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Center for Tobacco Prevention and Control Program Final Evaluation Report

Maryland Department of Health

UNIVERSITY OF BALTIMORE
Schaefer Center for Public Policy

Center for Tobacco Prevention and Control Program
Final Evaluation Report

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June 30, 2020

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ACKNOWLEDGEMENTS

The following Schaefer Center staff members played key roles in data collection and analysis of this final evaluation report.

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The research team is appreciative of the staff at the Maryland Department of Health, especially in the Center for Tobacco Prevention and Control, who supported this evaluation. The team would like to specifically acknowledge:

- Dawn Berkowitz, MPH, *Director, Center for Tobacco Prevention and Control*
- Dana Moncrief, MHS, *Chief, Statewide Public Health Initiatives*
- Christine Boyd, MPH, *Health Policy Analyst*
- Stephanie Papas, MPH, *Community Health Educator Statewide Initiatives*
- Nikardi Jallah, MPH, *Epidemiologist, YRBS Coordinator*

In addition, the research team offers deep thanks to the following individuals without whom this effort would not have been possible:

- Staff from the 24 LHDs in Maryland who participated in interviews, focus groups, surveys, strategic planning sessions, and data reviews;
- Grantees associated with the Center for Tobacco Prevention and Control who participated in interviews and strategic planning sessions; and,
- Staff from the Center for Tobacco Prevention and Control who participated in interviews and strategic planning sessions.

ABOUT THE SCHAEFER CENTER FOR PUBLIC POLICY

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

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

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

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

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EXECUTIVE SUMMARY

The Center for Tobacco Prevention and Control (CTPC) at the Maryland Department of Health (MDH) contracted with the Schaefer Center for Public Policy at the University of Baltimore, College of Public Affairs to conduct an evaluation of Maryland's Tobacco Control Program (the Program). The evaluation contract was in place from June 2017 through June 2020 and examined the program activities covering July 1, 2014 through December 31, 2019. An interim evaluation report was published in 2018[1]. This final evaluation report builds on the interim report to identify key progress including enhancements to data collection processes, greater collaboration in strategic planning initiatives, and enhanced program communications.

In the time since the Interim Report, the Program implemented several of the key recommendations including the development of a listserv to streamline communication between the Program and local health departments (LHDs), streamlining the annual grant application for LHDs for FY20, and completion of a program inventory report that documents how the Program is implemented across Maryland while providing detailed information for each jurisdiction and the state. Additionally, a new resource has been developed, "Partner Profiles," providing a snapshot of the accomplishments of local tobacco programs[2].

This evaluation also employed an implementation evaluation framework to examine the activities undertaken by CTPC, LHDs, and grantees to achieve the objectives of the 2015-2020 Maryland Comprehensive Cancer Control Plan, which is also the current state strategic plan, and to assess programmatic alignment with the 2014 Centers for Disease Control and Prevention's (CDC) Best Practices for Comprehensive Tobacco Control Programs. The Program objectives are to: reduce the prevalence of tobacco use among adults; reduce the prevalence of tobacco use among youth; decrease youth access to tobacco in the retail environment; reduce exposure of youth to secondhand smoke (SHS); and decrease exposure to SHS among Maryland residents by increasing voluntary household no smoking rules.

In completing this evaluation, the research team conducted an extensive review of documents from MDH and other sources; analyzed secondary data from a wide variety of sources such as the Behavioral Risk Factor Surveillance System (BRFSS) and the Youth Risk Behavior Survey/Youth

[1] The Interim Report is available here: https://phpa.health.maryland.gov/ohpetup/pages/Evaluation.aspx
[2] Partner Profiles are available here: https://phpa.health.maryland.gov/ohpetup/Pages/Evaluation.aspx

Tobacco Survey (YRBS/YTS); conducted interviews with representatives from each of the 24 Maryland LHDs, ten grantees, and nine CTPC staff; and conducted focus groups with representatives from the 24 Maryland LHDs. Additionally, the research team conducted a formal stakeholder survey to capture perceptions regarding the evaluation plan, research questions, and data collection efforts. To complement data collection, the research team provided strategic planning technical assistance to CTPC including hosting two stakeholder retreats and the development of comprehensive documentation related to the work of LHDs.

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

KEY FINDINGS

CTPC follows the CDC Best Practices for Comprehensive Tobacco Control Programs (Centers for Disease Control and Prevention, 2014). This evaluation considered the work accomplished across five core components. A summary of the findings include:

1. **Infrastructure, Administration, and Management.** Analysis of administrative documents, interviews, and strategic planning sessions found that CTPC program infrastructure reflects the fundamental elements of the CDC Best Practices model, such as: responsive planning, multi-level leadership, networked partnerships, managed resources, and engaged data. Additionally, CTPC demonstrated positive findings related to its sustainability, that is, the ability to maintain programming and corresponding benefits over time.
2. **State and Community/Local Interventions.** Across Maryland, CTPC supports tobacco prevention and control activities, including: funding two statewide resource centers; the Responsible Tobacco Retailer Initiative to support tobacco retailer compliance with youth access laws; and Minority Outreach and Technical Assistance Organizations (MOTA) as well as the Pregnancy and Tobacco Cessation Help (PATCH) Initiative to support tobacco prevention as well as cessation services to pregnant women and women of childbearing age. Additionally, all 24 LHDs in Maryland received state funding for tobacco control initiatives for school-based interventions, community-based interventions, local tobacco-use cessation interventions, and local enforcement of youth access restrictions. In addition, each LHD engages a representative local coalition to help plan tobacco control programming based on community needs. Together, these efforts reflect a robust state and community intervention strategy in alignment with the CDC Best Practices model.
3. **Mass-Reach Health Communication Interventions.** CTPC maintains a substantial mass-reach health communication strategy and reaches millions of Maryland residents every year through various campaigns. The campaigns are extensive, involve contracted expertise of an ad agency, and reflect the evolving landscape of tobacco use in Maryland. These efforts reflect the recommendations outlined in the CDC Best Practices model.
4. **Cessation Interventions.** CTPC supports several intervention strategies assisting Maryland residents with quitting tobacco use. At the state-level, CTPC funds the Maryland Tobacco Quitline (1-800-QUIT-NOW) to provide free cessation services to Marylanders age 13 and older. CTPC also supports various health systems including Johns Hopkins Health System, University of Maryland Health Systems, Sheppard Pratt, and Mosaic to incorporate tobacco treatment into routine clinical care. At the local-level, CTPC funds cessation activities for all 24 LHDs' tobacco control programs across the state. Together,

these efforts reflect a diverse cessation intervention strategy in alignment with the CDC Best Practices model.

5. **Surveillance and Evaluation.** Maryland conducts the Youth Risk Behavior Survey/Youth Tobacco Survey (YRBS/YTS) (middle and high school youth) and the Behavioral Risk Factor Surveillance System (BRFSS) (adult) surveys to produce jurisdiction-level and state-level estimates of key short-, intermediate-, and long-term outcomes. Data is used to track tobacco use rates among Maryland youth and adults to guide and support the implementation of the statewide comprehensive tobacco control program. Additionally, CTPC has implemented a new proprietary surveillance system to comprehensively monitor tobacco retailer compliance with state and federal restrictions on the sale of tobacco products to persons less than 18 years of age. These efforts reflect the CDC Best Practices recommendations for surveillance and evaluation.

Information on Research Questions, Goals and Objectives

To guide this evaluation, CTPC developed 11 research questions that align with the goals and objectives of the Program. A crosswalk between the research questions and program objectives is provided in Table 2. Findings for the research questions can be found in Table 6. Progress made toward each objective during the evaluation period is presented below.[3]

Objective 1: By 2020, reduce the prevalence of current cigarette smoking among adults by 5% to 15.6% from a 2013 baseline of 16.4%. In CY18, 12.5% of adults in Maryland currently smoked cigarettes, a decline of 23.8% from CY14.

Objective 2: By 2020, reduce high school youth tobacco use by 5% from a baseline of 16.9% in CY13. The percent of high school students who currently smoke cigarettes declined 70% from 16.9% in CY 13 to 5.0% in CY18.

Objective 3: Reduce the Synar Retailer Violation Rate (RVR) to 20% from a baseline of 24% in 2014. Maryland's RVR declined 64.7% from 24.1% in FFY14 to 8.5% in FFY19.

Objective 4: Reduce high school SHS exposure by 5% to 30.1% from a 2013 baseline of 31.7%. The percent of high school youth reporting that they had not been exposed to SHS indoors during the seven days before being surveyed increased from 68.3% in 2013 to 75.4% in 2018. This means that the percent of students exposed to SHS declined 22% from 31.7% in 2013 to 24.6% in 2018.

[3] The evaluation period is July 1, 2014 – December 31, 2019 (FY15-FY19). Outcome data in this report are presented as close to this period as possible. However, some measures are not available every year.

Objective 5: By 2020, decrease exposure to SHS among Maryland residents by increasing the number of voluntary household no smoking policies from 81.2% in 2013 to 85%. Most Maryland homes have voluntary no smoking rules. The percent households with no smoking policies increased to 89% in 2018, an increases of 9.6% from 2013.

RECOMMENDATIONS

Three administrative recommendations have been identified to encourage the allocation of resources and the expansion of programming to strategically meet the needs for tobacco control in Maryland for future years. Specifically, these recommendations support optimizing and aligning resources to focus on practices that are the most effective, viable, and successful. Table 8 at the end of this report includes suggested steps to operationalize these recommendations.

1. **Continue comprehensive, statewide improvements for data collection.** Continued strategic review of data collection processes could reveal opportunities for a centralized electronic data collection and reporting system or enhancements to the current system to be more standardized across jurisdictions.

2. **Continue investing in areas that work and strategically invest in areas of need.** Continued investment in areas of need across the state could improve outcomes at all levels; by targeting investment in high-need populations or high-need geographic areas, significant gains could be made in outcomes with these specific populations, in turn affecting statewide outcome measures.

3. **Formalize knowledge sharing by creating a resource repository.** A formalized system of resources, operating procedures, and state strategies would increase transparency, formalize operations, and create additional opportunities for communication.

Together, these three recommendations provide a path forward that strengthens the underlying decision-making infrastructure across the state to support expansion as well as improved outcomes in strategic areas of need. Enhancing data collection and resource sharing provides important mechanisms to reinforce the availability of information to all CTPC stakeholders. Further, this supports collaborative and intentional review of programmatic efforts to strategically focus on those areas that work – realizing the outcomes needed in the current Maryland landscape.

BACKGROUND

OVERVIEW OF MARYLAND TOBACCO CONTROL PROGRAM

The Maryland Tobacco Control Program is a statutory program (Title 13, Subtitle 10 of the Health General) overseen and implemented by the Center for Tobacco Prevention and Control (CTPC). Since 2000, state statute has directed a framework for the Program, which aligns with the five component areas outlined in the Centers for Disease Control and Prevention Best Practices for Tobacco Control Programs (Centers for Disease Control and Prevention, 2014). These component areas are: state and community/local interventions; cessation interventions; mass-reach health communications interventions; surveillance and evaluation; and infrastructure, administration, and management.

CTPC maintains a robust staff, many of whom have been with CTPC for more than ten years, demonstrating a continuity of programming and institutional knowledge. Staff roles align with CDC Best Practices to ensure a successful statewide program and include:

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

CTPC supports the Maryland Tobacco Quitline, 1-800-QUIT NOW, two statewide resource centers[4], local coalitions within each of Maryland's 24 jurisdictions, and numerous other partnerships. Funding is also provided to all 24 LHDs, which each have their own tobacco control programs that address school- and community-based programs, cessation, and enforcement activities.

[4] The Legal Resource Center for Public Health Policy (LRC) and the Maryland Resource Center for Quitting Use and Initiation of Tobacco (MDQuit).

Additional components of the CTPC include:

- Community-based programming including funding to organizations who reach vulnerable and underserved populations
- Health communications grantees
- Partnerships with other MDH entities (Centers for Cancer Prevention, Chronic Disease, and Oral Health programs, Maternal Child Health, WIC, Office of Minority Health and Health Disparities, Environmental Health, Medicaid, and Behavioral Health Administration)
- Health Systems grantees
- Statewide Advisory Board
- Statewide Tobacco Control Coalition

CTPC supports robust data collection as part of its surveillance and evaluation component. This includes middle school, high school, and adult surveys to produce jurisdiction-level and statewide estimates of key short-, intermediate-, and long-term outcomes. These data track tobacco use among Maryland youth and adults and support the implementation of a comprehensive tobacco control program.

During the evaluation period, CTPC utilized four distinct funding streams in support of tobacco control activities: State General Fund, CDC Office on Smoking and Health Core Grant, federal Prevention and Public Health funding (Quitline capacity), and State Cigarette Restitution Funds (Master Settlement Agreement [MSA] dollars). Most funds for the statewide program come from CRF dollars which are tied to a framework and operations governed by a statute adopted in 2000. Over the past 18 years, funding levels have fluctuated with a high of $21 million in 2000 to a current level of over $11 million (from state and federal funding combined). Additional background on the funding structure for CTPC can be found in Appendix 2.

The following is a timeline of tobacco control milestones in Maryland. CTPC has made great strides over the last two decades of work.

2000 The Center for Tobacco Prevention and Control is established using Master Settlement Agreement (MSA) dollars

2006 The Maryland Tobacco Quitline (1-800-QUIT-NOW) is launched

2007 Cigarette tax increased to $2/pack

2008 State Clean Indoor Air Act bans smoking in public places including restaurants and bars

2012 Non-premium cigar tax set at 70% of wholesale price; smokeless tobacco tax is set at 30% of wholesale price

2014 Evaluation period began (July 1, 2014)

2015 Responsible Tobacco Retailer Initiative is launched to reduce illegal tobacco sales to minors

2017 Licenses required to sell e-cigarettes/vapes

2018 Sale of Electronic Smoking Devices (ESDs), i.e., e-cigarettes, vapes, etc., to minors is criminalized; use/purchase of ESDs by minors becomes illegal.

2019 Minimum tobacco sales age raised from 18 to 21 years of age for all tobacco products, including ESDs; purchase/use/possession of tobacco by those under 21 years of age no longer criminalized; signage is required at retail outlets.

2019 Evaluation period ended (December 31, 2019)

PROGRAM GOALS AND OBJECTIVES

CTPC program goals align with CDC Best Practices for comprehensive tobacco control programs:

Goal 1: Prevent youth and young adults from initiating use of tobacco products;

Goal 2: Provide resources to assist residents in quitting tobacco use;

Goal 3: Eliminate exposure to secondhand smoke; and

Goal 4: Identify and eliminate tobacco-related health disparities among population groups disproportionately affected by tobacco-related death and disease (Center for Tobacco Prevention and Control, n.d.).

CTPC's program objectives guide decisions about programing, funding, and strategy. These objectives are aligned with both the CDC Core Work Plan as well as the Maryland Comprehensive Cancer Plan, which is also the state strategic plan. Table 1 connects the Program goals, objectives, and strategies.

Table 1: Crosswalk of Tobacco Control Program Goals, Objectives, and Strategies

Goals	Objectives	Strategies
Prevent initiation of tobacco among youth and young adults	1. By 2020, reduce the prevalence of tobacco use among high school youth by 5% to reach the following targets: Cigarette use – 11.3% (2013 baseline of 11.9%); Cigar use – 8% (2013 baseline of 12.5%); Smokeless tobacco – 6.9% (2013 baseline of 7.4%); All tobacco use – 16.1% (2013 baseline of 16.9%). 2. By 2020, decrease the retailer non-compliance rates for Synar inspections to 20% from a 2014 baseline of 24%.	• Restrict and enforce minors' access to tobacco products • Educate and inform stakeholders and decision-makers about evidence-based policies and programs to prevent initiation of tobacco use • Implement evidence-based, mass-reach health communication interventions to prevent initiation • Provide on-going training and technical assistance • Develop and maintain managed resources including adequate staffing, funding, sub-recipient grants and contracts • Disseminate and use surveillance data to inform planning and program implementation
Promote quitting among adults and youth	1. By 2020, reduce the prevalence of current cigarette smoking among adults by 5% to 15.6% from a 2013 baseline of 16.4%. 2. By 2020, reduce the prevalence of tobacco use among high school youth by 5% to reach the following targets: Cigarette use – 11.3% (2013 baseline of 11.9%); Cigar use – 8% (2013 baseline of 12.5%); Smokeless tobacco – 6.9% (2013 baseline of 7.4%); All tobacco use – 16.1% (2013 baseline of 16.9%).	• Maintain capacity for the Maryland Tobacco Quitline • Increase engagement of health care providers and systems to expand utilization of proven cessation methods • Implement evidence-based, mass-reach health communication interventions to promote cessation and support the Maryland Tobacco Quitline • Provide on-going training and technical assistance
Eliminate exposure to secondhand smoke	1. By 2020, reduce exposure of high school youth to secondhand smoke by 5% to 30.1% from a 2013 baseline of 31.7%. 2. By 2020, decrease exposure to SHS among Maryland residents by increasing the number of voluntary household no smoking policies from 81.2% to 85%.	• Increase policies for smoke-free multi-unit housing • Implement and enforce policies for tobacco-free public places • Educate and inform stakeholders and decision-makers about evidence-based policies and programs to reduce exposure to secondhand smoke • Implement evidence-based, mass-reach health communication interventions to reduce exposure to secondhand smoke • Provide on-going training and technical assistance • Disseminate and use of surveillance data to inform planning and program implementation
Identify and eliminate tobacco-related disparities among population groups	1. By 2020, reduce the prevalence of current cigarette smoking among adults by 5% to 15.6% from a 2013 baseline of 16.4%. 2. By 2020, reduce the prevalence of tobacco use among high school youth by 5% to reach the following targets: Cigarette use – 11.3% (2013 baseline of 11.9%); Cigar use – 8% (2013 baseline of 12.5%); Smokeless tobacco – 6.9% (2013 baseline of 7.4%); All tobacco use – 16.1% (2013 baseline of 16.9%).	• Use data to identify disparate populations and inform public health action • Implement evidence-based, mass-reach health communication interventions to reduce and eliminate tobacco related disparities among population groups • Develop and maintain managed resources including adequate staffing, funding, sub-recipient grants and contracts including community-based organizations and local coalitions • Provide on-going training and technical assistance to incorporate evidence-based cessation and prevention messages into routine clinical care, including facilities that serve behavioral health, Medicaid, and pregnant populations

KEY STAKEHOLDERS

CTPC has an extensive network of collaborative partnerships that inform its work and utilize its programming and data products. These include: the two statewide resource centers (Legal Resource Center [LRC] and MDQuit), the MDQuit Statewide Advisory Board, the Maryland Tobacco Quitline, all 24 LHDs and their respective coalitions, and the health communications agency under contract with CTPC. Additional partners include: health care providers, health care systems, members from the statewide Maryland Tobacco Control Coalition (voluntary organizations such as the American Lung Association, the American Cancer Society, and the American Heart Association, and other organizations), and the Maryland Cancer Collaborative.

EVALUATION DESIGN

STATEMENT OF NEED

Program evaluation is a critical organizational practice in public health and a necessary component of successful comprehensive tobacco control programs. CTPC was last comprehensively evaluated in 2007. Beginning in 2017, CTPC initiated a comprehensive multi-year evaluation effort that generated an interim and final evaluation report. The interim findings focused on programmatic activities and achievements, which are available in summary and full-length formats[5]. This final evaluation report focuses on data collection and analyses since the Interim Report with a focus on program implementation, infrastructure, and administration.

EVALUATION PURPOSE

The evaluation will produce practical and actionable recommendations to be used by CTPC and its partners. These recommendations will include opportunities to: improve program implementation and effectiveness; optimize resource utilization; and support implementation of CDC Best Practices. The evaluation will also demonstrate the Program's progress toward its short-, intermediate-, and long-term program goals.

INTENDED AUDIENCE

This evaluation is intended to inform the work of CTPC and its stakeholders described above.

[5] The Interim Report is available here: https://phpa.health.maryland.gov/ohpetup/pages/Evaluation.aspx

EVALUATION RESEARCH QUESTIONS

At the core of every evaluation are questions which guide the work to be accomplished. For this project, the research questions were developed to guide the evaluation and were articulated in the CTPC evaluation plan (Center for Tobacco Prevention and Control, 2015). For strategic planning purposes, these research questions were mapped to CTPC program objectives and goals. See Table 2.

Table 2: Evaluation Research Questions and Corresponding Program Objectives and Goals

Research Questions	Objective 1: Reduce adult smoking by 5%	Objective 2: Reduce HS tobacco use by 5%	Objective 3: Reduce Synar RVR to 20%	Objective 4: Reduce HS SHS exposure by 5%	Objective 5: Reduce SHS thru household no smoking policies	Goals 1-4[6]
Part A: Responsible Tobacco Retailer Initiative Reducing Youth Access to Tobacco Products						
1. Were responsible Tobacco Retailer resources appropriately allocated, developed, and distributed to partners?		X	X			Goal 1
2. To what extent was needed technical assistance (TA) provided to partners involved with implementing the Responsible Tobacco Retailer Initiative?		X	X			Goal 1
3. To what extent have CTPC and collaborative partners increased activities designed to increase education and outreach directed at licensed tobacco retailers? [7]		X	X			Goal 1
4. To what extent have CTPC and other statewide entities increased enforcement activities?[1]		X	X			Goal 1

[6] Goal 1 = Prevent Initiation of tobacco among youth and young adults, Goal 2 = Promote quitting among adults and youth, Goal 3 = Eliminate exposure to secondhand smoke, Goal 4 = Identify and eliminate tobacco-related disparities among population groups.

[7] The evaluation plan submitted to CDC included two questions that contained the limited timeframe of 2013-2015. The current evaluation report has eliminated "2013-2015" from these research questions to continue to make observations about trends into the present.

Research Questions	Objective 1: Reduce adult smoking by 5%	Objective 2: Reduce HS tobacco use by 5%	Objective 3: Reduce Synar RVR to 20%	Objective 4: Reduce HS SHS exposure by 5%	Objective 5: Reduce SHS thru household no smoking policies	Goals 1-4[6]
5. Did the Synar non-compliance rates decrease (from 24% in FFY14, 31% in FFY15) and to what extent did compliance with tobacco control policies related to youth access increase?		X	X			Goal 1
Part B: Maryland Comprehensive Tobacco Control Program Activities						
6. To what extent does the Maryland Tobacco Control Program implement the CDC Best Practices model and are the programmatic activities at the state and local level reflective of community needs?	X	X	X	X	X	Goal 1, 2, 3 & 4
7. To what extent has CTPC increased health communication interventions and messages reaching the general population and populations with negative disparities in the use of tobacco products and tobacco-related death and disease (racial/ethnic groups, low SES, Medicaid, Behavioral Health, LGBTQ, & youth)?	X	X				Goal 4
8. To what extent has CTPC and partners increased the number of implemented evidence-based interventions and strategies that address vulnerable and underserved populations?	X	X				Goal 4
9. To what extent has the Tobacco Program and its partners increased the demand for tobacco cessation and increased quit attempts?	X	X	X			Goal 1 & 2

Research Questions	Objective 1: Reduce adult smoking by 5%	Objective 2: Reduce HS tobacco use by 5%	Objective 3: Reduce Synar RVR to 20%	Objective 4: Reduce HS SHS exposure by 5%	Objective 5: Reduce SHS thru household no smoking policies	Goals 1-4[6]
10. To what extent did the use of tobacco products decrease since 2014?	X	X	X	X	X	Goal 1, 2 & 3
11. To what extent did the prevalence of tobacco use decrease among targeted high-risk populations?	X	X				Goal 4

EVALUATION METHODS

This evaluation utilized several different methods of data collection to address the research questions driving this assessment of CTPC. Data collection was largely qualitative in nature, including interviews, focus groups, administrative document reviews, and feedback from strategic planning sessions. When appropriate, quantitative data was also reviewed including administrative datasets, stakeholder surveys, and program activity inventories. This section presents the program evaluation methodology in more detail.

DATA COLLECTION AND ANALYSIS

Stakeholder Engagement Process

Stakeholder buy-in is critical to the success of the evaluation process and it is the ultimate utility and usability. CTPC supported two core activities to engage stakeholders in the beginning of the evaluation process in the fall of 2017. First, presentations were made to stakeholders to inform them of the evaluation process and research activities that would be taking place. Presentations were conducted for LHDs, Tobacco Control Program Coordinators, CTPC Health Systems grantees, and the MDQuit Advisory Board. Second, an online stakeholder survey was conducted to gauge stakeholder perceptions about the research plan, questions, and methods. Results of the email-based survey found 74% (n=23) of respondents reported that they were satisfied the research questions would yield useful information. Ongoing efforts to engage stakeholders as part of the strategic planning process continues to be a priority for CTPC. Please also see the following subsection titled “Strategic Planning Retreats”.

Document and Data Review

This project relied heavily on the review of documents and analysis of secondary data. The documents included legislation, CDC grants and guidelines, CTPC partner grant applications, CTPC partner grant reports, and prior evaluations of CTPC and/or partners. While most of the administrative files were formal reports, a portion of the files included administrative data compiled through the reporting and monitoring activities of CTPC. This included data from grantee reports as well as administrative data submitted annually as part of legislatively required reports. All administrative data from the LHD reports utilized in this evaluation has been validated and corrected for inclusion.

Interviews

In the fall of 2017, researchers performed semi-structured interviews of three groups associated with the CTPC: 1) LHD staff (n=24), 2) CTPC grantees (n=10), and 3) CTPC staff (n=9). Interviews were semi-structured and covered four topics: overview of the respective program; data and reporting; sustainability of local programs; and successes and challenges of implementation. LHDs were also asked specifically about target populations served by local programs. Each interview lasted between one to two hours and a transcript was created from a digital recording. Altogether, there were approximately 62 hours of interviews which generated 1,537 pages of transcripts. The coding structure developed for this project was derived from thematic and descriptive content covered in the interviews. The research team used manual and text searches to assign codes to interview content using NVivo 11 for Windows.

LHD Focus Groups

Focus groups were another primary data collection activity conducted in the fall of 2017. Four focus groups were conducted with LHD staff across Maryland. Representatives from 19 of Maryland's 24 LHDs participated in the focus groups. Discussions covered local tobacco control programs with a specific emphasis on the support received, barriers encountered, and what is required to implement these programs. Altogether, the focus groups lasted 7.75 hours and produced 104 pages of transcripts.

LHD Program Inventory

An inventory of LHD tobacco control program organizational structure and programming was prepared to document how the Program is implemented across LHDs in Maryland. In September and October of 2018, LHDs completed an online survey with a series of questions across 11 domains. Participation rates were high with 22 of 24 jurisdictions completing the survey. The data obtained from the inventory was compiled into a summary report[8].

LHD Partner Profiles

To support standardized representation of LHD programmatic activities, Partner Profiles for each of the 24 Maryland jurisdictions were prepared. A partner profile is an administrative tool that presents data points across a standard set of domains to support strategic reviews of programs with many partners. The partner profiles developed for CTPC incorporated data from the Program Inventory as well as other administrative reports and statewide datasets. In addition, profiles were drafted with iterative feedback from CTPC and staff from LHDs. Final versions of all

[8] The LHD Program Inventory is available here: https://phpa.health.maryland.gov/ohpetup/pages/Evaluation.aspx

profiles were compiled into a summary report and reviewed by CTPC as well as the LHDs for accuracy prior to releasing[9].

Strategic Planning Retreats

Two strategic planning retreats were held for CTPC, LHD, and Resource Center staff to expand on findings from the focus groups, interviews, and document reviews[10]. The retreats provided an opportunity for all partners to review state priorities and to determine opportunities for strengthening program infrastructure and collaboration to reach shared state goals. The retreats were held on October 11, 2018 and October 10, 2019 in centrally located Howard County with robust attendance from LHDs as well as staff from the statewide resource centers, MDQuit and the LRC, and CTPC.

The 2018 strategic planning retreat began with a morning discussion about statewide goals and strategies to improve outcomes. Afternoon breakout sessions allowed for a deeper dive into three topics: measuring and reporting performance, institutionalizing and managing knowledge, and maximizing program effectiveness. The 2018 retreat enabled discussion on the grant making process and LHD grant applications were reviewed ahead of the launch of a new grant template. New communications tools including the listserv were shared to further resource sharing between and among LHDs. Information from the 2018 retreat furthered the development of the "Partner Profiles". Partner Profiles are designed to showcase local tobacco program activities and accomplishments for program funders, coalition members, and other stakeholders as well as to support onboarding of new LHD staff.

The 2019 strategic planning retreat started with updates by Dawn Berkowitz, Director of the Center for Tobacco Prevention and Control and a presentation on Health Equity, Tobacco and Behavioral Health by Taslim van Hattum, Director of Practice Improvement for the National Behavioral Health Network for Tobacco & Cancer Control. The health equity presentation provided recommendations on addressing tobacco use in behavioral health populations such as adopting tobacco-/smoke-free facility/grounds, integrating tobacco treatment into behavioral health care, and using the Quitline and other evidence-based models. The afternoon breakout sessions focused on reviewing current strategies with a health equity lens, prioritizing strategies by highest likely impact on priority populations, and selecting the best performance measures. The input received on the strategies and related performance measures will be in the Maryland Tobacco Control Strategic Plan: 2020–2025.

[9] The Partner Profiles are available here: https://phpa.health.maryland.gov/ohpetup/pages/Evaluation.aspx
[10] The Strategic Planning Retreat Summary Reports for 2018 and 2019 are available here: https://phpa.health.maryland.gov/ohpetup/pages/Evaluation.aspx

STRENGTHS/LIMITATIONS

Evaluation strengths include large amounts of data collected, strong participation from CTPC stakeholders, and feedback loops with evaluation stakeholders to clarify findings. This evaluation benefits from uninhibited access to a great variety of data sources that were obtained over several years. The large amount of data sources provided a comprehensive picture of administrative and programmatic activities of CTPC. In addition, this evaluation had strong participation levels from CTPC stakeholders including LHDs, state grantees, and staff from state resource centers, allowing for many different points of observation. This evaluation was strengthened by robust LHD participation. This evaluation is also strengthened by engaging in regular feedback loops with CTPC and its stakeholders to clarify findings of the evaluation. This allowed the evaluation to "validate" the findings from those individuals who are subject matter experts.

Limitations to the evaluation include working with an abundance of data across a multi-year evaluation period, staff turnover, and limitations of administrative documents. While this evaluation benefits from access to considerable data sources and stakeholders, this also inhibited elements of the evaluation such as ensuring data accuracy and representativeness. In addition, some of the stakeholders experienced turnover during the evaluation period, most notably within LHDs. Also, there were times when administrative documents reviewed for this evaluation contained inaccuracies that compounded efforts to tabulate evaluation findings. Overall, the strengths of this work greatly outweigh the limitations.

EVALUATION RESULTS

Building on the findings from the interim evaluation, this report focuses on program implementation and is organized by CDC Best Practice Component Areas (Centers for Disease Control and Prevention, 2014), with a particular focus on CDC's Administration, Infrastructure, and Management Component, including an assessment of CTPC's sustainability capacity (Center for Public Health Systems Science, 2019). Also included is a summary table that maps progress made on research questions, including those addressed in the interim report, key data sources, evaluation results, and program goals.

Infrastructure, Administration, and Management

Consistent with CDC Best Practices, CTPC organizes its programs with a multi-level management approach and a supportive infrastructure (Centers for Disease Control and Prevention, 2017). Analysis of administrative document review, interviews, and strategic planning sessions related to this evaluation demonstrate that program infrastructure includes: responsive planning, multi-level leadership, networked partnerships, managed resources, and engaged data. Therefore, infrastructure includes not only funding and personnel (e.g., managed resources), but management structures (e.g., multi-level leadership and networked partnerships), strategic planning (e.g., responsive planning), and measurement tools (e.g., engaged data). More details and explanations on these terms can be found in Appendix 3.

CTPC provides strategic planning, oversight, technical assistance and training to LHDs, grantees, and partners. For LHDs, planning and oversight occurs as part of grant and program monitoring with technical assistance, strategic planning, and training occurring throughout the year at professional development events. For grantees and other funded partners, strategic planning and oversight is largely concentrated in the CTPC staff member operating as the contract monitor. CTPC has made efforts to be transparent about these formal efforts, such as presentations at statewide events, and informal efforts, such as updates on stakeholder conference calls. In this way, CTPC ensures that statewide efforts align with program goals and messaging.

In addition, CTPC has engaged in several new initiatives to expand their dedication to these best practices and addressing concerns revealed in the interim evaluation report. This included the development of a listserv among CTPC, LHDs, and partners to support the timely exchange of information across the network of funded partners. CTPC has also streamlined their grant applications for LHDs and provided comprehensive data summary sheets to each LHD to encourage data-driven programming. Relatedly, CTPC has developed a series of documents to organize programmatic information in a strategic manner. This includes the Partner Profiles and a statewide Program Inventory for all LHD programs, as described earlier in this report. These documents present data points across a standard set of domains to support documentation and strategic reviews of programming across multiple partners.

This evaluation also explored the sustainability of the CTPC program using the Program Sustainability Assessment Tool (Center for Public Health Systems Science, 2019)[11]. This framework consists of eight organizational and contextual domains related to the capacity of public health programs. Together, these domains reflect the sustainability capacity, or the ability to maintain programming and corresponding benefits over time.

[11] The Program Sustainability Assessment Tool was developed by the Center for Public Health System Science in the Brown School of Social Work at Washington University in St. Louis. More information: https://sustaintool.org/

Table 3: Evaluation Findings around Program Sustainability for CTPC

Sustainability Domain	Definition	Evaluation Observations
Communications	Strategic communication with stakeholders and the public about your program.	Data collected through interviews, focus groups, and strategic planning sessions revealed that stakeholders have noticed a dedicated effort to enhance the internal and external communication at CTPC. Examples of improvements include: hiring a communications firm to support statewide mass-reach communication campaigns; increase in statewide webinars and conference calls to support community-level work; development of a listserv; and changes to program administration (i.e., grant application; data collection definitions) that reflect information gathered during the evaluation period.
Environmental Support	Having a supportive internal and external climate for your program.	CTPC has sustained a comprehensive tobacco control program for nearly two decades, with programming and infrastructure that aligns with CDC Best Practices. This is a remarkable achievement and data collected from this evaluation demonstrate that CTPC continues to engage in activities to support strong and collaborative partnerships.
Funding Stability	Establishing a consistent financial base for your program.	Over the past 19 years, funding levels for the Program have fluctuated. However, since 2015, CTPC has secured additional state dollars to support tobacco enforcement initiatives; CTPC has also secured additional funds through its Tobacco Quitline Medicaid Match Program and by leveraging health systems' infrastructure to support increased Quitline referrals. To support the retailer initiative, Governor Hogan created a Tobacco Enforcement line item in the Cigarette Restitution Fund budget for approximately $2,000,000 beginning in FY17.

Sustainability Domain	Definition	Evaluation Observations
Organizational Capacity	Having the internal support and resources needed to effectively manage your program.	Administrative documents suggest CTPC maintains alignment between its mission and activities and robust staffing and leadership. However, there is an opportunity to expand shared resources and training for LHDs, as reflected in conversations from the interviews, focus groups, and strategic planning sessions.
Partnerships	Cultivating connections between your program and its stakeholders.	CTPC has a strong history of cultivating partnerships at the state and local level. This evaluation has documented extensive investment in LHDs, health systems, resource centers, coalitions, and volunteer organizations, reflecting a commitment to CDC Best Practices.
Program Adaptation	Taking actions that adapt your program to ensure its ongoing effectiveness.	Over the last two decades, CTPC has made considerable efforts to evolve the tobacco control program activities to reflect changes in state and local priorities, federal guidelines, evidence-based programs and/or best practices, and legislative requirements. Increased use of health systems to support tobacco cessation is one example. Other examples can be found in the Partner Profiles and Program Inventory Report[12].
Program Evaluation	Assessing your program to inform planning and document results.	Through administrative document review, this evaluation found that CTPC engages in robust data collection of its programming, supporting both surveillance and planning purposes. CTPC also has plans to continue program evaluation efforts to support enhanced strategic planning and standardization of data collection moving forward.

[12] The Partner Profiles and the Program Inventory Report are available here: https://phpa.health.maryland.gov/ohpetup/pages/Evaluation.aspx

Sustainability Domain	Definition	Evaluation Observations
Strategic Planning	Using processes that guide your program's directions, goals, and strategies.	Prior to 2017, ancillary strategic planning efforts were conducted; however, dedicated strategic planning efforts were not routinely conducted, likely as a result of flat-lined funding. As part of this evaluation process, CTPC supported strategic planning sessions with input from LHDs and partners to enhance programmatic efforts across the state and outcomes on key indicators. CTPC plans to continually engage its partners in strategic planning, including the development of the 2020-2025 Maryland Cancer Control Plan, which is also the state strategic plan.

Statewide Public Health Interventions

During the evaluation period, CTPC implemented three key statewide public health interventions: (1) State Funded Tobacco Use Prevention and Cessation Resource Centers (LRC[13] and MDQuit[14]); (2) Responsible Tobacco Retailer Initiative[15]; and (3) Minority Outreach and Technical Assistance Organizations (MOTA)[16] and Pregnancy and Tobacco Cessation Help (PATCH). Interviews and corresponding administrative documents showed several strengths in these statewide public health approaches. The Resource Centers discussed how the events they hold (i.e., trainings, conferences, webinars, and phone conferences) are some of the most successful mechanisms for gathering and exchanging information related to tobacco prevention and control with stakeholders from across the state. Both MDQuit and LRC host annual conferences that bring together providers and professionals from LHDs, healthcare organizations, state agencies, colleges and universities, and faith-based organizations as well as nationally recognized plenary speakers.

MOTA vendors noted how their size and community reputations allows them to be successful in reaching individuals that are often left out of more traditional public health services. Together, these activities align with CDC Best Practices – providing skills, resources, and information to community programs (Centers for Disease Control and Prevention, 2014) as well as cultivating networked partnerships (Centers for Disease Control and Prevention, 2017).

Documentation regarding the success of the Responsible Tobacco Retailer Initiative was provided in detail as part of the interim evaluation[17]. Highlights include: an online retail training module available in nine languages (identified as priority languages by LHDs); the distribution of postcard mailers, educational materials, and ancillary items (i.e., window clings and register calendars) to LHDs, MOTAs, and over 6,000 licensed tobacco and ESD retailers; improved partnerships with the Office of the Comptroller to increase enforcement efforts for retailers who violated youth tobacco sales laws on multiple occasions; and technical assistance webinars hosted by the LRC for local enforcement staff with tools and tips for conducting and documenting enforcement

[13] The Legal Resource Center for Public Health Policy (LRC) provides legal technical assistance to community groups, employers, LHDs, residents, and agencies across Maryland. The LRC is part of the School of Law at the University of Maryland.

[14] MDQuit links tobacco control professionals and healthcare providers to state tobacco initiatives; provides evidence-based resources and tools to local programs; and supports a collaborative network of tobacco prevention and cessation professionals. MDQuit is part of the University of Maryland Baltimore County.

[15] The Responsible Tobacco Retailer Initiative brings together community and state partners to educate retailers on youth tobacco sales laws and increase enforcement of these laws to reduce youth access to tobacco products.

[16] CTPC partners with the Minority Outreach and Technical Assistance (MOTA) Initiative (Maryland Department of Health, 2018a). MOTA was established in 2001 under the provisions of the Cigarette Restitution Fund (CRF) to support for MDH efforts to reach vulnerable populations and help the CRF program to engage minority populations to serve on tobacco and cancer community health coalitions

[17] The Interim Report is available here: https://phpa.health.maryland.gov/ohpetup/pages/Evaluation.aspx

visits, and a toolkit for LHDs on new youth access laws and civil monetary penalties for tobacco sales to minors.

Community/Local Public Health Interventions

All 24 LHDs receive state funding for tobacco control initiatives in their respective jurisdictions. Local tobacco control programs cover four components: school-based interventions; community-based interventions; local tobacco cessation interventions; and local enforcement of youth access restrictions. In addition, each LHD must have a local health coalition that is representative of their jurisdiction's diverse demographics and helps to plan tobacco control programming based on community needs. During this evaluation, it was observed that activities and accomplishments vary across the jurisdictions depending on local need, expertise, and resources. This is a strength of the CTPC because LHDs are designing efforts to influence individuals in their daily environment (i.e., work, school, public spaces) while aligning with CDC Best Practices (Centers for Disease Control and Prevention, 2014). To document these efforts, the Program Inventory Report and the Partner Profiles were created on tobacco control activities accomplished at the community level. These reports provide insight on the organizational structure of the LHD programs as well as the breadth of activities conducted across the state. Notable to these documents is that while the majority of LHDs provide core services (e.g., cessation activities or enforcement activities), in a few cases LHDs report that they do not provide these services directly. This reflects the commitment by CTPC and LHDs to tailor programming to meet the needs of their community and local coalitions. Please see the LHD Program Inventory Report and Partner Profiles for more information on how LHDs engage in tobacco control initiatives[18].

Mass-Reach Health Communication Interventions

CTPC implements health communication efforts with multiple CRF funding sources, as well as federal funds.

CTPC awarded a five-year media contract to Red House Communications (via competitive solicitation) in April 2017. Red House Communications designs, develops, and implements health communication campaigns to further CTPC program goals. The impact of mass reach media campaigns is summarized in Table 4 for FY19, FY18, and FY17.

[18] The LHD Program Inventory Report and Partner Profiles are available here: https://phpa.health.maryland.gov/ohpetup/pages/Evaluation.aspx

The campaigns have included:

- Multiple campaigns promoting the Quitline;
- Campaigns reaching those in vulnerable populations [e.g., Medicaid participants; individuals with behavioral health conditions including mental health and substance use disorders; pregnant women; and individuals who are lesbian, gay, bisexual, transgender, and queer (LGBTQ)];
- Responsible Tobacco Retailer campaign;
- Clean Indoor Air Act 10th Anniversary celebration (also known as "Clean Air Maryland"); and
- The Vape Experiment campaign.

Table 4: Mass-Reach Media Campaigns, Audience, and Impressions (FY17-FY19)

Media Campaign	Audience	Impressions (dates aired)
Mass-Reach Media		
"Real Marylander" TV testimonials were aired. In FY19, the Program's Director, Dawn Berkowitz, was interviewed as part of the WBFF "B'more Lifestyle" program and was featured on the MyTVBaltimore website. In FY18, Dawn Berkowitz, was interviewed as part of the "B 'more Lifestyle" program and on "Midday Maryland".	Testimonials ran on WJZ, WNUV, and WBFF, which cover the Baltimore Metro area; WBOC, which provides coverage for Ocean City/Salisbury market area; and Comcast Cable covering Prince George's and Montgomery Counties.	Over 11.8 million in FY19 (In FY19, dates aired: December 24, 2018 to January 30, 2019.) Over 10 million in 2018 (In FY18, dates aired were January 15, 2018 to June 25, 2018). Over 1.7 million in FY17 (December 16, 2016 to January 12, 2017
In FY17, a Spanish language testimonial was aired featuring Rose, a smoker who struggled with cancer.	Testimonial ran on WFDC and WMDO, Univision affiliate networks, and CTV.	Over 17.7 million in FY17 (December 19, 2016 to January 15, 2017)
An educational PSA promoting the Quitline. These ads were distributed via wall mounted video flat screens with audio in healthcare provider waiting rooms across the State.	Health care provider and hospital waiting rooms • 370 rooms in FY19 • 391 rooms in FY18 • 406 rooms in FY17	Over 2.9 million (In FY19, dates aired: December 3, 2019 to February 24, 2019 and May 27, 2019 to June 30, 2019) Over 780,000 in FY18, (June 15, 2018 to June 30, 2018). Over 8 million in FY17 (January 2, 2017 to March 31, 2017)

Media Campaign	Audience	Impressions (dates aired)
A 30-second audio PSA promoting the Quitline	Grocery store locations • 246 stores in FY19 • 237 stores in FY18 • 240 stores in FY17	Over 12 million in FY19 Over 4.3 million in FY18 Over 11 million in FY17
The Program placed 30-second radio ads across Baltimore radio stations. The stations included WERQ, WWIN, WZFT, WQSR, WLIF, and WWMX.	Baltimore radio listeners	Over 5 million in FY19 only (May 13, 2019 to June 16, 2019)
In June 2019, the Program sponsored a Z104.3 Summer Concert in Baltimore City. Quitline advertisements were disseminated through e- newsletters, Z104.3's website, iHeartRadio digital banners, and display screens at the concert venue.	Youth and young adults	1,500 concert attendees in FY19 only (June 2019)
Transit Mass-Reach Health Communication		
The Program placed the Quitline "Resolve to Quit" ads on transit mediums.	Maryland residents	An estimated 29 million in FY19 (December 17, 2018 to February 17, 2019) An estimated 34 million in FY18 (December 18, 2017 to February 11, 2018) An estimated 20 million in FY17 (December 19, 2016 to January 15, 2017)
In FY19, the Program placed Quitline "Ready to Quit" ads on transit mediums to raise awareness of the Quitline's free services available to Maryland residents. In FY18, the Program placed "Quitline Pregnancy" ads.	Baltimore City, Somerset, Wicomico, Worcester, Dorchester, Caroline, Talbot, and Harford Counties	Over 34 million in FY19 May 6, 2019 to June 6, 2019). Over 27 million in FY18 (May 7, 2018 to June 17, 2018).
Web and Digital Placements		
The Program placed Quitline ads on digital touch screens or jukeboxes in bars and restaurants across Maryland. In FY19, ads were on 413 devices. In FY18, ads were on 413 devices. In FY17, ads were on 400 devices.	Current smokers in bars and restaurants	Over 11 million (November 19, 2018 to February 3, 2019) Over 9 million (November 13, 2017 to February 4, 2018) Over 6 million (December 2016 to January 15, 2017)

Media Campaign	Audience	Impressions (dates aired)
The Program placed several web ads on Google Display/Video Network promoting the Quitline. In FY19, "Real Marylanders Testimonial" ads aired in February to coincide with National Healthy Heart Month; "No Tobacco Litter" ads aired in April/May 2019 to coincide with Earth Month; and modified versions the National LGBT Cancer Network's "Because Me" ads aired in May/June 2019 to coincide with LGBTQ Pride month. In FY18, the Program placed web ads on Google AdWords. In FY17, the Program placed web ads on Google Ad Words	Those that use the Google Display/Video Network and the National LGBT Cancer Network's webpage.	Over 2 million in FY19. Over 77,000 in FY18. Over 96,000 in FY17.
In FY19 and FY18, the Program placed web ads on WJZ.com promoting the Quitline and directing those who clicked on the ads to the Quitline website.	Visitors of the WJZ.com website.	Over 500,000 (December 24, 2018 to January 27, 2019) Over 500,000 (December 25, 2017 to February 11, 2018)
In FY19, the Program placed 30-second radio ads and a static banner display on Spotify radio.	Spotify radio users.	Over 1 million in FY19 (From December 24, 2018 to January 27, 2019 and May 6, 2019 to June 16, 2019).
The Program placed 225 Quitline ads on Gas Station TV in FY17 and FY18. • In FY18, 225 ads • In FY17, 210 ads	Gas Station TV viewers	Over 526,000 in FY18 (June 4, 2018 to June 24, 2018) Over 1 million in FY17 (February 21, 2017 to June 30, 2017)
In FY19 and FY18, the Program placed geo-filters on Snapchat to promote a smoke-free life during LGBTQ Pride celebrations across the state.	The Snapchat geo-filters were geo-targeted to Pride events occurring in Baltimore City, Frederick, Howard County, Annapolis, the Lower Eastern Shore Region, and the Mid-Shore Region in FY19. In FY18, the Snapchat geo-filters were geo-targeted to Pride events occurring in Baltimore City and Frederick.	Over 44,000 in FY19 (May 2, 2019 to June 29, 2019) Over 28,088 in FY18 (June 15, 2018 and June 24, 2018)

Media Campaign	Audience	Impressions (dates aired)
Health Communications Outreach to Targeted High-Risk Populations		
Using federal and state funding, the Program executed two "Point-of-Care" marketing campaigns to reach pregnant women, post-partum women, and women of child-bearing age.	Pregnant smokers	Over 4.3 million in FY19 (December 3, 2018 through February 24, 2019 and May 27, 2019 through June 30, 2019) Over 3.3 million in FY18 (November 13, 2017 through January 21, 2018, and May 14, 2018 through June 30, 2018) Over 1 million in FY17 (November 21, 2016 through December 2016)
Using federal and state funding, the Program executed two "Point-of-Care" marketing campaigns to reach Maryland's Medicaid participants and the health care providers who serve them.	Medicaid Participants and Health Care Providers	Over 4.3 million in FY19 (December 3, 2018 through February 24, 2019 and May 27, 2019 through June 30, 2019) Over 3.3 million in FY18 (November 13, 2017 through January 21, 2018, and May 14, 2018 through June 30, 2018) Over 1 million in FY17 (November 21, 2016 through December 2016)
Other		
The campaign, Breathing Easier, Breathing Cleaner, spanned FY18 and 2019. Ads were placed on outdoor digital billboards as well as digital jukeboxes in restaurants and bars across the state.	Multiple	Over 4.3 million
The Vape Experiment campaign - The Program placed ads on digital mediums including PulsePoint, Instagram, Spotify, Xbox, AMI Jukebox, and YouTube (FY19 and FY18)	Youth and young adults who use the internet and social media.	Over 22 million in FY19
In FY17, the toxic tobacco litter awareness campaign included ads in transit areas, Gas Station TV, radio ads and MVA ads.	Multiple	Over 62.6 million in FY17

Media Campaign	Audience	Impressions (dates aired)
In FY17, the smokeless tobacco use prevention campaign placed 32 bus ads.	Caroline, Dorchester, Kent, Queen Anne's, Somerset, Talbot, Wicomico, and Worcester counties buses	Over 4 million in FY17
In FY17, the smoke-free multi-unit housing campaign placed 340 ads on Baltimore City buses, light rail interiors and bus shelters.	Baltimore City public transit users	Approximately 19 million (May 29 – June 25, 2017)
Print ads were placed in the Maryland Nurse and the Army Navy playbook in 2017	Readers of the Maryland Nurse and the Army Navy playbook.	n/a

The impact of mass reach media campaigns is summarized in Table 5: Mass-Reach Media Campaigns, Audience, and Impressions (FY14-FY16) for FY14 to FY16. During these years, there was much greater inclusion of print advertising through various magazines and professional journals which was not as evident in more recent years. The data from FY14 is inconsistent from later years in that impressions were often not available, making timeline comparison over the earlier years challenging.

Of note, in FY16, the Program was able to leverage the CDC's National Tobacco Education Campaign, as well as television, transit, print, and digital media developed by the Program to promote the availability of the Quitline to Maryland residents. The CDC's National Tobacco Education Campaign, *Tips from Former Smokers (Tips*), ran from January 25 - June 12, 2016 (in addition to a radio-only promotion from June 20, 2016 - July 1, 2016 promoting availability of Nicotine Replacement Therapy), and increased demand for Quitline services in Maryland.

Table 5: Mass-Reach Media Campaigns, Audience, and Impressions (FY14-FY16)

Media Campaign	Audience	Impressions (dates aired)
Mass-Reach Media		
In FY16, the CDC's National Tobacco Education Campaign, Tips from Former Smokers (Tips) was placed nationally on television, radio, billboards, magazines, newspapers, and online for 20 weeks.	National reach	An estimated 16,035 total inbound calls were received by the Quitline (January 25 - June 12, 2016 [in addition to a radio-only promotion from June 20, 2016 - July 1, 2016])
In FY16, a statewide campaign ran on television (WJZ, WNUV, WMDT, EMDT and MeTV) and radio (Pandora) among other social media and post cards.	Maryland residents	Gross impressions of 1,958,258 (March 17, 2016 - June 30, 2016)

Media Campaign	Audience	Impressions (dates aired)
In FY15, a Maryland State Employee Campaign aimed to increase awareness about the Quitline and insurance cessation benefits for Maryland state employees. The campaign consisted of a 15 second television commercial on WJZ-TV, web banner on BaltimoreSun.com, and Facebook and Google ads.	Maryland state employees	Over 3.4 million (February 2, 2015 – March 15, 2015)
In FY15, an education campaign, *Tobacco Stops With Me,* aimed to increase awareness about the dangers of smokeless tobacco use with ads on traditional radio stations, buses, USA Today Sport and Orioles home game ads.	Radio listeners in the Eastern Shore and Western Maryland regions and Orioles fans	Radio - 11 million, buses – 2.7 million (February 16, 2015 – March 22, 2015)
Real Marylanders television ads for a New Year's promotion of the Quitline in FY14.	Maryland residents	The Quitline saw a 10% increase (December 15, 2014 – January 12, 2015).
In FY14, *The Cigar Trap* campaign included television ads along with radio, billboard, and print ads as well as transportation ads such as buses and metro cars.	Cigar smokers	n/a
In FY14, "Happy Caller" TV ads were paces.	n/a	n/a
Print media		
Chesapeake Family Magazine in FY16 and FY15	Parents	162,000 parents (April 1 - June 30, 2016) and (April 1- June 30, 2015)
Press Box in FY16 and FY15	Sports fans	Over 50,000 (April 1, 2016 - June 30, 2016) Over 50,000 (April, May, and June 2015)
Maryland Nurse quarterly publications in FY14, FY15 and FY16	Nurses	Reaches over 82,000 Maryland nurses
Maryland Academy of Family Physicians in FY16 and FY15	Physicians	Reaches over 2,100 family physicians
A *Real Marylander Ad* was run in the Baltimore Sun in FY15 (dates n/a)	Readers of The Baltimore Sun	Circulation was 309,000 and over 5 million website visitors per month in 2015
Sports Team Publications in FY16, FY15 and FY14	Sports fans	Reaches about 800,000
Maryland Dog Magazine in FY16 and in FY15	Dog lovers	Reaches over 30,000 in FY16 and FY15.

Media Campaign	Audience	Impressions (dates aired)
Baltimore Magazine and e-newsletter in FY16	Readers of Baltimore Magazine	Reaches 230,000.
Baltimore Gay Life magazine ad - leveraging existing CDC Tips ads in FY15.	those in the LGBT community and those living with HIV	Print distribution is over 9,000 and the website has 82,000 views annually (December 2014 – February 2015)
Fishing & Hunting Journal – Tobacco Stops with Me. advertising was placed on the journal's website and in monthly print publication	Smokeless tobacco users that read the Fishing & Hunting Journal.	Journal circulation is up to 15,000 copies per month (April, May, and June 2015)
Transit Ads		
Quitline ads were placed on transit mediums in FY15 (a New Year's resolution campaign; a campaign using CDC Tips ads targeting persons in the lesbian, gay, bisexual, transgender (LGBT) community and those living with HIV; and ads promoting the Quitline services for pregnant smokers.)	Public transit users	N/a
Quitline 10th Anniversary ads were placed on mass transit mediums in FY16.	Public transit users	Potentially 40 million (May 22, 2016 - June 26, 2016)
In FY16, the Program placed "Quitline Pregnancy" ads.	Public transit users	37 million (February 22, 2016 - March 27, 2016)
Web and Digital		
The Program placed Quitline ads on digital touch screens or jukeboxes in bars and restaurants across Maryland. In FY16, ads were on 368 devices. In FY15, ads were on 350 devices. In FY14, the number of devices was not reported.	Current smokers in bars and restaurants	Over 7 million (November 29, 2015 - January 15, 2016) Over 6 million (February 22, 2016 - March 20, 2016. Over 5 million (March 1, 2015 – April 30, 2015)
The Quitlines 10th Anniversary was displayed on the Baltimore Orioles main scoreboard at 50 Orioles home games in the 2016 season.	Baseball fans	Potential reach of 2 million.
The Program placed Quitline ads on Gas Station TV in FY15	Gas Station TV viewers	Over 5 million (March 1, 2015 – April 30, 2015)
Health Communications Outreach to Targeted High-Risk Populations		
In FY16, the Program executed two "Point-of-Care" marketing campaigns to reach pregnant women, post-partum	Pregnant smokers	Over 1.6 million (May to June 2016)

Media Campaign	Audience	Impressions (dates aired)
women, and women of child-bearing age. In FY15, the Program ran a campaign that included television, public transportation ads, online radio and Facebook ads directed at pregnant smokers.		Over 5.2 million (April 13, 2015 – June 20, 2015)
Using federal and state funding, the Program executed two "Point-of-Care" marketing campaigns to reach Maryland's Medicaid participants and the health care providers who serve them in FY16. In FY15, the Program aired a campaign of a television ad, public transportation ads, Facebook and Google ads.	Medicaid Participants and Health Care Providers	Over 1.6 million (FY16) Over 12 million (FY15)
In FY15, CTPC developed a media campaign that promoted quitting tobacco use among those recovering from mental illness and addictions. The campaign included television, transit, and internet ads as well as posters. An accompanying toolkit was sent to behavioral health professionals at over 360 provider sites.	Behavioral health professionals and family members of those in recovery to encourage quitting tobacco.	During the first week that the television ads ran in September 2014, the Quitline saw a 37% increase in call volume, and from August – September 2014 there was an increase in callers reporting attention deficit hyperactivity disorder from 4.1% to 4.9%, and bipolar disorder from 10.4% to 11.4%.
Other		
In FY16, the toxic tobacco litter awareness campaign ads were placed on Ocean City boardwalk tram tops and city-liner buses. In FY15, the toxic tobacco litter awareness campaign ads were placed on television, radio, and buses.	Residents of Baltimore and the Eastern shore	FY16 - Approximately 8 million (April 15, 2016 - June 30, 2016) FY15 – 14.5 million (television), 9.4 million (radio) (May 18, 2015 – June 14, 2015 and 30 million (April 15, 2015 – June 30, 2015).
In FY15, a Responsible Tobacco Retailer Campaign developed radio, transit, and billboard advertising along with resources to assist retailers in remaining compliant with all youth tobacco sales laws.	Statewide	Over 42 million (buses) and 14 million (billboards) and 16 million (radio) (May 18, 2015 – June 30, 2015)
In FY15, the smoke-free multi-unit housing campaign placed 251 ads on Baltimore City buses, light rail interiors and bus shelters, among others.	public transit users	Approximately 15 million (September 1, 2014 – November 18, 2014)

Cessation Interventions

CTPC supports several intervention strategies to promote cessation of tobacco use. This includes statewide and community-level interventions reflecting best practices for population-wide cessation efforts (Centers for Disease Control and Prevention, 2014). At the state level, CTPC funds the Maryland Tobacco Quitline (1-800-QUIT-NOW) to support cessation activities. The Maryland Tobacco Quitline, launched in 2006, provided tobacco treatment services to 8,155 phone and 1,340 web participants in FY19. This was an increase from 7,800 callers in FY18. The service reports a 33% quit rate for callers and a 26% quit rate for web-only participants at the seven months follow-up during the same timeframe.

The CTPC also funds cessation efforts through health systems including an electronic Quitline referral program at the University of Maryland Baltimore, School of Medicine and Johns Hopkins Hospital System. As part of an ongoing partnership with the University of Maryland, Baltimore School of Medicine, an electronic referral (e-referral) program from the University of Maryland Medical System (UMMS) to the Quitline through patient health records was implemented in December 2017. In FY18 (6 months), UMMS referred 342 patients to the Quitline, of which 63 accepted treatment. In FY19, the number of referrals increased to 957 with 117 accepting treatment. Provider training has been successful, with providers now utilizing tobacco treatment materials for their patients without being prompted. UMMS plans to bring tobacco screening and tobacco treatment services into their clinics to provide patients more engagement opportunities for tobacco treatment interventions.

As part of an ongoing partnership with Johns Hopkins Health System (JHHS), an e-referral program from the entire JHHS to the Quitline was implemented. In FY18, JHHS electronically referred 1,708 patients to the Quitline with over 400 patients accepting services. In FY19, the number of referrals to the Quitline increased to 1,949 patients with over 346 patients accepting services in FY19. Dashboard data supports the program to assist providers in the e-referral process.

At the community level, CTPC funds cessation activities for all 24 LHDs across the state. While participation in smoking cessation activities at LHDs has declined overtime, LHDs are adapting by increasing trainings and collaborations in their respective jurisdictions. LHDs have successfully supported robust numbers of referrals to the Maryland Tobacco Quitline as well as supporting health care provider training on various smoking cessation models and clinical guidelines.

Surveillance and Evaluation

Maryland conducts middle school, high school, and adult surveys to produce jurisdiction-level and statewide estimates of key short-, intermediate-, and long-term outcomes. Data is used to

track tobacco use rates among Maryland youth and adults to guide and support the implementation of the statewide comprehensive tobacco program. CTPC works closely with MDH's Center for Chronic Disease Prevention on assessing and analyzing questions. Data collection efforts include the CDC Youth Risk Behavior Survey/Youth Tobacco Survey (YRBS/YTS)[19], which included questions on awareness of cessation programs, use of e-cigarettes and vaping devices, and residential smoke-free rules (Prevention and Health Promotion Administration, 2017). During the most recent data collection cycle (fall 2018), the YRBS/YTS completed surveys in 181 middle schools and 184 high schools. Each year, MDH's Center for Chronic Disease Prevention and Control Maryland administers the Behavioral Risk Factor Surveillance System (BRFSS), which contains an enhanced tobacco module. CTPC uses BRFSS in place of the Maryland Adult Tobacco Survey (ATS). Data from these surveys are reported biennially to the Maryland General Assembly.

In addition to statewide surveys, CTPC also implemented a proprietary surveillance system, Counter Tools POST (Point of Sale Toolkit), which comprehensively monitors tobacco retailer compliance with existing state and federal restrictions on the sale of tobacco products to persons less than 18 years of age[20]. This system provides CTPC, LHDs, and law enforcement agencies historical information on retailer compliance with operations of the FDA, Synar, and LHD inspectors, as well as local law enforcement personnel. By integrating historical and real-time information on individual retailer compliance, the POST system can produce maps to support data visualizations on tobacco-related health disparities in their communities. With this combined robust data tool, jurisdictions can better direct their resources in a strategic and data-informed manner. By the end of 2019, all 24 jurisdictions were utilizing POST for enforcement efforts.

EVALUATION RESEARCH QUESTIONS RESULTS

In addition to reviewing the implementation of the tobacco control program, this evaluation also considered several research questions. The following table summarizes findings for each of the research questions. For each question, a summary is provided of the key findings, connection to the state goals, and key data sources.

Each of the questions also provides indicators that align with the metrics from the Evaluation Plan (see Appendix 2). While many of these key findings are related to outcome data, the recommendations from this evaluation focus on administrative data and communications.

[19] CDC recognizes it as YRBS as all applicable protocols and procedures are adhered to.
[20] In 2019, the sales age changed to 21 years of age in Maryland and collateral materials were updated to reflect this change.

Table 6: Summary of Key Findings[21]

Research Question	Summary of Key Findings, Connection to State Goals, and Key Data Sources[22]
Part A: Responsible Tobacco Retailer Initiative Reducing Youth Access to Tobacco Products	
1. Were responsible Tobacco Retailer resources appropriately allocated, developed, and distributed to partners?	**Key Findings**: CTPC develops a **comprehensive array of resources** to support the Responsible Retailer Initiative including a guidebook, quick reference guide, ancillary materials to be placed in stores (window clings, stickers, magnets, and posters), and an interactive online training. Trends in state data on youth initiation of smoking cigarettes and cigars, along with reductions in tobacco retailer noncompliance rates, suggests Tobacco Retailer resources are appropriately allocated, developed, and distributed to partners. Indicators of progress include: • In FY19, the Maryland state budget allocated $2,007,638 for LHD enforcement programs, media communications, and legal resource center training dollars. • A five-year contract is in place with LRC (2015-2020). • MDH funds 5-10 MOTAs directly each year • The Program awarded a five-year media contract to Red House Communications (via competitive solicitation) in April 2017 to design, develop, and implement health communication campaigns furthering Program goals. • Print media campaigns (i.e. newspaper articles, direct mail, brochures) as well as awareness campaigns via ads on local radio stations, television and cable access channels and online digital advertising were conducted. • Resource guides and materials were developed with Red House Communications for retailer education. All resources are available for download on NoTobaccoSalesToMinors.com. • The Program submitted Synar protocols to SAMHSA yearly for approval prior to conducting Synar checks.

[21]The evaluation plan submitted to CDC included two questions that contained the limited timeframe of 2013-2015. The current evaluation report has eliminated "2013-2015" from these research questions to continue to make observations about trends into the present.

[22] Under key findings, specific indicators outlined in the CDC Evaluation Plan are emphasized in **bold** font. For more information, please see

Appendix 4: Evaluation Plan for the Center for Tobacco Prevention and Control.

Research Question	Summary of Key Findings, Connection to State Goals, and Key Data Sources[22]
	Connection to State Goals: As it relates to Goal 1, this evaluation finds a strong connection between the development and distribution of Responsible Tobacco Retailer resources and progress being made to reduce tobacco use trends among Maryland youth and young adults. As a result, CTPC should continue to engage in efforts to allocate, develop, and distribute Responsible Tobacco Retailer resources.
	Key Data Sources: Document and Data Reviews; Interviews; LHD Focus Groups; LHD Program Inventory; LHD Partner Profiles
2. To what extent was needed technical assistance (TA) provided to partners involved with implementing the Responsible Tobacco Retailer Initiative?	**Key Findings:** Administrative documents and interviews noted that the Legal Resource Center, a statewide resource center, provides extensive technical assistance to partners involved with implementing the Responsible Tobacco Retailer Initiative. This included training, education, and assisting local authorities with adopting, implementing, and enforcing laws regarding tobacco sales to minors. LRC responded to **253 requests for technical assistance** in 2018 and **201** in 2019. Indicators of progress include: • A statewide technical assistance training webinar was held in 2019 for the Department, LHDs, law enforcement and partners on youth tobacco sales laws. • Forty-five LHD, staff, MDH staff, and Program partners attended. • All training presentations are posted online: https://www.law.umaryland.edu/Programs-and-Impact/Public-Health-Law/ • CTPC and LRC staff attended coalition meetings for all jurisdictions on a yearly basis. • In 2019, 201 technical assistance requests were received, consistent with the 200 requests received in FY16.
	Connection to State Goals: As it relates to Goal 1, this evaluation finds a powerful connection between technical assistance for the implementation of the Responsible Tobacco Retailer Initiative and tobacco use trends among youth and young adults. As a result, CTPC should continue to work with the LRC to provide technical assistance on youth tobacco laws, best practices for conducting retailer compliance checks, and tactics for educating the public and retailers about youth tobacco state laws.
	Key Data Sources: Document and Data Reviews; Interviews; LHD Focus Groups

Research Question	Summary of Key Findings, Connection to State Goals, and Key Data Sources[22]
3. To what extent have CTPC and collaborative partners increased activities designed to increase education and outreach directed at licensed tobacco retailers?	**Key Findings:** In FY 2015, the Responsible Tobacco Retailer Initiative placed a heavy emphasis on developing educational resources to assist retailers with remaining in compliance with the law. Trends for education and outreach activities for licensed tobacco retailers did increase. Specifically, state data show that the number of vendor education activities conducted by LHDs increased from in FY16 to FY18. However, funding for these activities has decreased since that time, resulting in some decreases in activity. Examples of activities that have decreased include the vendor education activities conducted by non-governmental organizations, the number of school based-collaborations for enforcement, and the number of tobacco retailer group training sessions. Nonetheless, CTPC and partners have continued to engage in this work and report solidified partnerships. A detailed discussion about these trends can be found in the Interim Evaluation Report[23]. Indicators of progress include: • In FY19, 827 in-person educational visits were conducted by LHDs and community-based organizations (CBOs) with tobacco merchants. • In FY19, there were 200 views of the retail training module and 120 views of the retailer quiz. Educational materials are also available for free to download and order from the website. This is comparable to FY18 with 228 views of the training module and 112 views of the retailer quiz. • In FY19, postcards, toolkits, and mini-packets containing 2018 calendars were sent to over 6,000 licensed tobacco retailers and vape shops in Maryland. Materials were also sent to all LHDs and community-based organization groups to assist with retailer educational visits. Please see Table 4 Mass-Reach Media Campaigns, Audience, Impressions for additional information about previous campaigns. • Between February 2019 and June 2019, there were 733 visitors to the Responsible Retailer Campaign website. • In FY18, focus groups were conducted with representatives from 19 of 24 LHDs.
	Connection to State Goals: As it related to Goal 1, this evaluation finds a strong connection between educational and outreach activities for licensed tobacco retailers and the tobacco use rates among youth and young adults. As a result, CTPC should continue to engage in extensive

[23] The Interim Evaluation Report is available at: https://phpa.health.maryland.gov/ohpetup/pages/Evaluation.aspx .

Research Question	Summary of Key Findings, Connection to State Goals, and Key Data Sources[22]
	tobacco retailer education and outreach programming as a component of the statewide strategy on preventing the initiation of tobacco use among youth and young adults.
	Key Data Sources: Document and Data Reviews; Interviews; LHD Focus Groups; LHD Program Inventory; LHD Partner Profiles
4. To what extent have CTPC and other statewide entities increased enforcement activities?	**Key Findings:** Trends show a **substantial increase of tobacco retailer compliance checks and tobacco sales citations issued during the evaluation period.** Indicators of progress include: • In FY19, 6,430 routine tobacco sales compliance checks were conducted compared to 2,236 sales compliance checks in FY14. • In FY19, 653 follow-up compliance checks to cited tobacco outlets were conducted. • In FY19, 92 follow-up compliance checks for Synar violators were conducted. • In FY19, 479 tobacco sales citations were issued compared to 255 citations in FY14. • Follow-up letters were sent in real time to all retailers inspected for Synar (approximately 600/year) regarding results of compliance checks. • In FY19, 143 tobacco sale outlets were referred to the Office of the Comptroller because of multiple affirmed violations for illegal sales of tobacco to youth compared to 201 tobacco sales outlets in FY16. • In FFY19, the FDA conducted 65,506 checks; 4,804 warning letters and 76 civil money penalties were issued. In FFY15, the FDA conducted 1,847 checks; 126 warning letters and 268 civil money penalties were issued.[24]
	Connection to State Goals: As it relates to Goal 1, this evaluation finds a pivotal connection between the increase in enforcement activities and tobacco use trends among youth and young adults. As a result, CTPC should continue to invest in statewide and local strategies that promote enforcement of tobacco retailers.
	Key Data Sources: Document and Data Reviews; Interviews; LHD Focus Groups
5. Did the Synar non-compliance rates decrease (from 24% in FFY14, 31% in FFY in 2015) and to what extent did compliance with tobacco	**Key Findings:** Maryland has **achieved significant success with reducing its Synar-related tobacco retailer non-compliance rates from a high of 31.4% in FFY15 to 8.5% in FFY19**, well below the national target of 20%. In 2019, Maryland passed statewide law increasing its minimum sales age to 21 years of age for all tobacco products, including e-cigarettes. Indicators of progress include:

[24] The FDA compliance check data is available for download at https://www.accessdata.fda.gov/scripts/oce/inspections/oce_insp_searching.cfm.

Research Question	Summary of Key Findings, Connection to State Goals, and Key Data Sources[22]
control policies related to youth access increase?	• In FFY19, 92 follow-up compliance checks for Synar violators were conducted. • In FFY19, 479 tobacco sales citations were issued compared to 255 citations in FFY14. • In FFY19, 203 violations were recorded compared to 394 violations in FFY15.[24]
	Connection to State Goals: As it relates to Goal 1, this evaluation finds a strong connection between the decreases in the Synar non-compliance rate and tobacco use trends among youth and young adults. As a result, CTPC should continue to invest in statewide and local strategies that promote an enforcement and compliance such as retailer education, community meetings to discuss youth access to tobacco, and collaborations with local organizations to conduct compliance checks.
	Key Data Sources: Document and Data Reviews; Interviews; LHD Focus Groups
Part B: Maryland Comprehensive Tobacco Control Program Activities	
6. To what extent does the Maryland Tobacco Control Program implement the CDC Best Practices model and are the programmatic activities at the state and local level reflective of community needs?	**Key Findings:** CTPC actively engages in CDC Best Practices and programmatic activities at the state and local level reflective of the community needs. Indicators of progress include: • The Program continued to fund the Maryland Tobacco Quitline and all 24 LHDs were funded by state statue. All LHD applications and workplans were approved yearly with indicators met. • To promote quitting, 26 organizations were funded in FY19 to provide services to help residents quit. Approximately 5-10 CBOs were awarded yearly. • The Program awarded a five-year media contract to Red House Communications (via competitive solicitation) in April 2017 to design, develop, and implement health communication campaigns furthering Program goals. • There are 14 state health department CTPC staff in alignment with CDC infrastructure recommendations. • The Program hired an external evaluator in 2017; the Schaefer Center was awarded a multi-year contract to conduct a comprehensive evaluation of the statewide Tobacco Use Prevention and Cessation Program. • Health systems, including Johns Hopkins Health System and the University of Maryland Medical System, were supported in their efforts to enable electronic referral to the Quitline. • Strategic planning retreats were held annually with statewide partners. • In the fall of 2018, an online survey for statewide partners was conducted to determine programmatic needs and resources available.

Research Question	Summary of Key Findings, Connection to State Goals, and Key Data Sources[22]
	• MDQuit Advisory Board meetings were held once a year, typically in October.
	Connection to State Goals: As it relates to Goal 1, 2, 3, and 4, this evaluation finds a compelling connection between CDC Best Practices and the following: trends of tobacco use and initiation among youth and young adults; trend in quitting among adults and youth; eliminating exposure to SHS; and eliminating tobacco-related disparities among population groups. As a result, CTPC should continue to utilize the CDC Best Practices framework and recommendations.
	Key Data Sources: Document and Data Reviews; Interviews; LHD Focus Groups; LHD Program Inventory; LHD Partner Profiles
7. To what extent has CTPC increased health communication interventions and messages reaching the general population and populations with negative disparities in the use of tobacco products and tobacco-related death and disease (**racial/ethnic** groups, low SES, Medicaid, Behavioral Health, LGBTQ, & youth)?	**Key Findings:** CTPC has an established record of providing mass-reach health communication interventions to both **general and target populations**. Indicators of progress include: • The Quitline consistently demonstrates a stable reach across Maryland, including minority populations, uninsured callers, and Medicaid participants. For information on populations identified please see Table 4. • Campaign messages include "Real Marylander" TV testimonials (over 11.8 million impressions), PSAs in health care provider offices and hospitals (over 2.9 million impressions), transit "Resolve to Quit" (an estimated 29 million impressions) and "Ready to Quit" ads (over 34 million impressions). For more on mass-reach media campaigns, please see Table 4. • CTPC was in line with metrics submitted as part of annual communications plans submitted to the CDC. • The Program awarded a five-year media contract to Red House Communications (via competitive solicitation) in April 2017 to design, develop, and implement health communication campaigns furthering Program goals. • Many free materials were developed and distributed. • The Program continued a strong web presence for the Quitline (at www.smokingstopshere.com). Maryland residents and health care providers can order free materials (including brochures, wallet cards, and posters) to promote the availability of the Quitline and to warn of the dangers of secondhand smoke.
	Connection to State Goals: As it relates to Goal 4, this evaluation finds a strong connection between CTPC's health communication efforts and decreasing tobacco-use disparities among target populations. As a result, CTPC should continue to its Responsible Retailer Initiative and

Research Question	Summary of Key Findings, Connection to State Goals, and Key Data Sources[22]
	Quitline media, as well as media campaigns to reach populations affected by tobacco use and tobacco-related health disparities (such as racial/ethnic Groups, low SES, Medicaid, behavioral health, LGBTQ, & youth).
	Key Data Sources: Document and Data Reviews; Interviews
8. To what extent has CTPC and partners increased the number of implemented evidence-based interventions and strategies that address vulnerable and underserved populations?	**Key Findings:** CTPC engages in evidence-based interventions and strategies to address vulnerable and underserved populations. Progress indicators include: • All 24 LHDs submitted workplans each fiscal year and implemented programs within approved workplans • In FY19, LHDs coordinated 24 local tobacco coalitions with a statewide membership of 498 people to ensure diverse representation and inclusive participation. The demographic composition of all the local coalitions was 29.7% African American, 3.6% Asian American, 57.2% Caucasian, 2.8% Hispanic/Latino, 0.2% Native American, and 6.4% other. Please see Table 4 for detailed media campaign information • Media campaigns were targeted to priority populations. This included the National LGBT Cancer Network's "Because Me" ads aired in May/June to coincide with LGBTQ Pride month. "Point of Care" marketing campaigns enhanced reach to Maryland's Medicaid participants. For other targeted mass-reach media campaigns, please see Table 4. • In FY19, over one-third of Quitline callers self-reported as Medicaid participants. • The Program had several media campaigns in addition to LHD-led outreach efforts. For detailed information, please see Table 4. • The Program maintained the Pregnancy Rewards Program to encourage and support pregnant smokers to use the Quitline. It received 152 calls in FY19. • In FY19, six Minority Outreach and Technical Assistance (MOTA) organizations were funded to conduct in-person educational visits and hold community meetings on youth access to tobacco and ESDs. • Smoking is banned in all Maryland public housing (effective date – July 31, 2018)[25]. HUD has given Public Housing Authorities the flexibility to include ENDS on the list of prohibited tobacco products.
	Connection to State Goals: As it relates to Goal 4, this evaluation finds a compelling connection between the implementation of evidence-based interventions and decreasing tobacco-use

[25] More information on the HUD ban on smoking in public housing and multifamily properties can be found here: https://www.hud.gov/program_offices/healthy_homes/smokefree.

Research Question	Summary of Key Findings, Connection to State Goals, and Key Data Sources[22]
	disparities among target populations. Specifically, CTPC has implemented strategies to promote improvements in the tobacco-use rates among Medicaid participants, pregnant women, behavioral health, and women of child-bearing age. CTPC should continue to engage in these efforts and pursue expanding them when feasible.
	Key Data Sources: Document and Data Reviews; Interviews; LHD Focus Groups; LHD Program Inventory; LHD Partner Profiles
9. To what extent has the Tobacco Program and its partners increased the demand for tobacco cessation and increased quit attempts?	**Key Findings:** Cessation activity trends for the **Maryland Tobacco Quitline have risen modestly**, while the number of adults who participate in cessation activities at LHDs has decreased. The decline in participation at the LHDs, likely due to some extent to market saturation, suggests that performance metrics should change to reflect outcomes over participation rates. Progress indicators include: • The Maryland Tobacco Quitline (Quitline) and provided tobacco treatment services to 8,155 phone and 1,340 web participants in FY19. • Of those enrolled in the Quitline, most participants had stopped using tobacco for 24 hours or longer (90% of phone, 84% of Web-Only). • At the 7-month follow-up evaluation, 33% of phone program respondents and 26% of the Web-only program respondents were quit from both tobacco and ENDS. • In FY19, MDQuit expanded its trainings to include the incorporation of tobacco treatment into substance use recovery programming (i.e., behavioral health treatment); this training reached 115 behavioral health providers through eight training sessions. • MDQuit provided several trainings each year including in-person and webinar trainings. MDQuit also posts trainings on their website (mdquit.org). • The Program continued its partnership with health systems to implement e-referral program from the healthcare organizations to the Quitline. One system, Johns Hopkins Health System electronically referred 1,949 patients to the Quitline with over 346 patients accepting services in FY19. University of Maryland, School of Medicine electronically referred 957 patients to the Quitline, resulting in 117 patients accepting services in FY19. The Quitline has provider trainings available on smokingstopshere.com. • In FY19, over one-third of Quitline callers self-reported as Medicaid participants. In FY18, 42% of callers to the Quitline self-reported being Medicaid participants. • The Program enhanced Quitline services to better support individuals with mental health conditions (MHCs) through a Tobacco Cessation Behavioral Health pilot

Research Question	Summary of Key Findings, Connection to State Goals, and Key Data Sources[22]
	program, which launched December 31, 2018. In its first six months, the Tobacco Cessation Behavioral Health pilot program enrolled 837 participants. Preliminary reports show 54 individuals completed all seven calls and 300 completed at least two calls. • In FY18, 23.5% of former smokers had quit compared to 22.5% in FY14. • In FY19, MDQuit expanded its trainings to include the incorporation of tobacco treatment into substance use recovery programming (i.e., behavioral health treatment); this training reached 115 behavioral health providers through eight training sessions.
	Connection to State Goals: As it relates to Goals 1 and 2, this evaluation finds a strong relationship between increase in tobacco cessation activities and quit attempts with tobacco use and quit rates among adults and youth. As a result, CTPC should continue to identify and promote cessation activities that promote a variety of opportunities to quit tobacco use for Marylanders.
	Key Data Sources: Document and Data Reviews; Interviews; LHD Focus Groups; LHD Program Inventory; LHD Partner Profiles
10. To what extent did the use of tobacco products decrease since 2014?	**Key Findings:** Maryland has made great progress on decreasing **youth and adult tobacco use.** However, youth e-cigarette use remains concerning. As a result, the number of youth educated by LHDs on e-cigarette prevention has risen dramatically as programs target this public health domain. Progress indicators include: • The prevalence of cigarette smoking in adults was 12.5% in 2018, down from 14.6% in CY14. • High school youth cigarette smoking was 5.0% in FY19, a decrease from 8.2% in FY14. • High school youth tobacco use including ESDs was 27.4% in 2018, an increase from 19.7% in 2014. • Youth initiation rates have decreased significantly from 17.9% in 2014 to 6.5% in 2018.
	Connection to State Goals: As it relates to Goals 1, 2, and 3, this evaluation finds a relationship between tobacco use rates and state trends in initiation, quitting, and exposure to secondhand smoke. As a result, CTPC should continue to support programming in this area with an emphasis on e-cigarette prevention for youth.
	Key Data Sources: Document and Data Reviews
11. To what extent did the prevalence of tobacco use decrease among targeted high-risk populations?	**Key Findings: Tobacco use rates for minority youth** are trending positively, although gaps between counties are significant. Programming that targets disparities remains a priority for CTPC. Progress indicators include: • The percent of African American youth who currently smoke cigarettes was 3.3% in CY18, down from 29.7% in CY14.

Research Question	Summary of Key Findings, Connection to State Goals, and Key Data Sources[22]
	• The percent of Hispanic youth who currently smoke cigarettes was 6.0% in CY18, down from 10.2% in CY14. • The percent of African American adults who currently smoke cigarettes was 13.7% in FY18, down from 16.8% in FY14. • The percent of Hispanic adults who currently smoke cigarettes was 6.8% in FY18, down from 8.2% in FY14.
	Connection to State Goals: As it relates to Goal 4, this evaluation finds a relationship between trends in tobacco use among target populations and eliminating tobacco-related disparities among population groups. CTPC should continue to invest resources in this area, with an emphasis on enhancing data collection to document prevalence trends for target groups.
	Key Data Sources: Document and Data Reviews

RECOMMENDATIONS & CONCLUSIONS

Due to robust implementation of CDC Best Practices, CTPC has achieved considerable success with its programmatic goals and objectives. This evaluation identifies several opportunities to further this work and strategically expand alignment with CDC Best Practices.

RECOMMENDATIONS FROM EVALUATION FINDINGS

Across the implementation evaluation findings, there exist administrative opportunities to enhance CTPC's future work. CTPC and their funded partners are continuously expected to exceed the previous year's efforts while not receiving additional financial support. This suggests a strategic need to focus on programmatic activities that are the most effective, successful, and viable. By focusing on the most effective, successful, and viable activities, CTPC can realize improvements in program implementation and outcomes. Further, continuing to integrate CDC Best Practices across program activities will help achieve resource optimization and program effectiveness.

To leverage these opportunities, this evaluation recommends that CTPC: (1) Continue statewide efforts for comprehensive improvements for data collection; (2) Continue investing in areas that work and strategically invest in areas of need; and (3) Formalize knowledge sharing by creating a resource repository. See Table 5 for a summary of each recommendation as well as details on their impact and related CDC best practice area.

Table 7: Summary of Evaluation Recommendations

Recommendation	Summary, Impact, and Related CDC Best Practice Area
1. Continue Statewide Efforts for Comprehensive Improvements for Data Collection	**Recommendation Summary**: Continue strategic reviews of data collection processes to identify where data collection procedures can be improved. This process should include important stakeholders, including LHD staff, to identify where data collection efforts could be improved.
	Progress Since Implementation Evaluation Report: In 2018, CTPC held a strategic planning session that included a breakout session to brainstorm opportunities for improvement in the current data collection processes for LHD grantees. Feedback from the breakout session was submitted to CTPC. Utilizing the breakout session feedback and other administrative feedback, CTPC made changes to the reporting process including the pilot of an online data collection system. In FY19, the Program streamlined the annual grant application for LHDs for FY20 and is developing an online reporting tool for both the annual LHD grant application and biannual LHD reports to continue to enhance administrative efficiencies. In FY19, the Schaefer Center also completed a program inventory report that documents how the Program is implemented across Maryland, providing detailed information for each jurisdiction and the state.
	Impact of Recommendation: Results of continued reviews could reveal further opportunities for a centralized electronic data collection and reporting system, or enhancements to the current system to increase standardization across jurisdictions. Improvements in data collection procedures may increase data utilization and improve gaps in LHD/stakeholder understanding of how data contributes to statewide accomplishments.
	Related CDC Best Practice Area: Infrastructure, Administration, and Management; Surveillance and Evaluation.

Recommendation	Summary, Impact, and Related CDC Best Practice Area
2. Continue Investing in Areas that Work and Strategically Invest in Areas of Need	**Summary**: Strategically invest in areas of need across the state, particularly in jurisdictions where there are large differences in performance measures. For example, while the state average for minority youth tobacco use is 13.0%, it is three times that rate in one jurisdiction; similarly, the state average for smoking during pregnancy is 5.9% but is nearly four times that rate in one jurisdiction.
	Progress Since Implementation Evaluation Report: CTPC engages in several activities throughout the year to promote feedback on programmatic activities that are driving improvements across the states. These include statewide trainings and information sessions with feedback evaluations and grantee reports from funded partners. In addition, CTPC has hosted two strategic planning sessions in 2018 and 2019 which facilitated feedback on program activities and other strategic administrative improvements. In 2019, "Partner Profiles" – two-page snapshots of each jurisdiction's tobacco control program – were designed to showcase local tobacco program activities and accomplishments.
	Impact: Strategically investing resources improves health outcomes at the local level for the groups benefiting from the targeted interventions; and, as a result of these local level improvements, the statewide average benefits as well. Strategic investment is a win-win scenario.
	Related CDC Best Practice Area: Statewide Public Health Interventions; Community Public Health Interventions; Mass-Reach Health Communications Interventions; and Cessation Interventions
3. Formalize Knowledge Sharing by Creating a Resource Repository	**Summary**: Develop a formalized system for the sharing of programmatic knowledge and resources. LHDs would like increased communication from CTPC about program priorities, program guidelines, and the work of other LHDs. Further, LHDs want an opportunity to learn from each other and to share resources like media materials and successful strategies. Helpful resources include an operational manual as well as a

Recommendation	Summary, Impact, and Related CDC Best Practice Area
	centralized repository to house certain resources such as standard operating procedures, FAQs, and technology solutions.
	Progress Since Implementation Evaluation Report: In the 2018, CTPC held a strategic planning session that included a breakout session to brainstorm opportunities for to create a resource repository for LHDs[26]. In FY19, the Program implemented several of the key recommendations, including the development of a listserv to streamline communication between the Program and LHDs, and to share new resources such as media products or school based ESD curricula.
	Impact: The importance of improved communication cannot be overstated. LHDs and stakeholders seek enhanced trust and transparency, both of which stem from improving formal communication efforts, such as a formalized knowledge sharing system.
	Related CDC Best Practice Area: Infrastructure, Administration, and Management; Statewide Public Health Interventions; Community Public Health Interventions; Mass-Reach Health Communications Interventions; and Cessation Interventions

[26] The 2018 Retreat Summary is available here: https://phpa.health.maryland.gov/ohpetup/Documents/Highlights-%20Strategic%20Planning%20Retreat_FINAL-12.3.18.pdf

Together, these three recommendations provide a path forward that strengthens the underlying decision-making infrastructure across the state to support outcome achievement in strategic areas of need. Enhancing data collection and resource sharing provides an important mechanism to bolster program communication and support collaboration. This also fosters coordinated and purposeful programmatic reviews to focus on those areas that work, thereby realizing the outcomes needed in the changing Maryland tobacco landscape.

Table 8: Steps to Operationalize Recommendations

Recommendation	Steps to Operationalize Recommendations
Continue Statewide Efforts for Comprehensive Improvements for Data Collection	**1) Review the tobacco data environment** A starting point is to identify data collection methods most appropriate for the targeted population. A logical next step is to enable access to data for the partners. There is often a need to increase the clarity in how tobacco-related data are measured, collected, and analyzed. There are often many challenges with finding current, relevant data that reliably captures the improvement brought about by the intervention. In areas where there are a lot of ongoing technology changes, new data sources may become available to be shared to add to the data. For example, the American Lung Association predicts growing use of data related to "ask, advise and refer" advice provided by health systems that is captured in Electronic Health Record systems (EHRs). Data that pertains to smaller subgroups in the population can be useful for targeted outreach. Social media outreach may also produce some new data tools as LHDs promote healthy behavior to younger, tech-savvy youth and young adults. 2) **Continue to communicate with LHDs and other partners to better understand their data needs.** In the current context, there has been a key recent policy change raising the minimum age of tobacco purchase in the state to 21 years of age both in Maryland and nationally (except for those in the military). Historically, states have been reluctant to financially support enforcement efforts that require retailers to train their clerks to request required identification from young adult tobacco purchasers. Enforcement data may be lagged or the investment in enforcement may be problematic.

Recommendation	Steps to Operationalize Recommendations
	An effective approach toward enforcement is to employ local enforcement teams that supervise an underage buy (who can now be an older teen) with minimal confrontation but issuance of warning letters. The warning letters, if unaddressed by retailers by providing required training for clerks could progress to temporary license suspension for repeat violators. There may be some middle step where the clerks who sell tobacco are required to first participate in an online training program reviewing the minimum age requirements. Trends in health care have entailed greater use of electronic health systems. Information sharing related to interactions with health systems may become more available due to changes in the public reporting systems and the data collection requirements of the accrediting agencies as well as the ability to easily make referrals at the "Point of Care" (POC) by many EHRs systems. While there are some efforts to enable POC marketing currently for Medicaid populations and others, this may be a growing area of opportunities to educate patients on the availability of the Quitline and other resources. Ongoing communication about how to best gauge the impact of local efforts with in setting up enforcement actions or targeted communication actions with data and build on improvements put in place already related to the grant process noted in Table 6. **3) Based on an understanding the data environment and the partner input, continue to identify areas to enhance where data collection efforts can be further improved.** Throughout the evaluation period, there has been continued discussion of how to measure progress using data so that each LHD is reporting data in the same manner. For instance, media reach is the total number of people who see the content. Impressions are the number of times the content is displayed, no matter if it was clicked or not. However, an impression means that content was delivered to someone's feed. It is easy, however, to mistake one for the other. Engagements are the interactions with the content (e.g. likes, retweets, etc.). Data that reflects counts of those who were "educated" might need definition to explain further what was entailed.

Recommendation	Steps to Operationalize Recommendations
	When using impressions as a key measure, overcounts can be a concern as well. For example, was each impression unique or did the billboard viewer see the billboard on the way to work and on the way register as two impressions. Similarly, an impression that leads to action (such as a phone call to the Quitline) is being measured the same way as an impression that was ignored.
Continue Investing in Areas that Work and Strategically Invest in Areas of Need	**1. Identify "peer counties" based on selected population demographic data and resources.** The county in Maryland is a geographic unit that is familiar and easy to understand. As counties have consistent boundaries they can be useful for comparisons over time. Many types of tobacco-use data are available at the country level. Groups of counties that are comparable based on demographic, social and economic indicators could be considered peers counties. A possible tool to help create peer counties is the County Health Rankings & Roadmaps (https://www.countyhealthrankings.org/app/maryland/2019/compare/snapshot). **2. Identify key outcome objectives such as minority youth smoking, smoking during pregnancy, etc.** Key goals include prevention and enforcement, cessation, reducing exposure to second-hand smoke and eliminating tobacco-related disparities. Different counties pursue different strategies at different times including population-based community interventions, counter-marketing, support for new programs and regulations and surveillance and evaluation efforts. It is often challenging to make comparisons about the different local efforts or to determine if a county has fallen behind their peer counties with respect to a given objective. Two areas that were noted for having some exaggerated disparities included both ***minority youth smoking*** and ***smoking during pregnancy***. While these may change over time, it would be helpful to have an alert system to note problem areas that should be addressed by different counties are they are discovered. It is also likely that gaps other than minority youth smoking and smoking during pregnancy exist between counties that might be valuable to note and address.

Recommendation	Steps to Operationalize Recommendations
	Maryland has identified many priority groups that are known to experience tobacco disparities including: Blacks/African Americans, those with behavioral health conditions, those living in rural areas, those in the military, persons with disabilities and Medicaid subscribers. Selecting a few of these priority populations for inclusion in the comparing relevant outcomes could help promote targeted outreach. **3. For the top 50% of the counties for each selected outcome objective, calculate the median rates.** In setting targets for county groups based on selected outcomes, one approach is to determine the target that has been achieved by the top 50% of the counties in the comparison group. The concept is that the target is realistic because the counties are comparable and that the top half have already achieved this benchmark. The goal could be more of stretch goal for more counties if the median rate for the top 75% of the counties are used as the target for all the counties. In examining capacity and effort, there must be resources in terms of funding, strategies and other resources to enable the effort to address the issue might be addressed through creating awareness, devising a new program or ensuring that health communications are reaching the appropriate audiences. 4) **Use these rates (that have already been achieved by peer LHDs) as targets to help bring the counties with the lower rates up coupled with strategies, training and/or grant funding as deemed appropriate.** Target setting should ideally enable a county to envision "What might be" and enable designing strategies that plan and prioritize processes that work well. The target setting will likely also help counties identify their many current successes, many of which are captured in the Partner Profiles. Strengths-based sharing methods should be used in developing strategies and tactics. Building on the previous successes and focusing on what works to eliminate remaining disparities should include hope, excitement and inspiration for a healthier community and an upcoming tobacco-free generation of youth.

Recommendation	Steps to Operationalize Recommendations
Formalize Knowledge Sharing by Creating a Resource Repository	**1. Establish the objectives for continually improving knowledge sharing.** A good knowledge sharing strategy should be aligned with the Program's four goals and related objectives. A value key associated with knowledge sharing is to increase awareness and understanding of the knowledge present in the organization. Knowledge sharing may entail an inventory of available knowledge resources. The development of a listserv was already in development and use toward the end of the evaluation period. A key benefit of the list serve was to enable LHDs to have quick access to an array of useful resources and to share their own resources for use by other LHDs. In the near future, knowledge sharing may also involve the development of recorded webinars, tools that enable group collaboration and tools to enable partnerships across professions and different types of organizations. **2. Identify and document the resources that are best practices that can be vetted and shared statewide through a continually updated resource repository.** In some cases, knowledge sharing can result in a large collection of resources and to have some sort of a rating system to help determine which resources have been most helpful can help associated the resources that are more helpful or those that might be considered best practices. Without a vetting process, documents that are not helpful will be shared equally often as those that are more helpful which will discourage use. **3. Determine policies for knowledge creation, capture, vetting, transfer, maintenance, archival and reporting.** There is considerable change in the tobacco use trends over time. Thus, the resource repository needs continual attention to add new resources and changing outdated ones as learning evolves. It might be helpful to have established policies about many aspects of information sharing from what information should be captured, how it will be vetted, whom it should be available to and how long it should be stored.

Recommendation	Steps to Operationalize Recommendations
	4. Determine and prioritize technology needs that might be access barriers to information sharing. Knowledge sharing today implies ready access to technology and tools such as the Internet. Additionally, there may be limited time and resources that are available for knowledge sharing. 5. **Define metrics to evaluate and improve the knowledge sharing among LHDs.** For an LHD to reach an identified target, it can be helpful to understand the best practices as identified by other LHDs who have been making progress on that objective. The LHDs who have the knowledge to share will need to communicate about the problems that they were facing, understand the level of detail needed in providing the resource and building trust with the audience. This type of sharing has value even the sharing of their experience in addressing the issue. There might be a need to evaluate with a view to improving the information transfer process.

CONCLUSION

In closing, this evaluation explored the implementation of the CTPC through an examination of its activities, LHDs, and grantees. The research team at the Schaefer Center for Public Policy conducted an extensive review of administrative documents and secondary data from the MDH and other sources; conducted interviews with representatives from LHDs, grantees, and CTPC staff; and conducted focus groups with representatives from the LHDs.

Findings reveal that CTPC is implementing the CDC Best Practices model in many different areas of the state. This allows CTPC to achieve the objectives established by the Maryland Comprehensive Cancer Control Plan and CDC Core workplan, including: reducing the prevalence of cigarette smoking among adults; reducing the prevalence of tobacco use among youth; decreasing youth access to tobacco in the retail environment; reducing exposure of youth to secondhand smoke (SHS); and decreasing exposure to secondhand smoke among Maryland residents by increasing the voluntary household no smoking rules.

As a result, CTPC has achieved considerable success toward its programmatic outcomes. Three administrative recommendations have been provided to encourage allocation of resources and expansion of programming to strategically meet the needs of the program for future years. These recommendations include: the continuation of comprehensive improvements for data collection; strategically investing in areas of need; and formalizing knowledge through a resource repository.

In looking to the future, CTPC and their partners need to critically align programming to meet the greatest needs presented across the state. Significant strides have been made since the inception of CTPC in 2000. However, CTPC's future work will require actively targeting resources to strategically achieve continued outcomes. This evaluation sheds light on the first steps that can be taken to ensure success for the next twenty years of CTPC.

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APPENDICES

APPENDIX 1: COMMON ACRONYMS

Acronym	Definition
ATS	American Tobacco Survey
BRFSS	Maryland Behavioral Risk Factor Surveillance System
CBO	Community-Based Organization
CDC	Centers for Disease Control and Prevention
CMMC	Counter-marketing and Media Component
CRF	Cigarette Restitution Fund
CTPC	Center for Tobacco Prevention and Control
CY	Calendar Year
DHMH	Maryland Department of Health and Mental Hygiene[1]
ESD	Electronic smoking device
FDA	U.S. Food and Drug Administration
FFY	Federal Fiscal Year
FY	State Fiscal Year
JHHS	Johns Hopkins Hospital System
LHDs	Local Health Departments
LPHC	Local Public Health Component
LRC	Legal Resource Center
MDH	Maryland Department of Health
MDQuit	Maryland Quitting Use and Initiation of Tobacco
MFR	Maryland Managing for Results
MOTA	Minority Outreach and Technical Assistance Organizations
MSA	Master Settlement Agreement
NGO	Non-governmental organization
PATCH	Pregnancy and Tobacco Cessation Help
SAMHSA	U.S. Substance Abuse and Mental Health Services Administration
SEC	Surveillance and Evaluation Component
SHS	Secondhand Smoke
SPHC	Statewide Public Health Component
Synar	The Synar Amendment
UMMS	University of Maryland Medical System
YRBS/YTS	Maryland Youth Risk Behavior Survey/Youth Tobacco Survey

APPENDIX 2: ADDITIONAL BACKGROUND INFORMATION ON MARYLAND'S CRF TOBACCO USE PREVENTION AND CESSATION PROGRAM

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

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

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

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

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

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

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

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

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

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

Maryland is a small state in terms of land area, but diverse geographically, economically, demographically, and politically. The economy is influenced by its close proximity to Washington, D.C., a large port, robust educational and healthcare industries, significant service sector,

growing technology sector, and an agricultural economy that until the early part of this century included significant tobacco farming. Demographically, Maryland has inner city neighborhoods in Baltimore, highly urbanized areas surrounding Washington, D.C. and Baltimore, suburban areas throughout the State, and rural areas in the West, South, and Eastern Shore. The bulk of racial and ethnic minorities reside in central Maryland. Overall educational attainment and income vary considerably across the State, with low income and educational attainment in both rural and inner-city communities. Maryland is comprised of 24 political jurisdictions [23 counties and Baltimore City], each with its own local public-school systems and LHDs. Counties have various levels of governing: 12 are county commissioner led, among these six are "home-rule;" and 11 are charter. Baltimore City has its own municipal governing body.

During the past 10 years, several policies have been enacted that impact Maryland tobacco programs, including prohibition of the sale or possession of e-cigarettes to persons less than 18 years of age; mandatory licensing for all sellers of tobacco products, including e-cigarettes; as well as minimum pricing laws for tobacco products—cigarettes are subject to an excise tax of $2/pack, non-premium cigars are taxed at a rate equivalent to this (70% of wholesale price), and smokeless products are taxed at approximately half that rate; only fire-safe cigarettes may be sold; the sale of clove cigarettes is prohibited; and restrictions on the placement of tobacco products have been adopted at the local level. Maryland's statewide clean indoor air legislation was implemented in 2008 and prohibits smoking indoors in all schools, places of employment, public areas, restaurants, and bars with few exceptions (i.e. tobacconist shops and hookah bars that do not sell food). The state clean indoor air law passed after several local laws were enacted. In 2019, state law increased the minimum sales age to 21 for all tobacco products, including e-cigarettes.

APPENDIX 3: INFRASTRUCTURE AND BEST PRACTICES

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

Responsive Plans and Planning

Plans may include a strategic plan, annual work plan, communications plan, evaluation plan, and sustainability plan. These plans are often collaboratively developed, flexible, and include evaluation feedback (see Table 9). Plans should also be responsive to changes.

Table 9: Responsive Plans

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

(Centers for Disease Control and Prevention, 2017c)

Multilevel Leadership

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

Networked Partnerships

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

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

Managed Resources

Managed resources are the funding and staff resources that support the program. The following strengthen managed resources: funding stability, directing resources to strategies with the greatest impact, sharing positions and resources, communicating program successes, developing

staff competencies, and training staff and partners (Centers for Disease Control and Prevention, 2017c).

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

Engaged Data

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

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

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

Introduction

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

As great strides have been made nationally and statewide, many believe that the tobacco epidemic has been 'solved'; yet 7,500 adults in Maryland still die each year due to tobacco-related causes, and hundreds of thousands more suffer from tobacco-related diseases such as COPD, emphysema and cancers. It is estimated that 92,000 Maryland adolescents alive today will die prematurely as a result of cigarette smoking.[27]

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

Evaluation Goals

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

Evaluation results will assist CTPC and its partners to assess: what programmatic components have been effective in reducing tobacco use behaviors and changing retailer behaviors; what should be expanded and replicated; where funds should be devoted and allocated; and the

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

current environment and resources available. Programs will be adjusted as necessary to ensure that efforts effectively contribute to reaching the statewide program goals: preventing initiation among youth and young adults; promoting quitting among adults and youth; eliminating exposure to secondhand smoke; and identifying and eliminating tobacco-related disparities among vulnerable and underserved populations.

Stakeholder Engagement/Stakeholder Assessment

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

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

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

Background and Program Description

Need/Context[28]

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

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

The Maryland adult smoking rate is 14.6% (2014). While this is lower than the national average of 17%,[29] it does not give a comprehensive view of *who* continues to use tobacco. Tobacco use in Maryland is correlated with lower educational attainment, lower income, those who rent versus own their homes, poor mental health status, and alcohol and drug abuse. In Maryland just 5.6% of college graduates currently smoke cigarettes as compared to 28.2% of those with only a high school diploma, GED, or less. Among those with a household income between $15,000 and $24,999, 20.6% currently smoke cigarettes, as compared to the 11% of households with an income greater than $50,000. Among persons diagnosed with a depressive disorder, 36% smoke cigarettes as compared to 21% of those who never had such a diagnosis.[30] The rate of smoking during pregnancy is considerably higher among the Medicaid population.

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

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

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

Objectives

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

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

Activities

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

Stage of Development

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

Resources/Inputs

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

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

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

Logic Model

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

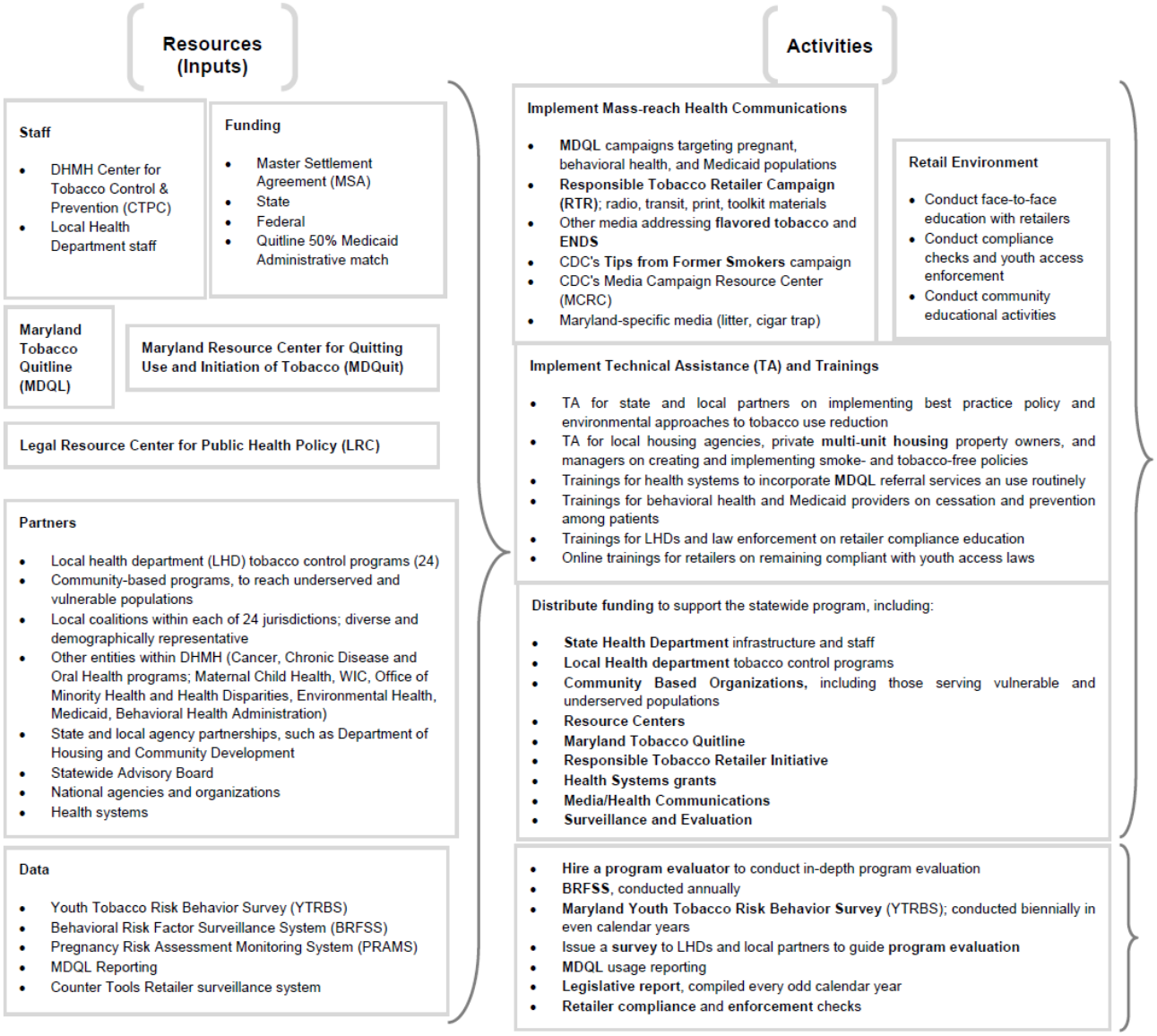
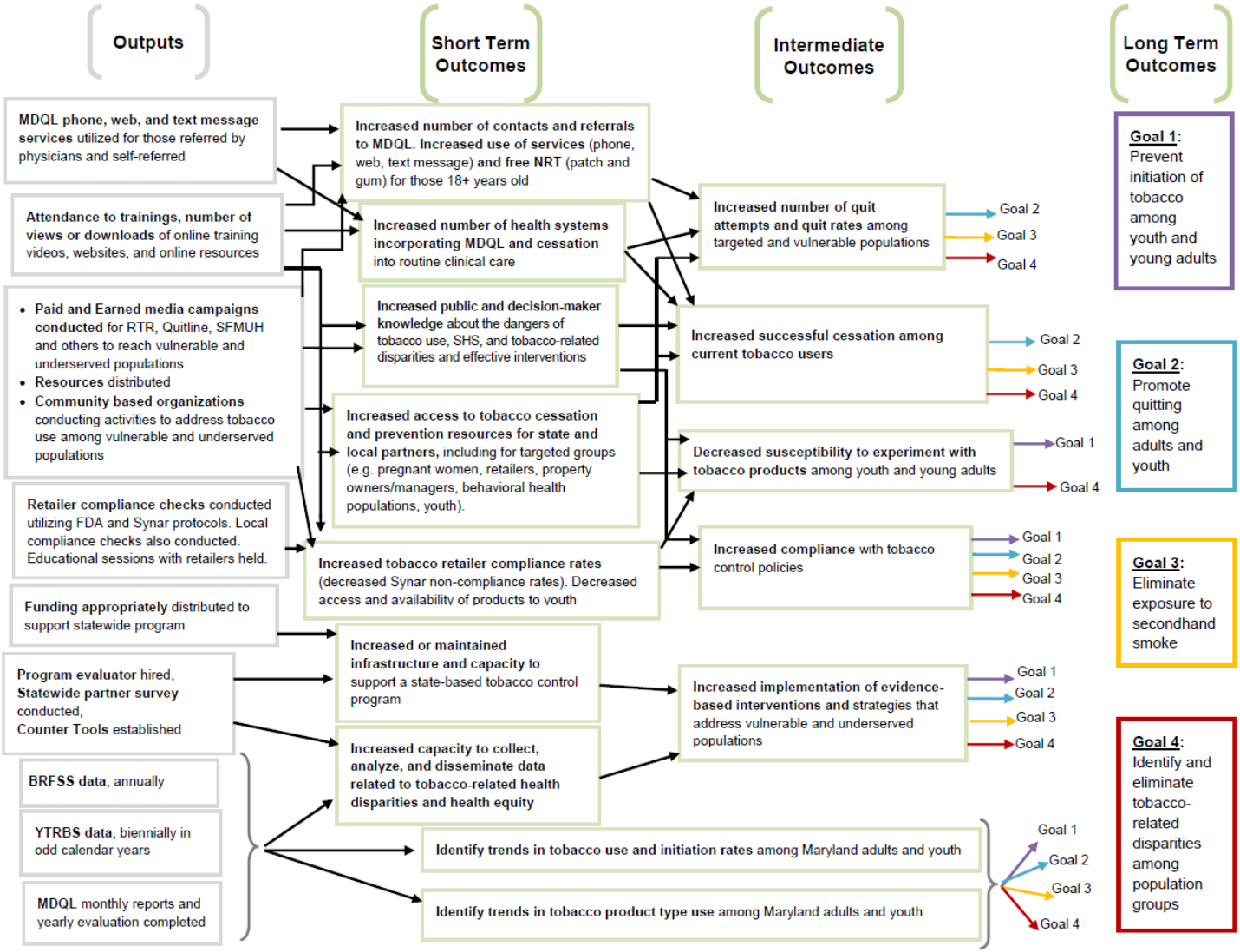


Figure 2: Logic Model Continued: Outputs and Outcomes (Part 2)



Evaluation Focus and Methods

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

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

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

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

Key Questions	Indicators (how will you know it?)	Method (how will you gather info?)	Data Source (who will have the information)	Frequency (when will the info be collected?)	Responsibility
4. To what extent have CTPC and other statewide entities increased enforcement activities from 2013 to 2015?	• # of local compliance checks conducted • # of compliance checks ("Synar" and FDA) conducted • # of citations issued • # of inspection follow-up letters to retailers issued • # of hearings conducted via the Comptroller's office for repeat offenders • # of warnings issued, licenses suspended/ revoked by Comptroller and/or FDA	• Document review • Surveillance	• LHD progress reports • Behavioral Health Administration (BHA) tracking sheets • FDA CTP inspection database • LHD and community-based organization progress reports • Comptroller hearing logs • Counter Tools surveillance program	• April – September: Synar checks conducted • Local and FDA checks ongoing • Ongoing communication with LHD and CBO grantees • Quarterly review of progress reports • Monthly meetings with Department decision makers • 2016 – Counter Tools program developed	• CTPC Director and Division Chiefs • BHA • LHDs • Comptroller's office
5. Did the Synar noncompliance rates decrease (from 24% in FFY14, 31% in FF2015) and to what extent did compliance with tobacco control policies related to youth access increase?	• # compliance checks conducted by LHDs and BHA • # of citations • # of violations	• Non-compliance rate determined by BHA • Local surveillance • Compliance checks utilizing youth ages 16-17 in line with FDA protocols • Document review	• BHA tracking documents • LHD progress reports • FDA CTP inspection database	• Synar – final rate determined by end of federal fiscal year (9/30) • Local rates – ongoing and reviewed quarterly	• CTPC Director and Division Chiefs • CTPC Surveillance/ Policy Analyst coordinator • BHA • LHDs

B. Maryland Comprehensive Tobacco Control Program Activities

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

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

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

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

Planning for use of evaluation findings

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

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

Planned Dissemination Efforts

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

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

External dissemination will include all member organizations of the MDQuit Advisory Board, the tobacco program at each LHD and their respective Health Officer, members of local coalitions, academic partners and funded resource centers, Cancer Collaborative members, and other stakeholders – including voluntary organizations and other state agencies. Findings will be shared via listservs, during presentations, as well as posted to the CTPC and resource center websites. When working with the evaluation contractor, CTPC will determine if tailored reports for LHDs or stakeholder groups are feasible.