608	445	38%
Private school students were educated on tobacco use prevention	1,175	1,037	823	1,236	481	-694	-59%
K-12 parents educated on tobacco use prevention.	n/d	n/d	4,766	8,685	3,616	-1,150	-24%
Students reached with peer programs in schools	9,141	12,403	5,658	10,772	4,630	-4,511	-49%

Note: n/d= no data available for the performance metric in the given year
(Maryland Department of Health and Mental Hygiene, 2013; 2014; 2015; 2016; Maryland Department of Health, 2018)

Given concerns over ESDs among youth, LHDs have been actively targeting programming to reach more youth regarding this behavior. As a result, over the last three years, the number of youth educated by LHDs on e-cigarette prevention has risen dramatically (21,954 in FY 2015; 25,321 in FY 2016; and 128,260 in FY 2017).

Smoking initiation among high school students is believed to be related to interpersonal social factors. For example, youth may begin tobacco use to fit in or have more friends. In Maryland, there appears to be room for growth to improve youth attitudes and perceptions of tobacco use.

Table 9 shows that from 2013-2016, there was a significant decline in the number of students educated on the dangers of tobacco use. In 2016, 74% of middle school students and 60.3% of high school students had been taught about the dangers of tobacco use, compared to 81.6% and 69.4% in 2013, respectively. Conversely, from 2013-2016, there was a slight increase in the number of cigarette smoking high school students who believed smokers had more friends than nonsmokers and believed smoking helped youth "Fit In" or "Look Cool." More work needs to be done to change attitudes of youth.

Table 9: Youth Attitudes and Beliefs toward Tobacco Use in Maryland

Indicator	2013	2014	2016
Middle school youth were taught about the dangers of tobacco use	81.6%	80.2%	74.0%
High school youth were taught about the dangers of tobacco use	69.4%	61.7%	60.3%
Cigarette smoking high school youth belief that smokers have more friends than nonsmokers.	52.4%	50.7%	54.1%
Cigarette smoking high school youth belief that smoking Helps Youth to 'Fit In' or 'Look Cool'	40.1%	37.4%	42.9%

(Maryland Department of Health, 2018)

Pregnancy and Tobacco Cessation Help (PATCH)

CTPC funds the Pregnancy and Tobacco Cessation Help (PATCH) initiative in jurisdictions across the state. The risks associated with smoking while pregnant are numerous and there is no shortage of research which document negative outcomes for mother and baby alike including preterm deliveries, low birth weight babies, and higher risks Sudden Infant Death Syndrome (SIDS) (U.S. Department of Health and Human Services., 2010). The PATCH initiative focuses on targeted smoking cessation, tobacco use screening, education, prevention, and treatment offered and made available to pregnant women, women of childbearing age, and to others within their household (Maryland Department of Health and Mental Hygiene, 2015). The program achieves several important accomplishments annually including community wide programming, improving practices for medical providers, and supporting regional partnerships to improve screening services for women of childbearing age. In FY 2017, the PATCH program incentivized 39 community partners and collectively education 6,862 women of childbearing age, including 1,992 pregnant women (Maryland Department of Health, 2018).

Over time, however, the funding for this program has waned. In FY 2014, there were 14 jurisdictions funded; 13 jurisdictions in FY 2015; 12 jurisdictions in FY 2016; and nine jurisdictions in FY 2017. This comes even though trends for pregnant females smoking during pregnancy for Maryland do not show as strong improvement as other population groups. Smoking rates for pregnant females smoking during pregnancy are trending down, though gaps between counties are increasing.

As mentioned in Question 7, CTPC has recently implemented health systems pilot programs encouraging providers to talk to their patients and refer tobacco users to the Maryland Tobacco Quitline through electronic referrals. These programs, in conjunction with the Centers for Disease Control and Prevention (CDC) Tips campaign and other mass media, have significantly increased call volume to the Maryland Tobacco Quitline. In order to enhance these efforts, CTPC also executed point of care campaigns (as described in Question 7). Combining evidence-based health communication campaigns with health systems change efforts to reach patients at the point of care has enabled CTPC to connect with and educate Maryland's Medicaid and pregnant populations where they receive care.

State Funded Tobacco Use Prevention and Cessation Resource Centers

The LRC provides legal technical assistance to community groups, employers, LHDs, residents, and agencies across Maryland on a variety of tobacco control topics, including the implementation of smoke-free multi-unit housing, grounds, parks, and other spaces. The LRC and CTPC provide technical assistance to residents in multi-unit housing regarding their rights and exposure to secondhand smoke. Populations that live in renter-occupied housing have significantly higher rates of cigarette use than those living in owner-occupied housing. This not only poses a risk to those living within the individual unit, but those who share a ventilation system or common wall with the smoking unit, as smoke travels through ventilation systems and seeps through walls.

MDQuit has continued efforts to expand outreach and offer training or technical assistance to healthcare providers to incorporate the Maryland Tobacco Quitline and evidence-based cessation treatment into routine clinical practice. MDQuit continues to move toward a streamlined Fax-To-Assist (F2A) certification. The F2A training teaches medical, social services and other healthcare providers interested in helping clients who smoke how to use the F2A referral program to the Maryland Tobacco Quitline. MDQuit also provides training to Medicaid and behavioral health providers on ways to incorporate tobacco cessation into routine clinical care.

CTPC also maintains a 50% administrative match with the Maryland Medicaid Department for Medicaid participants who call the Maryland Tobacco Quitline. This match helps to support smoking cessation activities in this population.

RESEARCH QUESTION 9

To what extent has the Tobacco Program and its partners increased the demand for tobacco cessation and increased quit attempts?

In Table 10, three years of smoking cessation data are provided. The table also includes a column to indicate the difference from FY 2015 to FY 2017. Trends for the Maryland Tobacco Quitline and LHDs move in opposite directions: cessation activities for the Maryland Tobacco Quitline

have risen modestly, while the number of adults who participate in cessation activities at LHDs has decreased. The steady decline in smoking cessation activities at LHDs is likely related to budget constraints. As it relates to this evaluation research question, the extent to which the demand for tobacco cessation at LHDs has decreased by 3,493 adult participants or 37% from FY 2015 to FY 2017. However, during the same period, the demand for tobacco cessation through the Maryland Tobacco Quitline has increased by 1,381 adults or 17%.

Table 10: Three-Year Trend of Smoking Cessation Activities at LHDs and the Maryland Tobacco Quitline

Indicator	FY 2015	FY 2016	FY 2017	Difference	Percent Change
Total Maryland Tobacco Quitline Callers	8,319	9,390	9,700	1,381	17%
Total adults participating in smoking cessation services at LHDs	9,518	7,157	6,025	-3,493	-37%

(Maryland Department of Health and Mental Hygiene, 2015; 2016; Maryland Department of Health, 2018)

In addition to cessation activities, there are several administrative data points that also capture the demand for cessation activities. Table 11 shows three years of smoking cessation activity data as provided by LHDs, broken down by demographic group. The table includes columns to indicate the difference and percentage change from FY 2015 to FY 2017. All demographic groups within the adult population have seen a decline in smoking cessation activity participants from FY 2015 through FY 2017.

Table 11: Three-year Trend of Smoking Cessation Activities in LHDs

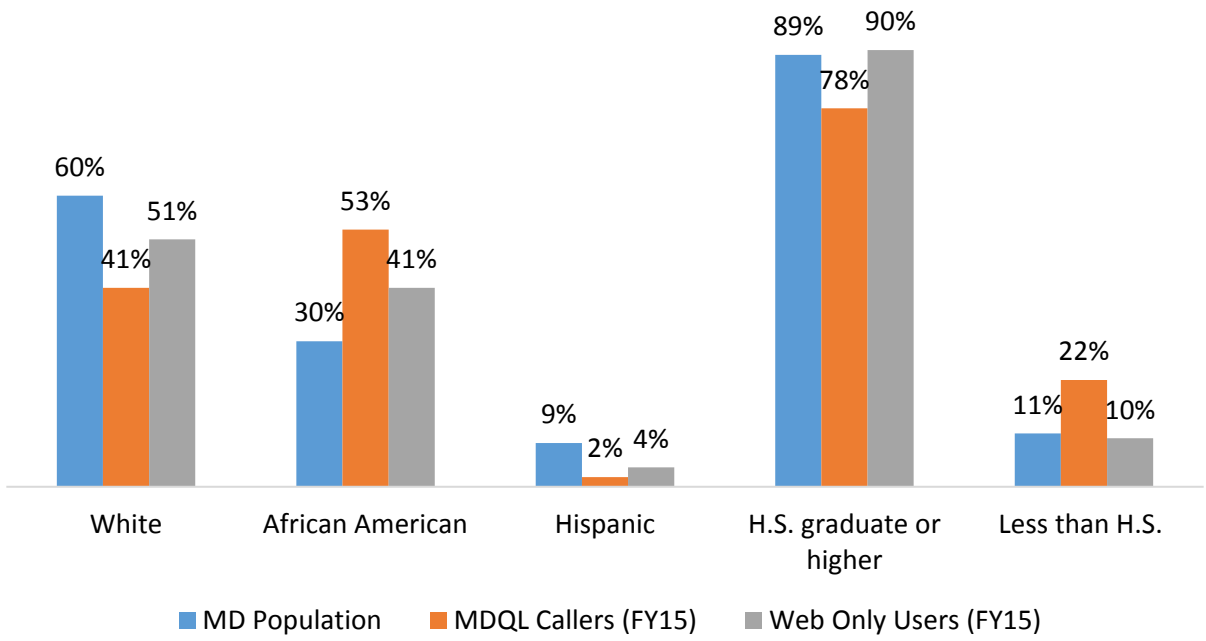
Indicator	FY 2015	FY 2016	FY 2017	Difference	Percent Change
Total adult participants	9,518	7,157	6,025	-3,493	-37%
Self-identified participants with behavioral health issues	1,432	1,608	1,116	-316	-22%
African American Participants	4,032	3,077	1,781	-2,251	-56%
Asian American Participants	145	98	55	-90	-62%
Pregnant women participants	323	75	115	-208	-64%
Hispanic/Latino Participants	1,069	486	245	-824	-77%
Native American Participants	245	47	20	-225	-92%

(Maryland Department of Health and Mental Hygiene, 2015; 2016; Maryland Department of Health, 2018)

While there has been a steady decline in smoking cessation activities at LHDs, likely related to budget constraints, Maryland offers additional options to support cessation. The Maryland

Tobacco Quitline has been particularly successful in reaching certain populations. See Figure 6. As this figure shows, while African Americans make up one third of Maryland's population, over half of Maryland Quitline callers and over a third of Web Only users were African American. This suggests that the Maryland Tobacco Quitline has successfully reached this population. There remains an opportunity to better reach White and Hispanic populations.

Figure 6: Demographics of Maryland Tobacco Quitline Uses Compared to the Maryland General Population



(Maryland Marketing Source, Inc., 2016)

CTPC has also been successful in reaching Medicaid and Pregnant Smoker populations in SFY 2016 through a comprehensive outreach approach (outlined in Question 7).

The following was achieved from July 2015 to June 2016:

- 165 pregnant smokers called the Quitline,
- Over 12% increase in calls from Medicaid participants (compared to SFY 2015), and
- Over 20% increase in overall call volume (compared to SFY 2015).

The Point of Care (POC) marketing campaign aired from May to June 2016 in doctors' offices and pharmacies, achieving the following:

- Direct messaging reached over 3 million Marylanders encouraging them to contact the Quitline,
- Nearly 14% increase in calls to the Quitline (compared to May-June 2015), and
- Over 335 callers reported hearing about the Quitline through a health professional.

In addition to cessation participation, the quit attempt rate is considered the best indicator of motivation to quit. According to BRFSS, past year quit attempts last longer than a full 24 hours among current smokers (that is, persons who had smoked more than 100 cigarettes during their lifetime and currently smoked "every day" or "some days"). In Maryland, among current and former smokers, 60.1% have made a quit attempt for greater than 24 hours in 2014. These figures are slightly lower than in 2013 when the quit attempt was 61.7%. The Maryland rates are similar to the national rates which have ranged from 50.9 to 53.4%. Quit rates are thought to predict annual cessation rates. According to BRFSS data for Maryland, the percent of smokers who quit in 2016 was 63.2% and ranged from 57.7% to 63.2% (Maryland Department of Health, 2018).

The Maryland Tobacco Quitline provides information about quit attempts and quit rates using a sample of users seven months after enrollment[10]. Quit attempts, as described by the Maryland Tobacco Quitline, occur when individuals have made a serious attempt to quit using tobacco that lasted at least 24 hours since enrolling in Quitline services, or had quit before enrolling and remained quit. Quit attempts among quitline users (callers or web only) are between 80% and 87%.

As mentioned previously in Question 8, MDQuit continues to train medical, social services and other healthcare providers interested in helping clients who smoke how to use the F2A referral program to the Maryland Tobacco Quitline. CTPC also maintains a 50% administrative match with the Maryland Medicaid Department for Medicaid participants who call the Maryland Tobacco Quitline. This match helps to support smoking cessation activities in this population.

[10] The Maryland Tobacco Quitline evaluations examined a random sample of Maryland Tobacco Quitline callers and Web Only users who enrolled in the program in fiscal years 2012, 2013, and 2014. To be eligible for this evaluation, callers needed to be 18 years of age or older at registration, complete at least one intervention call with a Quit Coach® or log in to the Web Only Program, consent for evaluation follow-up, provide a valid phone number (or valid email address for Web Only users), and speak English or Spanish.

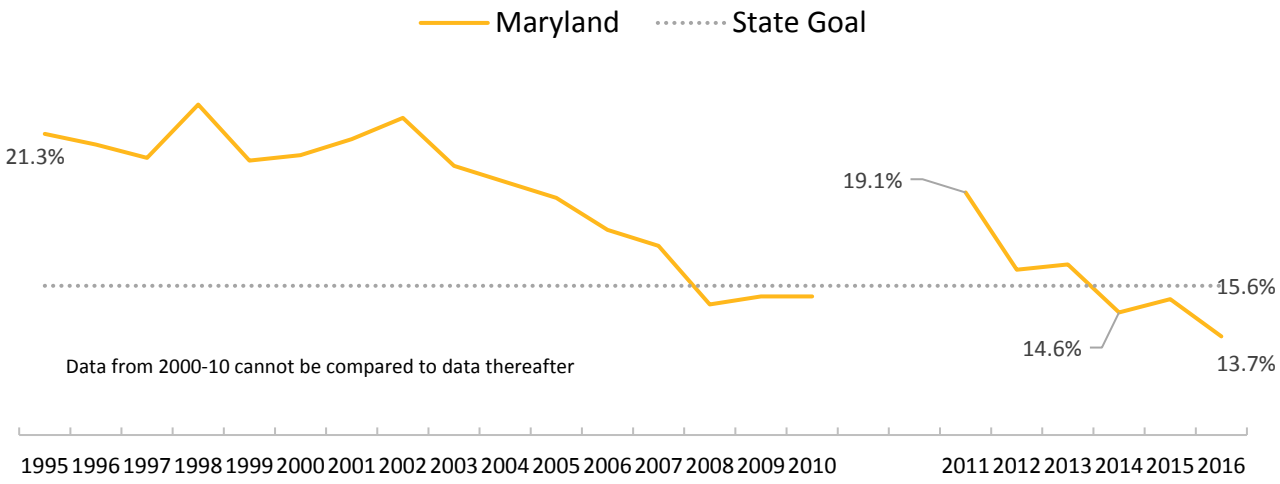
RESEARCH QUESTION 10

To what extent did the use of tobacco products decrease since 2014?

Maryland has seen great progress made on decreasing tobacco product usage for both adults and youth. The following section will address the evaluation research question by looking at trends for adults and youth to understand the extent to which tobacco usage has decreased since 2014.

In Maryland, the rate of cigarette-smoking adults has declined (28.3%) over the past five years from 19.1% in 2011 to 13.7% in 2016 (see Figure 7). As indicated by the yellow line, Maryland has achieved its objective to reduce adult smoking to 15.6% by 2020. This figure shows that since 2014, adult smoking rates have fallen from 14.6% to 13.7% in 2016, for a 6% decline.

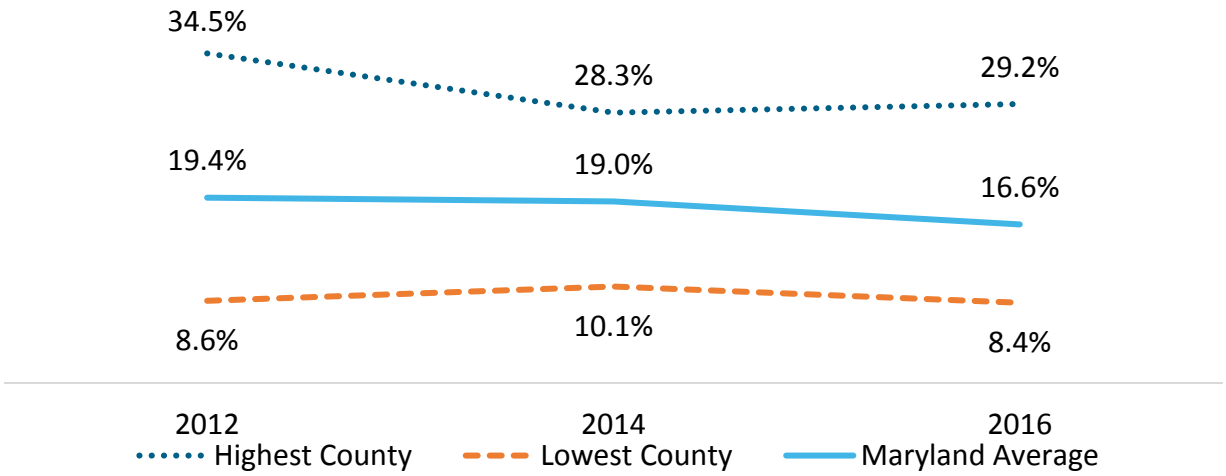
Figure 7: Current Cigarette Smoking Among Adults



(Maryland Department of Health, 2018)

The results from the BRFSS survey show that from 2012, the percent of adult tobacco users has declined from 19.4% to 16.6%. While the trend is promising, there remains room for continued, targeted work. Note that Figure 8 contains a range of tobacco use from across the 24 jurisdictions in Maryland. For each year, the county with the highest (dotted line) and the lowest (dashed line) tobacco use is illustrated. The gap between these points represents the difference in tobacco use rates from around the state (25.9% in 2012, 20.8% in 2016). While the gap is decreasing, like the overall tobacco use trend, a difference remains. Targeting programming should address how to bring those jurisdictions at the high end of the spectrum in line with the lower end.

Figure 8: Percentage of Current Adult Tobacco Use in Maryland [11]

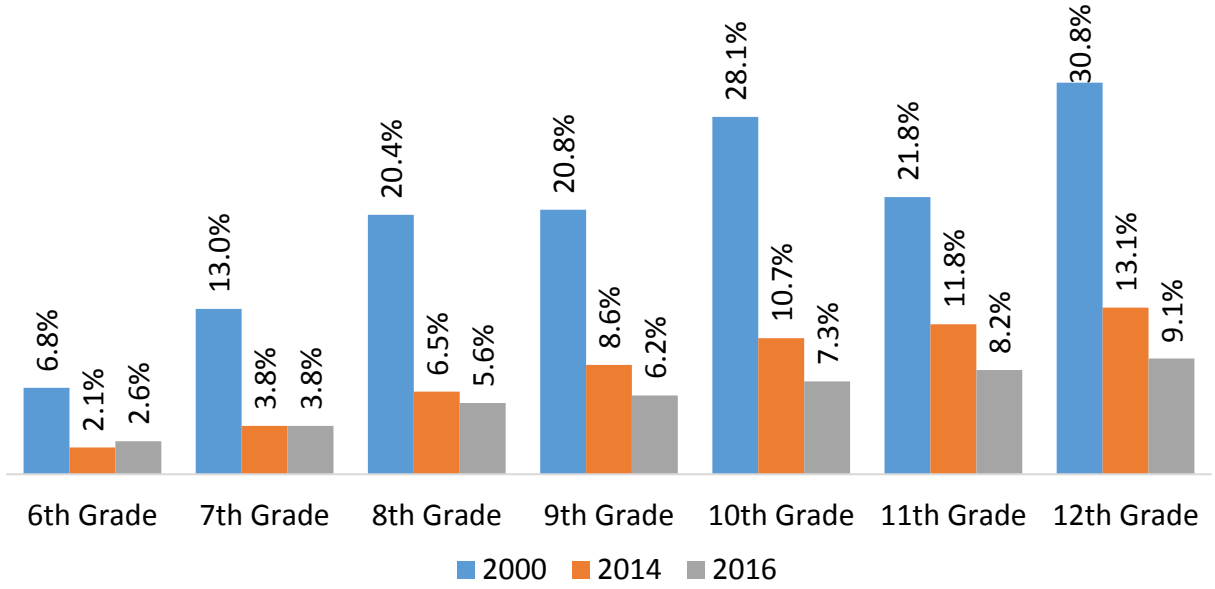


(Maryland Department of Health, 2018)

[11] Prior to 2012 Maryland's Behavioral Risk Factor Surveillance System (BRFSS) survey did not include questions about current use of cigarettes and cigars, and smokeless tobacco. Therefore, no BRFSS data on 'Any Tobacco Use' is available prior to 2012. Between 2000 and 2010, 'Any Tobacco Use' data was collected through Maryland's Adult Tobacco Survey (MATS). MATS data is not directly comparable to the BRFSS data. Historical MATS data can be accessed at: http://crf.maryland.gov/pdf/CRF-Biennial-Tobacco- Report-2000-2010.pdf

The tobacco initiation trends among Maryland middle and high school students have largely declined from 2000 to 2016, with a dramatic decline from 2000 to 2014. A less dramatic decline can be seen from 2014 to 2016, with an exception among 6th graders, noted in Figure 9.

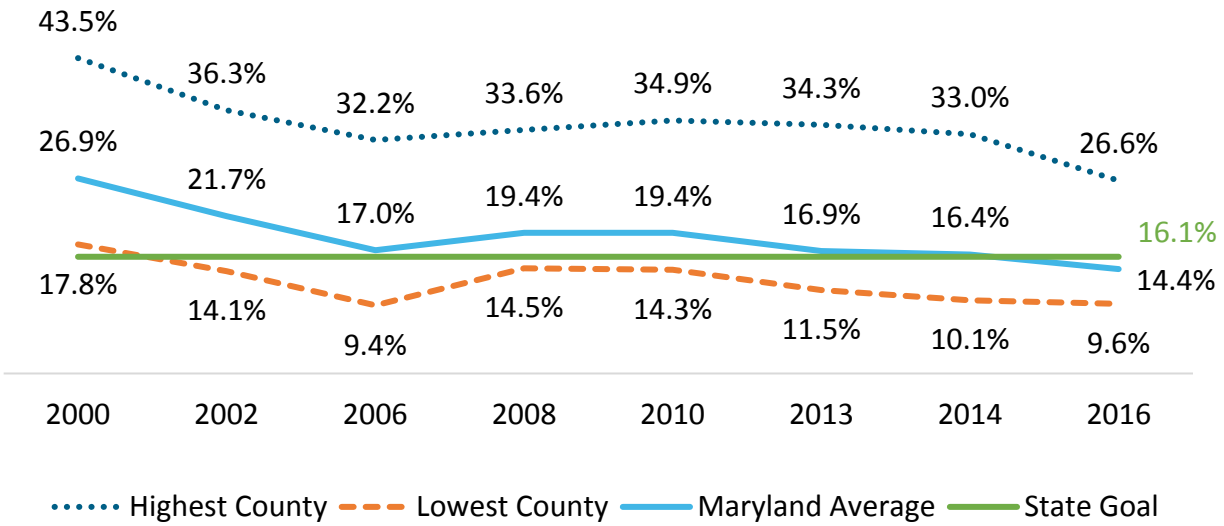
Figure 9: Maryland Youth Who Initiated Tobacco Use in Past Year, by Grade



(Maryland Department of Health, 2018)

Since 2000, the percent of youth tobacco users has declined from 26.9% to 14.4%. See Figure 10. These trends show that the state of Maryland has been successful in achieving the 2020 goal to reduce the prevalence of tobacco use among high school students to 16.1%. The figure shows that tobacco use in youth declined from 16.4% in 2014 to 14.4% in 2016. This decline represents a 12% decrease from 2014. However, the use of e-cigarettes among youth and young adults remains concerning; while the prevalence of high school youth electronic smoking devices (ESDs) use has declined from 2014 (20%) to 2016 (13.3%), this is still higher than any other tobacco product. Note, e-cigarettes are not included in the rate of 'tobacco use,' as seen below.

Figure 10: Percentage of Tobacco Use in Youth[12] in Maryland



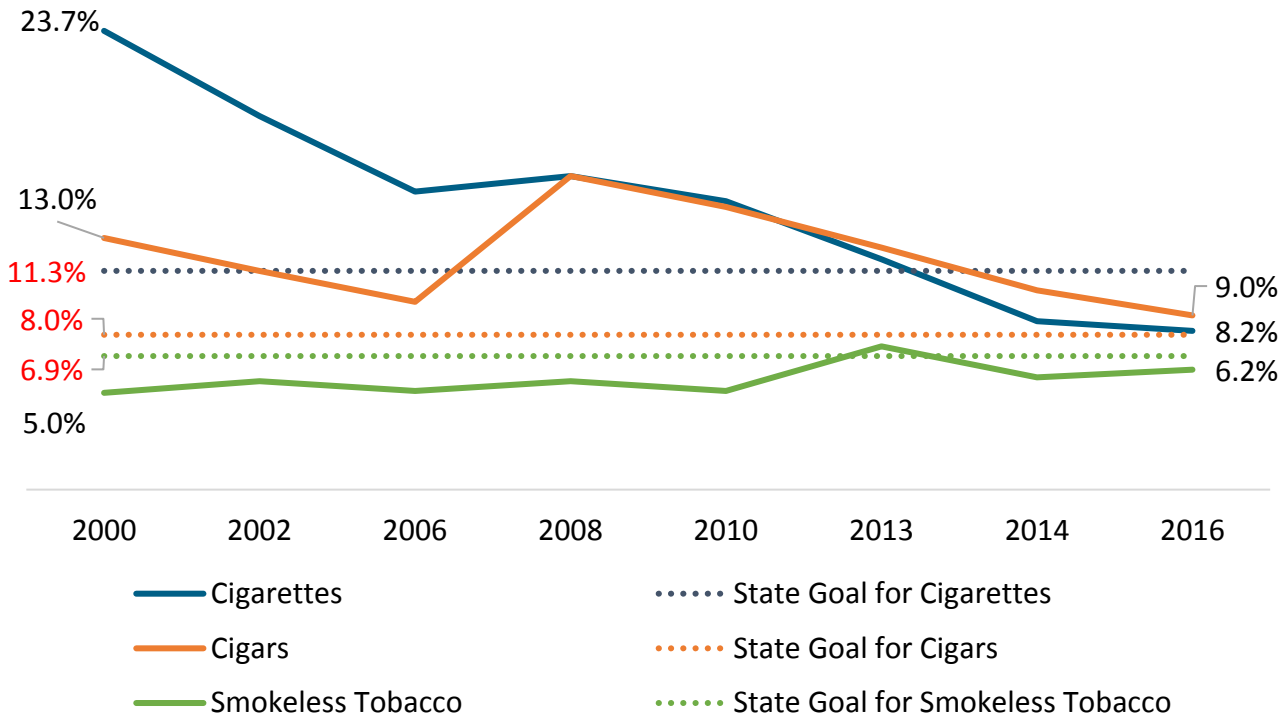
(Maryland Department of Health, 2018)

While the trend is promising, there remains room for continued, targeted work. Note that Figure 10 contains a range of tobacco use rates from across Maryland's 24 jurisdictions. For each year, the county with the highest (dotted line) and the lowest (dashed line) tobacco use rate for youth is illustrated. The gap between these points represents the difference in tobacco use rate from around the state (25.7% in 2000, 17.0% in 2016). While the gap, like the overall tobacco use rate, is decreasing over this time, a difference remains and targeting programming should address how to bring those jurisdictions at the high end of the spectrum in line with the lower end.

[12] Maryland public high school youth who completed the YRBS/YTS survey.

When looking at individual tobacco products, trends continue to show a decline in the use of cigarettes, cigars, and smokeless tobacco among high school youth. In Figure 11, the usage rates for these tobacco products is provided from 2000 through 2016. All three areas are decreasing. For cigarette and smokeless tobacco, the state achieved the 2020 goals in 2016, to reach 11.3% and 6.9% respectively. For use of cigars, the state is closing in on the goal of 8.0%, the 2016 rate is 9.0%. This is a commendable achievement.

Figure 11: Youth[13] Use of Cigarettes, Cigars, and Smokeless Tobacco in Maryland



(Maryland Department of Health, 2018)

While the initiation of tobacco products is generally declining in Maryland, the usage of e-cigarette among youth and young adults remains concerning. E-cigarette use, also known as vaping, has been controversial and regulation concerning it is still developing. In Maryland, prevalence of usage by youth of electronic smoking devises (ESDs) use and vaping are troubling. MDH reported that, in 2014, ESD/Vaping product use among high school students was 20%, compared to 15% for all tobacco products (Maryland Department of Health and Mental Hygiene, 2016). The most recent data does shows a decline from 2014 to 2016 as the statewide average for high school youth usage of ESD/vaping is 13.3% in 2016 (Maryland Department of Health, 2018). Given concerns over ESDs among youth, LHDs have been actively targeting programming to reach more youth regarding this behavior. As a result, over the last three years, the number of youth educated by LHDs on e-cigarette prevention has risen dramatically (21,954 in FY 2015; 25,321 in FY 2016; and 128,260 in FY 2017).

[13] Maryland Public High School Youth who completed the YRBS/YTS survey.

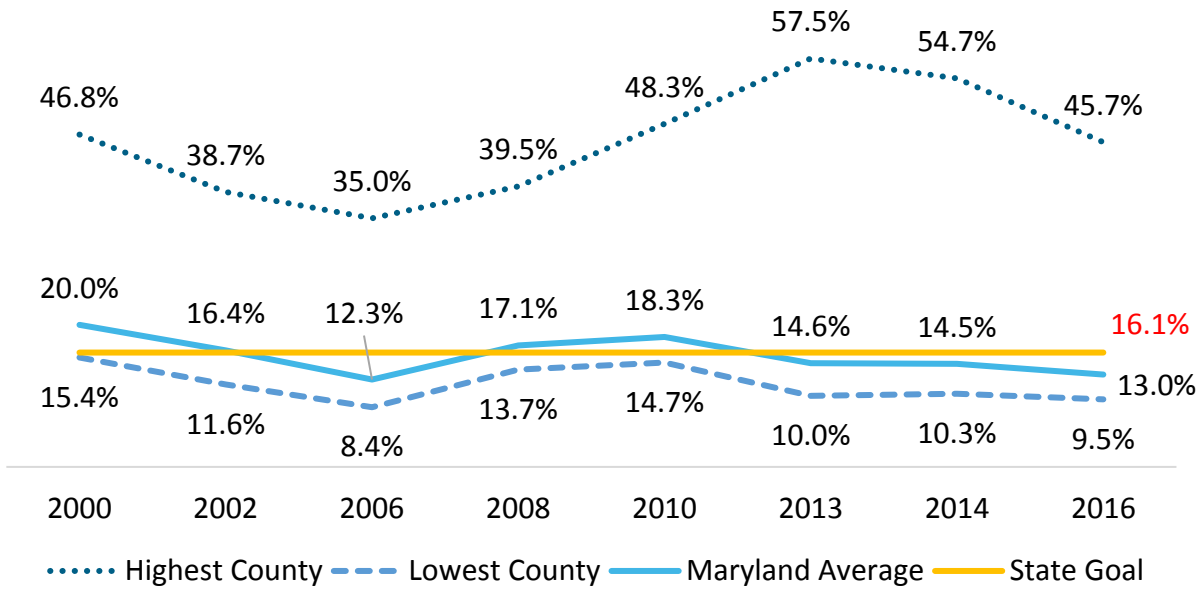
RESEARCH QUESTION 11

To what extent did the prevalence of tobacco use decrease among targeted high-risk populations?

Tobacco use rates for minority youth are trending positively though gaps between counties are significant. The following section will address the evaluation research question by looking at trends for minority youth, minority adults, and women who smoke while pregnant to understand the extent to which tobacco usage has decreased among these population groups.

The overall tobacco use rate has declined for minority youth in Maryland as measured by the YRBS/YTS, from 20% in 2000 to 13% in 2016. Rates of tobacco use for minority youth are below the state goal of 16.1% and have been for some time. Figure 12 shows the range from 24 Maryland jurisdictions with the highest (dotted line) and lowest (dashed line) usage rates over time. However, unlike in the overall trends, the gap between county rates has not decreased over time (a difference of 31.4% in 2000 to 36.2% in 2016)[14]. This suggests a need to continue developing programming that targets the disparities.

Figure 12: Tobacco Use Rates in Among Minority Youth[15] in Maryland



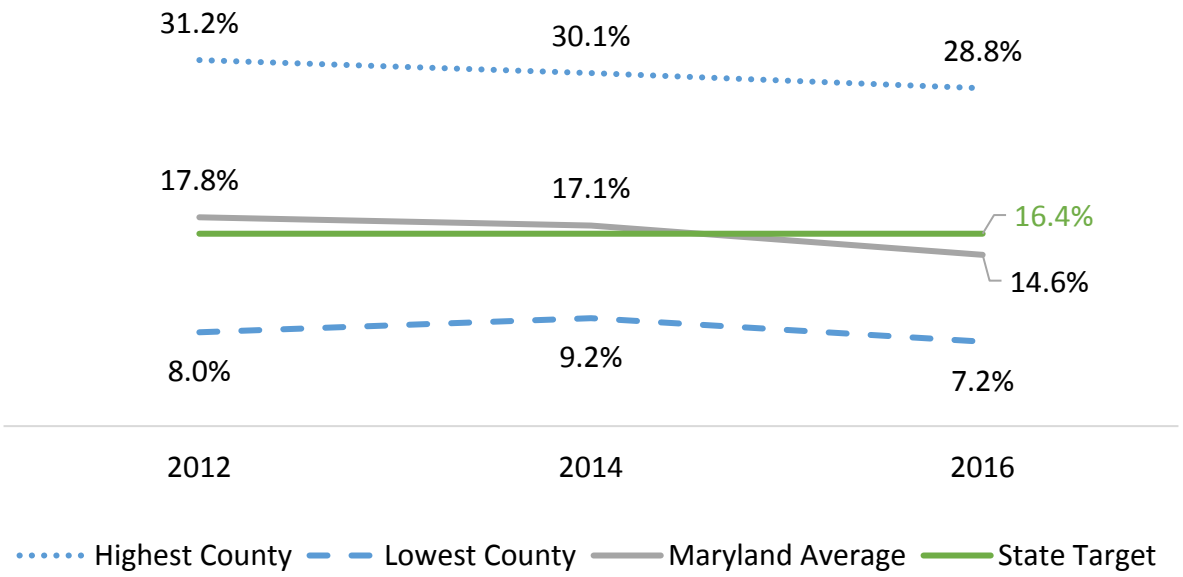
(Maryland Department of Health, 2018)

[14] While the YRBS/YTS follows a robust survey protocol, an important caveat to these data is that in some jurisdictions the number of respondents (N values) are small compared to larger jurisdictions. While the overall trends are useful for strategic decision-making and evaluation state-trends, one should use caution when making inferences from these data values.

[15] Maryland Public High School Youth who completed the YRBS/YTS survey.

The overall tobacco use rate has declined for minority adults[16] in Maryland, as measured by the BRFSS, from 17.8% in 2012 to 14.6% in 2016. Figure 13 includes the range for the 24 counties in Maryland with the highest (dotted line) and lowest (dashed line) usage rates for each of the three years. The gap between the highest and lowest rates has declined over time, from a difference of 23.2% in 2012 to 21.6% in 2016. There remains ample opportunity to bring the jurisdictions at the high end in line with those at the lower end.

Figure 13: Current Minority Adult Tobacco Users in Maryland

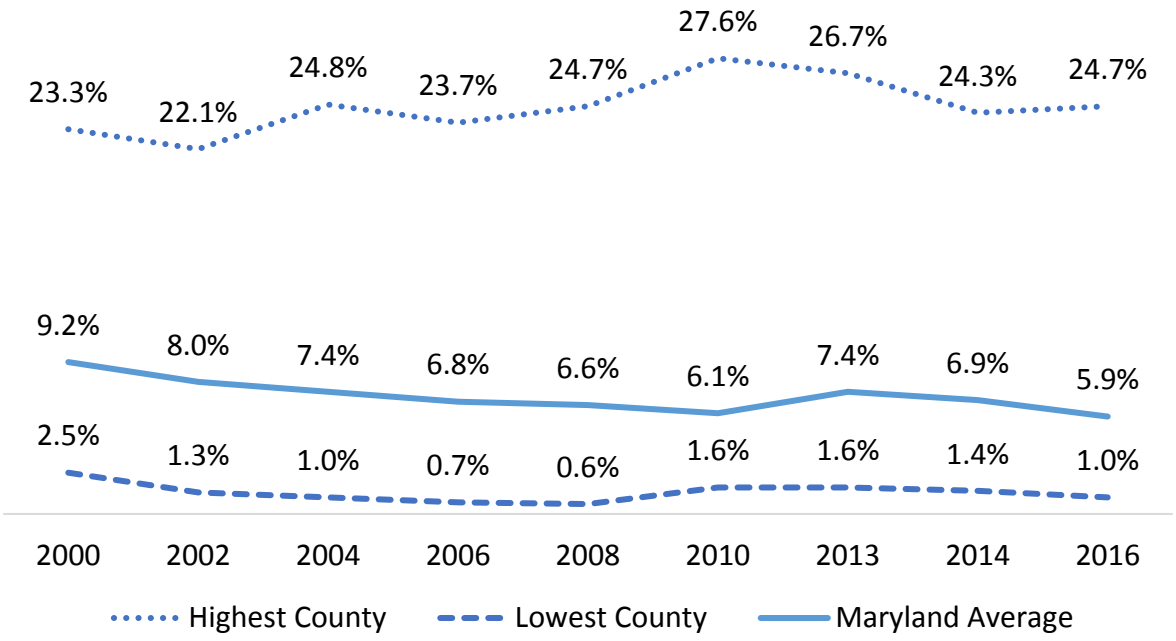


(Maryland Department of Health, 2018)

[16] Minority adults include racial and ethnic minorities as well as individuals who identify as women.

One additional adult population that Maryland targets specifically is pregnant women who smoke. The overall rate of women smoking during pregnancy has declined, as measured by the Vital Statistics Administration in Maryland, from 9.2% in 2000 to 5.9% in 2016. Unlike in the overall trends, Figure 14 shows that the gap between counties has not decreased over time (a difference of 20.8% in 2000 to 23.7% in 2016). This suggests a need to continue developing programming that targets the disparities.

Figure 14: Women Smoking During Pregnancy in Maryland



(Maryland Department of Health, 2018)

Although households in Maryland are increasingly recognizing the real health risks posed by secondhand smoke and are voluntarily choosing not to allow smoking inside their home, the rates of voluntary smoke-free home rules are not equal amongst all populations. In 2016, adults reported that 87.0% of Maryland households prohibited all smoking inside the residence (81.9% among those with no college education, 85.0% among those with some college, and 93.5% among college graduates).

Additionally, the proportion of Maryland households with a resident adult smoker and a resident child is significantly different for renter-occupied households compared to owner-occupied households. There has been a 26.5% decrease in owner-occupied households with adult smokers since 2012. However, there has not been a statistically significant change in the proportion of renter-occupied smoking households, which is consistent with higher rates of cigarette use among populations more likely to live in renter-occupied households. These indicate other areas for improvement.

Dissemination and Next Steps

This interim evaluation report is the first outcome in a multi-year evaluation and strategic planning partnership with the Schaefer Center. Following the submission of this report to the Centers for Disease Control and Prevention, the findings from this interim evaluation will be shared with stakeholders, including LHDs, grant-funded partners, advisory boards, coalition members, and other interested parties.

Facilitated strategic planning sessions with CTPC and stakeholders will be held in the fall/winter of 2018. These discussions will review the evaluation findings in greater detail, and inform the direction and focus of the Maryland Tobacco Control Program moving forward. Research evaluation questions will be discussed and adjusted for future evaluations, as needed. These discussions will inform an update to the statewide strategic plan and guide sustainability for the Maryland Tobacco Control Program.

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APPENDIX 1: COMMON ACRONYMS

Acronym	Definition
BRFSS	Maryland Behavioral Risk Factor Surveillance System
CDC	Centers for Disease Control and Prevention
CRF	Cigarette Restitution Fund
CTPC	Center for Tobacco Prevention and Control
DHMH	Maryland Department of Health and Mental Hygiene[17]
ESD	Electronic smoking device
FDA	U.S. Food and Drug Administration
FFY	Federal Fiscal Year
FY	State Fiscal Year
LHDs	Local Health Departments
LRC	Legal Resource Center
MDQuit	Maryland Quitting Use and Initiation of Tobacco
MDH	Maryland Department of Health
MFR	Maryland Managing for Results
MTCP	Maryland Tobacco Control Program
NGO	Non-governmental organization
SAMHSA	U.S. Substance Abuse and Mental Health Services Administration
SHS	Secondhand Smoke
Synar	The Synar Amendment
YRBS/YTS	Maryland Youth Risk Behavior Survey/Youth Tobacco Survey

[17] The former name of Maryland Department of Health.

Appendix 2: Additional Information on Maryland's CRF Tobacco Use Prevention and Cessation Program

In 2000 legislation was enacted establishing a Tobacco Use Prevention and Cessation Program within the Maryland Department of Health and Mental Hygiene. Funding for the program comes exclusively from Maryland's Cigarette Restitution Fund (CRF). The CRF is a State Special Fund which receives 100% of the net revenue Maryland receives as a consequence of the national Master Settlement Agreement and related litigation.

Funds from the CRF may only be expended through appropriations in the annual State budget bill as provided below:

1. The lesser of 90% or $100 million estimated to be available in the fiscal year must be appropriated;
2. At least 50% of the annual appropriation made must be for the following purposes:
    a. The CRF Tobacco Use Prevention and Cessation Program
    b. The CRF Cancer Prevention, Screening, and Treatment Program
    c. Other programs serving the following purposes:
        i. Reduction of the use of tobacco products by minors
        ii. Implementation of the Southern Maryland Regional Strategy-Action Plan for Agriculture adopted by the Tri-County Council for Southern Maryland with an emphasis on alternative crop uses for agricultural land now used for growing tobacco
        iii. Public school education campaigns to decrease tobacco use with initial emphasis on areas targeted by tobacco manufacturers in marketing and promoting cigarette and tobacco products
        iv. Smoking cessation programs
        v. Enforcement of the laws regarding tobacco sales
        vi. The purposes of the Maryland Healthcare Foundation
        vii. Primary health care in rural areas of the State and areas targeted by tobacco manufacturers in marketing and promoting cigarettes and other tobacco products
        viii. Prevention, treatment, and research concerning cancer, heart disease, lung disease, tobacco product use, and tobacco control, including operating costs and related capital projects
        ix. Substance abuse treatment and prevention programs
        x. Any other public purpose
3. At least 30% of the appropriations made must be for the Maryland Medical Assistance Program;
4. At least 0.15% must be for enforcement escrow requirements for MSA non-participating manufacturers;
5. Remainder may be appropriated for any lawful purpose.

Within the CRF Tobacco Program legislation itself, there is a requirement that at least $10 million be appropriated annually to the CRF Tobacco Program overall (this has changed year-to-year depending upon budgetary needs in the past). There is no requirement with respect to specific amounts to be appropriated to individual program components – but by CRF statute, appropriations must be made to individual components, not to the overall program. No funds appropriated to individual components may be transferred to other components or to other programs absent express authority provided in the annual budget bill.

The statutory 'CRF Tobacco Program' consists of the following components and elements:

1. **Local Public Health Component** (LPHC) – Funding is appropriated in the budget to this specific component. The LPHC appropriation is then distributed to each of the 24 local health departments in proportion to the total number of tobacco users within the jurisdiction to the State as a whole in accordance with a statutory formula. The interventions supported by LPHC through local health departments can include the following:
    a. School-based interventions
    b. Community-based interventions
    c. Local tobacco-use cessation interventions
    d. Local enforcement of youth access restrictions

2. **Statewide Public Health Component** (SPHC) – Funding is appropriated in the budget to this specific component. The SPHC can be used to fund any statewide tobacco control activity or for grants in support of specific projects and activities at the local level. Historically, the majority of SPHC appropriations, if any, have been used first to support the Maryland 1-800-QUIT-NOW Quitline.

3. **Counter-marketing and Media Component** (CMMC) – Funding appropriated in the budget to this specific component. The CMMC has remained unfunded for a number of years.

4. **Surveillance and Evaluation Component** (SEC) – Funding appropriated in the budget for this specific component. Focus is on surveillance activities through a combined Youth Tobacco Survey and Youth Risk Behavior Survey (officially YRBS) conducted biennially at the county-level with an average of 85,000 respondents and the annual Behavioral Risk Factor Surveillance System Survey with an average of 14,000 respondents.

5. **Administrative Component** – Funding appropriated in the budget for this specific component. Administrative costs are limited to 7% of funding at state and local level.

Maryland is a small state in terms of land area, but diverse geographically, economically, demographically, and politically. The economy is influenced by its close proximity to Washington, D.C., large port, robust educational and healthcare industries, significant service sector, growing technology sector, and agricultural economy that until the early part of this century included

significant tobacco farming. Demographically, Maryland has inner city neighborhoods in Baltimore, highly urbanized areas surrounding Washington, D.C. and Baltimore, suburban areas throughout the State, and rural areas in the west, south, and eastern shore. The bulk of racial and ethnic minorities reside in central Maryland. Overall educational attainment and income vary considerably across the State, with low income and educational attainment in both rural and inner-city communities. Maryland is comprised of 24 political jurisdictions [23 counties and Baltimore City], each with its own local public school systems and local health departments (LHDs). Counties have various levels of governing: 12 are county commissioner led, among these six are "home-rule;" and 11 are charter. Baltimore City has its own municipal governing body.

During the past 10 years, several policies have been enacted that greatly effect Maryland tobacco programs, including prohibition of the sale or possession of tobacco products, including e-cigarettes, to persons less than 18 years of age; mandatory licensing for all sellers of tobacco products, including e-cigarettes; as well as minimum pricing laws for tobacco products—cigarettes are subject to an excise tax of $2/pack, non-premium cigars are taxed at a rate equivalent to this (70% of wholesale price), and smokeless products are taxed at approximately half that rate; only fire-safe cigarettes may be sold; the sale of clove cigarettes is prohibited; and restrictions on the placement of tobacco products have been adopted at the local level. Maryland's statewide clean indoor air legislation was implemented in 2008 and prohibits smoking indoors in all schools, places of employment, public areas, restaurants, and bars with few exceptions (i.e. tobacconist shops and hookah bars that don't sell food). The state law passed after several local laws were enacted. There are no State or local laws that increase the minimum age to purchase tobacco products beyond 18 years of age.

APPENDIX 3: INFRASTRUCTURE AND BEST PRACTICES

Infrastructure includes not only funding and personnel (aka managed resources), but management structures (e.g. multi-level leadership and networked partnerships), responsive planning and plans (e.g., strategic plan, sustainability plan etc.), and measurement tools (e.g., engaged data). The five core components of infrastructure are discussed in detail in the *Best Practices Users Guide: Program Infrastructure in Tobacco Prevention and Control* and include: 1) Responsive Plans and Planning; 2) Multilevel Leadership; 3) Networked Partnerships; 4) Managed Resources; and, 5) Engaged Data (Centers for Disease Control and Prevention, 2017c).

Responsive Plans and Planning

Plans may include a strategic plan, annual work plan, communications plan, evaluation plan, and sustainability plan. These plans are often collaboratively developed, flexible, and include evaluation feedback (see Table 12). Plans should also be responsive to changes.

Table 12: Responsive Plans

Type of Plan	***Description of the main purpose of the plan***
Strategic Plan	Describes the goals and objectives that supports the program's mission.
Annual Work Plan	Lists objectives, activities and start and end dates that guide the work effort.
Communications Plan	Defines the messages and intended audiences for the program's communications.
The Evaluation Plan	Explains how the program will be evaluated and how the results of the evaluation will be used.
The Sustainability Plan	Details how the program will maintain or increase funding and sustain tobacco control achievements.

(Centers for Disease Control and Prevention, 2017c)

Multilevel Leadership

Tobacco control efforts benefit from leaders within the program (e.g. program staff) and from leaders outside the program, (e.g. community members or staff from partner organizations). "Multilevel leadership" means the leadership at all levels that interact with the program. It includes leadership within the program beyond the program manager. It also includes those across programs that have related goals, and leadership at the both the state and local level. Leadership is key to the development of relationships, communication, funding, and to enhance the interactive link among program components (Centers for Disease Control and Prevention, 2017c).

Networked Partnerships

Working with partners to achieve goals, developing quality partnerships, partnering with diverse groups and evaluating partnerships for program strengths, outcomes, and areas for improvement are part of this relationship focused component.

To evaluate the value of the partnership, the evaluation team would: identify strengths and challenges relevant to the partnership, determine if goals were met, promote public awareness of the partnership, and help it achieve tobacco control goals and be accountable (Centers for Disease Control and Prevention, 2017c).

Managed Resources

Managed resources are the funding and staff resources that support the program. To strengthen managed resources: Ensure funding stability, direct resources to strategies with the greatest impact, share positions and resources, communicate program successes, develop staff competencies, and train staff and partners (Centers for Disease Control and Prevention, 2017c).

Training staff and partners involves providing continuous guidance (e.g. orientation, onboarding, training and professional development). Staff training should be individually tailored and focus on the development of new competencies related to tobacco. Using the example of advancing the science around cessation programs, program leaders can develop staff competences in learning about and apply scientific evidence and contributing to the evidence base (e.g. writing articles) as well as learning about research limitations (Centers for Disease Control and Prevention, 2017c).

Engaged Data

Engaged data refers to working with data to promote action and it ensures data are used to promote public health goals. The sharing of data helps guide local systems and encourages partners to buy in. Programs can follow six steps to use engaged data: 1) Engage stakeholders, 2) Describe the program, 3) Choose questions to answer, 4) Gather credible data, 5) Develop conclusions, and 6) Share results and ensure use (Centers for Disease Control and Prevention, 2017c).

APPENDIX 4: EVALUATION PLAN FOR THE CENTER FOR TOBACCO PREVENTION AND CONTROL

The following pages include the evaluation plan submitted by the Center for Tobacco Prevention and Control at the Maryland Department of Health and Mental Hygiene. This plan was established as part of Funding Opportunity: FOA DP15-1509 CORE, CDC Award Term: March 29, 2015 – March 28, 2020, Grant #: 1U58DP005994-01, and CFDA: 93.305.

INTRODUCTION

The Maryland Department of Health and Mental Hygiene (DHMH), Center for Tobacco Prevention and Control (CTPC) oversees the statewide tobacco control program in Maryland (MD). Due to comprehensive statewide tobacco control programming, strong policies, cessation support services, and a vast network of partners, tobacco use in Maryland has decreased dramatically since 2000.

As great strides have been made nationally and statewide, many believe that the tobacco epidemic has been 'solved'; yet 7,500 adults in Maryland still die each year due to tobacco-related causes, and hundreds of thousands more suffer from tobacco-related diseases such as COPD, emphysema and cancers. It is estimated that 92,000 Maryland adolescents alive today will die prematurely as a result of cigarette smoking.[18]

CTPC provides oversight, technical assistance, and training to local health departments (LHDs), grantees, and partners ensuring that efforts are coordinated with the statewide program goals and messages. CTPC and its partners will continue to develop and implement programs to increase awareness of the dangers of tobacco use and secondhand smoke (SHS) exposure, encourage those who use tobacco to quit, and provide information on services available for residents who are ready to quit using tobacco.

EVALUATION GOALS

The purpose of the evaluation is to utilize a combination of process and outcome measures to determine the effectiveness of the Maryland Tobacco Control Program overall, as well as select targeted interventions, such as the Responsible Tobacco Retailer Initiative.

Evaluation results will assist CTPC and its partners to assess: what programmatic components have been effective in reducing tobacco use behaviors and changing retailer behaviors; what should be expanded and replicated; where funds should be devoted and allocated; and the current environment and resources available. Programs will be adjusted as necessary to ensure that efforts effectively contribute to reaching the statewide program goals: preventing initiation

[18] Tobacco Free Kids. "Key State-Specific Tobacco-Related Data and Rankings," March 7, 2016. Last Accessed March 11, 2016 at: http://www.tobaccofreekids.org/research/factsheets/pdf/0176.pdf.

among youth and young adults; promoting quitting among adults and youth; eliminating exposure to secondhand smoke; and identifying and eliminating tobacco-related disparities among vulnerable and underserved populations.

STAKEHOLDER ENGAGEMENT/STAKEHOLDER ASSESSMENT

The MDQuit Advisory Board acts as the statewide advisory body with representation of LHDs, voluntary organizations, academic partners, hospital-based organizations, behavioral health organizations, resource centers, and staff from DHMH. CTPC presented evaluation documents to the Board in October 2015. The next iteration of the evaluation plan was developed, as outlined below.

CTPC and its resource centers felt it was important to broaden the involvement of statewide partners and to obtain additional feedback before finalizing the evaluation plan. In spring of 2016, CTPC will be issuing a survey to representatives from LHDs, Local Health Officers, community based organizations, resource centers, voluntary organizations, and other partners to take stock of resources available, determine the needs of the local programs, as well as guide program goals and evaluation. Follow-up regional meetings at the local level will allow for further discussion of responses and focus areas that are useful to partners. At the beginning of 2016, state dollars became available to conduct a more in-depth and long term program evaluation. CTPC is currently in the process of selecting an evaluator outside of the Center who will conduct evaluation and reporting. With the results from the statewide survey and meetings, as well as in consultation with the evaluator, CTPC will adapt the evaluation plan as necessary.

The DHMH Center for Cancer Prevention and Control oversees the process for development of the Maryland Comprehensive Cancer Control Plan (MCCCP), which CTPC utilizes as its strategic plan. The new plan is slated to be released in late spring 2016. CTPC staff are active participants of the Maryland Cancer Collaborative, including sitting on the Steering Committee. In 2015, CTPC was involved with selecting goals and objectives for the new plan, which were presented at several feedback sessions with all Collaborative members. Final goals and objectives were determined as a result of these feedback sessions.

BACKGROUND AND PROGRAM DESCRIPTION

NEED/CONTEXT[19]

While Maryland (MD) has seen drastic decreases in cigarette use among youth, other tobacco products have become more prevalent. Populations that are harder to reach, such as those of lower socio-economic status (SES), behavioral health, and pregnant smokers, still have higher smoking rates than the general population. Within MD, youth attitudes are increasingly favorable towards tobacco use, and youth access via retail purchases is at unacceptably high levels. Smoking in public places is prohibited; however, many families, including those of lower SES, are exposed to smoking in their homes. New and emerging products continue to threaten the great progress MD has made with reducing tobacco use.

Nearly 15% of Maryland high school students currently use one or more types of tobacco products, which varies considerably among Maryland's 24 major political jurisdictions; 60% of these youths use flavored tobacco products, including flavored cigars, with fruit and candy flavors preferred by the majority. The smoking prevalence of Maryland high school youth is 14.9% (2014), yet, the use of Electronic Nicotine Delivery Systems (ENDS), or "vapes," is nearly 20% among high school youth. Statewide surveys have found that youth attitudes towards smoking are growing increasingly positive with youth believing that those who smoke have more friends and "look cool/fit in." Due to increasingly high rates over the past five years of Maryland tobacco retailers illegally selling tobacco to kids, youth have greater access to tobacco products, jeopardizing activities to reduce youth initiation.

The Maryland adult smoking rate is 14.6% (2014). While this is lower than the national average of 17%,[20] it does not give a comprehensive view of *who* continues to use tobacco. Tobacco use in Maryland is correlated with lower educational attainment, lower income, those who rent versus own their homes, poor mental health status, and alcohol and drug abuse. In Maryland just 5.6% of college graduates currently smoke cigarettes as compared to 28.2% of those with only a high school diploma, GED, or less. Among those with a household income between $15,000 and $24,999, 20.6% currently smoke cigarettes, as compared to the 11% of households with an income greater than $50,000. Among persons diagnosed with a depressive disorder, 36% smoke cigarettes as compared to 21% of those who never had such a diagnosis.[21] The rate of smoking during pregnancy is considerably higher among the Medicaid population.

[19] Maryland Department of Health and Mental Hygiene. Monitoring Changing Tobacco Use Behaviors: 2000 - 2014. Baltimore: Maryland Department of Health and Mental Hygiene, Prevention and Health Promotion Administration, Cancer and Chronic Disease Prevention Bureau, Center for Tobacco Prevention and Control. (Unpublished).

[20] Centers for Disease Control and Prevention. CDC Vital Signs: Current Cigarette Smoking Among Adults in the United States. December 8, 2015. http://www.cdc.gov/tobacco/data_statistics/fact_sheets/adult_data/cig_smoking/.

[21] Centers for Disease Control and Prevention. CDC Vital Signs: Adult Smoking - Focusing on People with Mental Illness. February 5, 2013. http://www.cdc.gov/vitalsigns/smokingandmentalillness/index.html.

Objectives

As outlined in the state strategic plan and CDC CORE workplan, the following objectives have been set:

1. By 2020, reduce the prevalence of current cigarette smoking among adults by 5% to 15.6% from a 2013 baseline of 16.4%.
2. By 2020, reduce the prevalence of tobacco use among high school youth by 5% to reach the following targets:
    a. Cigarette use – 11.3% (2013 baseline of 11.9%)
    b. Cigar use – 8% (2013 baseline of 12.5%)
    c. Smokeless tobacco – 6.9% (2013 baseline of 7.4%)
    d. All tobacco use – 16.1% (2013 baseline of 16.9%)
3. By 2020, decrease the retailer non-compliance rates for Synar inspections to 20% from a 2014 baseline of 24%.
4. By 2020, reduce exposure of high school youth to secondhand smoke by 5% to 30.1% from a 2013 baseline of 31.7%.
5. By 2020, decrease exposure to SHS among Maryland residents by increasing the number of voluntary household no smoking policies from 81.2% to 85%.

Activities

Implement ongoing health communication interventions regarding the dangers of flavored tobacco and ENDS, responsible retailer initiatives, smoke-free multi-unit housing, and Quitline; continue the multi-faceted Responsible Tobacco Retailer Initiative to reduce youth access to tobacco products; continue to support the Maryland Tobacco Quitline; collaborate with healthcare providers to incorporate smoking cessation into routine clinical care in hospital based systems; maintain partnership with the Maryland Medicaid program to support the Quitline; implement targeted programs that reach vulnerable and underserved populations and those that experience higher disparities of tobacco related death and disease.

Stage of Development

The Maryland Tobacco Control Program as a whole has been in place for over 15 years and is in the 'maintenance phase' of program development. Nevertheless, certain interventions within the statewide program are in the 'implementation phase,' e.g., the Responsible Tobacco Retailer Initiative. Evaluation results will assist CTPC and its partners to determine which programmatic components have been effective. As noted previously, CTPC will be sending an online survey to partners statewide to gain a more in-depth understanding of programmatic needs and a better picture of statewide program infrastructure operations. CTPC is in the process of selecting an outside evaluator for the program.

RESOURCES/INPUTS

The Maryland Tobacco Control Program receives funding support from the following sources: MSA dollars, state general funds and federal funds. The statewide program infrastructure is based upon the Centers for Disease Control and Prevention (CDC) *Best Practices for Comprehensive Tobacco Control Programs (2014)*: State and Community Interventions; Mass-Reach Health Communication Interventions; Cessation Interventions; Surveillance and Evaluation; and Infrastructure, Administration and Management. Funding is provided to all 24 Local Health Departments (LHDs), which each have their own tobacco control programs that address school- and community-based programs, cessation, and enforcement activities.

In addition to program funding, resources/inputs for the Maryland statewide tobacco control program include:

- State health department, Center for Tobacco Prevention and Control (14 staff members, based on CDC infrastructure recommendations)
- Two statewide resource centers:
  - Legal Resource Center for Public Health Policy (LRC)
  - Maryland Resource Center for Quitting Use and Initiation of Tobacco (MDQuit)
- The Maryland Tobacco Quitline, 1-800-QUIT-NOW (www.smokingstopshere.com)
- Local Health Department tobacco control programs in each of Maryland's 24 major political jurisdictions
- Local coalitions within each of Maryland's 24 major political jurisdictions that represent the diverse demographics of each jurisdiction
- Community-based programming, including funding organizations who reach vulnerable and underserved populations
- Health Communications contracts/activities
- Partnerships with other entities within the DHMH (Cancer, Chronic Disease and Oral Health programs; Maternal Child Health, WIC, Office of Minority Health and Health Disparities, Environmental Health, Medicaid, Behavioral Health Administration)
- Network of statewide supporters and partners (statewide Smoke-free Maryland coalition)
- Partnerships with state and local agencies, such as the Department of Housing and Community Development
- Statewide Advisory Board
- National agencies and organizations
- Health systems

LOGIC MODEL

The logic model for CTPC has been provided on pages 11 and 12 of this evaluation.

Evaluation Focus and Methods

Upon awarding a Contractor to conduct a formal evaluation, additional methods and data sources will be defined and the plan will be updated.

A. Responsible Tobacco Retailer Initiative – Reduce Youth Access to Tobacco Products

Key Questions	Indicators (how will you know it?)	Method (how will you gather info?)	Data Source (who will have the information)	Frequency (when will the info be collected?)	Responsibility
1. Were Responsible Tobacco Retailer resources appropriately allocated, developed, and distributed to partners?	• Funds allocated in state budget for enforcement programs • Funding distributed to state and all 24 local health departments (LHDs) • Funding distributed to community based organizations (CBOs) and Legal Resource Center (LRC) • Media contract(s) awarded • Traditional media campaigns developed • Resource guides and materials developed • Program work plans in line with acceptable activities outlined by SAMHSA	• Document review	• Fiscal tracking documentation of funding distribution to LHDs • LHD progress and expenditure reports • Reports from contracted CBOs and resource center • Media contract progress reports	• Ongoing review of funding distribution and expenditures • Ongoing monitoring of progress with media development throughout term of contract for each agency • Quarterly reports from LHDs	• Center for Tobacco Prevention and Control (CTPC) Director • CTPC Division Chiefs • LHD program coordinators and Local Health Officers

Key Questions	Indicators (how will you know it?)	Method (how will you gather info?)	Data Source (who will have the information)	Frequency (when will the info be collected?)	Responsibility
2. To what extent was needed technical assistance (TA) provided to partners involved with implementing the Responsible Tobacco Retailer Initiative?	• # of regional/ statewide training meetings held • # of people in attendance • Training presentations posted to LRC website/hits to website • # of local coalition meetings attended/ presented by CTPC and LRC staff • # of TA requests	□ Document review	• Meeting invitations sent/registrations received • Sign-in sheets at meetings/trainings • Tracking logs at LRC for number and type of TA requests received • Local coalition meeting notes	• Ongoing • Quarterly reports from LHDs • Quarterly reports from LRC	• CTPC Director • CTPC Division Chiefs • Legal Resource Center • LHDs
3. To what extent have CTPC and collaborative partners increased activities designed to increase education and outreach directed at licensed tobacco retailers from 2013 to 2015?	• # of face-to-face educational sessions conducted between LHDs, CBOs and retailers • # of traditional ads placed and the reach (GRP, impressions, frequency) • # of retailer packets and printed materials distributed and to whom • # of hits to the retailer campaign website • Focus groups conducted	• Document review • Qualitative/Focus groups	• LHD progress reports • CBO progress reports • Media contractor progress reports • Distribution center log of materials mailed to retailers and partner organizations • Google Analytics utilized to track website hits • Focus group reports	• Monthly review of materials requested/mailed • Media reach reviewed at the conclusion of each campaign – quarterly • Monthly review of website activity	• CTPC Director and Division Chiefs • LHDs • CBOs

Key Questions	Indicators (how will you know it?)	Method (how will you gather info?)	Data Source (who will have the information)	Frequency (when will the info be collected?)	Responsibility
4. To what extent have CTPC and other statewide entities increased enforcement activities from 2013 to 2015?	• # of local compliance checks conducted • # of compliance checks ("Synar" and FDA) conducted • # of citations issued • # of inspection follow-up letters to retailers issued • # of hearings conducted via the Comptroller's office for repeat offenders • # of warnings issued, licenses suspended/ revoked by Comptroller and/or FDA	• Document review • Surveillance	• LHD progress reports • Behavioral Health Administration (BHA) tracking sheets • FDA CTP inspection database • LHD and community-based organization progress reports • Comptroller hearing logs • Counter Tools surveillance program	• April – September: Synar checks conducted • Local and FDA checks ongoing • Ongoing communication with LHD and CBO grantees • Quarterly review of progress reports • Monthly meetings with Department decision makers • 2016 – Counter Tools program developed	• CTPC Director and Division Chiefs • BHA • LHDs • Comptroller's office
5. Did the Synar noncompliance rates decrease (from 24% in FFY2014, 31% in FF2015) and to what extent did compliance with tobacco control policies related to youth access increase?	• # compliance checks conducted by LHDs and BHA • # of citations • # of violations	• Non-compliance rate determined by BHA • Local surveillance • Compliance checks utilizing youth ages 16-17 in line with FDA protocols • Document review	• BHA tracking documents • LHD progress reports • FDA CTP inspection database	• Synar – final rate determined by end of federal fiscal year (9/30) • Local rates – ongoing and reviewed quarterly	• CTPC Director and Division Chiefs • CTPC Surveillance/ Policy Analyst coordinator • BHA • LHDs

B. Maryland Comprehensive Tobacco Control Program Activities

Key Questions	Indicators (how will you know it?)	Method (how will you gather info?)	Data Source (who will have the information)	Frequency (when will the info be collected?)	Responsibility
1. To what extent does the Maryland Tobacco Control Program implement the CDC Best Practices model and are the programmatic activities at the state and local levels reflective of community needs?	• All 24 LHDs funded, utilizing funding formula set by state statute LHD program work plans approved and indicators met • # of contracts awarded to CBOs • Multi-year contract awarded to media agency • # of state health department program staff, in line with CDC recommendations for infrastructure • Outside program evaluator hired and work plans approved • Quitline and health systems grants in place; work plans approved and implemented • Online survey for statewide partners conducted to determine programmatic needs and resources available • # of planning meetings held with statewide partners • # of meetings with MDQuit Advisory Board	• Document review • Site Visits Literature reviews • Literature reviews • Online surveys	• LHD progress reports • Contractor reports • Online survey results (sent to all LHDs, Local Health Officers, DHMH staff, resource centers and community partners) • Meeting notes • Site visits • Evaluation reports • Local coalition meeting notes • Planning meeting notes	• Annually – Site visits, Evaluation reports, planning meetings • Online survey – Spring 2016 • Quarterly – awarded contract reports • Additional methods to be determined upon award of outside Evaluator	• CTPC Director and Division Chiefs • MDQuit Advisory Board • Media Contractor • Evaluation Contractor • LHDs

Key Questions	Indicators (how will you know it?)	Method (how will you gather info?)	Data Source (who will have the information)	Frequency (when will the info be collected?)	Responsibility
2. To what extent has CTPC increased health communication interventions and messages reaching the general population and populations with negative disparities in the use of tobacco products and tobacco related death and disease (racial/ethnic groups, low SES, Medicaid, Behavioral Health, LGBT, & youth)?	• Populations identified • Campaign messages approved • Metrics met in the Health Communications Plan • Multi-year media contract in place; work plan approved and deliverables met • Reach/GRP data from various targeted campaigns • # of materials developed and distributed (Quitline, Retailer, Litter, smoke-free multi-unit housing, pregnancy, etc.)	• Qualitative/focus groups • Document review • Surveillance	• BRFSS data • YTRBS data • Distribution center log of materials mailed to retailers and partner organizations • Media contractor progress reports	• Pre/post campaigns • BRFSS – annually • YTRBS – biennially Focus groups prior to finalization of campaigns and as per work plan developed with media contractor • Monthly review of materials requested/mailed	• CTPC Director and Division Chiefs • Media contractors • Evaluation Contractor
3. To what extent has CTPC and partners increased the number of implemented evidence-based interventions and strategies that address vulnerable and underserved populations?	• LHD programs implemented as per approved work plans • # of local coalitions addressing activities targeting vulnerable and underserved populations • # and reach of media campaigns implemented targeting vulnerable and underserved populations • Increased participation among vulnerable populations on workgroups, advisory boards, and coalitions	• Document review	• LHD progress reports • CBO progress reports • Media contractor progress reports with reach information • Quitline reports • Health System grants progress reports • Medicaid Match reports	• LHD quarterly progress reports • Monthly review of materials requested/mailed • Media reach reviewed at the conclusion of each campaign • Quitline reports – reviewed monthly	• CTPC Director and Division Chiefs • LHDs • CBOs • MDQuit Advisory Board

Key Questions	Indicators (how will you know it?)	Method (how will you gather info?)	Data Source (who will have the information)	Frequency (when will the info be collected?)	Responsibility
	• # of contracts awarded to community-based organizations who reach target populations • # of activities promoting cessation services to vulnerable populations • # of callers to the Quitline identifying as members of vulnerable populations • # of callers identifying as Medicaid participants; • Medicaid match • # of Public Housing Authorities with smokefree housing policies				

Key Questions	Indicators (how will you know it?)	Method (how will you gather info?)	Data Source (who will have the information)	Frequency (when will the info be collected?)	Responsibility
4. To what extent has the Tobacco Program and its partners increased the demand for tobacco cessation and increased quit attempts?	• # of callers to the Quitline (QL) • # of residents utilizing web- and text-based services • # of callers registering for comprehensive QL services • # of health systems incorporating the QL and other cessation activities into routine clinical care • # of training opportunities with healthcare providers, including those working with Medicaid and Behavioral Health populations • % ever smokers who have quit • # of quit attempts	• Document review • Evaluation of Quitline services • Surveillance	• QL reports • QL evaluation report • Tracking documents from MDQuit trainings completed • Reports from health systems grantees implementing QL referrals and cessation into routine care • BRFSS	• Quarterly reports from grantees • Quitline evaluation conducted annually • Quitline monthly and yearly usage reports	• CTPC Director and Division Chiefs • MDQuit Resource Center • Quitline Contractor • Health systems grantees
5. To what extent did the use of tobacco products decrease since 2014?	• Youth prevalence/initiation rates • Adult prevalence rates	• Statewide youth and adult surveys	• BRFSS • YTRBS	• Annually – BRFSS • Biennially – YTRBS	• CTPC Director and Division Chiefs • CTPC Surveillance/ Policy Analyst coordinator • MDQuit • Evaluation Contractor
6. To what extent did the prevalence of tobacco use decrease among targeted high risk populations?	• Prevalence rates of youth in target populations • Prevalence rates of adults in target populations	• Statewide youth and adult surveys	• BRFSS • YTRBS	• Annually – BRFSS • Biennially – YTRBS	• CTPC Surveillance/ Evaluation staff • MDQuit • Evaluation Contractor

PLANNING FOR USE OF EVALUATION FINDINGS

CTPC will work with the MDQuit Advisory Board and the evaluation contractor to interpret results and to determine necessary program adjustments or modifications. The MDQuit Advisory Board meets twice a year, and email communication is ongoing to maintain contact with Board members. The Advisory Board will provide comment, feedback, and guidance with respect to program direction and dissemination planning.

The evaluation methods currently proposed include focus groups, surveillance, and 'document review' (contractor/grantee reports, tracking logs, database review, meeting notes, etc.). Resource centers, LHDs, health systems grantees, CBOs, and other contractors (i.e.,Quitline contractor, media contractors) will be responsible for providing reports and documentation of their activities as outlined in grants and contracts issued. CTPC staff are in constant communication with grantees, not only reviewing reports, but also through monthly/quarterly calls and site visits. Focus groups are conducted by professional evaluation companies, and CTPC staff are often able to observe focus groups. Youth and adult tobacco use surveillance is conducted through established and tested data collection protocols, and analyzed by CDC, contractors, and the CTPC surveillance coordinator. Quitline evaluation is conducted through a professional evaluation contractor that follows evaluation protocols that have been rigorously tested and are approved by NAQC. Retailer enforcement checks for Synar and FDA are conducted using an approved FDA/SAMHSA protocol, and staff from the Behavioral Health Administration are trained to conduct these inspections. Inspection data is checked by BHA staff and federal agencies before posting. Upon awarding an evaluation contractor, further quality assurance methods will be defined.

PLANNED DISSEMINATION EFFORTS

To ensure that the evaluation report will include information that is useful to various stakeholders, CTPC and its evaluation contractor will review the survey results obtained in spring 2016 and follow up regional meetings with stakeholders. These results will define what information local partners and statewide stakeholders will view as important, including results which are more critical of the program. The report will provide both successes and challenges to provide a realistic and balanced view of the tobacco control program. Recommendations for moving forward will be summarized.

Findings from the evaluation process will be widely distributed to both internal and external partners and stakeholders. Internal dissemination will include Centers within the Cancer and Chronic Disease Bureau, the Prevention and Health Promotion Administration Executive Team, the Deputy Secretary for Public Health, and the Secretary for DHMH.

External dissemination will include all member organizations of the MDQuit Advisory Board, the tobacco program at each LHD and their respective Health Officer, members of local coalitions, academic partners and funded resource centers, Cancer Collaborative members, and other stakeholders – including voluntary organizations and other state agencies. Findings will be

shared via listservs, during presentations, as well as posted to the CTPC and resource center websites. When working with the evaluation contractor, CTPC will determine if tailored reports for LHDs or stakeholder groups are feasible.