# *Making Maryland The Tobacco Free State*

## A Report to the Governor
***December 9, 1999***

The Task Force To End Smoking In Maryland


Martin P. Wasserman, M.D., J.D.
*Chair*

Senator Nathaniel J. McFadden
*Vice-Chair*

# "Making Maryland the Tobacco-Free State"

## A Report from the Governor's Task Force to End Smoking in Maryland

# "Making Maryland the Tobacco-Free State"

## A Report from the Governor's Task Force to End Smoking in Maryland


## ACKNOWLEDGMENTS

The Task Force thanks the many persons who helped us create this Report. Without their important contributions, we could not have completed our task.

First, we wish to thank the advocacy and broad public health communities who generously shared their time, knowledge, and considerable expertise in this process. The persons who spoke to the Task Force at our September conference from California, Massachusetts, and Montgomery County were gracious, thoughtful, and informative. In addition, staff from national organizations, including the National Campaign for Tobacco Free Kids and the Centers for Disease Control and Prevention provided the requisite knowledge base to anchor our work and move us forward.

Second, our thanks go to the many public health educators, practitioners, community partners, and concerned citizens of Maryland who provided testimony during the public meetings. Their valuable insights provided an important foundation for this Report. Special thanks go to the many individuals and officials who welcomed Task Force members into their communities in the eight locations that we visited.

Finally, the Task Force would like to thank the staff from the Maryland Department of Health and Mental Hygiene, Office of Health Promotion, Education and Tobacco Use Prevention; the Office of Health Assessment; and the Graphics Division for their unparalleled dedication and unprecedented support. The University of Maryland, Baltimore County, Center for Health Program Development and Management assisted us with the public meeting process with exceptional effort. Many hours were spent coordinating and assisting with the logistical arrangements for our visits to local communities. We also acknowledge the capable consultants from the Johns Hopkins University, School of Hygiene and Public Health who provided guidance in the areas of surveillance and program evaluation.

The Task Force wishes to thank these individuals for their contribution to making Maryland a healthier place for all of us.

# TABLE OF CONTENTS

# TABLE OF CONTENTS
## (Continued)

# ABSTRACT

**Problem:** Cigarette smoking is the leading cause of preventable death in the United States. Each year tobacco products kill over 7,500 Marylanders. Tobacco is a risk factor for the top four leading causes of death in Maryland (heart disease and stroke; cancer; pulmonary disease and diabetes). Among Maryland adolescents, smoking prevalence increased during the 1990's after several years of decline. In 1997 the economic burden of tobacco increased by 2% and cost Marylanders over $1.8 billion dollars. Certain racial/ethnic populations remain at high risk for tobacco use and often bear a disproportionate share of the human and economic cost of using tobacco products. No single factor determines patterns of tobacco use. The patterns result from a complex interaction of multiple factors, such as: socioeconomic status, cultural characteristics, stress, biological events, targeted marketing, tobacco pricing, and varying capacities of local communities to launch and sustain comprehensive tobacco control activities.

**Process:** Following the Master Settlement Agreement, Governor Parris N. Glendening established the *Task Force to End Smoking in Maryland* in June 1999. The Governor directed the Task Force to determine the most cost-effective way to spend $30 million annually during the first decade of the 21st century to reduce the harmful effects of tobacco products on Maryland residents. He asked the Task Force to be bold and aggressive and to pay special attention to minority populations and other groups targeted by the tobacco industry. In September, the Task Force invited nationally recognized speakers to an all-day conference to educate themselves, reflect on lessons learned from other states, and to prepare for the planning process for making Maryland tobacco-free. The Task Force then held a series of meetings across the state to gain public input for the Maryland program based upon guidelines established by the Centers for Disease Control. Traveling throughout the state provided Task Force members with an opportunity to learn first-hand about the needs and concerns of Marylanders from different geographic, racial, cultural, and other backgrounds.

**Results**: The Task Force envisions making Maryland the national leader in tobacco use prevention, control and cessation. Its mission is two-fold: to reduce initiation and tobacco use in Maryland by providing outreach to all populations with special emphasis on high risk and targeted groups; and to reduce secondhand smoke exposure, especially to children. The Task Force established nine goals to be achieved by the year 2010 that include: decrease adult smoking, especially in high risk groups; decrease school-age tobacco use; decrease smoking in pregnant women; increase smoking cessation during pregnancy; increase the number of insurance companies funding cessation activities; increase primary care providers giving advice to smokers; increase compliance with youth

access laws; decrease childhood exposure to secondhand smoke; and establish community coalitions in every jurisdiction. Overall, the Task Force made 46 recommendations to achieve stated health goals based on effective strategies in eight program areas: countermarketing/media; smoking cessation programs; community-based programs; school-age populations; statewide activities; enforcement; surveillance and evaluation; and administration. The Task Force and the citizens of Maryland are indebted to Governor Glendening's leadership in allowing this special opportunity to reduce the enormous health burden caused by tobacco products, especially for our children.

# EXECUTIVE SUMMARY

Building upon actions taken by the Maryland General Assembly earlier in the year, in June of 1999 Governor Parris N. Glendening unveiled a coordinated campaign to dramatically reduce tobacco use and cancer rates in the State of Maryland. He dedicated $1 billion over the next decade to this end and established three special Task Forces to address these problems. The Task Force To End Smoking in Maryland was selected to combat all forms of tobacco use in Maryland and decrease its harmful effects on our citizens.

## STATEMENT OF THE PROBLEM

Cigarette smoking is the leading cause of preventable death in the United States. Each year tobacco products kill over 7,500 Marylanders. Tobacco is a risk factor for the top four leading causes of death in Maryland (heart disease and stroke; cancer; pulmonary disease and diabetes). Smoking prevalence among Maryland adolescents increased during the 1990's after several years of decline. In 1997 the economic burden of tobacco to Marylanders was over $1.8 billion dollars. Certain racial/ethnic populations remain at high risk for tobacco use and often bear a disproportionate share of the human and economic cost of using tobacco products. No single factor determines patterns of tobacco use. The patterns result from a complex interaction of multiple factors, such as: socioeconomic status, cultural characteristics, stress, biological events, targeted marketing, tobacco pricing, and varying capacities of local communities to launch and sustain comprehensive tobacco control activities.

## THE PROCESS

Following the Master Settlement Agreement, Governor Parris N. Glendening established the *Task Force to End Smoking in Maryland* in June 1999. The Governor directed the Task Force to determine the most cost-effective way to spend $30 million annually during the first decade of the 21st century to reduce the harmful effects of tobacco products on Maryland residents. He asked the Task Force to be bold and aggressive and to pay special attention to minority populations and other groups targeted by the tobacco industry. In September, the Task Force invited nationally recognized speakers to an all-day conference to educate themselves, reflect on lessons learned from other states, and to prepare for the planning process for making Maryland tobacco-free. The Task Force then held a series of meetings across the state to gain public input for the Maryland program that is based upon guidelines established by the Centers for Disease Control and

Prevention. Traveling throughout the state provided Task Force members with an opportunity to learn first-hand about the needs and concerns of Marylanders from different geographic, racial, cultural, and other backgrounds.

## THE MARYLAND APPROACH
## VISION, MISSION, AND GOALS

The Task Force envisions making Maryland the national leader in tobacco use prevention, control and cessation. Its mission is two-fold: to reduce initiation and tobacco use in Maryland by providing outreach to all populations with special emphasis on high risk and targeted groups; and to reduce secondhand smoke exposure, especially to children.

**Vision**

Maryland will lead the nation in tobacco use prevention, control, and cessation.

**Mission**

Reduce initiation and tobacco use in Maryland by providing outreach to all populations with special emphasis on high risk and targeted groups.

Reduce secondhand smoke exposure, especially to children.

**Task Force Goals by 2010**

1. Decrease adult smoking in all sub-population groups by 50% from Maryland's baseline rate.
2. Decrease school-age tobacco use by 50%.
3. Decrease smoking by pregnant women by 50%.
4. Increase smoking cessation during pregnancy by 50% .
5. Increase the number of insurance companies funding smoking cessation programs to 100%.
6. Increase the number of primary care providers who give advice and support to patients who smoke to 90%.
7. Increase compliance with youth access laws to 99%.
8. Decrease childhood exposure to secondhand smoke by 75%.
9. Increase the number of jurisdictions with established community coalition(s) to 100%.

**CDC Programmatic Areas**

- Counter marketing/media;
- Smoking cessation programs;
- Community-based programs;
- School-age populations;
- Statewide activities;
- Enforcement;
- Surveillance and evaluation; and
- Administration.

The Task Force then reviewed eight programmatic areas identified by the Centers for Disease control and Prevention and developed its 46 specific recommendations. In addition, the Task Force offered legislative and policy recommendations.

## GENERAL PROGRAM RECOMMENDATIONS

Consistent with its vision and mission, the *Task Force to End Smoking in Maryland* offers the following set of recommendations to achieve the nine goals it established by 2010. Recommendations are organized according to eight of the best practice guidelines established by the Centers for Disease Control and Prevention (CDC). In addition, the Task Force identified specific criteria to guide the Request for Proposal process as applicable.

### Countermarketing/Media
[ $10 Million - Year 1 and $7.5 Million - Year 2]

The Media Campaign will be integrated within the entire statewide effort. It will be comprehensive, innovative, and aggressive.

### Tobacco Use Cessation
[$2 Million - Year 1 and $4.5 Million - Year 2]

The Cessation program will encompass all providers, be comprehensive, and funded through multiple sources. It will utilize the most current scientific practices.

## Local Communities
[$6 Million per Year]

The Public Meeting process clearly identified the Local Community as the primary prevention and service delivery site for Maryland's comprehensive program to attack tobacco use in the state. Where they exist, local, diverse and multi-disciplinary Community Coalitions should be supported. Where they do not exist, special efforts should be expended to create them.

## School-age Populations
[$4.5 Million per Year]

All children and youth, whether in or out of school or college, need to be targeted for help in tobacco avoidance. Individuals in all settings dealing with young people should be encouraged to serve as role models. Activities should be coordinated with existing efforts occurring in the local community.

## Statewide Activities
[$1.5 Million per Year]

The State will develop a capacity to provide appropriate technical assistance and other support as needed for local community activities. Statewide collaborative efforts with a variety of agencies will be pursued using Partnership Grants. A special program providing legal assistance on tobacco matters will be created in cooperation with the Office of the Attorney General.

## Enforcement
[$1.5 Million per Year]

The Enforcement effort should be aggressive, locally-based, and target illegal sales and violations of the Clean Indoor Air Act.

**Surveillance and Evaluation**
[$3 Million per Year]

The Surveillance and Evaluation activities will provide the scientific information and analysis for funding distribution based on community need and allow for information-based decision-making. It will assure that the State's resources are spent according to the best available evidence and are accomplishing optimal program outcomes.

**Administration**
[$1.5 Million per Year]

Sufficient Funding Must Be Provided to Assure Accountability for Implementation of the Comprehensive Anti-Tobacco Activities and Achievement of Program Goals.

# SPECIFIC PROGRAM RECOMMENDATIONS

**Countermarketing/Media**

- Select a single lead agency which has, or subcontracts with, Minority vendor(s) which have experience working within culturally specific communities. Targeted audiences include the African-American, Latino, and Asian communities.
- Develop a comprehensive, bold, and aggressive communications strategic plan with defined timelines and outcomes.
- Integrate free/paid media, speakers, promotions, and grassroots outreach.
- Limit paid television and radio to 66-75% of resources.
- Focus on the target audiences including minorities, youth, women, and low-income and undereducated populations.
- Develop a special program for "spit" tobacco.
- Conduct formative research and continuing evaluation using focus groups, field-testing and other methodologies.
- Require the innovative use of technology, including the Internet.
- Develop a Unifying Theme for the overall campaign.
- Vendors may not contact state officials in violation of Maryland's procurement process.

**Cessation**

- Work with insurance companies and the Legislature to achieve the goal of having Smoking Cessation programs included in all insurance policies sold within Maryland.
- Develop cost-sharing strategies including insurers, addicted recipients, and the state funding resource pool from the tobacco settlement agreement.
- Provide technical assistance to communities which request assistance in developing Cessation programs and to identify additional issues for public policy considerations.
- Follow Centers for Disease Control and Prevention (CDC)/Agency for Health Care Policy and Research (AHCPR) guidelines and utilize the best known scientific practice.
- Give special attention to "Spit" tobacco issues.
- Provide funding to community groups and local health departments to implement smoking cessation programs with particular attention to the targeted audiences especially those individuals who are uninsured or underinsured.
- Allocate funding to jurisdictions based upon most current tobacco use data as determined by the Health Secretary.

**Communities**

- Make grants to local community coalitions that submit a proposed plan of action consistent with overall program goals.
- Utilize existing administrative agencies such as local health departments or local management boards which will participate in the coalition and serve as fiscal agent in order to accomplish the coalition's goals and objectives.
- Offer technical assistance to the coalitions as needed and assist in expanding capacity by encouraging the development of regional networks.
- Coordinate all programmatic efforts including second hand smoke education, programs addressing the needs of out of school youth, and "spit tobacco."
- Develop plans from an analysis of community need based upon scientific information and surveillance data.
- Allocate funding to jurisdictions based upon most current tobacco use data as determined by the Health Secretary.

**School-Age Population**

- Target <u>all</u> young persons, particularly minorities and women, including those who are of age but not residing in an educational setting.
- Utilize best scientific practices and provide role-modeling behavior.
- Encourage those working with youth to serve as role models.
- Provide funding through existing administrative agencies such as Boards of Education, community colleges and public senior colleges and universities, and local management boards.
- Allocate funding to jurisdictions based upon most current tobacco use data as determined by the Health Secretary. Distribution allocations will be as follows: College age 30%; School age 60%; and Pre-school age 10%.

**Statewide Activities**

- Develop specialized technical assistance capabilities through a variety of mechanisms to support the needs of community groups using staff or outsourcing arrangements.
- Collaborative with special organizations such as: non-profit groups; the faith community; the business community; and minority communities.
- Create a special program to provide legal assistance to local communities on tobacco matters in cooperation with the Office of the Attorney General.

**Enforcement**

- Provide funds to each local jurisdiction to enforce existing anti-tobacco statutes and regulations.
- Provide funds directly to the chief executive or governing entity or through the State Comptroller's Office to create or support an aggressive enforcement initiative.
- Allocate funds based upon the number of tobacco retail outlets in the jurisdiction.
- Provide a special grant to the Maryland Occupational Safety and Health Administration (MOSH**)** to enhance the agency's current tobacco enforcement capacity.
- Encourage all licensing agencies, both state and local, to support enforcement activities.

**Surveillance and Evaluation**

- Develop comprehensive surveillance activities to measure tobacco product use by various populations.
- Obtain data for each jurisdiction which can be used for funding allocation.
- Monitor community compliance with youth access laws and discover new marketing schemes introduced by the tobacco industry.
- Identify a University or other institution of higher learning with knowledge and experience in tobacco evaluation and programs to:
    - Monitor program effectiveness and assess all program goals and objectives.
    - Develop and implement an annual evaluation plan for specific program components.
    - Encourage partnerships with additional academic institutions, or other entities.

**Administration**

- Develop request for proposals and oversee entire application process.
- Maintain accountability for all contracts and grants.
- Monitor expenditures and distribution targets.
- Provide reports to the Governor and Legislature.
- Work closely with the surveillance and evaluation vendors.
- Work with Advisory Task Force as recommended by the Task Force to End Smoking in Maryland.

# RECOMMENDED LEGISLATIVE AND POLICY STRATEGIES

The Task Force recommends the following legislative and policy strategies be adopted to complement Maryland's ambitious tobacco use reduction and prevention program.

## State and Local Strategies

- Revoke/Suspend Retail Tobacco License for Illegal Youth Sales.
- Eliminate Vending Machines that Dispense Tobacco Products.
- Increase Access to Smoking Cessation Services.
- Conduct Youth Tobacco Survey (YTS) and Youth Risk Behavior Survey (YRBS) in All School Systems Consistent with CDC recommendations.
- Eliminate Counter Displays of Tobacco Products.
- Change the Maryland Tax Stamp System to Prevent Smuggling.
- Enable Local Governments to Independently Establish More Stringent Tobacco Control Laws.
- Raise Tobacco Prices.
- Restrict Advertising by Tobacco Industry where legally possible.
- Encourage pharmacies to eliminate the sale of tobacco products.
- Expand MOSH protection to all employees in Maryland.
- Encourage the elimination of the sale of tobacco products within State buildings.

## Federal Strategies

- Assure Food and Drug Administration (FDA) Oversight of All Tobacco Products as Nicotine Delivery Devices.
- Request the Agency for Health Care Policy Research (AHCPR) to Review Best Practices Regarding Cessation Products in Pregnancy.
- Request the Internal Revenue Service (IRS) to include all facets of smoking cessation programs as eligible benefits for pretax medical/dental reimbursement accounts.

# CONCLUSION

The Task Force to End Smoking in Maryland is confident that through the implementation of these bold and aggressive strategy and policy recommendations the state of Maryland will certainly achieve its goals and accomplish its Vision of leading the nation in tobacco use prevention, control and cessation. The Task Force and the citizens of Maryland are indebted to Governor Glendening's leadership for providing this unique opportunity to reduce the enormous health burden caused by tobacco products on our citizens, particularly our children.

# THE PROBLEM:

## The Use of Tobacco Products

# NICOTINE ADDICTION

More Marylanders die prematurely from tobacco use, or exposure to secondhand smoke, than from any other single cause — including AIDS, alcohol, car accidents, murders, suicides, illegal drug use, and fires combined. Tobacco products claim the lives of more than 7,500 Marylanders annually.[1]

Relatively few of these deaths, however, are the result of the short-term use of tobacco products. Rather, it is the long-term and sustained use of tobacco products which is associated with most of the presently identified tobacco-related diseases. The tobacco industry has historically characterized the continued use of tobacco products as purely a matter of 'personal choice.' In contrast, those who use tobacco products often refer to their 'habit.' Scientific studies reveal that the continued use of tobacco has less to do with 'personal choice' or 'habit' than it does with nicotine addiction.[2]

> **Nic*o*tine** \'nik-u-"tEn\ n : a poisonous alkaloid $C_{10}H_{14}N_2$ that is the chief active principle of tobacco and that is used as an insecticide.
> *Merriam-Webster's Medical Dictionary, 1995 Edition*

According to the Food and Drug Administration (FDA), nicotine causes physiological and central nervous system effects on both the structure and function of the brain. Nicotine will reach the brain no more than 11 seconds after being ingested.[3] Nicotine is addictive because when it reaches the brain, its presence prompts the release of other chemicals (including dopamine) into the brain, which then can affect mood and alertness. As nicotine use continues, the brain undergoes physical changes which increase its ability to interact with nicotine. In response to the presence of nicotine, the brain releases *dopamine*. It is this release of dopamine that is responsible for the "rewarding" effect of nicotine use. The nicotine triggered release of dopamine is very similar to what occurs when other addictive drugs such as amphetamines and cocaine reach the brain.[4]

> Nicotine is rapidly absorbed into the bloodstream, reaching the brain in no more than 11 seconds.

When someone stops using tobacco products, they stop using nicotine. The withdrawal symptoms that a tobacco user who is trying to quit can experience include: irritability; difficulty in concentrating; anxiety; restlessness; increased hunger; depression; and a pronounced craving for the tobacco product and the nicotine it contains. These symptoms are *not* the result of trying to break a 'habit.' If the withdrawal symptoms were only the result of habit, it would be expected that placebos would also provide relief of these

symptoms.[5] Only Nicotine Replacement Therapy (NRT) relieves these symptoms.

## NICOTINE IS MORE ADDICTIVE THAN ALCOHOL, MARIJUANA OR COCAINE

While the rhetorical debate over "habit" and "personal choice" may be perpetuated by some, it is clear that nicotine's ability to addict tobacco users is far greater than that of alcohol, or even cocaine. The risk of becoming addicted to alcohol with regular use is one in nine. The risk of addiction to cocaine with regular use is one in four — while the risk of becoming addicted to nicotine with regular use is one in three.[6]

The National Household Survey on Drug Abuse (NHSDA) confirms that nicotine addiction is present in a large number of tobacco users and that a higher proportion of regular cigarette users are addicted than are users of other substances.[7] Of those respondents who reported daily use of various drugs during the month preceding the survey, 85% of cigarette users reported feeling "dependent" on their substance compared to 63% of cocaine users, 39% of marijuana users, and 33% of alcohol users.

Overall, the survey examined four separate indicators of "dependence": (1) feeling dependent on the substance being used; (2) feeling that they needed more of the substance to get the same effect they used to; (3) feeling unable to cut down on the use of the substance though they had tried; and (4) feeling sick or experienced withdrawal symptoms when they cut down on the use of the substance. (Cigarette users were the group that had the greatest percentage of respondents who stated that they experienced one or more of these indicators: cigarette users 91%; cocaine users 79%; marijuana users 60%; and alcohol users 48%.)

## NICOTINE ADDICTION IN THE GENERAL MARYLAND POPULATION

The addictive power of nicotine is readily apparent from surveys of smokers in Maryland. Despite 50% of those who smoke every day reporting serious attempts to quit smoking, the proportion of Marylanders who continue to smoke has remained relatively constant this decade.[8] The "staying power" of nicotine among Marylanders is also evident when you consider that approximately 90% of tobacco users begin their use before the age of eighteen and 50% of adult daily users have made serious attempts to quit; yet it is decades before most smokers become "former" smokers as is apparent from the following table.

It Takes a Long Time To Quit Smoking!

**Maryland Adults Who Have Ever Smoked 100 Cigarettes*
*and* No Longer Smoke**

| Age Range | Percentage Now Former Smokers |
|---|---|
| 18 - 24 | 29.4% |
| 25 - 34 | 39.1% |
| 35 - 44 | 42.6% |
| 45 - 54 | 60.5% |
| 55 - 64 | 61.2% |
| 65+ | 71.6% |

*Source: Maryland Behavioral Risk Factor Surveillance Survey of 1998.*
**100 cigarettes are equal to five packs of cigarettes.*

# NICOTINE ADDICTION IN TARGETED AND HIGH RISK POPULATIONS

## Racial and Ethnic Groups

There is growing evidence that some racial and ethnic minority populations *may* be more susceptible to nicotine addiction than the white population. A recent study found significant differences in the level of metabolized nicotine in the blood of different racial and ethnic groups, after adjusting for the number of cigarettes smoked daily, age, gender, body weight, the number of smokers in the home, and the number of hours exposed to second hand smoke at work.[9]

Population groups may vary in their susceptibility to nicotine addiction.

African Americans were found to have metabolized nicotine levels 12% to 50% higher than white smokers and 32% to 56% higher than Mexican American smokers. Whites and Mexican Americans were found to have similar levels when they smoked no more than five cigarettes (¼ pack) a day, but levels increased significantly for Mexican Americans when smoking more than five cigarettes each day.

Maryland's experience is entirely consistent with the view that some populations find it harder to cease using tobacco products than others. When the current smoking status of adults who had ever smoked at least five (5) packs of cigarettes was examined in 1998, 56.1% of whites described themselves as former smokers as compared to 40.9% of African Americans and 40.2% of all other races.[8]

## Youth

Nicotine addiction, while most commonly associated with the adult tobacco user, most often originates among youth under eighteen years of age. Tobacco use by youth is not a discrete behavior, but rather, a continuum with several stages, including: (1) experimentation; (2) regular smoking or use; and (3) nicotine addiction or dependence.[10] On average, the process of becoming a regular smoker and addicted to nicotine occurs over a period of 2-3 years.[11] As a youth moves across this continuum, ceasing to use tobacco products becomes more difficult as he or she becomes increasingly dependent upon nicotine.[12] A national survey of high school students found that although almost 73% of those students who had ever been daily smokers had tried to quit, only 13.5% of all students who had ever been daily smokers were now *former* smokers.[13]

A substantial number of youth who use tobacco products want to quit, but cannot. Almost 75% of the young people (10-22 years old) who use tobacco products every day say that they continue to use them because "it's really hard to quit." More than 90% of these young people experienced at least one symptom of withdrawal when they tried to quit.[14]

Easy to start — hard to quit!

When young people begin to use tobacco products, they seriously underestimate the power of nicotine to addict. Approximately 43% of young people (ages 10-22 years) who smoke as few as three cigarettes go on to become regular smokers. Almost 70% of the 12-17 year old's who smoke state that they would never start smoking if they could do it all over again.[15] Nearly three-quarters of those high school seniors who smoked daily and stated that they would not be smoking five years later, failed to quit.[10]

Again, Maryland's experience is consistent with these national findings. Of those who described themselves as regular smokers (at least ½ pack of cigarettes a day), 56.9% of eighth grade students, 61.0% of tenth grade students, and 57.8% of twelfth grade students reported that they had tried to quit smoking but had been unable to do so.[16]

# CONSEQUENCES OF USING AND BEING EXPOSED TO TOBACCO PRODUCTS

## TOBACCO-RELATED DISEASES

Science has found that the use of tobacco products, or exposure to secondhand smoke, is a "risk factor" for a number of diseases, conditions, and even injuries that can lead to a premature death. While a very broad spectrum of diseases have been implicated in varying degrees as being tobacco-related, the Centers for Disease Control and Prevention (CDC) adopted a conservative approach, using only the 27 diseases and conditions where science has found tobacco use to be a very significant tobacco "risk factor" for developing the disease. The CDC's list of tobacco-related diseases is set forth below, and includes various cancers, respiratory diseases, cardiovascular diseases, perinatal conditions, and burns.

### Centers for Disease Control and Prevention
### Tobacco-Related Disease Categories

| **Cancers (Neoplasms)** | **Cardiovascular Diseases** |
|---|---|
| 1. Lip, Oral Cavity, and Pharynx | 14. Ischemic Heart |
| 2. Esophagus | 15. Rheumatic Heart |
| 3. Pancreas | 16. Hypertension |
| 4. Larynx | 17. Pulmonary Heart |
| 5. Trachea, Lung, and Bronchus | 18. Cardiac Arrest |
| 6. Cervix Uteri | 19. Cerebrovascular |
| 7. Urinary Bladder | 20. Atherosclerosis |
| 8. Kidney and Other Urinary | 21. Aortic Aneurysm |
| **Perinatal Conditions** | 22. Other Arterial |
| 9. Short Gestation or Low Birth Weight | **Respiratory Diseases** |
| 10. Respiratory Distress | 23. Respiratory Tuberculosis |
| 11. Other Respiratory | 24. Bronchitis and Emphysema |
| 12. Sudden Infant Death | 25. Chronic Airway Obstruction |
| **Injuries** | 26. Pneumonia and Influenza |
| 13. Burn Deaths | 27. Asthma |

## TOBACCO USE AS A 'RISK FACTOR'

Tobacco use as a "risk factor" for a disease or condition means that the use of tobacco products is a statistically significant component in increasing the risk of contracting or suffering a particular disease or condition in comparison to those persons who do not use any tobacco products. For example, when lung cancer is identified as a "tobacco-related" disease, this does *not* mean that only tobacco users will get lung cancer, or even that all tobacco users will get lung cancer. It does mean, however, that those persons who use or have used tobacco products or who have been exposed to the by-products of tobacco products have a statistically significant greater risk of getting lung cancer than those who have never used or been exposed to tobacco products.

Cancer is not the only disease caused by Tobacco use.

## 'RELATIVE RISK' OF DISEASE

The "relative risk" of a tobacco user getting any particular disease or condition varies with the specific disease or condition. The relative risk of getting any of these diseases is generally highest for long-term current tobacco users, lower for former users, and lowest for those who have never used tobacco products at all.

For example: men who smoke have 22 times the risk of developing lung cancer than do non-smoking men;[1] smoking doubles the risk of heart disease; compared with nonsmokers, people who smoke less than half a pack of cigarettes have a death rate 30% higher, one to two packs a day, 100% higher, and two or more .packs a day, 140% higher.[2]

The more you smoke, the greater the risk of premature death.

Smoking at an early age increases the risk of lung cancer. For most smoking related cancers, the relative risk of getting a disease increases as the use or exposure to tobacco products continues over time.[3] A youth who starts smoking between the ages of 15 and 24 is ten to fourteen times more likely to die of lung cancer than a nonsmoker, but if smoking starts before age 15, the risk rises to nineteen times more likely.[4]

The earlier you start to smoke, the greater the risk of premature death.

# IMPACT OF TOBACCO-USE ON THE HEALTH OF THE GENERAL POPULATION

## Tobacco's Impact on the Nation's Health

Tobacco use causes more illness and death each year than the *combined* effects of AIDS, car accidents, homicide, suicide, fires, alcohol, and illegal drug use.[5] Each year, the death toll from tobacco use in the United States exceeds our nation's combined death toll from World War I, World War II, the Korean War, and the Vietnam War — *more than 400,000 lives lost annually to tobacco in the United States*.[3] As large as these numbers are, however, they do not tell the whole story of how tobacco use affects the health of the nation. For example, parents and other adults who smoke around children are estimated to be responsible for *2.2 million pediatric ear infections, 529,000 visits to a physician for asthma*, between *1.3-2.0 million doctors visits for coughs*, and *hundreds of thousands of cases of bronchitis and pneumonia* each year.[6]

National toll:
400,000 lives annually

## Tobacco's Impact on Maryland's Health

Using the Centers for Disease Control and Prevention's (CDC) Smoking-Attributable Mortality, Morbidity, and Economic Costs (SAMMEC) model, Maryland has estimated that over 7,500 of its residents die prematurely every year as a result of their use and/or exposure to tobacco products.[7] The top four causes of death in Maryland are: (1) cardiovascular disease and stroke; (2) cancer; (3) pulmonary diseases such as bronchitis and emphysema; and (4) diabetes. In 1995, these four categories were responsible for 69% of all deaths in Maryland. Tobacco use is a direct risk factor for the first three categories and is a risk factor for amputation with diabetes.

Maryland toll:
7,500 lives annually

## All Tobacco Products Are Implicated

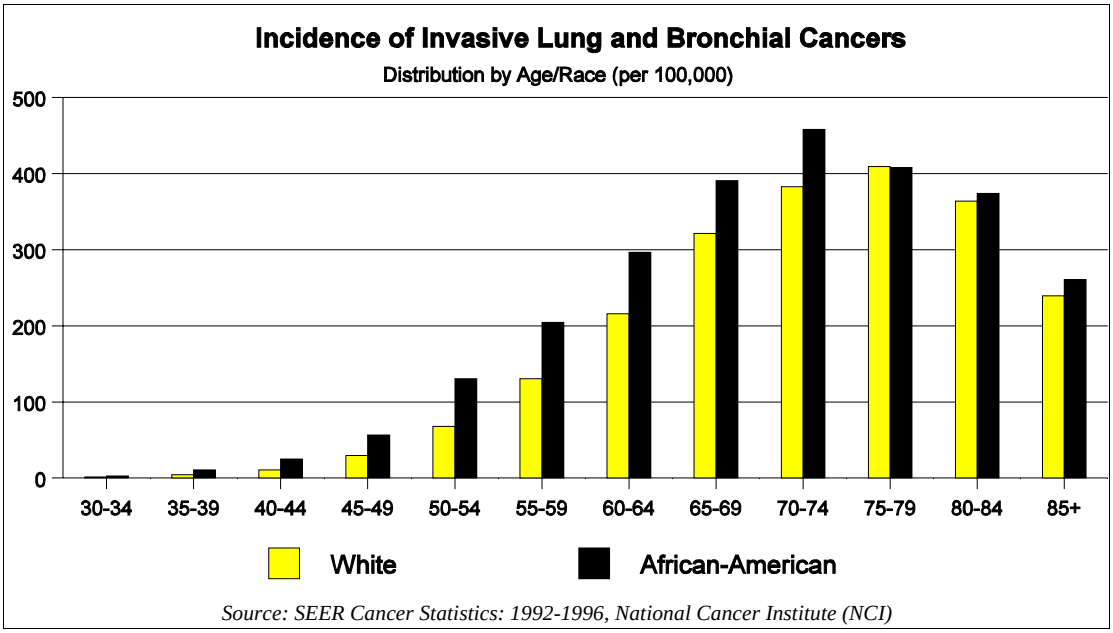
It is not just the cigarette smokers who are at increased risk of premature death from their use of a tobacco product. Cigar and pipe smoking are risk factors for oral cancer, esophageal cancer, laryngeal cancer, lung cancer, coronary heart disease, and chronic obstructive pulmonary disease. Users of smokeless (spit/chew) tobacco are at increased risk for oral cancer and other oral

Hazardous to your health:
Cigarettes, Cigars, Pipes, Smokeless Tobacco, and Fad Products

health problems. And even non-smokers are put at risk when they are exposed to second-hand smoke, facing increased risk of lung cancer, heart attack, asthma, bronchitis, and respiratory tract illnesses.[8]

## The Delay In Onset Of Many Tobacco-Related Diseases

Many of the tobacco-related diseases and conditions that have been identified to date manifest themselves decades after tobacco use has been initiated. The cardiovascular




diseases and cancers, in particular, are more often found in middle age or later, rather than among the youth and young adults who have just begun to use tobacco products. Lung and bronchus cancers provide an example of this facet of tobacco-related disease.

## Impact of Disease on Racial/Ethnic Groups

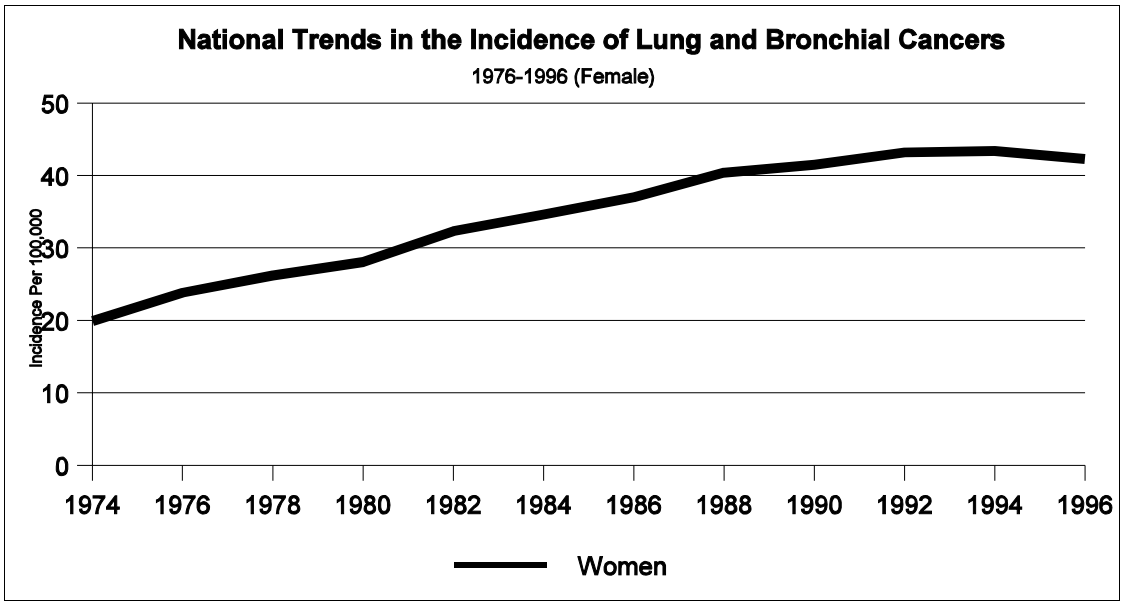
The impact of tobacco related disease is not uniform across Maryland, nor across sub-population groups. By way of illustration, the figure above shows that African-Americans have a higher incidence of lung and bronchus cancers at any age than does the white population. In Maryland, the incidence of lung and bronchus cancers in 1996 among the African-American population was 22.5% higher than in the White population (64.46 vs. 52.62 per 100,000).[9]

> Incidence of lung/bronchial cancer in African-American Marylanders is 22% higher than for Whites.

The disparity between the racial groups appears to be increasing. Nationally, the incidence of lung and bronchus cancers in 1973 among African Americans was 51.8 per 100,000. By 1996 incidence in this population had increased to 62.5 per 100,000 population (an increase of almost 21%). The disparity between these groups is also increasing in Maryland. Since 1992 the relative disparity in the incidence of lung and bronchus cancers between Maryland's white and non-white population has doubled (1992-11% and 1996-22%).[9]

## Impact of Tobacco-Related Disease on Women

Historically, men have been much more severely impacted than women by tobacco-related disease. Unfortunately, as women's use of tobacco products has achieved parity with men's use, the rate of tobacco related disease among women has also increased.




*Source: SEER Cancer Statistics: 1973-1996, National Cancer Institute (NCI).*

Using the incidence of lung and bronchus cancers as a proxy for tobacco-related diseases generally, the figure above shows the increasing incidence of lung cancers in women from 1974-1996. The Maryland Cancer Registry reports that women had an incidence of lung and bronchus cancers of 42.6 per 100,000 in 1992. By 1996, the incidence of this disease had increased by more than 21% to 51.8 per 100,000.

## Impact Of Tobacco Use On Youth

Every day, an estimated 3,000 youth in the United States become regular smokers — almost one-third will die prematurely of a tobacco-related disease.[10] More than 5 million

youth who are alive today will die prematurely because of a decision they will make as adolescents — the decision to use tobacco products.[11] On a per capita basis, this means that approximately 60 Maryland youth begin their regular use of tobacco products each day and 85,000 Maryland youth alive today will die prematurely of a tobacco related disease.

> 85,000 Maryland youth alive today will die prematurely from their use of tobacco products.

In a study comparing non-smoking high school seniors with their peers who were regular smokers and had started smoking by ninth grade, it was found that the smokers were: 2.4 times more likely to report poorer overall health; 2.4 to 2.7 times more likely to report a cough with phlegm or blood, shortness of breath, and wheezing or gasping; and 3.0 times more likely to have seen a doctor or other health professional for an emotional or psychological complaint.[12] Also, cigarette smokers have a lower level of lung function than those persons who have never smoked; reduced rate of lung growth; and an increased resting heart rate by two to three beats per minute.[3]

> Youth who smoke are more likely to report:
> - poorer overall health;
> - a cough with phlegm or blood;
> - shortness of breath, wheezing or gasping;
> - doctor visits for emotional complaints.

Smoking at an early age increases the risk of lung cancer. For most smoking related cancers, the risk rises as tobacco use continues.[3] A youth who starts smoking between the ages of 15 to 24 is 10 to 14 times more likely to die of lung cancer than a non-smoker, but if smoking starts before age 15, the risk rises to 19 times more likely.[4]

## Short-term Impact of Tobacco Use and Exposure To Tobacco Products

While much of the national discussion surrounding tobacco-related disease has focused on cancer and cardiovascular diseases, it is important to also recognize that a number of diseases and conditions can be much more immediate. Smoking during pregnancy and exposing infants to second hand smoke, for example, are all associated with perinatal conditions such as short gestation and low birth weight, respiratory distress, other respiratory conditions, and even Sudden Infant Death Syndrome (SIDS).

> Parental smoking can endanger the health of unborn children, newborns and children.

Parental concern over how tobacco use in the home can have an immediate impact on the health and well-being of children should not be limited to pregnancy or newborns. Many respiratory conditions, such as asthma, may have an immediate and significant impact on the health of children in the home.

## Geographic Disparities In Impact of Tobacco-Related Disease

The disparity in the impact of tobacco-related diseases and conditions is not limited to racial and ethnic communities. The following table clearly shows that the incidence of tobacco-related cancers is not uniform across Maryland.

Somerset County had the highest reported incidence of all cancers in 1996 at 195.98 per 100,000. Garrett County has the lowest incidence of all cancers, at 59.83 per 100,000. These same two counties are also at the extreme ends of the spectrum with respect to lung and bronchus cancers (a crude proxy for all tobacco-related cancers) with 108.69 per 100,000 and 44.9 per 100,000 respectively.

### Incidence of Lung and Bronchial Cancers in Maryland

Cancers Per 100,000 of Population (1996)

| Political Subdivision | Cancer Incidence | Political Subdivision | Cancer Incidence |
|---|---|---|---|
| Somerset Co. | 108.69 | Kent Co. | 71.85 |
| Worcester Co. | 97.48 | Cecil Co. | 68.44 |
| Baltimore City | 93.01 | Washington Co. | 66.56 |
| Anne Arundel Co. | 91.18 | Prince George's Co. | 66.1 |
| Wicomico Co. | 86.69 | Allegany Co. | 64.02 |
| Queen Anne's Co. | 76.53 | Baltimore Co. | 63.75 |
| Charles Co. | 75.69 | Carroll Co. | 63.01 |
| Caroline Co. | 75.58 | Talbot Co. | 56.68 |
| Calvert Co. | 73.59 | Howard Co. | 53.69 |
| Harford Co. | 75.48 | Frederick Co. | 46.88 |
| St. Mary's Co. | 73.53 | Montgomery Co. | 46.08 |
| Dorchester Co. | 72.06 | Garrett Co. | 44.90 |

*Source: Maryland Cancer Registry, 1996. Final Report, Department of Health and Mental Hygiene.*

## Impact of Second-Hand Smoke on Health

Second-hand smoke, also known as environmental tobacco smoke or ETS, is a by-product of tobacco use. To many non-smokers, the involuntary exposure to second-hand smoke is at the very least, a noxious public nuisance. To many others, including many in the scientific community, it represents a very real danger to the public health.

Second-hand smoke contains more than 4,000 substances, of which more than 40 are known to cause cancer.

Second-hand smoke contains more than 4,000 substances, of which more than 40 are known to cause cancer. These constituents of tobacco smoke are not limited to the area immediately surrounding the smoker, but can spread throughout a home or business unless positively contained in some manner.

Second-hand smoke impacts everyone, but the consequences of exposure are particularly apparent with respect to children. Second-hand smoke has been found to be *causally* linked with the following in children:[13]

- lower respiratory tract infections
- increased fluid in the middle ear
- upper respiratory tract irritation
- reduced lung function
- additional episodes of asthma
- increased severity of asthmatic symptoms
- reduced oxygen flow to tissues

In addition to the causal relationships above, second-hand smoke is associated with the following additional conditions: Sudden Infant Death Syndrome (SIDS); acute middle ear infections; tonsillectomy; meningococcal infections; cancers and leukemias in childhood; slower growth; adverse neurobehavioral effects; upper respiratory tract infections; and unfavorable cholesterol levels and initiation of atherosclerosis (heart disease).[13]

**Children's Exposure to Tobacco Smoke Is Responsible For**[13]

- 13% of ear infections
- 24% of tonsillectomies and adenoidectomies
- 26% of tympanostomy tube insertions
- 13% of asthma cases
- 16% of physician visits for coughs
- 20% of all lung infections in children under 5
- 136-212 childhood deaths from lower respiratory infection
- 148 childhood deaths from fires started by tobacco products
- 1,868-2,708 SIDS deaths

## ECONOMIC IMPACT OF TOBACCO-RELATED DISEASE[14]

The economic impact of tobacco use on the economy is staggering. University of California-San Francisco researchers recently announced they estimate that tobacco use cost the nation $89.5 billion in health care costs in 1997 alone. In 1993, the estimated health care cost of tobacco was $73 billion. The increase of $16.5 billion over that five year period represents an increase of 22.6%.

Tobacco use will cost Maryland $2 billion a year in health care costs as we enter the new millennium!

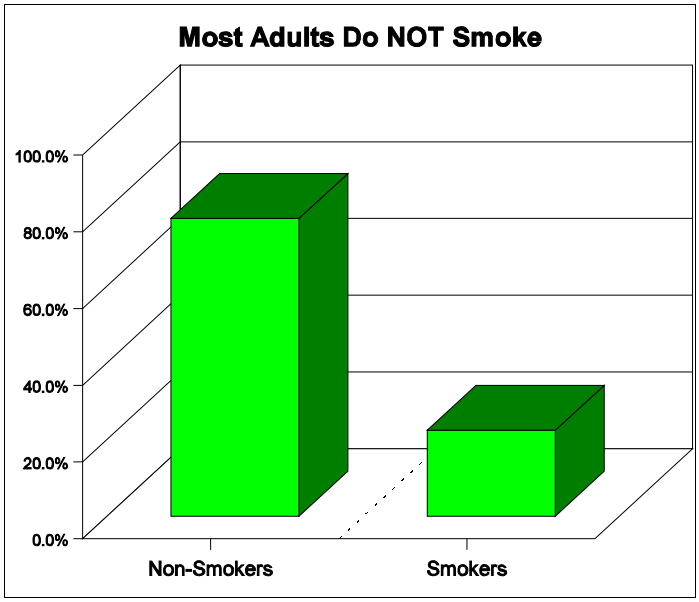
On a per capita basis, the economic cost of tobacco use to the Maryland economy, for health care costs alone, was almost $1.8 billion in 1997. If the apparent rate of increase continues, the cost will be over $2 billion a year as we start the millennium.

# PREVALENCE OF TOBACCO USE BY THE GENERAL POPULATION

In Maryland, anyone age eighteen or older may legally use tobacco products. However, the vast majority of adult Marylanders do not use tobacco products. The three primary tobacco products used in Maryland are cigarettes, smokeless tobacco, and cigars. Cigarette use has historically received the greatest amount of attention from the media, health officials, and health researches. Consequently, much more information is available with respect to the prevalence of cigarette use in Maryland in comparison to other tobacco.

## CIGARETTE USE

The percentage of the adult population who use tobacco products has varied considerably over time. In 1965, just after the release of the landmark U.S. Surgeon General's report on the hazards of tobacco use, over 42% of the adult U.S. population described themselves as currently smoking.[1] By 1998, this percentage had dropped to just under 23%.[2] This amounts to a 45% decrease in the use of cigarettes during the last 33 years. During the past 20 years, from 1978 through 1998, cigarette use declined nationally by almost 33%.



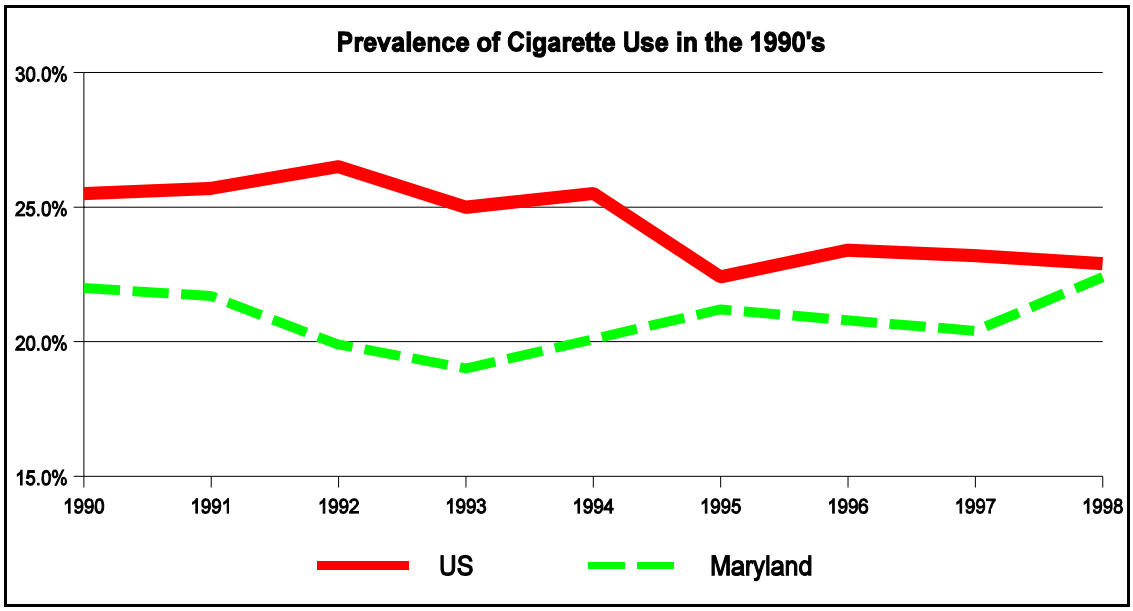

The proportion of Maryland residents who smoke cigarettes has also declined significantly since the 1970's. In 1978, it was estimated that 35.8% of Maryland residents were smokers. In 1998, it is estimated that 22.4% of residents are cigarette smokers. This represents more than a 37% decline in cigarette smokers during that 20 year period as compared to the national decline of 33% during this same period. Despite this very significant decline in the use of cigarettes, the relatively few Marylander's who smoke have nonetheless been large enough to make tobacco-related disease the largest single cause of premature death in Maryland.

## Recent Trends in Cigarette Use

While the long-term trend (1960's to 1990's) in cigarette use appears to be quite favorable with significant declines in cigarette use, data from the 1990's is much more ambiguous. In 1990, Maryland estimated that 22% of adult residents currently used cigarettes.[3] In 1998, this estimate was 22.4%.[2]

> Is tobacco use increasing in Maryland?

In fact, estimates of current cigarette use have varied throughout the 1990's. These comparatively small short-term changes in cigarette use may reflect actual short-term fluctuations, be an artifact of the data collection process, or imply that very little change




*Source: Behavioral Risk Factor Surveillance System, 1990-1998.*

is actually occurring since the changes are often within the estimates margin of error. Regardless of the reason, it is clear that the relative large long-term decrease in cigarette use by the general population has not continued into the 1990's in Maryland or the US as a whole. Between 1990 and 1998, cigarette use in the general US population declined by 9%. In Maryland, the result is the opposite, with an almost 2% increase in the prevalence of cigarette use.

> Tobacco Use 1990-1998
>
> US - 9%
> MD + 2%

### Intensity of Cigarette Use

Differences in the frequency of use of tobacco products (intensity) are important. The greater the use of tobacco products, the greater the exposure to the risk of tobacco-related disease and ingestion of nicotine. Tobacco users are not a homogenous group with respect to either the risk of disease or the severity of their addiction to nicotine.

In Maryland, those who smoke cigarettes every day outnumber those who describe themselves as smoking only on some days or occasionally by almost 3:1.[2] Even within the group of everyday cigarette smokers there is significant variation in the intensity of use. Some smoke relatively few cigarettes a day. Others smoke several packs of cigarettes every day. In 1998, almost 84% of Maryland adult everyday smokers reported that they smoked up to 1 pack of cigarettes each and every day. Almost 13% reported smoking somewhere between 1 and 2 packs each day, with just over 2% reporting that they smoked more than 2 packs every day.[2]

> In Maryland, adult "everyday" smokers outnumber "occasional" smokers by almost 3:1.

### Desire to Quit Smoking

A significant number of cigarette smokers in Maryland want to stop smoking. In 1998, approximately 50% of adult Maryland *everyday* smokers made at least one serious attempt to quit smoking, quitting for at least one day.[2] Their lack of success is evident from the fact that smoking prevalence in Maryland has not declined in proportion to these quit attempts and may in fact be slowly increasing.

> 50% of adult "everyday" smokers want to quit.

## CIGAR USE

In comparison to cigarette use, the proportion of the adult Maryland population that is currently smoking cigars is relatively small. In 1998, the first year in which cigar use was included in Maryland's Behavioral Risk Factor Surveillance Survey, only 5% of the population reported having smoked a cigar during the month preceding the survey. No information is available with respect to what proportion of cigar smokers also are cigarette smokers.

> 5% of Maryland adults smoke cigars.

# SMOKELESS TOBACCO USE

Smokeless tobacco (spit/chew) is the least used tobacco product in Maryland as a whole. The 1994 Maryland Behavioral Risk Factor Surveillance Survey found that only 1.4% of adults reported that they currently used smokeless tobacco. Anecdotal evidence, however, suggests that the prevalence of use is concentrated in a relatively few geographic regions of the state. Therefore, the magnitude of the problem presented by smokeless tobacco may be much greater for some communities than is indicated by statewide prevalence indicators.

# USE OF TOBACCO PRODUCTS BY TARGETED AND HIGH RISK POPULATIONS

## TOBACCO INDUSTRY TARGETING OF SUB-POPULATIONS

The tobacco industry claims that they do not now and never have marketed their products to minors. However, recently released industry documents provide ample proof that the industry targets children as a replacement market for those adult smokers who manage to quit or die, and has been doing so for decades.

> An internal memo from August 30, 1978 from Lorillard marketer T.L. Achey to former Lorillard president Curtis Judge suggested the company make a cigarette to compete with Philip Morris' Marlboro brand, since *"the base of our business is the high school student"*.

"the base of our business is the high school student"

> Another internal document from a Canadian tobacco company affiliated with a tobacco company in the U.S. states "*If the last ten years have taught us anything, it is that* ***the industry is dominated by the companies who respond most effectively to needs of the younger smokers***."

The tobacco industry spends at least $6 billion per year on advertising in the US, being out spent by only the automobile industry. According to a 1992 Gallup[1] survey, 50% of all adolescent smokers and 25% of adolescent *non*smokers owned at least one promotional item from a tobacco company. Studies confirm that tobacco advertising and promotion is especially effective among youth.

One recent CDC study found that *86% of minors who purchase their own cigarettes buy one of the three most heavily advertised brands* — Marlboro, Camel, or Newport.[2] Another study found that brand preference varies widely among ethnic groups, with 70% of white 12th grade smokers preferring Marlboro, and 80% of African American 12th grade smokers choosing Newport.

The launching of RJ Reynolds' "Joe Camel" campaign in 1988 illustrates the

effectiveness of tobacco industry advertising on youth. At the time the media campaign was launched, Camel was not typically regarded as a "youth" brand. Only 2% of 18 and 19 year olds reported smoking Camels in a 1978-1980 survey (no data are available on a younger market).[3] Internal industry documents show that "officially" the campaign was targeting the 18–24 year old market. However, the criteria for choosing the retail outlets to launch the campaign specifically included those locations which were " . . . *located across from, adjacent to [or] in the general vicinity of the High Schools . . .* "[4]

Tobacco Industry Advertising:
- targets youth;
- highly effective;
- lethal in its consequences.

During the period from 1989 through 1993, during which advertising for the new Joe Camel campaign jumped 59% from $27 million to $43 million, Camel's share among youth increased by more than 50%, while its adult market remained stable.[2] If the ability of tobacco industry advertising to effectively reach under-age youth was ever in doubt, it was put to rest by a study showing that children as young as 3–6 years old recognized Joe Camel, knew he was associated with cigarettes, and that they were as familiar with Joe Camel as they were with Mickey Mouse.[5]

Successful marketing practices are not exclusive to cigarette manufactures. Cigar and smokeless tobacco manufacturers use them as well. In the 1970's UST, a smokeless tobacco company redesigned its product and refocused its advertising to appeal to young people, especially young men. Industry documents now show that the company created "starter" brands with lower nicotine levels because the higher levels were difficult for beginners to handle. The company expected customers to "graduate" to the higher level products. They also developed a cherry-flavored product. This remarketing strategy resulted in a 1500% increase in the use of snuff by 18–19 year old boys between 1970 and 1991.

"Starter" brands of smokeless tobacco were created, including some with fruit flavors, with the expectation that users would "graduate" to higher level products.

Advertising and promotional efforts have an important influence on the decision to use tobacco products. Unfortunately, research that has been conducted to date has provided little data with regard to the specific impact of such efforts on the various sub-population groups in the United States other than youth generally. Nonetheless, we do know that market segmentation is a well-developed and highly utilized mechanism used by corporate America to appeal to the populations that they wish to reach. There is no reason to believe that the tobacco industry does not use this same strategy. This means that they seek to develop marketing and product strategies that reach the specific sub-

populations that they wish to market their products. For example, the tobacco industry heavily promotes and markets mentholated cigarettes to the African-American community where Newport has become the cigarette brand of preference. Virginia Slims has similarly been marketed and promoted to women.

Tobacco Industry Marketing:
- encourages experimentation with tobacco products;
- deters current users from quitting;
- prompts former users to start again; and
- serves as an external cue to use tobacco products.

# TOBACCO USE BY YOUTH AND YOUNG ADULTS

For many youth and young adults, the delay between the onset of tobacco use and the most serious health consequences of that use (premature death), diminishes their perception of the seriousness of the risk that tobacco poses to them or those around them. Other risk behaviors, such as drinking-and-driving, are perceived as being more dangerous than tobacco use. In fact, there are risk behaviors that pose far greater *immediate* risk of death, but none outdo tobacco's long term consequences.

## Nicotine Addiction

What is often missed in the debate over the health consequences of risk behaviors is the *immediate* risk to youth of nicotine addiction. A person who does not begin smoking in childhood is unlikely to ever become addicted to tobacco products.[3] Although the tobacco industry has argued that the choice to use tobacco is an adult one, nicotine addiction typically takes hold well before one becomes an adult and can freely make the "adult" decision to use tobacco products.[6] The average youth smoker starts at ate 13 and becomes a daily smoker by age 14½.[7] The younger one is when they begin their use of tobacco products, the more strongly they become addicted to nicotine.[3]

Seventy percent of youth who smoke report that they regret ever starting, and 75% of youth smokers report having at least one failed attempt at quitting.[8,9] Teenagers feel a sense of regret and helplessness in regard to their addiction. A focus group report conducted by a tobacco company noted, "However intriguing smoking was at 11, 12, or 13, by the age of 16 or 17 many regretted their use of cigarettes for health reasons and

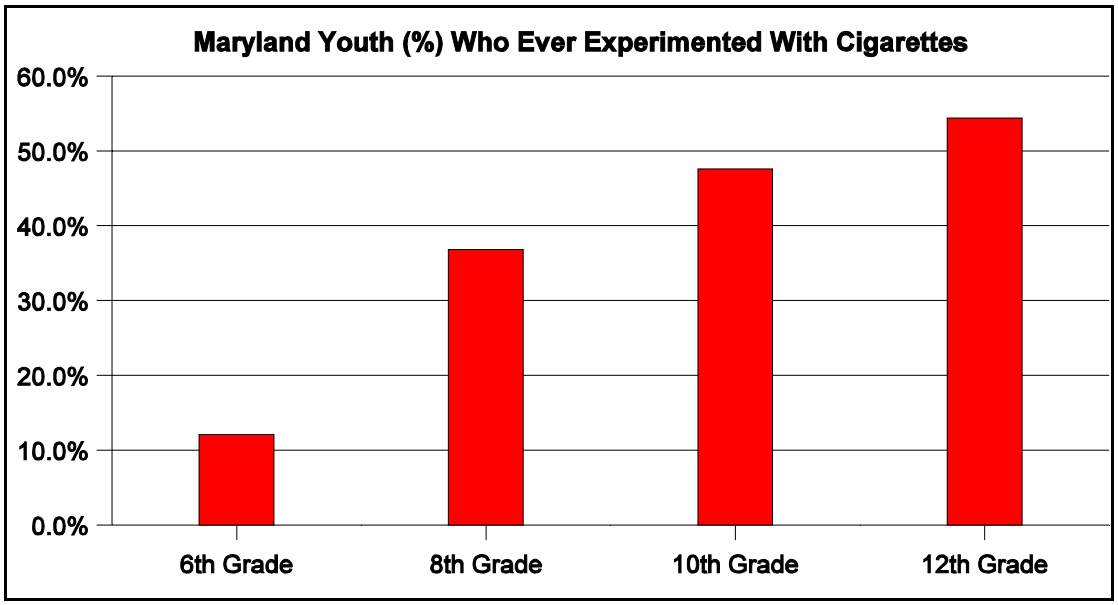
70% of youth who smoke report that they regret ever starting.

because they feel unable to stop smoking when they want to." Over half claim they want to quit. However, they cannot quit any easier than adults can.[10] A subsequent report stated, "The desire to quit seems to come earlier now that before, even prior to the end of high school. In fact, it often seems to take hold as soon as the recent starter admits to himself that he is hooked on smoking.

> "...the desire to quit, and actually carrying it out, are two quite different things, as the would-be quitter soon learns."[11]

## Experimentation With Tobacco Products

Experimentation with tobacco products begins at an early age for youth across the nation, and Maryland youth are no exception. Data collected by the Maryland State Department of Education (MSDE) in its 1996 Maryland Adolescent Survey revealed that significant numbers of Maryland youth had experimented with cigarettes: 12.1% by 6th grade; 36.8% by 8th grade; 47.6% by 10th grade; and 54.4% by 12th grade.



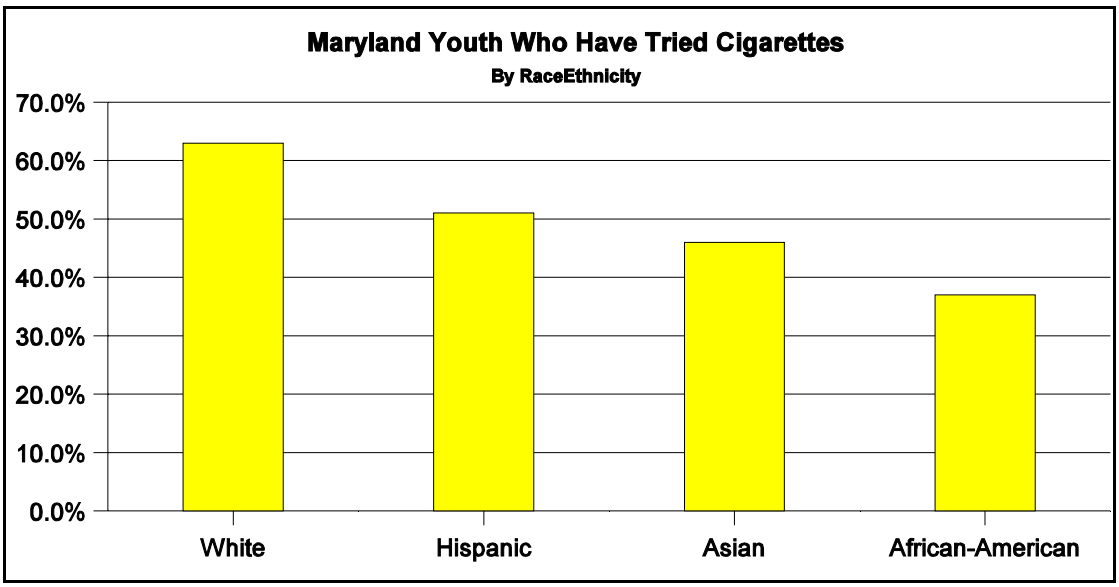

*Source: Maryland Adolescent Survey of 1996.*

Middle school appears to be when most Maryland youth experiment with cigarettes. Between 6th and 8th grades there is a 200% increase in the proportion of students who experiment, as compared to a 29% increase between 8th and 10th grades and only a 14% increase between 10th and 12th grades. Almost 68% of Maryland youth who will ever experiment with cigarettes have done so before

> 68% of youth who will ever try cigarettes, will do so *before* high school.

they leave the 8th grade, and almost 88% by 10th grade.

Youth comprise 90% of the new users of tobacco products each year.[12] Caucasian youth have the highest rate of ever trying cigarettes (63%), followed by Hispanic (51%), Asian




*Source: Maryland Adolescent Survey of 1996*

(46%), and finally African-American youth (37%). There is little difference between the genders with respect to experimenting with cigarettes, 50.5% of males and 49.5% of females experimented by 12th grade.

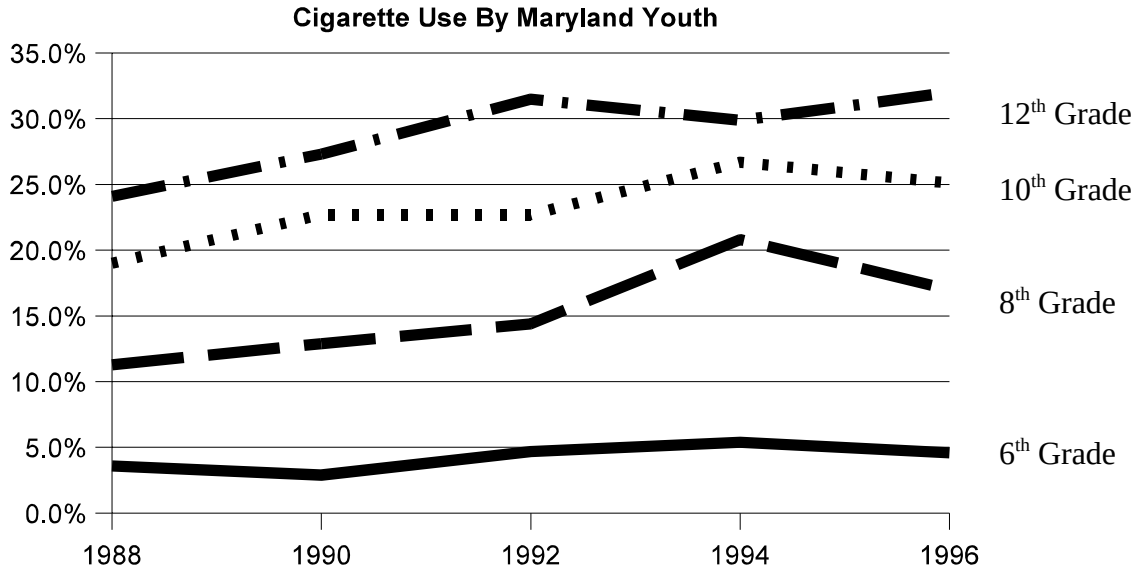
**Prevalence of Tobacco Use Among Youth**

Between 1988 (inception of the 'Joe Camel' ad campaign) and 1996, the nation saw a 50% increase in the percentage of youth in grades 9 through 12 who had become smokers. The number of youth who had become daily smokers during this same period increased by 73%.[13]

There is no reason to suspect that the overall trends are different in Maryland. In 1988 24.1% of Maryland's 12th graders reported they were smoking cigarettes and by 1996 32.0% reported being cigarette smokers, an increase of almost 32%.[14] Maryland's 8th graders also increased their current use of cigarettes, going from 11.3% in 1988 to 17% in 1996, an increase of over 50%.[14] In 1988, 3.9% of Maryland's high school seniors reported that they had used smokeless tobacco in the past 30 days. By 1996, this percentage had increased to 5.1%. For 8th graders, current use went from 1.9% in 1988 to 2.7% in 1996.[14]

Maryland: 1988-1996

Cigarette smoking increased 50% among 8th graders and 32% among 12th graders.




## Prevalence of Tobacco use By Young Adults (Ages 18-24)

Smoking prevalence among college students has seen the most dramatic increase in the past 20 years. The Harvard School of Public Health recently conducted a survey, published in the *Journal of the American Medical Association*, which reported a 25% increase in smoking between 1993 and 1997. The survey found that smoking rose among all students regardless of age, sex, race, or geographic region.[15]

Smoking by college students increased by 25% between 1993 and 1997.

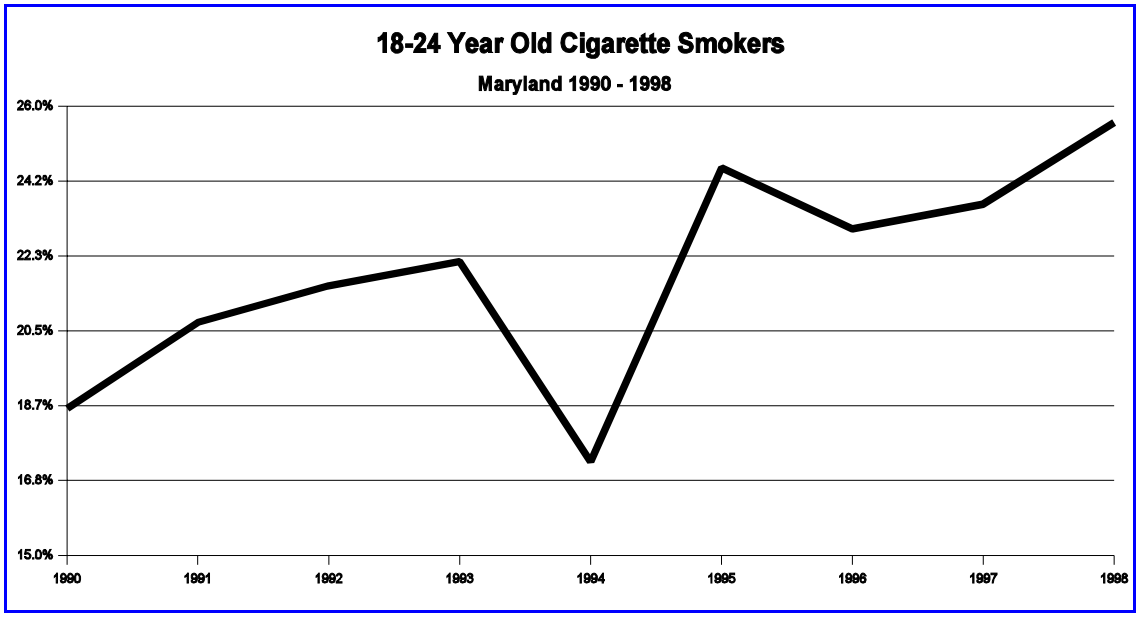
- Ninety percent of college smokers said they *started* smoking in high school.
- White students smoked more than African-American, Asian, and Hispanic/Latino students, however, smoking among African-American students increased 43%.
- Smoking among female students increased 31%.
- Older students were less likely to smoke than younger students.
- Nearly 25% said they began smoking *regularly* in college.
- Almost 50% said they had tried to quit smoking in the last year.

These figures are alarming because college students have historically been the group most resistant to smoking, smoking less than their non-college peers. If the rates of this group have increased, it is an indicator for the rest of this age group as a whole. In fact, data on the college age young adults indicates a significant increase in the use of tobacco products. In 1990 18.6% smoked and now in 1998, 25.6% smoke, an increase of 37.6%.[16]

> Smoking by Maryland 18-24 year old's increased by almost 37% between 1990 and 1998.

Troubling also is the fact that young adults do not view tobacco as the addictive product it has been proven to be. College students largely do not attribute their smoking to advertising of the tobacco industry, and do not see it as an addictive product — USA TODAY reports a junior at Rutger's University stating, "*It's just a bad habit for me. I don't see how I could get hooked*."[17]

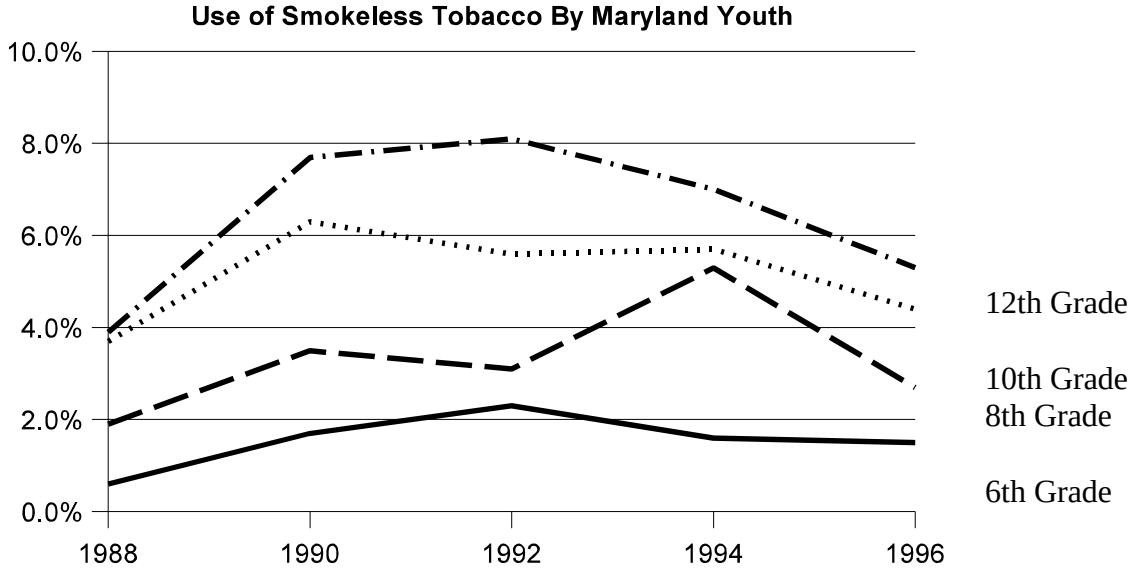
> Young adults often fail to appreciate the addictiveness of nicotine.




*Source: Maryland Behavioral Risk Factor Surveillance Surveys, 1990-1998.*

## Smokeless Tobacco Use

In 1988, 3.9% of Maryland's high school seniors reported that they had used smokeless tobacco in the past 30 days. By 1996, this percentage had increased to 5.1%. For 8th graders, current use went from 1.9% in 1988 to 2.7% in 1996. Nonetheless, the overall trend appears to be that of declining use after reaching peak usage earlier this decade.




*Source: Maryland Adolescent Survey of 1988-1996.*

## Tobacco Use is a 'Gateway' Behavior

There is little doubt that the use of tobacco products is a 'gateway' behavior that can precede or accompany other risk behaviors by youth. Youth generally try cigarettes at a younger age than alcohol or other illegal drugs such as marijuana.

**Age of First Use — As Reported by Maryland 12th Graders[14]**

| Age | Cigarettes | Beer | Marijuana |
|---|---|---|---|
| <= 10 yrs. | 11.7% | 9.7% | 2.0% |
| 11 - 12 yrs. | 18.6% | 11.9% | 7.2% |
| 13 - 14 yrs. | 34.5% | 31.8% | 33.1% |
| 15 - 16 yrs. | 27.8% | 38.4% | 47.5% |
| >= 17 yrs. | 7.4% | 8.1% | 10.2% |

Smoking cigarettes is a behavior that continues as other risk behaviors are adopted. Data from the 1996 Maryland Adolescent Survey suggests that 12th grade students that identified themselves as smokers were more likely to have used marijuana the preceding 30 days (58.2%) than those students who were not smokers but who were currently using alcohol (47.3%).

First cigarettes...then what?

**Students Who Used *More Than One* Substance in the Last 30 Days**[14]

| Substance Used in Last 30 Days | Grade | | | |
|---|---|---|---|---|
| | 6 | 8 | 10 | 12 |
| **Smoked in the Last 30 Days *AND*** | | | | |
| also drank in the last 30 days | 44.3% | 74.9% | 79.3% | 84.2% |
| also used marijuana in the last 30 days | 22.4% | 45.1% | 58.2% | 58.2% |
| **Drank in the Last 30 Days *AND*** | | | | |
| also smoked in the last 30 days | 25.9% | 46.9% | 45.6% | 51.4% |
| also used marijuana in the last 30 days | 15.9% | 36.8% | 43.1% | 47.3% |
| **Used Marijuana in the Last 30 Days *AND*** | | | | |
| also smoked in the last 30 days | 58.1% | 65.8% | 65.2% | 68.0% |
| also drank in the last 30 days | 70.3% | 85.8% | 84.0% | 90.3% |

## Youth Access to Tobacco Products.

In Maryland it is illegal to sell tobacco products to persons under the age of eighteen. Nonetheless, the fact that under-age youth in Maryland continue to smoke cigarettes, cigars, and use smokeless tobacco provides clear evidence that youth are readily able to obtain these tobacco products when they so choose.

> In Maryland it is illegal to sell tobacco products to persons under the age of eighteen.

Maryland began a statewide program in 1996 to determine the degree to which tobacco retailers were complying with Maryland's youth access laws. In that first year, only 46% of tobacco retailers were found to be complying with the law. In 1997 and 1998 compliance rates were approximately 64%. In 1998, 21% of 15 year-old's, 36% of 16 year-old's, and 45% of 17 year-old's were successful in purchasing tobacco products.[18]

> It remains too easy for under-age youth to get cigarettes and other tobacco products.

Both state and national figures show that youth, particularly the youngest ones, are likely to buy their cigarettes from vending machines. These purchases can be made quickly and unnoticed by adults. The 1998 Maryland Synar data show that 70% of vending machine purchase attempts by under-age youth were *not* challenged. Easy access is not limited to vending machines; self-service displays also allow underage youth to easily buy or often shoplift cigarettes and other tobacco products.

> Vending machines and self-service displays provide easy access to tobacco products for youngest tobacco users.

# RACIAL AND ETHNIC MINORITIES

Racial and ethnic minorities suffer disproportionately from the health consequences of tobacco use. What is less clear today is whether there is any significant disparity in the overall prevalence in the use of tobacco products by these populations. Certainly, these disparities, if they exist, are not as significant as are those with respect to the impact of disease.

> Maryland African-Americans and other racial and ethnic groups smoked cigarettes and used tobacco products at approximately the same rate at the White population.

Throughout the 1990's, approximately the same proportions of the adult African-American and White populations in Maryland have been found to use of cigarettes. In 1998 23.8% of African-Americans were smoking cigarettes in comparison to 21.7% of Whites and 23.9% for all other racial and ethnic groups.[19]

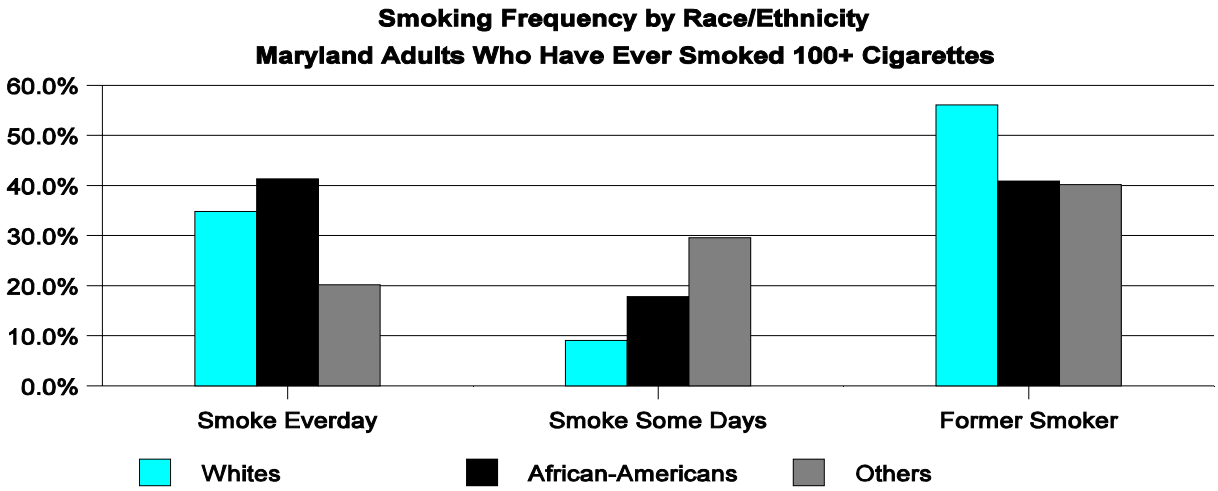
## Desire to Quit Smoking

In 1998, more then 62.3% of African-Americans smokers reported that they had made at least one serious attempt to quit during the preceding 12 months (62.3%), than had Whites (47.2%), Hispanics (42.3%), and Other (40.4%). How successful these groups were in remaining tobacco-free also varies considerably. When 'former' smokers were asked how long it had been since they had last had a cigarette, there was a similar difference between the racial and ethnic groups.

> Significantly more African-Americans report attempting to quit than other racial or ethnic groups.

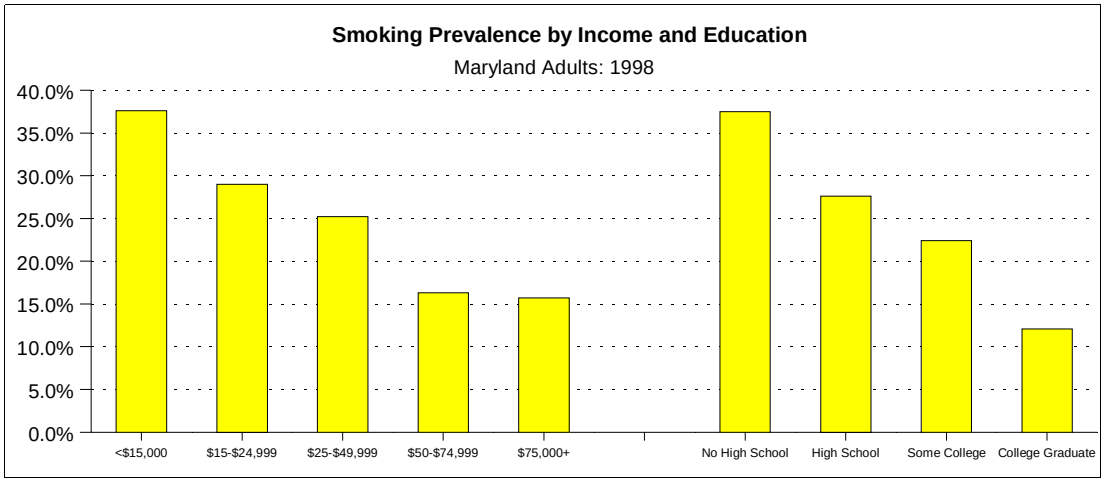
## Intensity of Smoking Behavior

The relatively small differences in overall smoking prevalence does not tell the whole story. When examining the intensity of current smoking behaviors among those persons who have ever smoked at least 5 packs of cigarettes, differences between Maryland's racial and ethnic groups begin to emerge.




# LOW INCOME/EDUCATION POPULATIONS

While a great deal of attention is focused on youth and minority use of tobacco products, populations which are defined by income level and educational attainment show greater disparities in tobacco use.




*Source: Maryland Behavioral Risk Factor Surveillance Survey of 1998*

# REFERENCES

## NICOTINE ADDICTION


1. Department of Health and Mental Hygiene (DHMH), Office of Planning, Evaluation and Program Development (OPEPD).

2. Centers for Disease Control and Prevention (CDC). *The Health Consequences of Smoking: Nicotine Addiction—a report of the Surgeon General*. Rockville, Maryland: US Department of Health and Human Services, Public Health Service, CDC, 1988.

3. Benowitz. *Clinical Pharmacology of Inhaled Drugs of Abuse: Implications in Understanding Nicotine Dependence Research*. 1990 - Monograph 99. National Institute on Drug Abuse.

4. See: Wise and Rompre. Brain Dopamine and Reward. *Ann Rev Psychol*. 1989. 40: pp.191-225; Clarke PBS. Mesolimbic Dopamine Activation-The Key to Nicotine Reinforcement? *The Biology of Nicotine Dependence*. Wiley, Chister (Ciba Foundation Symposium 152), 1990. pp. 153-168.

5. Stoleman and Jarvis. The Scientific Case That Nicotine Is Addictive. *Psychopharmacology* 1995. 117(2): pp. 2-10.

6. Anthony, Warner and Costlier. Comparative Epidemiology of Dependence on Tobacco, Alcohol, Controlled Substances and Inhalants. *Basic Findings from the National Comorbidity Survey*, 1994. 2:244-268.

7. Morbidity and Mortality Weekly Report (MMWR). *Symptoms of Substance Dependence Associated with Use of Cigarettes, Alcohol, and Illicit Drugs—United States, 1991-1992.* November 10, 1995, Vol.44, pp. 830-839; American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. Washington, D.C., 1994.

8. Maryland Behavioral Risk Factor Surveillance Survey (BRFSS) of 1998. Maryland Department of Health and Mental Hygiene.

9. Caraballo, Giovino and Mauer. Racial and Ethnic Differences in Serum Cotinine Levels of Cigarette Smokers, Third National Health and Nutrition Examination Survey, 1988-1991. *JAMA* July 8, 1998. V280 n2.

10. Maryland Behavioral Risk Factor Surveillance Survey of 1998. Maryland

Department of Health and Mental Hygiene (DHMH).

11. US Department of Health and Human Services. *Preventing Tobacco Use Among Young People: a Report of the Surgeon General*. Atlanta, Georgia: US Department of Health and Human Services, Public Health Service, CDC. 1994.

12. Giovino, Zhu, and Tomar. *Epidemiology of Tobacco Use and Symptoms of Nicotine Addiction in the U.S.* Testimony to the FDA, Aug. 2, 1994; U.S. Department of Health and Human Services, *Preventing Tobacco Use Among Young People: A Report of the Surgeon General*. Atlanta, GA: U.S. Department of Health and Human Services, PHS, CDC, NCCDPHP, OSH, May, 1994. CDC. 1994.

13. National Cancer Institute. *Strategies to Control Tobacco Use in the United States: A Blueprint for Public Health Action in the 1990's*. Bethesda, Maryland: US Department of Health and Human Services, National Institutes of Health; NIH, 1991, publication no. 92-3316. (Smoking and tobacco control monograph no. 1).

14. Morbidity and Mortality Weekly Report. *Selected Cigarette Smoking Initiation and Quitting Behaviors Among High School Students—United States, 1997*. May 22, 1998. 47(19): 386-389.

15. MMWR. 1994. *Current Trends Reasons for Tobacco Use and Symptoms of Nicotine Withdrawal Among Adolescent and Young Tobacco Users--United States.* October 21, 1994, 439410; 745-750.

16. Gallup, 1992.

17. U.S. Department of Health and Human Services, *Preventing Tobacco Use Among Young People: A Report of the Surgeon General*. Atlanta, GA: U.S. Department of Health and Human Services, PHS, CDC, NCCDPHP, OSH, May, 1994. CDC. 1994.

18. Maryland Adolescent Survey of 1996.

## CONSEQUENCES OF USING AND BEING EXPOSED TO TOBACCO PRODUCTS

1. Centers for Disease Control and Prevention, *Smoking Attributable Morbidity, Mortality and Economic Costs* (SAMMEC) software.

2. American Cancer Society. *Questions About Smoking, Tobacco, and Health.* 1982.

3. U.S. Department of Health and Human Services. *Preventing Tobacco Use Among Young People: A Report of the Surgeon General*. Atlanta, GA: U.S. Department of Health and Human Services, PHS, CDC, NCCDPHP, OSH, May, 1994.

4. American Lung Association, 1997.

5. Lynch and Bonnie, eds. *Growing Up Tobacco Free: Preventing Nicotine Addiction in Children and Youth*. Washington, DC: National Academy Press, 1994.

6. American Cancer Society. *Tick, Tick, Tick.* 1996.

7. Maryland Department of Health and Mental Hygiene, Office of Public Health Assessment, using CDC's SAMMEC software.

8. American Public Health Association. *Chronic Disease Epidemiology and Control*, 2nd edition, 1998.

9. Maryland Cancer Registry. *Final Report.* Maryland Department of Health and Mental Hygiene, 1996.

10. Tye. Stop Teenage Addiction in Tobacco. *Tobacco and Youth Reporter*, Springfield MA, Autumn 1990.

11. DiFranza and Lew. Morbidity and Mortality in Children Associated with the Use of Tobacco Products by Other People. *Pediatrics* 1996. 97(4).

12. Aarday, Giovino, Schulman, et al. Cigarette Smoking and Self-Reported Health Problems Among U.S. High School Seniors, 1982-1989, *American Health Promotion*, 1995, 10(2):111-116.

13. See: diFranza and Lew. Morbidity and Mortality in Children Associated with the Use of Tobacco Products by Other People, *Pediatrics*, 1996, 97:560-568; Samet. *Synthesis: The Health Effects of Tobacco Smoke Exposure on Children.* January 7, 1999; and California EPA. *Final Report: Health Effects of Exposure to Environmental Tobacco Smoke*, September 1997.

14. Health Care Finance Review, 1999, 20:1-19.

## PREVALENCE OF TOBACCO USE BY THE GENERAL POPULATION

1. Consumer Population Survey, 1965.

2. Behavioral Risk Factor Surveillance Survey, 1998.

3. Behavioral Risk Factor Surveillance Survey, 1990.

## THE USE OF TOBACCO PRODUCTS BY TARGETED AND HIGH RISK POPULATIONS

1. Gallup Survey. George H. Gallup International Institute, Princeton, NJ: 1992:59.

2. CDC. Changes in the Cigarette Brand Preference of Adolescent Smokers—1989 to 1993. *Morbidity and Mortality Weekly Report*, August, 1994.

3. U.S. Department of Health and Human Services. *Preventing Tobacco Use Among Young People: A Report of the Surgeon General*. Atlanta, GA: U.S. Department of Health and Human Services, PHS, CDC, NCCDPHP, OSH, May, 1994.

4. Warlick. Internal Memo from RJ Reynolds Division Manager, April 5, 1990.

5. Fischer, Schwartz and Richards, et al. Brand Logo Recognized by Children Aged 3 to 6 Years: Mickey Mouse and Old Joe the Camel. *Journal of the American Medical Association*, 1991. 266:3145-3158.

6. Kessler. Nicotine Addiction in Young People. *New England Journal of Medicine*. 1995. 333:186-189.

7. RWJF. *Results of a National Survey to Access Public Attitudes About Policy Alternatives for Limiting Minors' Access to Tobacco Products*, December 1994.

8. Gallup Survey. *Teenage Attitudes and Behavior Concerning Tobacco: A Report of the Findings*. Princeton, NJ: GH Gallup International Institute, 1992:54.

9. Moss, Giovino, et al. *Recent Trends in Adolescent Smoking, Smoking Uptake Correlates, and Expansion About the Future*. Advance data from vital and health statistics, #221. Hyattsville, MD: NCHS, 1992 (DHHS publication number [PHS] 93-1250).

10. Kwechansky Marketing Research. *Project 16*. Montreal, Quebec, Canada: Imperial Tobacco, 10/18/77:vi.

11. Kwechansky Marketing Research. *Project Plus/Minus - 3 or Cry 11: Study Highlights*. Montreal, Quebec, Canada: 5/7/82:1.

12. DiFranza and Lew. Morbidity and Mortality in Children Associated with the Use of Tobacco Products by Other People. *Pediatrics*. 1996. 97(4)

13. Centers for Disease Control and Prevention, 1998.

14. Maryland Adolescent Survey of 1996.

15. Conlon.. *Study Finds Smoking Up Among US College Students*. Reuters, November 17, 1998; Davis. *College Smoking Increases At An Alarming 28%*. USA Today: Page D10. November 18, 1998; Rosenbaum. *Smoking by College Students on the Rise, Research Finds*. New York Times: Page A18. November 18, 1998; and Schwartz. *Smoking Rate Rises for College Students.* The Washington Post: Page A2, November 18, 1998.

16. Maryland Behavioral Risk Factor Surveillance Surveys, 1990 and 1998.

17. Davis and Fowler. *Collegians Lighting Up: Smoke-Free Zones Spreading Across Nation's Campuses*. USA Today: Page A1. March 4, 19900.

18. Maryland Synar Report, 1998.

19. Maryland Behavioral Risk Factor Surveillance Survey of 1998.

# THE PROCESS:

## Expert Opinion And Public Input

# INTRODUCTION

In November of 1998, Maryland agreed to a "national" settlement of its civil lawsuit against the tobacco industry. In bringing this action against the tobacco industry, Maryland had sought to recover the billions of dollars spent on medical treatment provided to the thousands of victims of tobacco-related disease. In addition to a number of restrictions on the marketing and advertising of tobacco products agreed to by the tobacco industry as a part of the settlement, Maryland is to receive an estimated $4.2 billion in damages during the next 25 years.

## Maryland Tobacco Settlement Legislation

In early 1999, the Maryland General Assembly passed HB 751 and SB 334 which created the "Cigarette Restitution Fund" to receive the tobacco settlement monies as they were paid to Maryland (payments are estimated to begin July 1, 2000). The Governor is directed by this legislation to include the lesser of 90% or $100,000,000 of the Fund in his annual budget. Of this amount, at least 50% must be budgeted for the following::

- reduction of the use of tobacco products by minors;
- implementation of the southern Maryland regional strategy plan for agriculture with an emphasis on alternative crop uses for agricultural land now used for growing tobacco;
- public and school education campaigns to decrease tobacco use with initial emphasis on areas targeted by tobacco manufacturers;
- smoking cessation programs; enforcement of the laws regarding tobacco sales; the purposes of the Maryland Health Care Foundation;
- primary health care in rural areas of Maryland; and
- prevention, treatment, and research concerning cancer, heart disease, lung disease, tobacco product use, and tobacco control.

Also during the 1999 legislative session, the General Assembly passed HB 190 and SB 143 which provided in pertinent part for the Governor to include a minimum of $21 million annually in his budget to fund activities recommended by the Centers for Disease Control and Prevention (CDC) for the purpose of reducing tobacco use in Maryland.

## Governor Glendening's Settlement Strategy

On June 3, 1999 Governor Glendening signed an Executive Order (.01.01.1999.17) establishing three separate Task Forces to oversee the distribution of funding from the Tobacco Settlement for smoking cessation, health and agricultural initiatives. At the

same time, the Governor announced that he would commit to providing $30 million annually for ten years to a new and aggressive in Maryland to reduce the use of tobacco products.

The task forces created by the Governor included: (1) The Task Force to End Smoking in Maryland; (2) The Task Force to Conquer Cancer in Maryland; and (3) The Task Force on Tobacco Crop Conversion in Maryland.

## The Governor's Task Force To End Smoking In Maryland

Under the direction of Chairman Dr. Martin P. Wasserman and Vice-Chair State Senator Nathaniel J. McFadden, the Task Force to End Smoking in Maryland developed a process which would produce specific recommendations for an aggressive new Maryland program to reduce tobacco use. The Task Force sought first to ascertain "best practices" with respect to tobacco use reduction, cessation and initiation prevention from the CDC, nationally recognized experts in these areas, and those with expertise in other states with ambitious tobacco control programs such as California, Massachusetts, and Florida. Next, the Task Force sought input from people and communities across Maryland during a series of eight public hearings. The Task Force then crafted nine aggressive goals, 46 specific program recommendations, and 15 policy and legislative recommendations.

# MARYLAND'S 1999 TOBACCO SETTLEMENT LEGISLATION

## In pertinent part, House Bill 190/Senate Bill 143 [increasing excise tax on cigarettes]

SECTION 4.
That for fiscal year 2001 and each fiscal year thereafter, the Governor shall include not less than $21,000,000 in the annual budget in appropriations for activities aimed at reducing tobacco use in Maryland as recommended by the Centers for Disease Control and Prevention, including:

(1) Media campaigns aimed at reducing smoking initiation and encouraging smokers to quit smoking;
(2) Media campaigns educating the public about the dangers of secondhand smoke exposure;
(3) Enforcement of existing laws banning the sale or distribution of tobacco products to minors;
(4) Promotion and implementation of smoking cessation programs; and
(5) Implementation of school-based tobacco education programs.

## In its entirety, House Bill 751/SB 334 [Creating the Maryland's "Cigarette Restitution Fund"]

FOR the purpose of establishing a Cigarette Restitution Fund; providing for the distribution of certain revenues to the Fund; providing for expenditures from the Fund by appropriation; prohibiting the Fund from being expended in violation of certain restrictions or limitations; requiring the Fund to be expended for certain purposes; requiring that priority be given to certain purposes; providing that disbursements from the Fund to certain programs be used in a certain manner; authorizing certain funds to be expended for any legal purpose; requiring the Governor to prepare a certain plan; requiring the Governor to submit a certain plan to the General Assembly by a certain date; requiring the Governor to include certain information in the annual State budget submission; requiring the Governor to report certain information; providing that this Act applies to certain funds estimated in a certain State budget; and generally relating to the Cigarette Restitution Fund.

WHEREAS, The State of Maryland has agreed to the settlement of litigation against tobacco manufacturers; and

WHEREAS, The basis of the tobacco settlement is injury to State finances caused by

smoking-related illnesses of Maryland citizens; and

WHEREAS, The federal government may seek recoupment of a portion of the tobacco settlement revenues if those revenues are not used for certain purposes; and

WHEREAS, African American publications contain approximately 12% more cigarette advertising than other widespread publications and the density of tobacco billboard advertising is consistently highest in African American communities; and

WHEREAS, The General Assembly finds it is necessary to establish a process to account for and allocate the tobacco settlement funds in a manner that meets critical needs and retains State control of the funds; now, therefore,

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That the Laws of Maryland read as follows:

Article - State Finance and Procurement
23 7-317.
( A ) THERE IS A CIGARETTE RESTITUTION FUND.

( B ) (1) THE FUND IS A CONTINUING, NONLAPSING FUND THAT IS NOT SUBJECT TO § 7-302 OF THIS SUBTITLE.
(2) THERE SHALL BE CREDITED TO THE FUND ALL REVENUES CONSISTING OF FUNDS RECEIVED BY THE STATE FROM ANY SOURCE RESULTING, DIRECTLY OR INDIRECTLY, FROM ANY JUDGMENT AGAINST OR SETTLEMENT WITH TOBACCO PRODUCT MANUFACTURERS, TOBACCO RESEARCH ASSOCIATIONS, OR ANY OTHER PERSON IN THE TOBACCO INDUSTRY RELATING TO LITIGATION, ADMINISTRATIVE PROCEEDINGS, OR ANY OTHER CLAIMS MADE OR PROSECUTED BY THE STATE TO RECOVER DAMAGES FOR VIOLATIONS OF STATE LAW.

( C ) THE TREASURER SHALL:
(1) INVEST AND REINVEST THE FUND IN THE SAME MANNER AS OTHER STATE FUNDS; AND
(2) CREDIT ANY INVESTMENT EARNINGS TO THE FUND.

( D ) EXPENDITURES FROM THE FUND SHALL BE MADE BY AN APPROPRIATION IN THE ANNUAL STATE BUDGET.

( E ) (1) THE FUND SHALL BE EXPENDED SUBJECT TO ANY RESTRICTIONS ON ITS USE OR OTHER LIMITATIONS ON ITS ALLOCATION THAT ARE:
(I) EXPRESSLY PROVIDED BY STATUTE;
(II) REQUIRED AS A CONDITION OF THE ACCEPTANCE OF FUNDS; OR
(III) DETERMINED TO BE NECESSARY TO AVOID

RECOUPMENT BY THE FEDERAL GOVERNMENT OF MONEY PAID TO THE FUND.

(2) DISBURSEMENTS FROM THE FUND TO PROGRAMS FUNDED BY THE STATE OR WITH FEDERAL FUNDS ADMINISTERED BY THE STATE SHALL BE USED SOLELY TO SUPPLEMENT, AND NOT TO SUPPLANT, FUNDS OTHERWISE AVAILABLE FOR THE PROGRAMS UNDER FEDERAL OR STATE LAW AS PROVIDED IN THIS SECTION.

( F ) (1) EXPENDITURES FROM THE CIGARETTE RESTITUTION FUND SHALL BE MADE FOR 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 AND 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 HEALTH CARE FOUNDATION UNDER TITLE 20, SUBTITLE 5 OF THE HEALTH - GENERAL ARTICLE;

(VII) PRIMARY HEALTH CARE IN RURAL AREAS OF THE STATE AND AREAS TARGETED BY TOBACCO MANUFACTURERS IN MARKETING AND PROMOTING CIGARETTE AND 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; AND

(X) ANY OTHER PUBLIC PURPOSE.

(2) THE PROVISIONS OF THIS SUBSECTION MAY NOT BE CONSTRUED TO AFFECT THE GOVERNOR'S POWERS WITH RESPECT TO A REQUEST FOR AN APPROPRIATION IN THE ANNUAL BUDGET BILL.

( G ) (1) AMOUNTS MAY ONLY BE EXPENDED FROM THE FUND THROUGH APPROPRIATIONS IN THE STATE BUDGET BILL AS PROVIDED IN THIS SUBSECTION.

(2) THE GOVERNOR SHALL INCLUDE IN THE ANNUAL BUDGET BILL APPROPRIATIONS FROM THE FUND EQUIVALENT TO THE LESSER OF $100,000,000 OR 90% OF THE FUNDS ESTIMATED TO BE AVAILABLE TO

THE FUND IN THE FISCAL YEAR FOR WHICH THE APPROPRIATIONS ARE MADE.

(3) FOR EACH FISCAL YEAR FOR WHICH APPROPRIATIONS ARE MADE, AT LEAST 50% OF THE APPROPRIATIONS SHALL BE MADE FOR THOSE PURPOSES ENUMERATED IN SUBSECTION (F)(1)(I) THROUGH (IX) OF THIS SECTION SUBJECT TO THE REQUIREMENT OF SUBSECTION (E)(2) OF THIS SECTION.

(4) ANY ADDITIONAL APPROPRIATIONS, NOT SUBJECT TO PARAGRAPH (3) OF THIS SUBSECTION, MAY BE MADE FOR ANY LAWFUL PURPOSE.

( H ) FOR EACH PROGRAM, PROJECT OR ACTIVITY RECEIVING FUNDS APPROPRIATED UNDER SUBSECTION (G)(3) OF THIS SECTION, THE GOVERNOR SHALL:

(1) DEVELOP APPROPRIATE STATEMENTS OF VISION, MISSION, KEY GOALS, KEY OBJECTIVES, AND KEY PERFORMANCE INDICATORS AND REPORT THESE STATEMENTS IN A DISCRETE PART OF THE STATE BUDGET SUBMISSION, WHICH SHALL ALSO PROVIDE DATA FOR KEY PERFORMANCE INDICATORS; AND

(2) REPORT ANNUALLY, SUBJECT TO § 2-1246 OF THE STATE GOVERNMENT ARTICLE, TO THE GENERAL ASSEMBLY NO LATER THAN OCTOBER 1 ON:

(I) TOTAL FUNDS EXPENDED, BY PROGRAM AND SUBDIVISION, IN THE PRIOR FISCAL YEAR FROM THE FUND ESTABLISHED UNDER THIS SECTION; AND

(II) THE SPECIFIC OUTCOMES OR PUBLIC BENEFITS RESULTING FROM THAT EXPENDITURE.

SECTION 2. AND BE IT FURTHER ENACTED, That the Governor shall prepare a statewide plan for accessing funds available under the Public Education Fund and the Tobacco Enforcement Fund established under the Master Tobacco Settlement Agreement. This plan shall be submitted to the General Assembly no later than January 1, 2000.

SECTION 3. AND BE IT FURTHER ENACTED, That this Act shall apply to any funds estimated in the fiscal 2000 State Budget (Chapter _____ (H.B. 120) of the Acts of the General Assembly of 1999) and appropriated to the Dedicated Purpose Fund.

SECTION 4. AND BE IT FURTHER ENACTED, That this Act shall take effect July 1, 1999.

# GOVERNOR'S EXECUTIVE ORDER

**01.01.1999.17**

## CONQUERING CANCER IN MARYLAND

WHEREAS, The State of Maryland is a signatory party to the Master Tobacco Settlement reached in litigation filed by multiple states against the tobacco industry to recover Medicaid costs associated with smoking;

WHEREAS, As a signatory party to the Tobacco Settlement, Maryland will receive funds to enable it to make extraordinary strides in education, health and agriculture, which will transform Maryland into an anti-cancer State; and

WHEREAS, It is essential to the achievement of our goals that we assemble the leading minds, practitioners and concerned community activists to plan for the most effective distribution of Tobacco Settlement monies targeted for programs to end smoking and conquer cancer in Maryland.

NOW, THEREFORE, I, PARRIS N. GLENDENING, GOVERNOR OF THE STATE OF MARYLAND,

BY VIRTUE OF THE AUTHORITY VESTED IN ME BY THE CONSTITUTION AND THE LAWS OF MARYLAND, HEREBY PROCLAIM THE FOLLOWING EXECUTIVE ORDER, EFFECTIVE IMMEDIATELY:

A. Establishment. Three Task Forces are established to oversee the distribution of funding from the Tobacco Settlement for smoking cessation, health and agricultural initiatives. They are:

(1) The Task Force to End Smoking in Maryland;

(2) The Task Force to Conquer Cancer in Maryland; and,

(3) The Task Force on Tobacco Crop Conversion in Maryland.

B. Membership, Duties and Staffing. The Task Forces shall be structured, directed and supported in the following manner:

(1) Task Force to End Smoking in Maryland.

( a ) Composition. The Task Force shall be comprised of up to 21 members appointed by the Governor, including:

I. Two members of the Senate nominated by the President of the Senate;

ii. Two members of the House of Delegates nominated by the Speaker of the House of the Delegates; and

iii. Up to 17 members with interest or expertise in this area, including but not limited to representatives of State government, public or private education and health agencies, organizations that advocate for smoking cessation and for the interests of children, the health care industry, businesses, parents, students and the community.

iv. The Governor shall designate a Chair and a Vice Chair from among the members of the Task Force.

( b ) Duties. The Task Force shall plan for the implementation of a substantial and aggressive program to dramatically reduce tobacco consumption in Maryland, modeled after the comprehensive anti-smoking program recommended by the Centers for Disease Control. The plan would place special emphasis on programs and initiatives to reach youths, as well as minority communities that experience a disproportionately high incidence of health problems associated with tobacco consumption.

( c ) Staffing. The Department of Health and Mental Hygiene shall provide staff support to the Task Force.

(2) Task Force to Conquer Cancer in Maryland.

( a ) Composition. The Task Force shall be comprised of up to 21 members appointed by the Governor, including:

I. Two members of the Senate nominated by the President of the Senate;

ii. Two members of the House of Delegates nominated by the Speaker of the House of the Delegates; and

iii. Up to 17 members with interest or expertise in this area, including but not limited to representatives of State government, public or private medical research institutions, the health care and the health insurance industry, patient advocacy and disease specialty organizations, businesses and the community.

iv. The Governor shall designate a Chair and a Vice Chair from among the members of the Task Force.

( b ) Duties. The Task Force shall make recommendations for allocation of funding from the Tobacco Settlement to achieve the goal of making Maryland

the premier place in the Nation for cancer prevention, education, research and treatment. The recommendations of the Task Force shall reflect the need to improve access to, and parity of health care for minority communities and individuals who live in rural areas of the State.

( c ) Staffing. The Department of Health and Mental Hygiene shall provide staff support to the Task Force.

(3) Task Force on Tobacco Crop Conversion in Maryland.

( a ) Composition. The Task Force shall be comprised of up to 13 members appointed by the Governor, including:

I. Two members of the Senate nominated by the President of the Senate;

ii. Two members of the House of Delegates nominated by the Speaker of the House of the Delegates; and

iii. Up to 9 members with interest or expertise in this area, including but not limited to representatives of State government, agricultural and environmental organizations, farm credit institutions, regional or local development groups, businesses and the community.

iv. The Governor shall designate a Chair and a Vice Chair from among the members of the Task Force.

( b ) Duties. The Task Force shall plan for the implementation of recommendations for the conversion of tobacco to non-tobacco crops, while preserving the rural-agricultural nature of the region and maintaining the economic viability of the community.

( c ) Staffing. The Maryland Department of Agriculture shall provide staff support to the Task Force.

(4) Task Force members shall serve at the pleasure of the Governor.

(5) Task Force members may not receive any compensation for their services, but may receive reimbursement for reasonable expenses incurred in the performance of their duties in accordance with the State Standard Travel Regulations and as provided in the State budget.

C. Reports. The Task Forces shall provide recommendations to the Governor on or before October 31, 1999. Thereafter, the Governor may choose to delegate continuing duties to the Task Forces in the implementation of approved action plans.

GIVEN Under My Hand and the Great Seal of the State of Maryland, in the City of Annapolis, this 3rd Day of June, 1999.

Parris N. Glendening

Governor

ATTEST:

John T. Willis

Secretary of State

# TASK FORCE MEETING SCHEDULE

The first two meetings of the Task Force were to learn and discuss the current best practices in tobacco control, cessation and prevention in the nation. The second of these meetings was an all day Seminar with some of the leading experts in tobacco use reduction, prevention and cessation. Thereafter, the Task Force accepted public testimony at eight public meetings, and written testimony from one other site where the public meeting was canceled due to Hurricane Floyd. The Task Force then held five additional meetings to formulate and finalize its recommendations.

| Date | Type | Location |
|---|---|---|
| August 17, 1999 | Task Force Meeting | House Ways and Means, Annapolis |
| September 8, 1999 | Task Force Seminar | Maritime Institute, Baltimore |
| September 13, 1999 | Public Testimony | Charles Co. Health Dept., LaPlata |
| September 15, 1999 | Public Testimony | Western MD Hosp. Ctr., Hagerstown |
| September 15, 1999 | Public Testimony | Allegany Co. Health Dept., Cumberland |
| September 16, 1999 | Public Testimony | Cecil Community College, North East (canceled) |
| September 23, 1999 | Public Testimony | Montgomery Co. Council Bldg., Rockville |
| September 27, 1999 | Public Testimony | Deer's Head, Salisbury |
| September 27, 1999 | Public Testimony | Chesapeake College, Wye Mills |
| September 28, 1999 | Task Force Meeting | House Ways and Means, Annapolis |
| September 29, 1999 | Public Testimony | Urban Medical Institute, Baltimore |
| September 30, 1999 | Public Testimony | RMS Building, Largo |
| October 6, 1999 | Task Force Meeting | Columbia Interfaith Center, Columbia |
| October 14, 1999 | Task Force Meeting | Columbia Interfaith Center, Columbia |
| October 19, 1999 | Task Force Meeting | Columbia Interfaith Center, Columbia |
| October 27, 1999 | Task Force Meeting | Columbia Interfaith Center, Columbia |

# PUBLIC MEETING SUMMARY

## INTRODUCTION

The Task Force to End Smoking in Maryland scheduled nine public meetings across the state in September 1999. The Northern Maryland meeting was canceled due to Hurricane Floyd. During the meetings the Task Force accepted testimony concerning Maryland's goal of ending smoking and reducing tobacco related diseases.

The opportunity to testify at the meetings was open to all. Individuals who participated included members of the business, advocacy, church, health, school, local, medical, social work, dental, aging, law enforcement, government and student communities. Several people recounted personal stories.

The Task Force requested that testimony relate to: 1) the need for a comprehensive tobacco control program; 2) the use of one or more components of the Centers for Disease Control and Prevention's (CDC) Best Practices for Comprehensive Tobacco Control guidelines; and 3) program implementation and/or element(s). Participants were asked to refrain from discussing matters pertaining to their own specific projects for future services delivery. Requests for Proposals (RFPs) will be solicited at a later date but interest forms were made available at the meetings.

The minutes of each meeting containing more specific details are posted on the Maryland Department of Health and Mental Hygiene's web site at:

***http://www.dhmh.state.md.us/esm/html/task_force_hear.htm***

## RESULTS

A total of 322 people attended the public meetings and 189 offered testimony. Written testimony following the meetings was also accepted. Meetings were held in various geographic regions easily accessible to the public and within one hour's drive time to allow all citizens an opportunity to testify.

Meetings were held in the: Baltimore Metropolitan Area (85 attendees, 36 testimonies); on the Eastern Shore (two meetings, Chesapeake College - 45 attendees, 27 testimonies and Wicomico County - 37 attendees, 33 testimonies); Northern Maryland (7 written testimonies due to Hurricane Floyd); Southern Maryland (30 attendees, 14 testimonies);

Washington Metropolitan Area (two meetings, Montgomery County - 45 attendees, 28 testimonies and Largo - 25 attendees, 13 testimonies); and, Western Maryland (two meetings, Allegany County - 25 attendees, 17 testimonies and Washington County - 30 attendees, 13 testimonies).

# THE MARYLAND MODEL

Those testifying voiced overwhelming support for the Maryland Model to End Smoking which: establishes a long term, sustained effort that includes the CDC guidelines; is community focused with emphasis on statewide infrastructure; is inclusive of all population groups with emphasis on special populations such as minorities, youth, and women; utilizes proven successful strategies, innovative approaches, and modern technology; clearly outlines vision, mission, and goals; and, alters the social culture to make tobacco products undesirable.

## Administration

Those who testified expressed that implementation of an effective tobacco control program requires a strong management structure. Topics raised included: the need to assure appropriate funding for oversight, coordination, and achievement of goals, including surveillance and evaluation components. The development of methodologies to assure implementation, the development of RFPs, and the monitoring of expenditures were also discussed.

## Countermarketing/Media

Many people mentioned the need to produce a countermarketing/media campaign that incorporates a unifying theme, disseminates frank information about the tobacco industry, supports a cultural change to renounce smoking, is appropriate to the target population, and utilizes multiple technologies.

## Cessation

Much of the testimony centered on cessation efforts. Individuals stated that all health care practitioners should be involved in anti smoking efforts, that cost sharing programs should be developed, and that current best scientific practices should be employed. Both health insurers and tobacco users should be involved in payment for cessation services.

## Community Based Programs

Multiple statements reflected the view that community programs are essential to success. Testimony centered around the need to support local health departments and existing coalitions that promote tobacco control activities and the need to leverage current people/dollar resources. The dangers of secondhand smoke and smokeless ("spit") tobacco were emphasized. The Task Force was advised to include youth (in-school and drop-outs) and other distinct populations in the planning process. The regional nature of the meetings resulted in many requests for the balanced use of funds within jurisdictions according to racial/cultural diversity, income, geography, and other factors.

## School-Based Programs

Concern about school-age populations from kindergarten through college emerged during the meetings. Testimony included the need to focus upon: discouraging the sale of tobacco products on college campuses; provision of early intervention starting in elementary school with major emphasis on middle school age children reinforced by "booster" sessions in high school; modeling positive adult behaviors; the elimination of tobacco products from school property; coordination of community efforts; and, program provision in a variety of youth-oriented environments.

## Enforcement

It became clear during the meetings that the public believes there is a need to enforce all existing anti-tobacco laws and assure that appropriate agencies in each locale are made aware of current rules and regulations.

## Surveillance

Many attendees noted the importance of collecting base line data regarding age, ethnicity, product consumed, and locality. Several people mentioned using the Youth Tobacco Survey (YTS) and the Youth Risk Behavior Survey (YRBS) for data collection. There was additional testimony that stressed the need for information analysis in the course of program design.

## Statewide Partnership Grants

Creation of a statewide effort inclusive of all localities was brought up often during testimony. In pursuit of this aim, individuals discussed the provision of technical and grant writing assistance using science - based principles and best practices and a need for

strong management, administration, and training. Some people mentioned approaches such as the initiation of state wide support groups and the use of distance based learning.

## Conclusion

The meetings were an integral part of the overall planning process for the Maryland program. During the meetings the Task Force members expressed their appreciation to the attendees for their time, effort, and enthusiasm. Traveling throughout the state provided Task Force members with an opportunity to learn more about the needs and concerns of Marylanders from different geographic, racial, cultural, and other backgrounds on a first-hand basis.

# Web Page

## Task Force to End Smoking in Maryland

***Governor Glendening's Efforts to end Smoking in Maryland***

Welcome to the ***End Smoking in Maryland*** website. Governor Parris N. Glendening has vowed to "extinguish" tobacco use over the next decade in our State and has pledged $300 Million to accomplish this goal. This site will keep you informed of our progress. Initially it will advise you of the specific actions of the Governor's special ***Task Force to End Smoking in Maryland*** and other related activities.

*Martin P. Wasserman, M.D., J.D., Chair*
*Governor's Task Force to End Smoking in Maryland*

# THE RESULTS:

# THE MARYLAND APPROACH

# RECOMMENDATIONS

# THE MARYLAND APPROACH

## TASK FORCE
## VISION, MISSION, AND GUIDING PRINCIPLES

Governor Glendening selected a committed group of individuals to serve on the Task Force to End Smoking in Maryland. Most were recognized leaders in the field and were appointed for this reason. Each member recognized the unique and historic opportunity and responsibility for tobacco control that was provided by the Governor's extraordinary level of funding for this activity. Members were aware of Maryland's excessive cancer rate and knew that tobacco is the single most important cause of these illnesses as well as being responsible for most of the heart disease in the state. The Task Force vowed to use its influence to markedly reduce tobacco use which would ultimately reduce the morbidity and mortality from each of these conditions.

Following the Symposium provided by the CDC and other national leaders and the eight public meetings held throughout the state of Maryland, the Task Force members agreed upon the following statement of its Vision.

### VISION

**Maryland will lead the Nation in Tobacco Use Prevention, Control, and Cessation.**

During the course of the discussion, members commented that they would work toward having Maryland, the Free State, become **"Maryland, the Tobacco Free State".**

Governor Glendening, during his initial press briefing, exhorted the Task Force to reach

out to all populations and specifically identified those groups which had been successfully targeted by the tobacco industry. During the process of information-gathering, the Task Force repeatedly heard about the impact of environmental tobacco smoke. It learned that secondhand smoke caused over 1,000 deaths each year in Maryland and was the third leading cause of "preventable" deaths in Maryland.

At the conclusion of this process the Task Force derived its MISSION:

## MISSION

**Reduce initiation and tobacco use in Maryland by providing outreach to all populations with special emphasis on high risk and targeted groups.**

**Reduce secondhand smoke exposure, especially to children.**

After developing its VISION and MISSION, the Task Force created a framework through which it would ultimately develop its goals and specific strategy recommendations. The Task Force was fortunate in having been thoroughly briefed concerning the Guidelines provided by the Centers for Disease Control and Prevention. The Task Force also realized that it had been given substantial funding to accomplish its objectives. A set of Principles was established to guide the rest of the process to help members direct resources toward each of the CDC Guidelines.

## GUIDING PRINCIPLES

- Develop a Long Term, Sustained Effort Focused On Tobacco
- Assure It Is Comprehensive; Include All the CDC Guidelines.
- Make It Community- Focused; Create a Statewide Infrastructure
- Emphasize Special Populations (Minorities, Youth and Women)
- Develop a Balanced Approach Using:
  - Proven Successful Activities
  - Innovative and Creative Approaches
  - Modern Media/Technology Utilization
- Establish Vision, Mission, and Goals
  - Surveillance, Monitoring, and Evaluation
- Develop Strategies for the Allocation of Funds
  - Open, Impartial, and Public
  - Change the Cultural and Social Norms

After completing the Guiding Principles, the Task Force proceeded to create a specific overarching principle for each of the CDC program areas. These formed the framework for the individual policy recommendations contained in the next section of the Report.

# TASK FORCE GOALS

With a Vision and Mission guiding them, and a set of general and specific principles in mind, the Task Force, after listening to the testimony of Maryland citizens, defined nine Goals to achieve by the conclusion of the first decade of the twenty-first century.

**GOAL 1** **Decrease Adult Smoking in All Subpopulation Groups by 50% from Maryland's Baseline Rate**.

Total Adult Population (over 18 y/o)

All Racial and Ethnic Groups

Men and Women

Below Poverty Level

**GOAL 2** **Decrease School-Age Tobacco Use by 50%.**

Any Tobacco Product

Cigarettes and "Spit" Tobacco

**GOAL 3** **Decrease Smoking by Pregnant Women by 50%.**

**GOAL 4** **Increase Smoking Cessation During Pregnancy by 50%.**

**GOAL 5** **Increase the Number of Insurance Companies Funding Smoking Cessation Programs to 100%.**

**GOAL 6** **Increase the Number of Primary Care Providers Who Give Advice and Support to Patients Who Smoke to 90%.**

**GOAL 7** **Increase Compliance with Youth Access Laws to 99%.**

**GOAL 8** **Reduce childhood exposure to secondhand smoke by 75%.**

**GOAL 9** **Increase the Number of Jurisdictions With Established Community Coalition(s) to 100%.**

With a bold and aggressive approach involving all sectors within the state, the Task Force believes these goals can be attained by the year 2010. Parents, teachers, advocacy groups, business and religious leaders, youth and minority members, and government must all work together to address this problem through an unprecedented and comprehensive attack using new and unique approaches in order to be successful. In addition new legislative initiatives will be required. These specific legislative strategies are also included in the Report.

The Task Force is very optimistic that through implementation of its recommendations and a concerted and sustained effort by all of the citizens of the state of Maryland, the far-reaching goals can be achieved and the Vision attained. The Task Force and the citizens of Maryland are indebted to Governor Glendening for providing the leadership and support to give us this special opportunity to Leave a Legacy and make a major difference for the future of our children and our children's children as we stand at the threshold of the next century. Together we Marylanders can do Great Things.

# RECOMMENDATIONS

Governor Parris N. Glendening directed the *Task Force to End Smoking in Maryland* to determine the most cost effective way to spend $30 million annually during the first decade of the 21st century to reduce the harmful effects of tobacco products on Maryland residents. He asked the group to pay special attention to minority populations and other groups targeted by the tobacco industry. He desired a bold and aggressive approach and directed one-third of the effort toward this end. Our recommendations incorporate this approach.

Consistent with its Vision and Mission, the *Task Force to End Smoking in Maryland* offers the following set of recommendations to achieve the nine goals outlined previously by the year 2010. Recommendations are organized according to the best practice guidelines established by the Centers for Disease Control and Prevention (CDC). For each of these Guidelines, the Task Force identified an Overarching Principle and a specific funding amount.

In those situations where external vendors would be used, the Task Force identified a set of criteria to guide the Request for Proposal process:

- Give Preference to Maryland-based Vendors.
- Give Preference for Previous Experience in Tobacco or Health Activities.
- Assure Culturally-Specific Experience with Minority Communities.
- Provide experience working with Youth and Adolescents.
- Demonstrate Capability for Innovative Activities and Use of State of the Art Technologies.
- Have Work Experience with the Public Sector.
- Demonstrate Performance in the Specific Content Area for at least Three Years.
- Have Work Experience with Rural Communities.
- Maximize the Use of State Funds through Pre-existing Materials, Funding Partnerships, and Resource Matching.
- Have No History of Having Worked for the Tobacco Industry.
- VENDORS MAY NOT CONTACT STATE OFFICIALS IN VIOLATION OF

MARYLAND'S PROCUREMENT PROCESS.

## COUNTERMARKETING/MEDIA

$10 Million - Year 1 and $7.5 Million - Year 2

**The Media Campaign will be integrated within the entire statewide effort. It will be comprehensive, innovative, and aggressive.**

- Select a single lead agency which has, or subcontracts with, Minority vendor(s) which have experience working within culturally specific communities. Targeted audiences include but are not limited to the African-American, Latino, and Asian communities.
- Develop a comprehensive, bold, and aggressive communications strategic plan with defined timelines and outcomes.
- Integrate free/paid media, speakers, promotions, and grassroots outreach.
- Limit paid television and radio to no more than 66-75% of resources.
- Focus on the target audiences including minorities, youth, women, and low income and undereducated populations.
- Develop a special program for "spit tobacco."
- Conduct formative research and continuing evaluation using focus groups, field-testing and other methodologies.
- Require the innovative use of technology, including the Internet.
- Develop a Unifying Theme for the overall program.
- VENDORS MAY NOT CONTACT STATE OFFICIALS IN VIOLATION OF MARYLAND'S PROCUREMENT PROCESS.

## CESSATION

$2 Million - Year 1 and $4.5 Million - Year 2

**The Cessation program will encompass all providers, be comprehensive, and funded through multiple sources. It will utilize the most current scientific**

**practices.**

- Work with Insurance Companies and the Legislature to achieve the goal of having Smoking Cessation programs included in all insurance policies sold within the state of Maryland.
- Develop cost-sharing strategies including insurers, addicted recipients, and the state funding resource pool from the tobacco settlement agreement.
- Provide technical assistance to communities which request assistance in developing Cessation programs and to identify additional issues for public policy considerations.
- Follow Centers for Disease Control and Prevention (CDC) /Agency for Health Care Policy and Research (AHCPR) guidelines and the best known scientific practice.
- Give special attention to "spit tobacco" issues.
- Provide funding to community groups and local health departments to implement smoking cessation programs with particular attention to the targeted audiences especially those individuals who are uninsured or underinsured.
- Allocate funding to jurisdictions based upon most current tobacco use data as determined by the Health Secretary.

# COMMUNITY

$6 Million a Year

**The Public Meeting process identified the Local Community as the primary prevention and service delivery site for Maryland's comprehensive program to attack tobacco use in the state. Where they exist, local, diverse and multi-disciplinary Community Coalitions should be supported. Where they do not exist, special efforts should be expended to create them.**

- Make grants to local community coalitions that submit a proposed plan of action consistent with overall program goals.
- Utilize existing administrative agencies such as local health departments or local management boards which will participate in the coalition and serve as fiscal agent in order to accomplish the coalition's goals and objectives.
- Offer technical assistance to the coalitions as needed and assist in expanding

capacity by encouraging the development of regional networks.

- Coordinate all programmatic efforts including second hand smoke education, programs addressing the needs of out of school youth, and "spit tobacco."
- Develop plans from an analysis of community need based upon scientific information and surveillance data.
- Allocate funding to jurisdictions based upon most current tobacco use data as determined by the Health Secretary.

## SCHOOL-AGE POPULATIONS

$4.5 Million a Year

**All children and youth, whether in or out of school or college, need to be targeted for help in tobacco avoidance. Individuals in all settings dealing with young people need to serve as role models. Activities should be coordinated with existing efforts occurring in the local community.**

- Target all young persons, particularly minorities and women, including those who are of age but not residing in an educational setting.
- Utilize best scientific practices.
- Encourage those working with youth to serve as role models.
- Provide funding through existing administrative agencies such as Boards of Education, community colleges and public senior colleges and universities, and local management boards.
- Allocate funding to jurisdictions based upon most current tobacco use data as determined by the Health Secretary. Distribution allocations will be as follows: College age 30%; School age 60%; and Pre-school age 10%.

## STATEWIDE ACTIVITIES

$1.5 Million a Year

**The State will develop a capacity to provide appropriate technical assistance and other support as needed for**

**local community activities. Statewide collaborative efforts with a variety of agencies will be pursued using Partnership Grants. A special program providing legal assistance on tobacco matters will be created in cooperation with the Office of the Attorney General.**

- Develop specialized technical assistance capabilities through a variety of mechanisms to support the needs of community groups using staff or outsourcing arrangements.
- Collaborative with special organizations such as: Non-profit Groups; the Faith Community; the Business Community; and Minority Communities.
- Create a special program to provide legal assistance to local communities on tobacco matters in cooperation with the Office of the Attorney General.

## ENFORCEMENT

$1.5 Million a Year

**The Enforcement effort should be aggressive, locally based, and target illegal sales and violations of the Clean Indoor Air Act.**

- Provide funds to each local jurisdiction to enforce existing anti-tobacco statutes and regulations.
- Provide funds directly to the chief executive or governing entity or through the State Comptroller's Office to create or support an aggressive enforcement initiative.
- Allocate funds based upon the number of tobacco retail outlets in the jurisdiction.
- Provide a special grant to the Maryland Occupational Safety and Health Administration (MOSH**)** to enhance the agency's current tobacco enforcement capacity.
- Encourage all licensing agencies, both state and local, to support enforcement activities.

## SURVEILLANCE AND EVALUATION

$3 Million a Year

**The Surveillance and Evaluation activities will provide the scientific information and analysis for funding distribution based on community need and allow for information-based decision-making. It will assure that the State's resources are spent according to the best available evidence and are accomplishing optimal program outcomes.**

- Develop comprehensive surveillance activities to measure tobacco product use by various populations.
- Obtain data for each jurisdiction which can be used for funding allocation.
- Monitor community compliance with youth access laws and discover new marketing schemes introduced by the tobacco industry.
- Identify a University or other institution of higher learning with knowledge and experience in tobacco evaluation and programs to:
    - Monitor program effectiveness and assess all program goals and objectives.
    - Develop and implement an annual evaluation plan for specific program components.
    - Encourage partnerships with additional academic institutions, or other entities.

## ADMINISTRATION

$1.5 Million a Year

**Sufficient Funding Must Be Provided to Assure Accountability for Implementation of the Comprehensive Anti-Tobacco Activities and Achievement of Program Goals.**

**The Office to End Smoking in Maryland and the Department of Health and Mental Hygiene will partner to provide administrative oversight and overall program coordination for the State's comprehensive anti-tobacco**

**initiative. Together they will:**

- Develop request for proposals and oversee entire application process.
- Maintain accountability for all contracts and grants.
- Monitor expenditures and distribution targets.
- Provide reports to the Governor and Legislature.
- Work closely with the surveillance and evaluation vendors.
- Work with Advisory Task Force as recommended by the Task Force to End Smoking in Maryland.

# LEGISLATIVE AND POLICY AGENDA

Following the development of the above set of recommendations the Task Force realized that in order to accomplish the goals and objectives additional legislative and policy actions would be required. After considerable and thoughtful deliberations the Task Force developed a legislative and policy agenda to further support the program's vision, mission and goals.

**State and Local Strategies:**

- Revoke/Suspend Retail Tobacco License for Illegal Youth Sales.
- Eliminate Vending Machines that Dispense Tobacco Products.
- Increase Access to Smoking Cessation Services.
- Conduct Youth Tobacco Survey (YTS) and Youth Risk Behavior Survey (YRBS) in All School Systems Consistent with CDC recommendations.
- Eliminate Counter Displays of Tobacco Products.
- Change the Maryland Tax Stamp System to Prevent Smuggling.
- Enable Local Governments to Independently Establish More Stringent Tobacco

Control Laws.

- Raise Tobacco Prices.
- Restrict Advertising by Tobacco Industry where legally possible.
- Encourage pharmacies to eliminate the sale of tobacco products.
- Expand MOSH protection to all employees in Maryland.
- Encourage the elimination of the sale of tobacco products within State buildings.

**Federal Strategies:**

- Assure Food and Drug Administration (FDA) Oversight of All Tobacco Products as Nicotine Delivery Devices.
- Request the Agency for Health Care Policy Research (AHCPR) to Review Best Practices Regarding Cessation Products in Pregnancy.
- Request the Internal Revenue Service (IRS) to include all facets of smoking cessation programs as eligible benefits for pretax medical/dental reimbursement accounts.

# CONCLUSION

The Task Force to End Smoking in Maryland is confident that through the implementation of these bold and aggressive strategy and policy recommendations the State of Maryland will achieve its goals and accomplish its vision of ***leading the Nation in tobacco use prevention, control and cessation.***

# TASK FORCE MEMBER'S BIOGRAPHICAL INFORMATION

## Martin P. Wasserman, M.D., J.D., Chair

Dr. Wasserman is currently a Visiting Professor at the Johns Hopkins School of Public Health where he serves as Director of the Office to End Smoking in Maryland. He graduated cum laude (phi beta kappa) from Williams College, in Williamstown, Massachusetts and subsequently earned his medical degree at Johns Hopkins University, where he has been inducted into the Alpha Omega Alpha Honor Society. Following his training in Pediatrics in Rochester, New York, he served in the Indian Health Service in New Mexico and then returned to Maryland where he attended the University of Maryland School of Law and was admitted to the Maryland Bar. Most recently, Dr. Wasserman served as the Maryland Secretary of the Department of Health and Mental Hygiene from 1994-1999. Prior to that, he was the local health officer in both Prince George's and Montgomery Counties. Dr. Wasserman has received special recognition from the American Medical Association, The Ford Foundation, the John F. Kennedy School of Government, and the American Dental Association for his career efforts. He serves on a number of national and community boards.

## Honorable Nathaniel J. McFadden, M.S., Vice-Chair

State Senator Nathaniel J. McFadden graduated from Morgan State University with a B.A. in 1968 and completed his M.S. studies there in 1972. Senator Mc Fadden has worked for the Baltimore City Public School System since 1968. He began his first Senate term in the General Assembly in 1995. Since that time, he has sat on the Senate Budget and Taxation Committee. Senator McFadden has been active in local politics since 1982, serving as Councilman on the Baltimore City Council until 1987. Between 1985 and 1988, Mr. McFadden acted as Chairman of the Urban Services Agency. In addition, he has served on the Off-Street Parking Commission (1983-1987) and as the Secretary of the Executive Board of the Democratic State Central Committee. Senator McFadden sits on the Board of Directors of the East Baltimore Community Corporation.

He is formerly a member of the on the Polytechnic High School Executive Board and the Polytechnic Parents Association . He is also a member of the Local No. 340 of the Baltimore's Teachers' Union.

## Attorney General J. Joseph Curran, Jr., LLB, Honorary Co-Chair

Maryland Attorney General J. Joseph Curran was first elected State's Attorney General in 1986 after serving four years as Lieutenant Governor with Governor Harry Hughes. Attorney General Curran attended Baltimore parochial schools, Loyola High School, the University of Baltimore, and the University of Baltimore Law School. He began his career in public service in 1958 when he was elected to the House of Delegates while still a law student. In 1962, he was elected to the State Senate where he served on the Judicial Proceedings Committee. In 1967, Mr. Curran was selected as Chairman of the Judicial Proceedings Committee, a position he held for 16 years. During his tenure in the General Assembly, Mr. Curran supported initiatives, including legislation to improve the courts and the corrections system, toughen drunk driving laws, guarantee equal rights, and require handgun permits. He also sponsored legislation to modernize Maryland's divorce and alimony laws, reform adoption and guardianship laws, and protect victims of domestic violence. As Lieutenant Governor, Mr. Curran served as legislative liaison for Governor Hughes' Administration bills and was appointed to chair Task Forces on drunk driving, the insanity defense, victims' services and liability insurance. As Maryland's Attorney General, Joseph Curran has been a national leader in consumer protection, criminal investigations, Medicaid fraud prosecution, securities regulations, and antitrust enforcement.

## Honorable Kweisi Mfume, M.A., Honorary Co-Chair

Kweisi Mfume currently serves as President and Chief Executive Officer of the National Association for the Advancement of Colored People (NAACP). Mr. Mfume has held this position since February 15, 1996, after being unanimously elected to the post by the NAACP's Board of Directors. Mr. Mfume represented Maryland's 7$^{th}$ Congressional District for 10 years and left his congressional seat to assume the role of President of the NAACP. Mr. Mfume graduated magna cum laude from Morgan State University in 1976 and later returned as an adjunct professor, teaching courses in both political science and communications. He subsequently earned a Masters degree in liberal arts, with a concentration in International Studies, from Johns Hopkins University. As a member of the House of Representatives, Mr. Mfume consistently advocated landmark minority business and civil rights legislation. He successfully co-sponsored and helped to pass the Americans with Disabilities Act. Mr. Mfume served two successful terms as Chairman of the Congressional Black Caucus and later served as the Caucus' Chair of the Task Force to Preserve Affirmative Action. During his last term in Congress, he was

appointed by the House Democratic Caucus as the Vice Chairman for Communications. Since assuming the position of President and CEO of the NAACP, Mr. Mfume has presided over the elimination of the Association's debt, raised the standards and expectation of the NAACP branches nationwide, and has worked with the NAACP volunteers across the country to help usher in a whole new generation of civil rights leaders across the country. His five-point action agenda, which encompasses Civil Rights, Political Empowerment, Educational Excellence, Economic Development and Youth Outreach, has given the NAACP a clear and compelling blueprint for the 21st century.

# TASK FORCE MEMBERS

## Arnold "Skip" Amass, Pharm.D.

Dr. Arnold "Skip" Amass recently retired as the Chief of Pharmacy, Agency Smoking Policy Compliance Officer and Drug Program Coordinator for the NSA. He holds a Bachelor of Science degree in biology from Western Maryland College and a Doctor of Pharmacy degree from the University of Maryland School of Pharmacy. Dr. Amass served on the first Governor's Commission to write no-smoking regulations for Maryland Public Schools. He also led a Department of Defense clinical trial of the nicotine patch in a smoking cessation program. Dr. Amass gives annual lectures on smoking cessation programs for the U.S. Army Occupational Health Officers certification. Additionally, Dr. Amass has held leadership positions in the pharmaceutical industry, the retail industry, and in government service. He has held leadership positions with the Carroll Community College, the Maryland State Board of Education, the National Board of Directors, of the American Cancer Society, the Maryland Pharmaceutical Association, and Rotary International.

## Albert L. Blumberg, M.D.

Dr. Albert L. Blumberg is currently serving as the President of Smoke Free Maryland and as the President-Elect of the Medical and Chirurgical Faculty of Maryland. He holds a B.S. from The Pennsylvania State University and an M.D. from Jefferson Medical College. Dr. Blumberg has held numerous faculty appointments including Assistant Professor of Radiation Therapy at the University of Pennsylvania School of Medicine and Instructor in Oncology and Radiologic Sciences at The Johns Hopkins Hospital. He is currently the Vice-Chairman of the Department of Radiation Oncology at the Greater Baltimore Medical Center. In addition, from 1984 until 1991, he served as the Medical Director of the John M. McGovern, M.D. Memorial Oncology Support Program at the Greater Baltimore Medical Center. Between 1995 and 1996, Dr. Blumberg acted as the

Medical Director and Chief of the Division of Radiation Oncology, at the Peninsula Regional Medical Center. His hospital appointments are numerous and include positions held at the University of Pennsylvania Hospital the Presbyterian-University of Pennsylvania Medical Center, and the Graduate Hospital, all in Philadelphia. Since 1978, Dr. Blumberg has been a certified member of the American Board of Radiology. He is a member of the American Medical Association, the American Society of Therapeutic Radiology and Oncology, the American College of Physician Executives, and the American College of Radiology.

## Michaeline Fedder, M.A.

Michaeline Fedder is the Director of Advocacy for the American Heart Association in Maryland. In this capacity, she coordinates, implements, and evaluates the American Heart Association's public advocacy program. Prior to this appointment, Ms. Fedder served as the Deputy Executive Director of Research, Medical and Community Programs for the Maryland chapter of the AHA. She has also acted as the Director of the AHA's Medical and Community Programs. Ms. Fedder holds a Bachelor of Arts degree from Queen's College in New York, New York. She has a Masters degree in Voluntary Agency Management from Central Michigan University. She is a recipient of the Maryland Public Health Association Health Education Award and has been recognized as a Lifetime Fellow of the American Heart Association National Staff Society.

## Hathaway Ferebee, M.C.P.

Since 1996, Hathaway Ferebee is the Executive Director of Safe and Sound Campaign, in Baltimore, Maryland. She graduated from the Mary Baldwin College with a B.A. in Sociology in 1975. In 1989, Ms. Hathaway obtained a Masters of Community Planning from the University of Maryland at Baltimore. From 1995 to 1996, Ms. Hathaway worked as a Program Officer for the Baltimore Community Foundation. Between 1989 and 1995, she worked as the Executive Director-Citizens Planning & Housing Association in Baltimore, Maryland. Ms. Hathaway also served as the Director of Development for Big Brothers and Big Sisters of Central Maryland, in Baltimore, Maryland from 1986 to 1989. She has served as Co-Chair on both the Governor's Office of Children, Youth, and Families' Policy Team and Empower Baltimore's Advisory Council. She has been a member of the Community Law Center Board since 1994, as well as a member of the After School Opportunity Act Advisory Board.

## Honorable Barbara A. Frush

State Delegate Barbara A. Frush was first elected to the Maryland House of Delegates in November, 1994. Prior to joining the Maryland General Assembly in January, 1995, Ms.

Frush worked in Annapolis as an aide to Senator Art Dorman. She also spent twelve years working on Capitol Hill as a legislative aide for former U.S. Congressman James O'Hara. Ms. Frush currently serves on both the State Environmental Matters Committee, as well as the Environmental Subcommittee. Additionally, as Vice Chairperson of the Prince George's Delegation, Ms. Frush hears State bills that deal with local issues, and is a member of the County Affairs Committee of the Delegation. She also serves as a member of the Commission on Aging, the Legislative Joint Committee on Group Homes, and served on the Joint Legislative Task Force On Organ and Tissue Donation. She has recently worked with Prince George's County's Education Funding Joint Task Force and the Joint Committee on Children, Youth and Families.

## Catherine R. Gira, Ph.D.

Dr. Catherine Gira became the President of Frostburg State University in September of 1991. Her prior work experience includes a nine year stint as Provost of the University of Baltimore, where she had also worked as Acting Dean of the College of Liberal Arts, and as a professor of English. Dr. Gira has been extensively involved in numerous national and state professional associations, including: The American Association of University Administrators; Federation of State Humanities Councils; Commission on Higher Education, Middle States Association, and Executive Committee; Maryland Humanities Council; and the Maryland Association of Higher Education. Dr. Gira currently serves on several regional and national boards, including those of the Western Maryland Health System, the Rocky Gap Foundation, the Regional Education Service Agency, the Cumberland Theater, Leadership Maryland, and the Maryland Symphony Orchestra. In addition to these accomplishments, Dr. Gira has been recognized as Woman of the Year by the Maryland Legislature, and as one of Maryland's Top 100 Women. In 1997, she was inducted into the Women's Hall of Fame. She has published numerous articles on Shakespeare, Renaissance art, literature, and issues in higher education. Dr. Gira also authored a bibliographic and critical study of Shakespeare's Henry IV, which was published in 1994 by the Garland Publishing Company.

## Lucy Howey

Lucy Howey is a senior at Wilde Lake High School, in Columbia, Maryland. She is a member of the yearbook staff, participates in the GT mentorship program, and an Executive Board Member on the Maryland Association of Student Councils. Miss Howey was a delegate at the National Association of Student Councils Conference in 1998 and again in 1999. She is a member of the Wilde Lake Tennis Team and the Equestrian Club. Ms. Howey has been recognized as SGA Officer of the Year and as an honor roll student.

## Robin Joynes

Robin Joynes has 15 years experience in resource development and project management, as well as in public relations. Ms. Joynes has worked with national, progressive non-profits, small community-based organizations, religious institutions, voluntary health organizations, and international nursing associations. She is the President and Senior Development Officer for Sunnia Communications, LLC, a full-service social marketing and public relations firm which develops social marketing strategies, public relations campaigns, health care promotions, strategic plans, and culturally specific advertising. During the summer of 1998, Ms. Joynes acted as the communications consultant for an international health conference in Gaborone, Botswana. After earning a Bachelor of Arts degree in political science from the University of North Carolina at Chapel Hill, she completed supplemental course work in Non-profit Management and Fundraising Development at Trinity College and at George Washington University, both located in Washington, D.C.

## Bishop Douglas I. Miles, M.A.

Douglas I. Miles is the Bishop of the Koinonia Baptist Church, where he supervises two pastors and a ministerial staff consisting of three ordained and three licentiate ministers. He obtained a Bachelor of Arts in Humanistic Studies at the Johns Hopkins University and a Masters degree in Theology from St. Mary's University and Seminary' Ecumenical Institute. Bishop Miles has acted as President of the Interdenominational Ministerial Alliance and as the Co-chair of the Greater Baltimore Interfaith Clergy Alliance. He is a candidate for Doctor of Ministry and is an honorary Doctor of Divinity.

## Karl K. Pence, M.A.

Karl K. Pence, 51, a resident of Hollywood in St. Mary's County, is a high school Latin and English teacher currently on leave to serve as president of the 51,000-member Maryland State Teacher's Association. A graduate of Indiana University (B.A.'72, M.A. '74), Pence has served as MSTA president since 1993. With his wife, Ernestine, Pence has two daughters pursuing careers and a 7$^{th}$ grader son at home.

## Honorable Samuel I. Rosenberg, J.D.

Samuel "Sandy" Rosenberg was first elected to the Maryland General Assembly in 1982. During his tenure, he has served on the Appropriations Committee (1983-present), and currently chairs the Appropriations Subcommittee on Health and Human Resources. He was the lead sponsor of the law establishing priorities for the use of the money Maryland

will receive from the settlement of the state's lawsuit against the tobacco industry. Mr. Rosenberg graduated from Amherst College with a Bachelor of Arts degree in 1972. Three years later, he earned a J.D. degree from Columbia University Law School in New York, New York. He is a law professor.

## John M. Ryan, M.D., M.B.A.

John M. Ryan, a graduate of the Indiana School of Medicine, is a pediatrician. Dr. Ryan is also certified in Preventive Medicine. He was a Trainee in Epidemiology at the Yale School of Medicine Laboratory Epidemiology Public Health. He has spent several years at the Cincinnati Health Department Epidemiology and Maternal Child Health. He has served as the Talbot County Health Officer since 1988. In addition, he holds an M.B.A. from Xavier, in Ohio.

## Terrell Smith

Terrell Smith is a senior at City College High School in Baltimore, Maryland, where he is member of the debate team. He has been active in numerous policy and advocacy groups such as the tobacco tax initiative. Mr. Smith is currently working on the health initiative and the child protected gun initiative. He is a chairperson for the Youth As Resources Board of Directors.

## Bishop Larry Lee Thomas, D.D.

Bishop Larry Lee Thomas, Sr. graduated from Morgan State University where he studied teaching and majored in Special and Physical Education. He then went on to pursue a Doctorate in Divinity from the Redeemed Bible Institute. Bishop Thomas completed his pastoral studies at the Urban Alternative Church Development and Leadership Conference, in Dallas, Texas. Bishop Thomas has been preaching the gospel since 1980. He was ordained as an Elder in 1981 and appointed as Pastor of the St. James Church of the Apostolic Faith in 1991. He is the President of the United Black Clergy of Anne Arundel County, the Vice-President of the Glen Burnie Ministerium, and serves on the Financial Committee of the Apostolic Ministrial Alliance of Baltimore. He also serves on many different boards within the community. Bishop Thomas serves on the Welfare Reform Board and the Cancer Committee of North Arundel Hospital. He is Chairman of the religious committee and coalition known as RESPECT. In addition to his membership on the Task Force, Bishop Thomas serves on the Children's Initiative Board, an organization committed to smoking cessation among teenagers.

## Honorable Christopher Van Hollen, J.D.

Maryland State Senator Christopher Van Hollen (D) represents District 18 in the Maryland General Assembly. He graduated from Swarthmore College in 1982 with a Bachelor of Arts degree. Shortly thereafter, he obtained an MPP from the John F. Kennedy School of Government at Harvard University. In 1990, he earned a J.D. degree from Georgetown Law School. He is currently a partner at the law firm of Arent, Fox, Kintner, Plotkin & Kahn. He is a member of the American Bar Association, the Maryland State Bar Association, and the Montgomery Country Bar Association. Mr. Van Hollen has been active in government for several years. From 1985-1987, he served as a legislative assistant in the office of U.S. Senator Charles Mathias. Between 1989 and 1991, Van Hollen acted as the Senior Legislative Advisor in former Governor William Donald Schaefer's Federal Relations Office. During his tenure in the Maryland General Assembly, he has acted as the Vice-Chairman on the County Affairs Committee and as Chairman of the School Board Redistricting Committee for the Montgomery County Delegation. In addition, he has sat on the House Joint Committee on Pensions, the House Environmental Matters Committee (1991-1992), and the House Appropriations Committee (1992-1994). Since 1995, Senator Van Hollen has been a member of the Senate Budget &Taxation Committee and is currently the Chairman of the Administrative, Executive and Legislative Review (AELR) Committee.

## Mario Franco VillaSanta

Mario Franco VillaSanta has extensive experience in commercial real estate. He organized the V-3 Group, a corporation that is engaged in the business of commercial real estate development, management, investments, and consulting within the mid-Atlantic region. Mr. VillaSanta is also the co-founder and principal of the Corridor Commercial Real Estate Group, a full service regional real estate brokerage firm and of the Superior Real Estate Group, a full service residential real estate company. He was involved in negotiations for the purchase, renovation, and lease-up of an historic, ten-story, 275,000 square foot, multi-million dollar building in Baltimore.

## Mary M. Weaver

Mary M. "Margie" Weaver is currently Division Chief of Vaccines for Children at the Maryland State Department of Health and Mental Hygiene. She has worked previously in public health education with the American Heart Association from 1989-1993 and the Wicomico County Health Department from 1993-1996, where she began the Tobacco Use & Cessation Program. Ms. Weaver is currently beginning her second term as Government Relations & Advocacy Workgroup for the Maryland State Region of the American Cancer Society. She resides in Frederick County.

### Karen M. White

Karen M. White currently serves as the Deputy Chief of Staff to Lt. Governor Kathleen Kennedy Townsend and Senior Advisor to Governor Parris N. Glendening of the state of Maryland. Ms. White served as Campaign Manager for the successful 1998 re-election of Governor Glendening and Lt. Governor Townsend. In this capacity, she managed a staff of over fifty people and served as both the chief executive of all campaign-related operations and as the most senior advisor to both candidates for political, communications, and administrative matters. Under Ms. White's leadership, the Glendening-Townsend campaign raised over six million dollars. Furthermore, the 1998 Maryland Governor's Re-election Campaign was considered one of the toughest in the country. Under White's leadership, the campaign was successful by a 12-point margin. Karen White has also served as Campaign Manager for many other statewide campaigns around the country. She has extensive experience in grassroots organizing, media relations, and statewide marketing campaigns. In addition to her campaign experience, Ms. White is considered one of the nation's leading trainers on political campaigns, with clients that include the National Women's Political Caucus, the National Association of Letter Carriers and the Democratic National Committee (DNC). She lives in Annapolis, Maryland, along with her husband, Rob Johnson, and their young daughter, McCall.

### Arnold Williams, C.P.A.

After graduating from the University of Baltimore with a Bachelor of Science in Accounting, Arnold Williams became a Certified Public Accountant. Since 1983, Mr. Williams has worked as the Managing Director of Abrams, Foster, Nole & Williams, P.A., in Baltimore, where he also serves as a Partner in charge of Accounting and Consulting Services. Mr. Williams is a member of the American Institute of Certified Public Accountants, the Maryland Association of Certified Public Accountants, the National Association of Black Accountants, the Baltimore City Chamber of Commerce, the Baltimore Corporation of Housing Partnerships, and the Baltimore Development Corporation.

## CONSULTANTS

### Hoover Adger, M.D., M.P.H.

Hoover Adger is Associate Professor of Pediatrics at The Johns Hopkins University School of Medicine and Deputy Director for Adolescent Medicine at The Johns Hopkins Hospital in Baltimore, Maryland. After graduating cum laude from Ohio University in

1975 with a B.S. in Zoology, he earned his medical degree from Case Western Reserve University School of Medicine in Cleveland, Ohio. In 1989, Dr. Adger completed his studies toward an M.P.H. (Health Policy and Management) at The Johns Hopkins University School of Hygiene and Public Health. In 1984, he joined the faculty of the Johns Hopkins School of Medicine and Hospital, serving as Director of Substance Abuse Assessment/Intervention Team at the Hospital's Adolescent Program. Dr. Adger has also served as the Director of The Johns Hopkins Substance Abuse Faculty Development Program. In February 1997, Dr. Adger was selected to be Deputy Director of the White House Office of National Drug Control Policy. In July 1998, he returned to Johns Hopkins to resume his duties as Associate Director of the Adolescent Program.

## Jonathan Samet, M.D., M.S.

Jonathan M. Samet is Professor and Chairman of the Department of Epidemiology of the Johns Hopkins University School of Hygiene and Public Health. He received a Bachelor's degree in Chemistry and Physics from Harvard College, an M.D. degree from the University of Rochester School of Medicine and Dentistry, and a Master of Science degree in Epidemiology from the Harvard School of Public Health. He is a trained clinician in internal medicine and pulmonary diseases. At The Johns Hopkins University School of Hygiene and Public Health, Dr. Samet is Co-Director of the Risk Sciences and Public Policy Institute. His research has addressed the effect of inhaled pollutants in the general environment and in the workplace. He has written widely on the health effects of active and passive smoking. Dr. Samet has served as Consultant Editor for Reports of the Surgeon General on Smoking and Health. He has served on the Science Advisory Board for the U.S. Environmental Protection Agency and was Chairman of the Biological Effects of Ionizing Radiation Committee VI of the National Research Council. He is presently Chairman of the National Research Council's Committee on Research Priorities for Airborne Particulate Matter. He was elected to the Institute of Medicine of the National Academy of Sciences in 1997.