Center for Tobacco Prevention and Control
Maryland Department of Health and Mental Hygiene
Evaluation Plan
Funding Opportunity: FOA DP15-1509 CORE
CDC Award Term: March 29, 2015 – March 28, 2020
Grant #: 1U58DP005994-01
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.[1]

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

Evaluation Goals

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

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

[1] 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.

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[2]

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

[2] 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).

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%,[3] 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.[4] The rate of smoking during pregnancy is considerably higher among the Medicaid population.

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

[3] 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/.

[4] 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.

tobacco products; continue to support the Maryland Tobacco Quitline; collaborate with healthcare providers to incorporate smoking cessation into routine clinical care in hospital based systems; maintain partnership with the Maryland Medicaid program to support the Quitline; implement targeted programs that reach vulnerable and underserved populations and those that experience higher disparities of tobacco-related death and disease.

Stage of Development

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

Resources/Inputs

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

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

- State health department, Center for Tobacco Prevention and Control (14 staff members, based on CDC infrastructure recommendations)
- Two statewide resource centers:
    - Legal Resource Center for Public Health Policy (LRC)
    - Maryland Resource Center for Quitting Use and Initiation of Tobacco (MDQuit)
- The Maryland Tobacco Quitline, 1-800-QUIT-NOW (www.smokingstopshere.com)
- Local Health Department tobacco control programs in each of Maryland's 24 major political jurisdictions
- Local coalitions within each of Maryland's 24 major political jurisdictions that represent the diverse demographics of each jurisdiction
- Community-based programming, including funding organizations who reach vulnerable and underserved populations
- Health Communications contracts/activities

- Partnerships with other entities within the DHMH (Cancer, Chronic Disease and Oral Health programs; Maternal Child Health, WIC, Office of Minority Health and Health Disparities, Environmental Health, Medicaid, Behavioral Health Administration)
- Network of statewide supporters and partners (statewide Smoke-free Maryland coalition)
- Partnerships with state and local agencies, such as the Department of Housing and Community Development
- Statewide Advisory Board
- National agencies and organizations
- Health systems

Logic Model – <u>See Attachment</u>

Evaluation Focus and Methods

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

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

Key Questions	Indicators (how will you know it?)	Method (how will you gather info?)	Data Source (who will have the information)	Frequency (when will the info be collected?)	Responsibility
1. Were Responsible Tobacco Retailer resources appropriately allocated, developed, and distributed to partners?	• Funds allocated in state budget for enforcement programs • Funding distributed to state and all 24 local health departments (LHDs) • Funding distributed to community based organizations (CBOs) and Legal Resource Center (LRC) • Media contract(s) awarded • Traditional media campaigns developed	• 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

	• Resource guides and materials developed • Program work plans in line with acceptable activities outlined by SAMHSA				
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 activitiy	• CTPC Director and Division Chiefs • LHDs • CBOs

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 non-compliance rates decrease (from 24% in FFY2014, 31% in FF2015) and to what extent did compliance with tobacco control policies related to youth access increase?	• # compliance checks conducted by LHDs and BHA • # of citations • # of violations	• Non-compliance rate determined by BHA • Local surveillance • Compliance checks utilizing youth ages 16-17 in line with FDA protocols • Document review	• BHA tracking documents • LHD progress reports • FDA CTP inspection database	• Synar – final rate determined by end of federal fiscal year (9/30) • Local rates – ongoing and reviewed quarterly	• CTPC Director and Division Chiefs • CTPC Surveillance/ Policy Analyst coordinator • BHA • LHDs

B. Maryland Comprehensive Tobacco Control Program Activities

Key Questions	Indicators (how will you know it?)	Method (how will you gather info?)	Data Source (who will have the information)	Frequency (when will the info be collected?)	Responsibility
1. To what extent does the Maryland Tobacco Control Program implement the CDC	• All 24 LHDs funded, utilizing funding formula set by state statute • LHD program work plans	• Document review • Site Visits • Literature	• LHD progress reports • Contractor reports • Online survey results (sent to all LHDs,	• Annually – Site visits, Evaluation reports, planning meetings • Online survey –	• CTPC Director and Division Chiefs • MDQuit Advisory Board

Best Practices model and are the programmatic activities at the state and local levels reflective of community needs?	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	reviews • Online survey	Local Health Officers, DHMH staff, resource centers and community partners) • Meeting notes • Site visits • Evaluation reports • Local coalition meeting notes • Planning meeting notes	Spring 2016 • Quarterly – awarded contract reports • Additional methods to be determined upon award of outside Evaluator	• Media Contractor • Evaluation Contractor • LHDs
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	• Populations identified • Campaign messages approved • Metrics met in the Health Communications Plan • Multi-year media contract in place; work plan approved and deliverables met	• 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	• CTPC Director and Division Chiefs • Media contractors • Evaluation Contractor

products and tobacco-related death and disease (racial/ethnic groups, low SES, Medicaid, Behavioral Health, LGBT, & youth)?	• Reach/GRP data from various targeted campaigns • # of materials developed and distributed (Quitline, Retailer, Litter, smoke-free multi-unit housing, pregnancy, etc)			• Monthly review of materials requested/mailed	
3. To what extent has CTPC and partners increased the number of implemented evidence-based interventions and strategies that address vulnerable and underserved populations?	• LHD programs implemented as per approved work plans • # of local coalitions addressing activities targeting vulnerable and underserved populations • # and reach of media campaigns implemented targeting vulnerable and underserved populations • Increased participation among vulnerable populations on workgroups, advisory boards, and coalitions • # 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	• 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

	• # of Public Housing Authorities with smoke-free housing policies				
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 listserves, 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.

Appendix B - Logic Model

Resources (Inputs)

Staff

- DHMH Center for Tobacco Control & Prevention (CTPC)
- Local Health Department staff

Funding

- Master Settlement Agreement (MSA)
- State
- Federal
- Quitline 50% Medicaid Administrative match

Maryland Tobacco Quitline (MDQL)

Maryland Resource Center for Quitting Use and Initiation of Tobacco (MDQuit)

Legal Resource Center for Public Health Policy (LRC)

Partners

- Local health department (LHD) tobacco control programs (24)
- Community-based programs, to reach underserved and vulnerable populations
- Local coalitions within each of 24 jurisdictions; diverse and demographically representative
- Other entities within 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)
- State and local agency partnerships, such as Department of Housing and Community Development
- Statewide Advisory Board
- National agencies and organizations
- Health systems

Data

- Youth Tobacco Risk Behavior Survey (YTRBS)
- Behavioral Risk Factor Surveillance System (BRFSS)
- Pregnancy Risk Assessment Monitoring System (PRAMS)
- MDQL Reporting
- Counter Tools Retailer surveillance system

Activities

Implement Mass-reach Health Communications

- **MDQL** campaigns targeting pregnant, behavioral health, and Medicaid populations
- **Responsible Tobacco Retailer Campaign (RTR)**; radio, transit, print, toolkit materials
- Other media addressing **flavored tobacco** and **ENDS**
- CDC's **Tips from Former Smokers** campaign
- CDC's Media Campaign Resource Center (MCRC)
- Maryland-specific media (litter, cigar trap)

Retail Environment

- Conduct face-to-face education with retailers
- Conduct compliance checks and youth access enforcement
- Conduct community educational activities

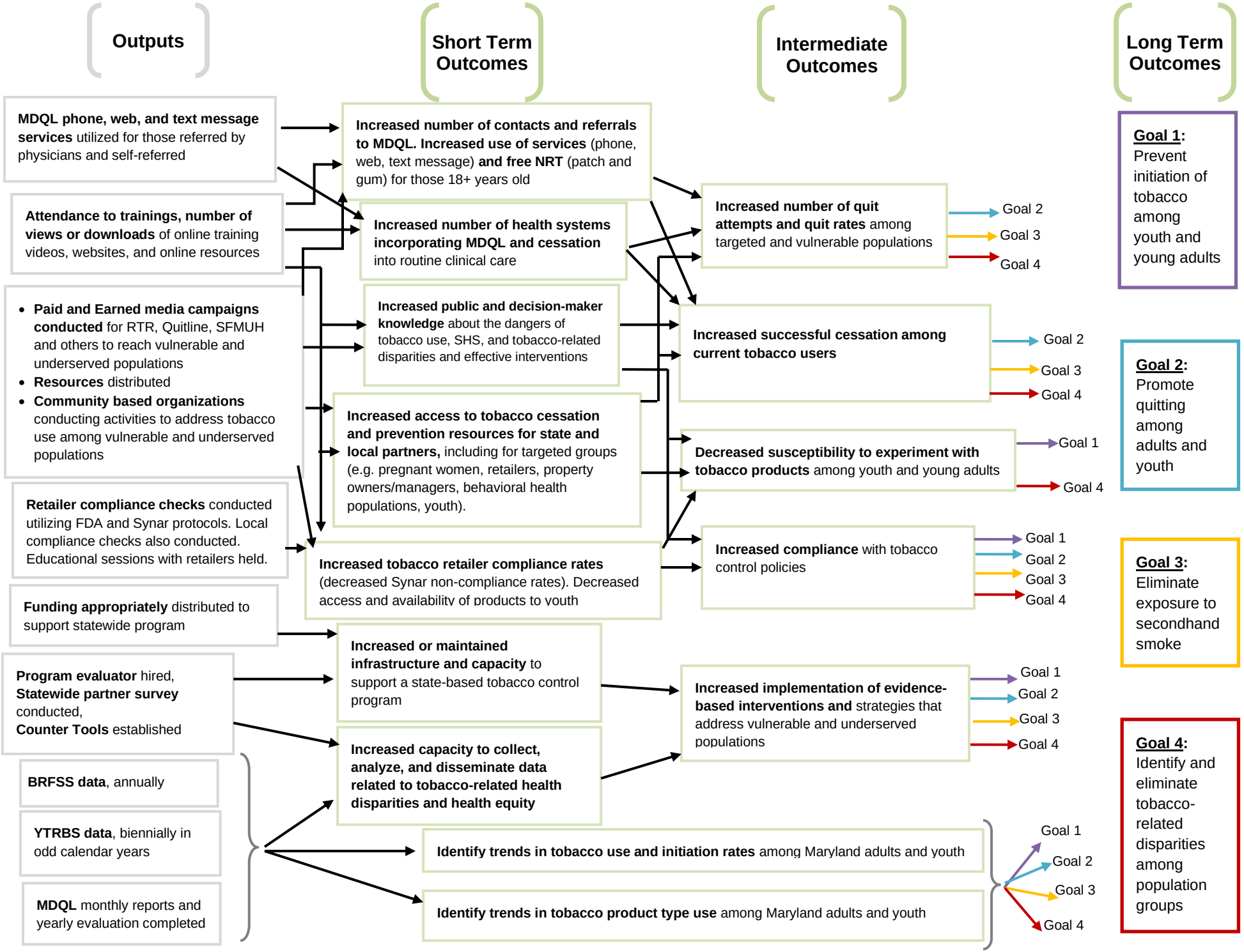
Implement Technical Assistance (TA) and Trainings

- TA for state and local partners on implementing best practice policy and environmental approaches to tobacco use reduction
- TA for local housing agencies, private **multi-unit housing** property owners, and managers on creating and implementing smoke- and tobacco-free policies
- Trainings for health systems to incorporate **MDQL** referral services an use routinely
- Trainings for behavioral health and Medicaid providers on cessation and prevention among patients
- Trainings for LHDs and law enforcement on retailer compliance education
- Online trainings for retailers on remaining compliant with youth access laws

Distribute funding to support the statewide program, including:

- **State Health Department** infrastructure and staff
- **Local Health department** tobacco control programs
- **Community Based Organizations,** including those serving vulnerable and underserved populations
- **Resource Centers**
- **Maryland Tobacco Quitline**
- **Responsible Tobacco Retailer Initiative**
- **Health Systems grants**
- **Media/Health Communications**
- **Surveillance and Evaluation**

- **Hire a program evaluator** to conduct in-depth program evaluation
- **BRFSS**, conducted annually
- **Maryland Youth Tobacco Risk Behavior Survey** (YTRBS); conducted biennially in even calendar years
- Issue a **survey** to LHDs and local partners to guide **program evaluation**
- **MDQL** usage reporting
- **Legislative report**, compiled every odd calendar year
- **Retailer compliance** and **enforcement** checks


Outputs
Short Term Outcomes
Intermediate Outcomes
Long Term Outcomes
MDQL phone, web, and text message services utilized for those referred by physicians and self-referred
Attendance to trainings, number of views or downloads of online training videos, websites, and online resources
Paid and Earned media campaigns conducted for RTR, Quitline, SFMUH and others to reach vulnerable and underserved populations
Resources distributed
Community based organizations conducting activities to address tobacco use among vulnerable and underserved populations
Retailer compliance checks conducted utilizing FDA and Synar protocols. Local compliance checks also conducted. Educational sessions with retailers held.
Funding appropriately distributed to support statewide program
Program evaluator hired, Statewide partner survey conducted, Counter Tools established
BRFSS data, annually
YTRBS data, biennially in odd calendar years
MDQL monthly reports and yearly evaluation completed
Increased number of contacts and referrals to MDQL. Increased use of services (phone, web, text message) and free NRT (patch and gum) for those 18+ years old
Increased number of health systems incorporating MDQL and cessation into routine clinical care
Increased public and decision-maker knowledge about the dangers of tobacco use, SHS, and tobacco-related disparities and effective interventions
Increased access to tobacco cessation and prevention resources for state and local partners, including for targeted groups (e.g. pregnant women, retailers, property owners/managers, behavioral health populations, youth).
Increased tobacco retailer compliance rates (decreased Synar non-compliance rates). Decreased access and availability of products to youth
Increased or maintained infrastructure and capacity to support a state-based tobacco control program
Increased capacity to collect, analyze, and disseminate data related to tobacco-related health disparities and health equity
Increased number of quit attempts and quit rates among targeted and vulnerable populations
Goal 2
Goal 3
Goal 4
Increased successful cessation among current tobacco users
Goal 2
Goal 3
Goal 4
Decreased susceptibility to experiment with tobacco products among youth and young adults
Goal 1
Goal 4
Increased compliance with tobacco control policies
Goal 1
Goal 2
Goal 3
Goal 4
Increased implementation of evidence-based interventions and strategies that address vulnerable and underserved populations
Goal 1
Goal 2
Goal 3
Goal 4
Identify trends in tobacco use and initiation rates among Maryland adults and youth
Identify trends in tobacco product type use among Maryland adults and youth
Goal 1
Goal 2
Goal 3
Goal 4
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

MARYLAND REDUCES TOBACCO SALES TO YOUTH. IT'S NOT A MINOR THING!

MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CENTER FOR TOBACCO PREVENTION AND CONTROL

SUMMARY

Despite Maryland's success in lowering youth and adult prevalence rates, a disturbing trend came to light in 2014 – retailers were illegally selling tobacco to kids at increasing rates since 2010. Meaning, tobacco products were getting into the hands of young people – negating efforts to prevent youth from using these harmful products.

Through retailer education, increased enforcement of youth access laws, and partnerships between State, local and retail entities, Maryland reversed this trend with illegal tobacco sales declining significantly – by 56% from 2014 to 2015.[i] Notwithstanding this success, youth access to tobacco at the point of sale remains a major public health concern in Maryland.

CHALLENGE

Tobacco use can lead to a lifetime of addiction and negative health consequences – such as cancer, stroke, and COPD – as well as death. According to the 2014 Surgeon General's Report, nearly 90% of smokers start before they're 18; youth are more sensitive to nicotine than adults, and "the younger smokers are when they start, the more likely they are to become addicted."[ii]

Retailer behavior is the strongest predictor in the sale of cigarettes to youth[iii] and youth who perceive cigarettes as easy to get are more likely to become regular smokers than those who perceive them as hard to get.[iv]

In an effort to reduce youth access, tobacco retailer compliance has been tied to federal substance abuse prevention and treatment funding for over two decades. All states are required to enforce youth access laws and find no more than 20% of retailers out of compliance. Unfortunately, Maryland inspectors found 24% and over 31% of retailers sold tobacco to minors in 2013 and 2014 (respectively),[i] providing a substantial threat to substance abuse services.[1]

Though federal tobacco sales laws require retailers to check ID of everyone under 27 attempting to purchase tobacco, in 2014, just 37% of Maryland youth reported being asked for photo ID when attempting to purchase cigarettes and nearly 70% of *regular* youth smokers reported being able to purchase cigarettes directly or obtain through a proxy purchase.[2,v]

HOW TO GET INVOLVED

Restricting youth access to tobacco is a key component in reducing youth tobacco use.

You can help!

- Educate retailers in your community about tobacco sales laws and how to remain compliant.
- Talk to parents and other stakeholders about the importance of keeping tobacco out of the hands of kids.

Learn more, order and download free materials at **NoTobaccoSalesToMinors.com.**

Contact:

Dawn Berkowitz
Director, Center for Tobacco Prevention and Control
NoTobaccoSalesToMinors.com
Dhmh.NoTobaccoSalesToMinors@Maryland.gov

1 If a retailer violation rate of 20% or less is not maintained, states risk losing 40% of their federal substance abuse treatment funding ($13M in Maryland). Maryland negotiated an alternate penalty and provided $5.3M in new state dollars to increase enforcement and retailer education, avoiding the 40% cut to program funds, given rates decline.

2 Proxy purchase – underage youth give money to adults 18 and older to buy or gain access to tobacco products for them.

SOLUTION

In 2014, Maryland launched the *Responsible Tobacco Retailer Initiative* – bringing together community and state partners to educate retailers on youth tobacco sales laws and increase enforcement of these laws. Success could not have been achieved without the partnerships between the Center for Tobacco Prevention and Control (CTPC), Behavioral Health Administration (BHA), the Comptroller's office, Local Health Departments (LHDs), Department leadership, statewide resource centers, community organizations, and the retail community.

"THIS REDUCTION IN ILLEGAL TOBACCO SALES TO MARYLAND'S YOUTH COULD NOT HAVE BEEN DONE WITHOUT A PARTNERSHIP BETWEEN THE STATE AND THE RETAIL COMMUNITY," SAID GOV. LARRY HOGAN. "WE KNOW MOST SMOKERS START WHEN THEY ARE UNDERAGE. THIS PARTNERSHIP IS LITERALLY AN INVESTMENT IN MARYLAND'S FUTURE."
-GOVERNOR LARRY HOGAN

Key program components include: development and placement of media (radio, transit, and billboard) and a corresponding website (NoTobaccoSalesToMinors.com); development and distribution of educational materials to assist retailers with remaining in compliance with the laws; statewide trainings for LHDs, law enforcement and compliance officers; face-to-face retailer education; and an increased number of compliance checks at the local level. The Comptroller's office proved to be a strong partnership, and took swift action to suspend licenses of retailers with reported repeat violations.

RESULTS

From May 2015 to March 2016, the statewide media campaign achieved over 250 million impressions, with Department leadership conducting 14 radio interviews and issuing two press releases. The website – NoTobaccoSalesToMinors.com – had 11,828 page views with dramatic increases in traffic during ad flights. CTPC and LHDs distributed over 12,000 toolkits. CTPC and the Legal Resource Center hosted six statewide trainings for law enforcement and compliance officers. From July 2014 to June 2015, LHDs and community groups conducted nearly 4,500 face-to-face education sessions at tobacco sales outlets, educated 73 youth cited for possession of tobacco, and held 83 community education meetings on youth access to tobacco. LHDs also conducted 3,798 compliance checks and issued 545 citations during the same time.

This concerted effort between State, local, public and private entities in Maryland to reduce youth access to tobacco has proven successful – State compliance inspections from 2015 show less than 14% of retailers are selling tobacco to minors, **a 56% reduction from 2014**.[i]

SUSTAINING SUCCESS

As a result of these efforts, the Governor submitted a state budget with additional funds to sustain the *Initiative,* allowing retailer education, enforcement of youth access laws and the statewide media campaign to continue. Maintaining a presence in the retail community while reinforcing responsible tobacco retailer messaging will encourage retailer compliance with youth access laws. Many partnerships were enhanced over the past two years; all parties recognize the need to continue addressing youth access to tobacco. Sustaining the success of the *Initiative* will not only avoid costly penalties to vital state substance abuse treatment programs, but it's also the right thing to do – protect kids from the harmful effects of tobacco.

---

[i] According to FFY16 BHA Synar Inspections (Unpublished).
[ii] U.S. Department of Health and Human Services. *The Health Consequences of Smoking: 50 Years of Progress. A Report of the Surgeon General.* Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, January 2014.
[iii] Klondoff, A & Landrine, H, "Predicting youth access to tobacco: the role of youth versus store-clerk behavior and issues of ecological validity," Health Psychology 23(5):517-524, September 2004.
[iv] Doubeni, C, et al., "Perceived Accessibility as a Predictor of Youth Smoking," Annals of Family Medicine 16(1):137-45, July/August 2008.
[v] 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).

MARYLAND CONTINUES TO REDUCE TOBACCO SALES TO YOUTH. IT'S NOT A MINOR THING!

MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CENTER FOR TOBACCO PREVENTION AND CONTROL

SUMMARY

Tobacco use rates in Maryland continue to decline. State inspection data, however, revealed that a high percentage of retailers were illegally selling tobacco to kids. To reverse this trend, Maryland launched the *Responsible Tobacco Retailer Initiative* in 2014. In just two years after the launch, the rate of illegal tobacco sales to minors dropped to 11%[i] - a 65% reduction from 2014. Now, **nearly 90% of retailers are in compliance and refusing to sell tobacco to kids.**

CHALLENGE

Tobacco use among youth and young adults in any form, including e-cigarettes, is not safe[ii] and can lead to a lifetime of addiction and negative health consequences – such as cancer, stroke, and COPD – as well as death. Nicotine exposure can also harm brain development in kids. Nearly 90% of smokers start before they're 18;[iii] and in recent years an alarming number of youth have begun using e-cigarettes.

Annual compliance checks are conducted to ensure retailers follow the law and do not illegally sell tobacco to kids. Unfortunately, in 2013 and 2014, Maryland inspectors found 24% and over 31% of retailers sold tobacco to minors (respectively).[i,1] State and local efforts have led to a dramatic decrease to 11%. Despite this success, reducing youth access to tobacco remains a major public health priority in Maryland.

YOUR INVOLVEMENT IS KEY!

- Talk to parents about why it's important to keep tobacco, *including e-cigarettes,* away from kids.
- Remind local retailers of their unique position to prevent youth access to tobacco.
- Educate local retailers on tobacco sales laws and how to remain compliant.

Learn more, order and download free materials at **NoTobaccoSalesToMinors.com.**

Contact:
Dawn Berkowitz
Director, Center for Tobacco Prevention and Control
NoTobaccoSalesToMinors.com
Dhmh.NoTobaccoSalesToMinors@Maryland.gov

SOLUTION

In 2014, Maryland launched the *Responsible Tobacco Retailer Initiative* – bringing together community and state partners to educate retailers on youth tobacco sales laws and increase enforcement of these laws. Success could not have been achieved without the partnerships between the Center for Tobacco Prevention and Control, Behavioral Health Administration, the Comptroller's office, Local Health Departments (LHDs), Department leadership, statewide resource centers, community organizations, and the retail community.

Key program components include: development of media, educational materials (including translated versions), and a corresponding website with materials order form and online training (NoTobaccoSalesToMinors.com); outreach to retailers via direct mailings and press releases; statewide trainings for LHDs, law enforcement and compliance officers; face-to-face retailer education; and an increased number of compliance checks and enforcement at the local level. The Comptroller's Office proved to be a strong partnership, and took swift action to suspend licenses of retailers with reported repeat violation.

1 The Federal Synar Amendment requires states to maintain a retailer violation rate of 20% or less. If not maintained, states risk losing 40% of their federal substance abuse treatment funding ($13M in Maryland). In 2014 and 2015, Maryland negotiated an alternate penalty and provided new state dollars to increase enforcement and retailer education, avoiding the 40% cut to program funds, given rates decline.

Grant #: 6 NU58DP005994-02 CFDA: 93.305

RESULTS

As of March 2017, the statewide media campaign achieved over 440 million impressions, with Department leadership conducting 20 radio interviews and issuing two press releases. The website –NoTobaccoSalesToMinors.com – had dramatic increases in traffic during ad flights and after mailings, with over 8,500 visits from January 1, 2016 - March 28, 2017. Thousands of toolkits and ancillary materials have been distributed via direct mailings, online orders, and education sessions conducted by LHDs. From July 2014 to June 2016, LHDs and community groups conducted nearly 6,500 face-to-face education sessions at tobacco sales outlets, educated 73 youth cited for possession of tobacco, and held 132 community education meetings on youth access to tobacco. LHDs also conducted 10,000 compliance checks and issued 895 citations during the same time.

"This effort to boost Maryland tobacco retailers' compliance was the culmination of the Maryland Department of Health's programs stepping up our efforts for the cause of protecting Maryland children's health. It also involved crucial partnerships within state government and with the private sector. We are heartened by the success we've seen and are ever focused on the room that we still have to improve health outcomes for our residents."
-Dr. Howard Haft, Deputy Secretary, Maryland Department of Health and Mental Hygiene

This concerted effort and partnerships between State, local, public and private entities in Maryland to reduce youth access to tobacco has proven successful – State compliance inspections from 2016 show less than 11% of retailers are selling tobacco to minors, **a 65% reduction from 2014**.[i]

SUSTAINING SUCCESS

Due to the success of the *Initiative*, the Governor allocated an additional $2 million to continue and expand efforts in SFY17, with level funding proposed for SFY18. Maryland will continue to fund LHDs to expand partnerships, educate retailers, and conduct compliance checks; fund resource centers to provide training and technical assistance; develop and distribute materials to retailers; place media; expand partnerships; and implement and adapt an online tracking tool to efficiently manage compliance and enforcement data. Maintaining a presence in the retail community while reinforcing responsible tobacco retailer messaging will encourage retailer compliance with youth access laws. Protecting kids from the harmful effects of tobacco remains a top priority for Maryland.

LOCAL SPOTLIGHT: BALTIMORE COUNTY

In 2014, Baltimore County had the highest non-compliance rate in the State, with **55% of retailers** selling tobacco to kids. In 2016, the non-compliance rate *dropped to **1.25%***, one of the lowest in the State. This was accomplished through state support, local partnerships, and a strong and sustained presence in the retail environment. Baltimore County credits their success to the following activities:

- Retailer education. From July 2015-June 2016, over 1,000 retail staff were educated on sales laws.
- Consistent fines for both failure to ID everyone under 27(local law) and the sale of tobacco to anyone under 18.
- Increased compliance checks and repeat checks of stores that were out of compliance. In 2016, over 4,000 checks were completed with over 800 retailers.
- Referrals to the Comptroller's Office. Since the spring of 2015, over 200 tobacco retailers were referred to the Comptroller, resulting in 87 reprimands and 42 license suspensions.

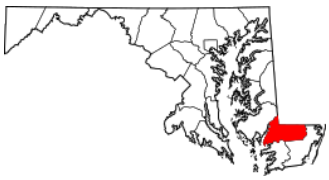
[i] According to FFY16 & FFY17 BHA Synar Inspections (Unpublished).
[ii] U.S. Department of Health and Human Services. *E-Cigarette Use Among Youth and Young Adults. A Report of the Surgeon General.* Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2016
[iii] U.S. Department of Health and Human Services. *The Health Consequences of Smoking: 50 Years of Progress. A Report of the Surgeon General.* Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, January 2014.

Local Efforts Protect Residents from Secondhand Smoke and E-cigarette Aerosol: The City of Salisbury, Maryland

Maryland Department of Health
Center for Tobacco Prevention and Control

Summary

Maryland recently celebrated the 10 Year anniversary of the Clean Indoor Air Act–since February 1, 2008, Maryland residents have been protected from secondhand smoke exposure in the workplace, restaurants, bars, and indoor public spaces. However, over the past decade, the use of new and emerging tobacco products, such as Electronic Smoking Devices (ESDs)–aka e-cigarettes, vapes, "JUULs," etc.–have been introduced. Since these products were not a part of the common landscape 10 years ago, they were not included in Maryland's statewide smoke-free legislation. Local jurisdictions in Maryland are not preempted from enacting stricter policies and several have begun to lead the way in extending protection from ESDs wherever combustible tobacco use is not permitted. The City of Salisbury (in Wicomico County, MD), home to over 30,000 residents and the "fastest growing city in Maryland,"[1] has made all publicly-owned spaces smoke-free.



Get Involved:

- Remind business owners they can implement no-smoking/vaping/ tobacco use rules on their property.
- Talk to parents about why it's important to keep all tobacco products, including e-cigarettes, away from kids.
- Support the establishment of local policies to promote the well-being and health of all citizens.

Contact:

Dawn Berkowitz, Director
Center for Tobacco Prevention and Control
Maryland Department of Health
Dawn.Berkowitz@Maryland.gov

Challenge

Tobacco products continue to evolve and ESDs have taken over the market, especially with youth and young adult users. There is no statewide law that prohibits ESD use and the health effects of secondhand ESD 'vapor' exposure in adults is not well known. However, the U.S. Surgeon General states children and youth should not use or be exposed to these products as nicotine impairs brain development. There is also a misconception that ESDs emit harmless water vapor vs the actual aerosol that can contain harmful chemicals.[2]

Prohibition of ESD use in places frequented by youth–like parks, beaches, and zoos–not only reduces exposure to secondhand e-cigarette aerosol, but it also negates the idea that vaping/smoking is the norm. According to 2016 Maryland YRBS/YTS data,[3] youth use ESDs at high rates–13.3 percent of Maryland high school youth and 17 percent of Wicomico County high school youth. ESD use among Maryland youth exceeds use of any other tobacco product.

---

1 https://salisbury.md/growing-building-working, accessed April 4, 2018
2 E-cigarette Use Among Youth and Young Adults: A Report of the Surgeon General, 2016. Retrieved March 30, 2018 from www.surgeongeneral.gov/library/2016ecigarettes/index.html.
3 Combined statewide Maryland Youth Risk Behavior Survey/Youth Tobacco Survey

MARYLAND Department of Health

Grant #: 5 NU58DP005994-03 CFDA: 93.305

Solution

In 2014, the Wicomico County Health Department began ramping up its ESD prevention initiative to educate youth on the dangers of ESDs. From July 1, 2014 – June 30, 2017 they educated over 12,000 youth.

The Wicomico County Health Department has also been a longtime supporter of smoke-/tobacco-free policies to protect the health of all residents, and in 2014, the Wicomico County Health Department strengthened its smoke-free campus policy to include the prohibition of ESDs in all indoor and most outdoor areas. As a result of Wicomico County's long-term commitment to protect kids from secondhand smoke and e-cigarette aerosol, the Salisbury Police Department initiated a discussion with the City Council to eliminate smoking and vaping in all publicly-owned areas of the City.

> "THE CITIZENS WHO HAVE EXPRESSED CONCERN ABOUT THEIR CHILDREN EXPERIENCING SECONDHAND SMOKE ON PLAYGROUNDS AND PARKS WILL, I'M SURE, BE DELIGHTED TO HEAR THAT SALISBURY HAS JOINED THE RANKS OF… OTHER FAMILY-FRIENDLY TOWNS AND CITIES."
>
> JAKE DAY, MAYOR
> SALISBURY, MD

Quote Source:
www.wboc.com/story/36360446/public-smoking-and-vaping-ban-takes-effect-in-salisbury

The Salisbury City Council voted in September 2017 to prohibit smoking and vaping in all public parks and other publicly-owned spaces throughout the city, effective immediately upon passage. The ordinance makes smoking and vaping illegal in, on, or within 25 feet of bus shelters and public owned/leased/operated buildings and vehicles. This includes the Salisbury Zoo, the Riverwalk, the Skate Park, the Marina Building, and more. Violators may be fined up to $1,000 or receive up to 48 hours of community service for repeat violations.

Results

This law has the potential to **protect over 30,000 residents** of Salisbury, MD as well as thousands of visitors each year **from secondhand smoke and e-cigarette aerosol**. The initiative will also reduce the amount of toxic tobacco litter that is found in parks, beaches, and waterways throughout Maryland.

Sustaining Success

The Salisbury Police Department is responsible for enforcing the law through the issuance of monetary citations or community service hours; they have posted signs to remind residents that there is no smoking or vaping in public spaces. Additionally, Wicomico County Health Department will continue to promote the adoption of smoke-/vape-free spaces throughout the entire County and will continue its focus on youth e-cigarette use prevention.

Wicomico County, and in particular, the City of Salisbury, are perfect examples of how organizations can work together to promote, implement, and enforce policies that protect the health and well-being of all. The Maryland Department of Health will continue to support all local health departments and highlight Wicomico County's success in preventing exposure to secondhand smoke and e-cigarette aerosol while combating youth ESD use.

CELEBRATING MARYLAND'S FIRST SMOKE-FREE GENERATION:
10 YEARS (AND COUNTING) OF BREATHING EASIER, BREATHING CLEANER

Maryland Department of Health
Center for Tobacco Prevention and Control

Summary

In 2008, Maryland enacted comprehensive smoke-free legislation known as Clean Air Maryland, protecting residents from exposure to secondhand smoke in the workplace and indoor public spaces, including restaurants, bars and common areas of apartment buildings. More than a decade of smoke-free air means Maryland youth ages 10 and younger are the state's **first smoke-free generation**; elementary-aged school children in Maryland have never been exposed to a smoke-filled restaurant or public venue. Throughout 2018, Maryland marked the 10th anniversary of Clean Air Maryland with *Breathing Easier, Breathing Cleaner*, a campaign to raise awareness about the positive impact of smoke-free indoor spaces and the availability of free resources to help Marylanders quit tobacco use.

Challenge

The U.S. Surgeon General has stated there is no risk-free level of exposure to secondhand smoke.[1] The only way to fully protect nonsmokers from the harmful effects of secondhand smoke is to completely prohibit smoking in indoor venues. Maryland residents have been protected from secondhand smoke indoors since 2008, when Clean Air Maryland took effect. The percentage of Maryland youth not exposed to secondhand smoke indoors nearly doubled from 38 percent in 2000 to 74 percent in 2016, with the largest single-year increase directly after the passage of Clean Air Maryland.[2] Nearly nine in 10 employees are now protected from secondhand smoke in the workplace and most Maryland homes have voluntary no-smoking rules, even if a smoker lives there.[2]

In the 10 years since Maryland's smoke-free law passed, new challenges have emerged. Public enthusiasm has ebbed since Clean Air has been out of the spotlight, and new electronic tobacco products (e-cigarettes) entered the tobacco landscape. Because they were not commonplace 10 years ago, e-cigarettes were not included in Clean Air Maryland — and are still not covered.

Get Involved:

- Engage youth volunteers in health promotion activities such as youth e-cigarette prevention and cessation education
- Identify opportunities to strengthen smoke-free protections in your community, such as eliminating smoke-free exemptions
- Display Clean Air Maryland materials to support a healthy, tobacco-free norm in Maryland

Contact:

Dawn Berkowitz, Director
Center for Tobacco Prevention and Control
Maryland Department of Health
dawn.berkowitz@maryland.gov

To order free Clean Air Maryland materials and to find resources to help those ready to quit tobacco use, visit: https://smokingstopshere.com/.

[1] U.S. Department of Health and Human Services. *The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General.* Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, Coordinating Center for Health Promotion, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2006.

[2] Maryland Department of Health. Monitoring Changing Tobacco Use Behaviors: 2000–2016. Summary Report. December 2018. Accessed 2 April 2019 at https://phpa.health.maryland.gov/ohpetup/Documents/2000-2016%20Summary%20Report_Monitoring%20Changing%20Tobacco%20Use%20Behaviors.pdf

MARYLAND Department of Health

Grant #: 5 NU58DP005994-04 CFDA: 93.305

Solution

In 2018, the Maryland Department of Health (MDH) implemented a commemorative campaign, *Breathing Easier, Breathing Cleaner*, featuring digital media and high-impact public outreach. The MDH placed *Breathing Easier, Breathing Cleaner* ads on outdoor digital billboards and digital touch screens on jukeboxes in restaurants and bars across the state. Jukebox ads engaged patrons by offering a free song for taking part in a clean air quiz. Additionally, 150 restaurants and bars were contacted about participating in the campaign; interested establishments received restaurant "kits" containing coasters, pens, table tents, window adhesives, posters and postcards, as well as wallet cards for the Maryland Tobacco Quitline. Volunteers (recruited from Maryland high schools, colleges and local libraries) hand-delivered the kits to help ensure receipt and intended use of campaign materials.

"CLEAN AIR MARYLAND HAS PROTECTED MILLIONS OF RESIDENTS AND VISITORS FROM THE PROVEN DANGERS OF SECONDHAND SMOKE OVER THE LAST DECADE. AND, IT HAS HELPED SET A HEALTHY EXAMPLE FOR THE YOUNG PEOPLE IN OUR STATE."

Jocelyn Collins, Maryland's government relations director, American Cancer Society Cancer Action Network

Source: MDH Press Release, Aug 30, 2018

The volunteers also played a pivotal role in the campaign's public outreach component and engaged residents at community events, including the MDH's interactive booth at the Maryland State Fair. Using games and quizzes, volunteers encouraged residents to reflect on the impact smoke-free spaces have had on their lives. The MDH kicked off the 10-day celebration at the State Fair with a press event at a nearby restaurant to recognize many of the statewide partners who were instrumental in promoting Clean Air Maryland more than 10 years ago. Elementary-aged youth from the first smoke-free generation also joined the festivities.

Results

Breathing Easier, Breathing Cleaner achieved more than four million impressions through digital billboards and close to seven million impressions through jukebox advertising, which also provided valuable feedback about residents' knowledge of the impacts of secondhand smoke exposure. More than 75 bars and restaurants proudly used and displayed Clean Air Maryland materials, reaching an estimated 50,000 residents. An additional 18,000 residents were directly reached at community events, including the Maryland State Fair, where **residents were re-energized about smoke-free protections**. Many reflected on the positive impact of smoke-free spaces, including its role in supporting many quit journeys, while others called attention to Clean Air gaps, such as smoking lounges in Maryland casinos and indoor e-cigarette use.

Sustaining Success

Counties and local municipal governments can enact smoke-free protections that are more stringent than state law, and several have begun to do so. The City of Salisbury recently banned smoking and e-cigarette use in all public parks and publicly-owned spaces, including its zoo and Riverwalk. Montgomery County enacted Maryland's first ban on smoking and e-cigarette use on patios and outdoor areas of restaurants and bars. Passage of local laws is often a driving force for statewide policy change.

PPHF: Tobacco Use Prevention- Maryland's Public Health Approaches for Ensuring Quitline Capacity- financed solely by the 2015 Prevention and Public Health Funds
Grant Award # 6NU58DP005345-02
Catalog of Federal Domestic Assistance Number: 93.735

Maryland Department of Health and Mental Hygiene

Center for Tobacco Prevention and Control

Maryland's Public Health Approaches for Ensuring Quitline Capacity

Year Two Success Story

Reducing Tobacco-Related Health Disparities in Maryland: Connecting Pregnant Women and Medicaid Participants with Free Cessation Services

Maryland Department of Health and Mental Hygiene, Center for Tobacco Prevention and Control

SUMMARY

As smoking continues to be a leading cause of poor pregnancy outcomes, quitting tobacco use is one of the most important steps a pregnant woman can take to improve her health and that of her child. In Maryland, rates of smoking during pregnancy are considerably higher in the Medicaid population; Medicaid participants in general are also more likely to use tobacco and experience greater health disparities. The Maryland Department of Health and Mental Hygiene, Center for Tobacco Prevention and Control (CTPC) implemented outreach efforts to inform residents about free cessation services – such as the Maryland Tobacco Quitline – to help them quit tobacco use and improve their health. As 80% of tobacco users see a health care provider each year, the health care system presents a crucial opportunity to reduce smoking rates among diverse and at-risk populations. CTPC enhanced current health systems by implementing e-referrals to the Quitline, increasing outreach through providers to pregnant and Medicaid populations, and using Prevention and Public Health Funds (PPHF) to support Point of Care[1] (POC) marketing campaigns. Due to these concerted efforts, calls from Medicaid and pregnant residents increased dramatically. POC campaigns reached more than 3 million residents with direct messaging that encourages tobacco users to contact the Quitline.

CHALLENGE

Smoking prevalence among adults in Maryland decreased from 19.1% in 2011 to 14.6% in 2014.[2] While this is a significant drop, it does not tell the whole story – more than 680,000 adults still smoke,[3] and many of these individuals belong to at-risk populations that bear a disproportionate burden of tobacco use and related disease. In 2013, 8% of women in Maryland smoked during the last three months of pregnancy and 11% of mothers smoked postpartum. Nearly a third of women reported that their healthcare provider did **not** discuss the effects of smoking during prenatal visits.[4] Medicaid enrollees have a higher smoking prevalence than the general population, with over 30% of adult Medicaid enrollees (under the age of 65) who smoke, compared with 18.1% of U.S. adults of all ages.[5] To reduce the burden of tobacco use and related disease, the Maryland Tobacco Quitline provides FREE, evidence-based telephone counseling to Marylanders 13 years and older to help them quit tobacco. Services are available 24/7, in English, Spanish, and other languages. Enhanced services are available for pregnant tobacco users and youth. Residents can receive a free supply of Nicotine Replacement Therapy, web, and text

YOUR INVOLVEMENT IS KEY

Providers play a significant role with helping their patients to quit tobacco use and to connect them to effective treatment options. The first step is simply talking to patients about tobacco use, followed by a referral to evidence-based cessation services, such as the Maryland Tobacco Quitline. CTPC has made it easier for providers to connect patients to the Quitline by integrating an e-referral into Electronic Health Records. The Quitline proactively calls the patient within 48 hours of the referral. Quitline materials on display in waiting rooms and offices allow patients to review Quitline services that are offered and what to expect when calling. Having materials available at the POC also prompts patients to discuss condition-management and services during their visit. Providers can order FREE materials at www.smokingstopshere.com.

Maryland's 1-800 QUIT NOW
1-800-784-8669 SmokingStopsHere.com

Contact:
Dawn Berkowitz
Director,
Center for Tobacco Prevention and Control
dawn.berkowitz@maryland.gov

[1] Any facility where an individual receives medical treatment, such as hospitals, physicians' offices, retail health clinics, and urgent care centers.
[2] Centers for Disease Control and Prevention (CDC). *Behavioral Risk Factor Surveillance System Survey Data*. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2014
[3] https://www.tobaccofreekids.org/facts_issues/toll_us/maryland
[4] http://phpa.dhmh.maryland.gov/mch/Documents/2013%20MD%20PRAMS%20annual%20report.pdf
[5] http://www.medicaid.gov/medicaid-chip-program-information/by-state/maryland.html

support. While these free cessation resources are available for all Marylanders, ***the pressing challenge is connecting priority populations to these effective resources.***

SOLUTION

CTPC implemented a multi-pronged approach to encourage pregnant smokers and Medicaid participants to call the Quitline. Over the past 4 years, CTPC has executed targeted media campaigns featuring real Marylanders offering testimonials of their positive experiences with the Quitline, including a pregnant smoker who was also a Medicaid beneficiary. CTPC has recently implemented health systems pilot programs encouraging providers to talk to their patients and refer tobacco users to the Quitline through electronic referrals. These programs, in conjunction with the Centers for Disease Control and Prevention (CDC) Tips campaign and other mass media, have significantly increased call volume to the Quitline. In order to enhance these efforts, CTPC executed POC campaigns. POC marketing offers patients actionable information on key health conditions and lifestyle changes that directly influences the way they think about their health and encourages them to discuss condition-management with their physician. Combining evidence-based health communication campaigns with health systems change efforts to reach patients at the POC has enabled CTPC to connect with and educate Maryland's Medicaid and pregnant populations where they receive care.

RESULTS

Through a comprehensive outreach approach, the following was achieved from July 2015 to June 2016:

- 165 pregnant smokers called the Quitline,
- An over 12% increase in calls from Medicaid participants (compared to SFY15),
- An over 20% increase in overall call volume (compared to SFY15).

"The posters and literature are very informative for the people that we see in our office regularly." *- Brian Knight, Program Director, Men and Families Center*

The POC campaign aired from May to June 2016 in 242 doctors' offices and pharmacies statewide, achieving the following:

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

SUSTAINING SUCCESS

One of the primary goals of CTPC is to reduce tobacco-related health disparities, including tobacco users who are Medicaid participants, pregnant women, and women of child-bearing age. CTPC utilizes multiple avenues to sustain the reach and Quitline utilization among these vulnerable populations. CTPC will continue to provide intensive and tailored messaging and outreach to promote cessation resources and connect pregnant women and Medicaid participants, as well as healthcare providers treating these populations, to free and effective cessation services. CTPC supports Local Health Departments and healthcare facilities to incorporate Quitline referrals into health systems, thereby making tobacco cessation part of routine clinical care. CTPC maintains a strong partnership with Medicaid – including utilization of a 50% administrative match from Medicaid for callers who are Medicaid participants – and provides training to Medicaid providers on guiding discussions with patients on tobacco cessation. Many partners, including statewide resource centers, and other Centers and Administrations within the Department of Health, address tobacco cessation and promote the Quitline. These concerted efforts and partnerships will sustain and further programs that will assist with connecting residents to effective cessation services and reducing tobacco-related health disparities among vulnerable populations in Maryland.

Grant Number: 6NU58DP005345-02
CFDA Number: 93.735

MARYLAND Department of Health and Mental Hygiene

PPHF: Tobacco Use Prevention- Maryland's Public Health Approaches for Ensuring Quitline Capacity-financed solely by the 2016 Prevention and Public Health Funds
Grant Award # 5NU58DP005345-03-00
Catalog of Federal Domestic Assistance Number: 93.735

Maryland Department of Health and Mental Hygiene

Center for Tobacco Prevention and Control

Maryland's Public Health Approaches for Ensuring Quitline Capacity

Year Three Success Story

MARYLAND
Department of Health

Maryland's 1-800 QUIT NOW
1-800-784-8669 SmokingStopsHere.com

Reducing Tobacco- Use Health Disparities in Maryland: Implementing a Smoking Cessation Program for a Psychiatric Hospital

Maryland Department of Health, Center for Tobacco Prevention and Control

SUMMARY

In order to provide effective cessation interventions for Maryland residents, relationships with healthcare systems and key stakeholders in the healthcare sector must be built and maintained. To that end, the Center for Tobacco Prevention and Control (CTPC) is collaborating with six local and state organizations – including Sheppard Pratt Health System– to fully integrate tobacco dependence treatment into clinical workflows and connect patients to evidence-based services, including the Maryland Tobacco Quitline. Sheppard Pratt has demonstrated great progress by expanding cessation services to their patients who suffer from mental health and substance abuse disorders. In the fall of 2015, Sheppard Pratt established a smoking cessation program and hired a Tobacco Dependence Treatment Coordinator. Since the program's inception, over 2,500 patients have received smoking cessation services.

CHALLENGE

Since 2000, cigarette smoking and other tobacco use has drastically declined among adults in Maryland and nationally. Yet, high tobacco use rates and related health disparities among certain populations – such as behavioral health – still remain. The prevalence of smoking in adults with mental illness continues to be disproportionately high; a recent study found that more than 60% of patients with schizophrenia were cigarette smokers.[1] While Sheppard Pratt became a smoke-free campus in 2005, smoking cessation counseling was nevertheless not provided system-wide. Currently, almost half of the adults admitted to Sheppard Pratt for inpatient psychiatric services report they smoke cigarettes;[2] this rate increases significantly among residents who have co-occurring problems with substance abuse – cigarette smoking is consistently near 80%. In comparison, the prevalence of cigarette smoking among Maryland adults overall is 15%.[3]

YOUR INVOLVEMENT IS KEY

Health systems change is crucial in reducing tobacco-related disparities. Tobacco cessation is important in psychiatric treatment plans because quitting tobacco can improve the physical health and life expectancy of all patients who use tobacco. Health systems that treat residents with behavioral health issues can:

1. Implement policies to ensure a system is tobacco free.
2. Screen all patients on tobacco use.
3. Maintain dedicated cessation staff.
4. Connect patients to evidence-based cessation services as part of the treatment program.

Having a system in place allows patients to receive services and medications quickly and make a tobacco quit plan easily. During the crucial time after discharge, providers can make referrals to the Maryland Tobacco Quitline with patients receiving a follow-up call from the Quitline within one day after discharge.

SOLUTION

CTPC provided grant funding (state-dollars) to Sheppard Pratt to advance health system changes for tobacco dependence treatment for patients participating in adult inpatient and partial hospital programs.

1. Dickerson, F., Stallings, C.R., Origoni, A.E., Vaughan, C., Khushalani, S., Schroeder, J., & Yolken, R.H. (2013). Cigarette Smoking Among Persons With Schizophrenia or Bipolar Disorder in Routine Clinical Settings, 1999-2011. *Psychiatric Services, 64*: 44-50.
2. Walsh, R., Schweinfurth, L., Dickerson, F. (2015). Smoking and smoking cessation treatment among hospitalized psychiatric patients. *Psychiatric Services, 66*(4): 442-443.
3. Centers for Disease Control and Prevention (CDC). Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2015.

Efforts include: systematically screening patients at admission for tobacco use; educating and training clinicians in regards to treatment services for tobacco dependence and delivering these services to patients; continuing treatment after discharge from a hospital program; updating Electronic Medical Records to document all tobacco dependence treatment services; and evaluating and sustaining the treatment program. The hospital was motivated by the *Tobacco Measure 3* from the Centers for Medicaid and Medicare Services that incentivizes hospitals based on the percentage of adult inpatients who are screened for tobacco use at admission and the percentage of screen-positive patients who are offered smoking cessation treatment during the hospital stay and at discharge. In addition, smoking cessation services in the hospital became a focus of quality improvement activities. A Tobacco Dependence Treatment Coordinator (TDTC) was hired in 2015 and developed a program across the inpatient programs that was customized to the specific needs of each unit (Young Adult, Psychotic Disorders, Adult Day Hospital, Sullivan Day Hospital, Co-occurring Disorders, and Crisis Stabilization). This program ensures resident screening for tobacco use, smoking cessation counseling utilizing motivational interviewing to address residents' level of readiness to quit, nicotine replacement therapy, and referrals at discharge for continued cessation services. The primary cessation referral for patients at discharge is the Quitline's Fax-to-Assist program, in which staff fax refer a patient who agrees to receive a call from the Quitline within a day after discharge.

RESULTS

In the first year of grant funding from CTPC (11/2015 to 6/2016), a total of 943 residents received smoking cessation counseling, with 114 fax referrals to the Quitline upon discharge. Due to the successful implementation of the program, CTPC continued funding into the next fiscal year and services were expanded to adults admitted to other specialized hospital units, including: geriatric services, trauma disorders, eating disorders, as well as the residents on a second hospital campus. From July 2016 to June 2017, a total of 1,582 residents received smoking cessation counseling, with 393 fax referrals made to the Quitline upon discharge.

SUSTAINING SUCCESS

CTPC and Sheppard Pratt are committed to sustaining this smoking cessation program. The program has expanded to include additional personnel with a part-time smoking cessation counselor and a peer mentor assisting the TDTC. Staff members in several hospital units lead smoking cessation groups that are built into the treatment protocol. The TDTC collaborates regularly with quality improvement efforts such as modifying the Electronic Medical Record in order to better integrate smoking cessation services into the workflow of the hospital. CTPC is able to sustain a portion of the program with State Fiscal Year 18 funding, and Sheppard Pratt continues to provide resources to meet clinical demands for smoking cessation services throughout the hospital system and change the hospital culture so that smoking cessation is perceived as an important part of psychiatric treatment. CTPC has been fortunate to receive Prevention and Public Health Funds to enhance Quitline capacity and support referrals from health system programs, such as Sheppard Pratt.

Contact:
Dawn Berkowitz
Director, Center for Tobacco Prevention and Control
Dawn.Berkowitz@Maryland.gov

Grant Number: 5NU58DP005345-03-00,CFDA Number: 93.735

PPHF: Tobacco Use Prevention- Maryland's Public Health Approaches for Ensuring Quitline Capacity-financed solely by the 2017 Prevention and Public Health Funds
Grant Award # 6NU58DP005345-04
Catalog of Federal Domestic Assistance Number: 93.735

Maryland Department of Health

Center for Tobacco Prevention and Control

Maryland's Public Health Approaches for Ensuring Quitline Capacity

Year Four Success Story

Maryland's Public Health Approaches for Ensuring Quitline Capacity

Maryland Department of Health, Center for Tobacco Prevention and Control (MDH, CTPC)

SUMMARY

For nearly two decades, tobacco use rates have significantly declined in Maryland. This decline, however, is not uniform across all populations and nearly 800,000 Maryland residents still smoke cigarettes or use some form of tobacco. To help reach those disproportionately affected by tobacco use, the Center for Tobacco Prevention and Control (CTPC) partnered with two major health systems—the Johns Hopkins Health System and the University of Maryland Medical System in Baltimore—to prioritize tobacco cessation interventions in their clinics.

As a result of these partnerships, over 2,000 patients have been electronically referred (e-referral) to the Maryland Tobacco Quitline. Nearly a quarter of these patients accepted cessation services, many of whom would otherwise not have received such support.

PROVIDER INVOLVEMENT IS KEY

As a provider, you can promote the benefits of including tobacco cessation services into routine clinic care:

- Expand knowledge of evidence-based cessation interventions for Maryland tobacco users
- Reduce patient barriers in accessing the cessation services they need
- Reduce time required to refer patients to cessation services
- Reinforce the benefits of tobacco cessation interventions to patients
- Provide existing free cessation services to patients, such as the Maryland Tobacco Quitline

Contact:
Dawn Berkowitz, Director
Center for Tobacco Prevention and Control
Dawn.Berkowitz@Maryland.gov

CHALLENGE

From 2000-2016, cigarette smoking and other tobacco use has declined in Maryland; yet, tobacco-related disparities remain. Over 30 percent of adults making less than $15,000 annually and nearly 27 percent of adults without a high school degree are current smokers. Approximately 69 percent of adults receiving both mental health and substance abuse-related services report being cigarette smokers, compared to the overall Maryland adult smoking rate of 14 percent. [1]

Tobacco use is strongly associated with cancer and chronic disease. Physicians strive to offer USPSTF[2] guideline recommended tobacco cessation services; however, competing demands in the clinic interfere with this objective.

SOLUTION

CTPC partnered with two health systems, Johns Hopkins Hospital System (JHHS) and University of Maryland Medical System (UMMS) in Baltimore, to reduce barriers to tobacco cessation in clinical settings while supporting patients in their efforts to quit tobacco for good.

---

[1] Maryland Department of Health. Monitoring Changing Tobacco Use Behaviors: 2000-2016. Baltimore: Maryland Department of Health, Prevention and Health Promotion Administration, Cancer and Chronic Disease Bureau, Center for Tobacco Prevention and Control, May 2018. Accessed 24 July 2018 at < https://phpa.health.maryland.gov/ohpetup/Documents/2000%20-%202016%20Legislative%20Report%20Monitoring%20Changing%20Tobacco%20Use%20Behaviors.pdf>.

[2] U.S. Preventive Services Task Force. *Final Recommendation Statement. Tobacco Smoking Cessation in Adults, Including Pregnant Women: Behavioral and Pharmacotherapy Interventions.* Accessed 24 July 2018 at <www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/tobacco-use-in-adults-and-pregnant-women-counseling-and-interventions1>.

Together, these health systems have more than four million outpatient visits per year,[3,4] ensuring outreach and engagement of hard-to-reach and underserved populations.

Champions within JHHS and UMMS worked with CTPC to integrate e-referrals to the Maryland Tobacco Quitline into their existing electronic medical record systems. Both health systems have since developed provider trainings on brief tobacco interventions and how to use the electronic medical record system interface to increase the number of e-referrals to the Quitline. These trainings help prioritize tobacco cessation for patients in the clinical setting.

RESULTS

In 2016, the JHHS Moore Clinic for HIV Care, located in Baltimore City, piloted the e-referral program. Primary care clinics (that serve the highest number of Medicaid tobacco users in Maryland) began utilizing the e-referral program in 2017. Currently, JHHS is rolling out the e-referral program through their entire hospital system and are exploring the most effective ways to increase provider utilization. JHHS has e-referred 1,708 patients to the Maryland Tobacco Quitline; over 400 patients have accepted services.

In 2015, UMMS piloted the e-referral program in primary care practices through the Maryland Learning Collaborative.[5] Focus group testing was conducted in 2016 to assist with refining messages that engage providers in program adoption. UMMS officially launched the e-referral program for their entire health system in December 2017. As of its system-wide implementation, UMMS has e-referred 342 patients to the Maryland Tobacco Quitline with over 63 patients accepting services.

SUSTAINING SUCCESS

CTPC, JHHS and UMMS are committed to sustaining e-referrals to the Quitline and prioritizing tobacco cessation interventions in the clinical setting.

Both health systems plan to expand current efforts over the next year to increase access to services, such as the Maryland Tobacco Quitline, that assist patients with quitting tobacco use for good:

JHHS intends to administer a survey to assess optimal delivery of its provider training program to improve smoking cessation counseling skills and increase e-referral rates to the Quitline. In addition, JHHS is developing processes in their electronic medical record system to link the Quitline e-referral with appropriate tobacco cessation nicotine replacement therapy or medications.

UMMS will continue to train providers on smoking cessation counseling and e-referrals to the Quitline. Past trainings have proven successful, as more UMMS providers are accessing smoking cessation materials for their patients without being prompted. UMMS will also bring tobacco screening and smoking cessation services into their pregnancy programs to support expecting or new parents/families and women with mental health needs.

These efforts will help to set the stage for implementing similar programs in other Maryland health systems, reducing tobacco-related disparities and creating a healthier Maryland.

---

[3] UMMS Fact Sheet. Accessed 24 July 2018 at < https://www.umms.org/-/media/files/umms/about-us/umms-fact-sheet-122017.pdf?la=en&hash=2C248C4CAFDC6C850E66E07775C9A5C165C35978>.

[4] Fast Facts: Johns Hopkins Medicine. Accessed 24 July 2018 at < https://www.hopkinsmedicine.org/about/downloads/JHM-Fast-Facts.pdf >.

[5] Maryland Learning Collaborative. Accessed 24 July 2018 at <http://www.medschool.umaryland.edu/familymedicine/mdlearning/>.

Grant Number: 6NU58DP005345-04 CFDA Number: 93.735

Maryland Tobacco Quitline
2018 Media Focus Groups

Summary Report

Maryland Marketing Source, Inc.

October 2018

Executive Summary: Introduction & Methodology

- The Maryland Tobacco Quitline (MDQL) is a free service, sponsored by the Maryland Department of Health (MDH) and administered by Optum, that is offered to Maryland residents who need assistance with quitting the use of tobacco products.

- As part of their continuing efforts to encourage Maryland residents to stop using tobacco products, Optum and MDH has partnered with Red House Communications to develop potential media concepts to motivate tobacco users with behavioral health conditions to contact MDQL. Optum and MDH have also partnered with Maryland Marketing Source, Inc. to test the impact and effectiveness of the media concepts. This report describes the results of the media concept testing.

- To achieve the goals of the media concept testing, six (6) in-person focus groups were conducted at Baltimore Research in Baltimore, MD among qualified Maryland residents. The focus groups were segmented as follows:
  - On October 3, 2018, two (2) focus groups were conducted among current tobacco users who also have been diagnosed with a behavioral health condition. Nine (9) people participated in each of these groups and they each received a $150 honorarium.
  - On October 4, 2018, the two (2) focus groups were each comprised of ten (10) Behavioral Healthcare Professionals who treat patients who use tobacco products and also manage other behavioral health conditions and/or addictions. They received $350 as a thank-you honorarium.
  - On October 5, 2018, two (2) focus groups were conducted among residents who have family members who use tobacco products and are also diagnosed with a behavioral health condition. Nine (9) people participated in the first of these groups and ten (10) people participated in the second one. Each participant in this segment received an honorarium of $150.

Executive Summary: Introduction & Methodology (cont.)

- The qualitative research participants were recruited via proprietary databases and social media outreach. MMS screened all participants via telephone, then sent invitations via email and conducted reminder calls and text messages prior to the scheduled group and interview times.

- Additionally, MMS staff was also responsible for the following tasks:
  - Preparing documentation to assist Optum with the IRB approval process.
  - Crafting the screening instruments.
  - Developing three discussion guides, one for each segment.
  - Managing facility logistics.
  - Gaining the informed consent of each participant.
  - Moderating the focus groups.
  - Dispensing the honoraria.
  - Providing Optum with full transcripts of the focus groups.
  - Writing a detailed report summarizing the conversations.

- **Please note:** Qualitative research cannot be generalized nor be considered representative of populations at large. Instead, qualitative research provides insights which are focused on the human element, rich with detail, and digs deeper into the participants' emotional responses and experiences.

Executive Summary: Key Discoveries

- There was no clear-cut media campaign that stood out among study participants as the best at communicating that people can quit using tobacco while also addressing other mental and/or physical ailments.
- Many group members across each segment agreed that quitting tobacco is more difficult when dealing with additional stressors like mental illness or substance abuse. Also, quitting tobacco is not necessarily a priority for people who are receiving treatment for additional concerns.
- Messaging geared towards current tobacco users may need to ride the extreme – either they need to be very negative and scary or incredibly uplifting and positive. Luke warm messaging does not hit home with them. However, messaging aimed toward the people who support others who are trying to quit tobacco (i.e., family members and Behavioral Health Professionals) should be positive.
- The people portrayed in the media tested in this study were believable and relatable.
- Fewer words can be more impactful if they are the right words. Study participants agreed that concepts with a lot of copy would be ignored or not read completely.
- Many felt that the Quitline logo should stand out more prominently.

Executive Summary: Key Discoveries (cont.)

- Study participants report that font matters. Where copy is placed, the color, and the typeface all influence if and how a message is received.
- The concept picturing the corkscrew with the cigarette resonated across each segment.
- Digital and social media formats are the most common methods through which participants consume their news and stay updated.
- Participants in all three segments reported that the tobacco products used most commonly by themselves, their patients, and/or their family members include **cigarettes**, **vapes/e-cigarettes**, and **cigars**.
- Tobacco use is already well known to be unhealthy and expensive. Quitting is challenging and something for which a person must be 'ready'.

Maryland Department of Health
Behavioral Health Concept Testing // Preliminary Results
October 1, 2018

Overview of Findings: *Continue the Good* and *You Can Quit* (Existing Campaign) were leaders in most top-two box metrics in comparison to *Reward Yourself*. Both *Continue* and *Quit* had categories in which they were leaders:

- *Continue the Good* had the best top-two box score for the questions: "Does a good job talking to patients" and "Does a good job talking to HCPs"
- *You Can Quit* had the best top-two box scores for questions: "Goes well with concept statement," "How Good is it at Grabbing Attention," "How Informative" and "How Convincing."
- *Reward Yourself* lagged behind the other two concepts, except in its perceived ability to communicate the link between tobacco-cessation and recovery from other behavioral health conditions. *Reward Yourself* was the most effective in this category.

Early Directional Insights: It may be the case that one concept is stronger for communicating with HCPs and the other for patients. These concepts could use further testing among consumers to determine ultimate efficacy:

- *You Can Quit* is a strong platform in the minds of HCPs for communicating with their patients – for a variety of reasons. However, HCPs prefer *Continue the Good* when evaluating a communication platform meant to communicate with other HCPs.
- Generally, HCPs understood *Quit* to be communicating that tobacco-cessation is as important to one's health as treating other behavioral health conditions. However, *Reward Yourself* best communicated the link between tobacco-cessation and recovery from other behavioral health conditions.

Additional Early Learning: Knowledge of, preference for, and effectiveness of the treatment of tobacco addiction in conjunction with other behavioral health issues is a mixed bag among HCPs:

- The majority of HCPs (74%) understand that tobacco-cessation will result in better outcomes for patients, half (47%) believe it is important to their patients, and 80% address it with their patients, but they're less certain about whether tobacco-cessation is helpful or harmful to the recovery process.
- 34% neither agree nor disagree that tobacco use can be helpful to the recovery process, and 19% agree with the statement.
- 42% neither agree nor disagree that it's best if patients quit using tobacco at the same time they're addressing other behavioral health concerns.
- 35% don't believe their patients would be responsive to tobacco-cessation while treating other behavioral health conditions.

Potential Questions for Focus Groups:

- If you find *You Can Quit* to be attention-grabbing, what part of the poster grabs your attention first/best?
- If you find *Continue the Good* to be attention-grabbing, what part of the poster grabs your attention first/best?
- What makes a good advertisement for smoking cessation in your opinion?
- When we look at *You Can Quit* next to *Continue the Good*, which one does the better job in grabbing your attention? Which one is most informative? Which one do you think other people like you would find attractive?
- What information or tools might you need to quit smoking?

KDH RESEARCH & COMMUNICATION

Stakeholders highlights report for *qualitative research to support statewide youth and young adult tobacco control initiatives in Maryland*

Maryland
DEPARTMENT OF HEALTH

KDH Research and Communication, Inc.

Kristen D. Holtz
President and CEO
kholtz@kdhrc.com
404-395-8711

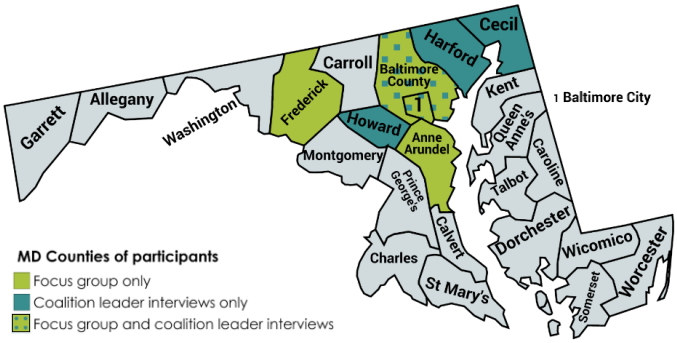
Nicole I. Wanty
Senior Research Associate
nwanty@kdhrc.com
404-968-8005

Nikki Hill
Research Assistant
lhill@kdhrc.com
404-998-9171

Maryland Youth and Young Adult Tobacco Control Focus Groups and In-Depth Interviews, December 2019 Highlights Report

Section I: Project Background

The Maryland Department of Health, Center for Tobacco Prevention and Control (CTPC) conducted focus groups and in-depth interviews between September – November 2019 to better understand the trends in electronic smoking device (ESD) use among Maryland (MD) youth (ages 16-17) and young adults (ages 18-23). This report highlights the results and recommendations based on the following activities.



Eight in-person focus groups

All participants (n=71) were youth and young adults at-risk for vaping or current users.

Eight in-depth phone interviews

All participants were drug-free coalition leaders in MD who served as coordinators, directors, or educators with 9-22 years of experience in drug or tobacco-related prevention, including in MD schools.

This report refers to ESDs as "vapes" to remain consistent with qualitative data.

Section II: Findings

> "About 50% of my friend group has one [a vape]"
> - Young adult, focus group

Background – Vaping is popular among MD youth and young adults and school vaping violations continue to increase. However, vaping-associated hospitalizations and deaths have somewhat decreased the popularity of vapes. While JUUL was identified as the most popular vape, followed by Suorin devices, other products were mentioned due to their affordability, such as NJOY devices. Youth and young adults mostly vape socially (e.g., parties), but some vape alone.

Motivations to vape

- Peer pressure
- Living in the moment
- Curiosity
- Flavors
- Lack of evidence on harms
- Creating "clouds" (i.e., the smoke exhaled after vaping)

Motivations to abstain from vaping

- Peer influence
- Decreased athletic ability
- Financial hurdles
- Influence on siblings

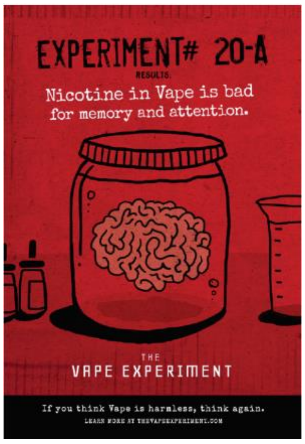
Flavors were important to these groups but seemed more important when youth and young adults first begin vaping compared to those who have vaped for a long period of time.

> "[Flavors are important] because you're not going to order smokes that don't taste or smell good."
> - Youth, focus group

The most popular flavors mentioned by focus group participants included **mint**, **bubble gum**, **mango**, and **tobacco**.

> **"Aerosol**...I don't think a lot of people associate JUULing with [it]."
> - Youth, focus group

Awareness – Generally, youth and young adults are aware of a vape's ingredients but are unaware that vapes emit aerosol and not water vapor. Many stated if they knew they were inhaling aerosolized chemicals, rather than "water vapor," they would not vape. Further, these groups do not consider themselves addicted to vaping if they can go over a week without vaping.



Advertising – Youth and young adults prefer ads with unfamiliar facts, including the serious harmful effects of vaping (e.g., brain development, cancer, death) and shocking ingredients (e.g., formaldehyde). They prefer multiple ad styles, including dark, scary, misdirection, testimonials, inspirational, and ads with real people like them. The Vape Experiment ads appealed to focus group participants and were identified as scary and attention-grabbing.

Overall, the best platforms to reach youth were (1) mall, billboard, or bus ads, (2) Instagram, and (3) Snapchat; the best platforms for young adults were (1) Facebook, (2) Instagram, and (3) Twitter.

Section III: Lessons Learned

Vaping Trends

- JUUL is the most popular vape product among youth and young adults.
- Youth and young adults are motivated to vape by peer influence, curiosity, a desire to live in the moment, and a lack of evidence regarding the harms of vapes.

Vape Prevention Media Campaign Development

- Use the terms "vape" and "vaping" throughout the campaign.
- Focus messaging on current news, reasons why these groups vape, vaping related to cigarettes, descriptions of chemicals, influences on younger siblings, monetary costs, decreasing athletic ability, and serious harmful effects of vaping.
- Avoid directly stating "don't vape" in messaging.
- Include scary words that indicate severe harm (e.g. death, poison, permanent) in ads.
- Place ads on Instagram, Snapchat, and Twitter. Gear any Facebook ads towards young adults and parents.

Coalition Leaders Recommendations for Addressing Vape Use in Schools

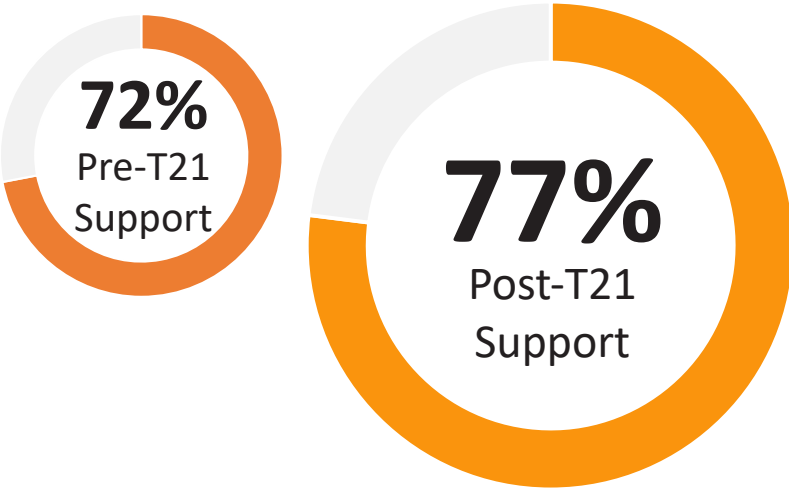
- Adopt a drug-free coalition within MD schools.
- Use students to influence their peers.
- Create a consistent campaign across all schools.
- Develop straightforward anti-vaping policies that teachers understand how to enforce.
- Offer in-school rehabilitation treatments.

Assessing the Maryland Tobacco Retail Environment

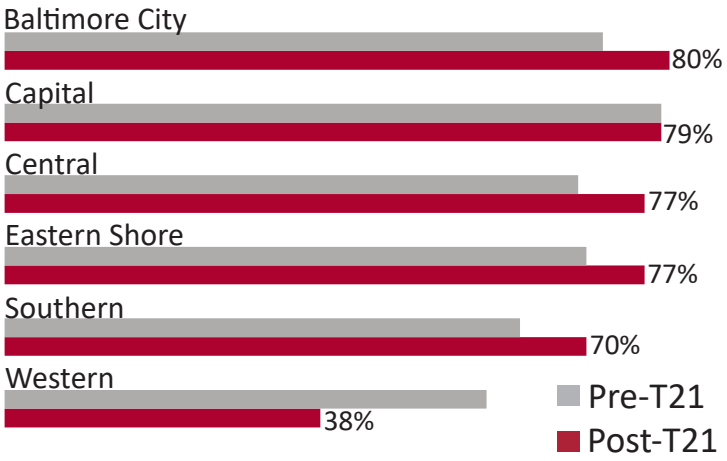
The minimum legal sales age for tobacco products increased from 18 to 21.
A survey was distributed to Maryland Retailers before the law went into effect and seven months after to evaluate the impact of the Tobacco 21 law in Maryland.

Tobacco 21 policies rely on retailer compliance to achieve reductions in youth access to, and initiation use of, tobacco products.

Maryland tobacco retailers strongly support Tobacco 21 (T21).



T21 support by region



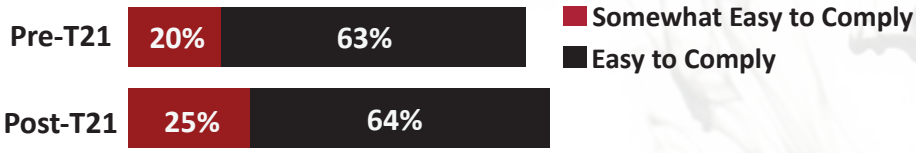
Retailer efforts to comply with T21 will help protect Maryland youth and young adults.

85%
said T21 has had minor or no impact on business.

68%
said T21 has caused them to ID more.

71%
believe that T21 will make it harder for youth to get tobacco products.

Most retailers find T21 easy to comply with and enforce.



The primary reason for difficulty in law compliance is upset customers.

The Maryland Department of Health surveyed over 300 licensed tobacco retailers after the implementation of Tobacco 21. This post-implementation survey was distributed in Spring 2020, and may have been impacted by COVID-19. During this time, some retailers may not have been open for business, while others may have been adjusting their retail practices to adhere to safety and health protocols.

For more information about T21, please visit:
www.NoTobaccoSalestoMinors.com
MDH.tobaccocontrol@maryland.gov
410-767-5529

Maryland
DEPARTMENT OF HEALTH

Assessing the Maryland Tobacco Retail Enviroment

What do **Maryland Tobacco Retailers** think of **T21**?

80% said that when they **follow policies that reduce youth access to tobacco** products, they feel like they're **helping their community**.

61% agree that **increasing the sales age** to 21 **prevents youth under 21 from starting** to use tobacco products and electronic smoking devices.

When asked about the **military exemption** component of the law, **many retailers noted** that the **law is confusing and hard to understand**.

* The Federal T21 law does not include a military exemption. No tobacco products should be sold to anyone under 21.*

1 in 2 want additional outreach and marketing — including posters and ads to help increase consumer awareness of the T21 law.

Who participated in the survey?

	Pre-T21	Post-T21
Owners	41%	56%
Managers	48%	39%
Clerks	7%	4%
Someone else	4%	2%

For more information about T21, please visit:
www.NoTobaccoSalestoMinors.com

NORTH AMERICAN QUITLINE CONSORTIUM

NAQC Medicaid Learning Community

Moving Towards More Sustainable Quitlines

| CASE STUDY |

A Case Study to Support Gaining Federal Medicaid Match for State Tobacco Cessation Quitlines: Maryland

OVERVIEW

In a letter to State Medicaid Directors on June 24, 2011 the Centers for Medicare and Medicaid Services (CMS) provided guidance on tobacco cessation quitlines as an allowable Medicaid administrative cost expenditure. This decision allows states to claim the 50 percent federal administrative match rate for quitline services to Medicaid beneficiaries. State tobacco control programs viewed the new guideline as 1) a tool for building new relationships with their state Medicaid agencies or strengthening existing ones; 2) a window of opportunity in which to engage their state Medicaid agencies in a broader discussion of comprehensive cessation benefits for the Medicaid population of tobacco users; and 3) a way to further build quitline sustainability efforts through public-public cost-sharing partnerships.

In less than a year, eight states (Arkansas, Colorado, Louisiana, Maryland, Massachusetts, Montana, North Carolina and Oklahoma) have executed Memorandums of Understanding that allow the state tobacco control program to claim the 50 percent federal matching rate for allowable quitline expenditures and four more states are well on their way (Arizona, California, Delaware and Indiana). However, there are many barriers to successful implementation of the new CMS guideline (e.g., cost allocation methodology approval) that have hindered these states, as well as those who are just beginning their partnership efforts with Medicaid.

Despite the challenges and the intensity of effort, working to establish a public-public partnership with Medicaid is critical to ensuring access to evidence-based cessation treatment by a population disparately impacted by tobacco's harm; to encouraging comprehensive cessation coverage by Medicaid for ***all*** of its covered lives; and to supporting the sustainability and success of quitlines. With the goal to inspire, support, encourage and direct states in their cost-sharing efforts, *A Case Study to Support Gaining Federal Medicaid Match for State Tobacco Cessation Quitlines,* offers quick-to-read yet detailed guidance from one successful state, with broader lessons learned through NAQC's Medicaid Learning Community woven throughout. This case study includes the following sections:

1. ***Background***
2. ***Building the Relationship***
3. ***Challenges to the Relationship***
4. ***Building the Agreements: Memorandum of Understanding and Cost Allocation Plan***
5. ***Building the Infrastructure***
6. ***Challenges to the Process***
7. ***Final Thoughts***
8. ***Resources***

Throughout the document readers will find important things to consider before moving forward in partnership with state Medicaid partners in blue font and building blocks for success in text boxes.

BACKGROUND

Maryland has a current smoking prevalence of 15.2% or 672,000 smokers and dedicates approximately 1 million per year to their quitline budget. All Maryland residents who are 18 or older are eligible to receive up to four quitline counseling sessions and four

weeks of nicotine replacement therapy (patch or gum). In State Fiscal Year (SFY) 2011, 30% of callers (1,800) to the quitline were Medicaid beneficiaries.

Roughly 1 in 6.5 Marylanders are covered by Medicaid including those with full benefits, partial benefits and dual-eligibles. 82% of Medicaid beneficiaries are served through seven Managed Care Organizations (MCOs), the majority of whom are children. 18% of beneficiaries are fee-for-service (FFS) and these are mostly dual-eligibles, individuals in spend-down categories, in nursing homes or in long-term care.

What do you know about your state's Medicaid population? Who are they? How are they covered (managed care or fee-for-service)? What percentage are tobacco users and how many call the quitline? What cessation benefits do they have? How many MCOs does your state have? What is the relationship between your state Medicaid agency and the MCOs they contract with?

BUILDING THE RELATIONSHIP

Beginning in 2009 and armed with an analysis of quitline costs for serving the Medicaid population, the Maryland Tobacco Control Program (TCP) started to reach out to state Medicaid staff to gather information. Cessation benefits for those covered by Medicaid, as well as private insurers, was vague up to this point so the TCP began to explore cessation benefits covered under Medicaid Managed Care plans specifically. They began to have conversations with their state Medicaid agency about potential collaboration and these conversations resulted in an American Recovery and Reinvestment Act (ARRA) -funded project that examined all tobacco cessation benefits in Maryland, including Medicaid.

Fast-forward to April 2011 and the TCP was asked to collaborate with the state Medicaid agency to develop Maryland's application for the Medicaid Incentives for the Prevention of Chronic Disease grant program. The Medicaid Incentives for the Prevention of Chronic Disease grant program (MIPCD), which will provide a total of $85 million over five years, is intended to test the effectiveness of providing incentives directly to Medicaid beneficiaries of all ages who participate in MIPCD prevention programs, and change their health risks and outcomes by adopting healthy behaviors.

Even though Maryland's application was not funded, the process resulted in increased understanding between the partners, a specific focus by Medicaid on tobacco cessation, and strengthened relationships between staff members. Additional support for the partnership between the TCP and Medicaid came in June of 2011 with the new CMS guideline on quitlines. Together the partners developed a plan to submit a cost allocation methodology to CMS for approval. The methodology was submitted to CMS in October 2011 and approved in December 2011. The programs finalized the MOU in March 2012.

Critical elements to building relationship with your state Medicaid agency include:

- *Understanding where Medicaid is housed within your state administration.*
- *Meeting with Medicaid to gather information on the specific structure of*
- *Medicaid in your state.*
- *Ensuring that you have a solid understanding of how Medicaid works in your state.*
- *Understanding and appreciating that the Medicaid staff are most likely as busy as you are!*
- *Providing an overview of quitline services including how many of their members are served, cost savings projections, and quit and satisfaction rates.*
- *Asking Medicaid to provide an overview/presentation of how the Medicaid infrastructure works in your particular state, and how it differs from other states.*
- *Involving key influencers and leveraging their support of the work.*
- *Knowing what your "ask" is and what the benefit is to **them.***

CHALLENGES TO THE RELATIONSHIP

Having a positive, trusting relationship with your state's Medicaid agency is a critical element to success. As is the case with most systems-change efforts, an internal champion for cessation can be extremely helpful. Often this person serves as conduit,

translator and convener. Unfortunately, there are state tobacco programs that find it nearly impossible to build relationship with their state Medicaid agency – either due to historical mistrust, political and budget climate, or the simple fact that tobacco cessation is not on the very-full Medicaid radar. To move forward in drawing down federal funds to support quitline services to Medicaid beneficiaries (and to support quitline sustainability) a tobacco program MUST have a relationship with their state Medicaid agency, as federal CMS funds can *only* flow to a state Medicaid agency. The MOU is the mechanism by which the state Medicaid agency agrees to transfer those funds to the state tobacco program. Working out the details of the MOU becomes the heart of the work between the two partners.

While the MOU is the mechanism by which the state Medicaid agency agrees to transfer funds to the tobacco program, an amendment to the Medicaid agency's cost allocation plan is the document that outlines exactly how they will develop and document administrative claims for quitline services and becomes the second big hurdle for tobacco programs in this effort. Public Assistance Cost Allocation Plans (PACAPs) are under the purview of the Division of Cost Allocation (DCA) in the U.S. Department of Health and Human Services. In accordance with Subpart E of 45 CFR Part 95 and OMB Circular A-87, a state's cost allocation plan must be amended and approved by DCA before federal funds would be available for the cost of quitline administrative activities claimed through an MOU and cost allocation methodology.

However, CMS (regional *and* central offices) works directly with DCA in the PACAP review and approval process. Under this process, DCA will not approve a PACAP without CMS review and approval of the cost allocation methodologies. The PACAP must make explicit reference to the methodologies, claiming mechanisms, interagency agreements/MOUs, and other relevant issues that will be used for submitting Medicaid administrative claims and appropriately allocating costs. **Further details on MOUs and CAPs in Building the Agreements: Memorandum of Understanding and Cost Allocation Plan.*

What some states have learned is that without a positive, trusting relationship between the state Medicaid agency and their CMS regional office, the work to develop an approved cost allocation methodology, without requirements for overly burdensome data and reporting, is difficult. One state tobacco program reports that their state Medicaid partner is creating roadblocks to cost allocation methodology development, due in part to reports of prior and current difficulties with their CMS regional office. The state tobacco program has been told that while CMS will initially agree to a simple methodology format, the Medicaid agency cites prior problems that cause them to distrust CMS instructions on the methodology. While a tobacco program has little control over the relationship between their Medicaid partner and the CMS regional office, remember that knowledge is power! The more the partners know and understand about quitlines and how they are operated and evaluated, the better. Their confidence in your understanding and tracking of the numbers behind the proposed dollar amounts goes a long way.

BUILDING THE AGREEMENTS: MEMORANDUM OF UNDERSTANDING AND COST ALLOCATION PLAN

A memorandum of understanding (MOU) is a document describing a mutual agreement between parties. It most often indicates an intended common line of action and many government agencies use MOUs to define a relationship between departments or agencies. Critical components of any MOU include a clearly defined purpose, a detailed scope of the relationship or agreement and distinctly outlined roles and responsibilities for each party.

What is Maryland's best advice when starting work on an MOU with Medicaid? Be clear about its purpose. For example:

> *"To establish procedures for claiming Title XIX Federal Fund match on allowed Medicaid-related administrative costs expended in the operation of the quitline."*

In their MOU, Maryland used existing CAP language and stated that CMS had approved Maryland's methodology for allocating a Medicaid share of certain allowed administrative costs in the operation the quitline *(most other states do this process in opposite order: first execute the MOU; include language in the MOU that it is dependent on an approved CAP methodology; and then work to get the CAP methodology approved).* Maryland's MOU language needed to include:

- Assurance that costs submitted do not duplicate costs claimed under any other Federal grant, or duplicate costs included in the indirect cost pool.

- Assurance that it has sufficient State match for the Medicaid-related expenditures, and that the State match on expenditures claimed as Medicaid-related is not being used as State match on any other Federal grants.
- Assurance that Medicaid would distribute the match as a transfer of Federal revenue from the Medical Care Programs to an account designated by the Program. Assurance that Medicaid would serve as a pass-through agency.

The MOU also includes clearly defined responsibilities of both the tobacco program and the state Medicaid partner based on the assurances above, including requiring the tobacco program to provide quarterly reports identifying the Medicaid-related administrative costs of the quitline.

Building Block: Understanding *their* Concerns

Know the specific barriers to financial support from your Medicaid agency's perspective and address these first. It goes without saying that you will need to be prepared to explain and defend costs associated with quitline services and your expected return on investment (ROI). However, if pushback from your Medicaid agency has little to do with ROI and is instead rooted in concern about your program's ability to maintain your assurance of the state match requirement, you'll need to shift your strategy a bit!

Medicaid administrative claiming is the payment of Federal Financial Participation (FFP), at different matching rates (the matching rate for quitlines is 50%), for amounts "found necessary by the Secretary for the proper and efficient administration of the state plan". State and local governments allocate these administrative costs to the Medicaid program in accordance with a cost allocation plan (CAP) approved by the Department of Health and Human Services, Division of Cost Allocation (DCA) after CMS reviews and comments on the fairness of the allocation methodologies. Federal regulations (45 CFR § 95.507) require that cost allocation plans conform to the accounting principles and standards in Office of Management and Budget (OMB) Circular A-87, "Cost Principles for State, Local, and Indian Tribal Governments" (A-87).

Administrative claiming must be directly related to Medicaid program administration and payment may only be made for the percentage of time actually spent on Medicaid-eligible individuals. A CAP is the tool by which the state describes the procedures used to identify, measure, and allocate administrative costs among benefiting Federal and State programs. Claims for administrative costs must be made in accordance with a state's cost allocation plan.

Maryland's CAP, based on an existing template provided to the tobacco program by the regional CMS office, includes language assuring that:

- the state quitline serves both a Medicaid and non-Medicaid population;
- upon intake to the quitline counseling program, callers are asked their insurance status and name of insurance;
- monthly client utilization data is compiled from this intake survey;
- the survey data indicates 30% of callers were Medicaid enrollees; and
- the state will use intake survey data and the compilation of resultant client data to determine the quarterly percentage of Medicaid callers to total callers as the Medicaid allocation factor against claimable quitline expenditures.

In the CAP, be clear about the source document(s) / tracking data that will serve as the basis for the Medicaid / non-Medicaid allocation, how that data is gathered, and how it will be applied. If at all possible, base the allocation on data that is updated quarterly and can be readily audited. Be clear on the financial impact to CMS. For example, be sure to highlight the estimated Federal fund reimbursement and any estimated growth in the next five years. When projecting growth in the next five years remember to take into account changes coming as a result of healthcare reform!

Federal guidance specifically provides for allocation methods that may include a survey of callers or a calculation of a Medicaid eligibility ratio in the total universe of callers. In Maryland's approach, the intake survey provides the source data for the quarterly allocation ratio.

Building Block: Cost Allocation Plan

Development of the Cost Allocation Plan (CAP) methodology is a team effort. It is likely that the tobacco program staff does not speak "Medicaid" and the Medicaid program staff does not speak "quitline." Clarity is essential so that NOTHING is assumed in the development of the CAP (or the MOU for that matter!). Feel free to pass along the summary of the NAQC webinar on the quitline guideline featuring Sharon Brown of CMS to your state's Medicaid team to increase their understanding of the guideline. Determine if your state Medicaid agency has an existing CAP that could be utilized as a template for the CMS application. If an existing CAP template can be utilized, request a sample and work with Medicaid budget personnel to fill it out appropriately. Be sure to use reports from your quitline service provider to help build the CAP methodology!

BUILDING THE INFRASTRUCTURE

Establishing a relationship with Medicaid, arriving at a decision to implement the guideline, reaching agreement on the terms and conditions of the MOU, writing the CAP methodology and receiving approval from DCA are steps in the sometimes-lengthy process to draw down Federal funds for quitline administrative expenditures. However, once this work is complete, the infrastructure that supports the drawdown of the funds must be developed and implemented. This often means that even more new partners from within Medicaid must be engaged (e.g., Office of Health Services, Office of Finance, and Medicaid Pharmacy Program staff). Together with your partners you will have to define and develop the reimbursement processes, reporting methods and timelines, invoicing functions, tracking systems and how internal challenges will be addressed.

Using intake surveys and the compilation of client data from their service provider, Maryland takes the quarterly percentage of Medicaid callers to total callers as the Medicaid allocation factor against claimable quitline expenditures. The State Quitline Coordinator then reviews the invoices developed by their service provider, prepares a tracking sheet that outlines costs for quitline counseling services and gathers additional supporting documents such as a monthly report of all self-reported Medicaid callers and sends them to the Medicaid program as a claim. The claim is then approved and submitted by Medicaid Office of Finance to CMS Regional Offices. Medicaid is then reimbursed and the funds are placed into the tobacco program's account through the State Fiscal Management System.

CHALLENGES TO THE PROCESS

Aside from challenges stemming from a lack of understanding about Medicaid and partners, there are process-related challenges that can impact negatively on progress toward implementation of CMS's quitline guideline. For instance, it is important to understand the full range of internal state processes that may need to take place in order to implement the CMS guideline on quitlines and begin drawing down federal matching funds. There may be processes that fall outside of the administrative realm of operations that can take time (e.g., legislated transfer of spending authority). Knowing what these are ahead of time is critical to planning efforts.

Communication processes also pose a potential threat to progress. For example, there are state tobacco programs in health departments that are not allowed to communicate with Medicaid agency staff directly and instead must work through agency directors. If the health department director does not view implementation of the quitline guideline as critical, communication stops or is difficult at best. Often tobacco program staff find themselves first having to "sell" the importance of the effort to health department leadership before even setting off to build a relationship with Medicaid.

Once the work begins to develop the MOU, staying in constant contact with Medicaid staff is essential – to answer questions, to provide data, to ensure proper cost projections. If the tobacco program staff person must either work through someone else to communicate with Medicaid or must have all communication reviewed and approved, the process is slowed considerably.

There are also process-related barriers that neither the tobacco or Medicaid partners have control over. Seemingly endless staff turnover and under-staffed programs are often reported as challenges by state tobacco programs engaged in Medicaid-related efforts. For example, one state successfully executed an MOU to draw down federal matching funds for quitline administrative expenditures but the health department's budget office made it clear that they would not be able to process any new invoices

from the tobacco program to Medicaid for six months!

FINAL THOUGHTS

As everyone knows, once a partnership is developed you must also work to maintain it. Continuing the partnership with Medicaid should go beyond the monthly or quarterly invoices for federal funds. Routinely invite your Medicaid partners to join tobacco-related calls or webinars that they may find useful to their work; promote the partnership to other state agencies, highlighting that together you were able to draw down additional funds for the state's health; make the quitline "real" for Medicaid staff by letting them know about the successful quit attempts made by the people they serve. Keeping state Medicaid agencies engaged in tobacco control beyond drawing down the federal match for quitline services becomes a key strategy for ensuring a comprehensive approach to the quality of, and access to, tobacco cessation treatment in a state.

In just over a year, eight states have successfully executed an MOU with their state Medicaid partner to secure federal matching funds for quitline services to Medicaid beneficiaries. Several additional state tobacco programs are in varies stages of partnership building and even more are starting to consider how public-public partnerships may lend to the sustainability of their quitline – especially as some tobacco programs are seeing 30-40% of all callers reporting that they are Medicaid-insured. While there are certainly challenges to implementation of the CMS guideline, it serves as a critical step toward broader dialogue with Medicaid on the issue of comprehensive cessation coverage, an example of successful partnering to highlight in future cost-sharing efforts, and a state tobacco program's commitment to ensuring quality and accessible cessation treatment options building a working relationship with new for a population of tobacco users most impacted by its harm.

Building Block: Final Words of Wisdom from NAQC's Medicaid Learning Community

You will be working with a very large agency with many regulations. You might get different answers from different people at different times throughout the process. Be sure to keep a paper trail of decisions made and agreed upon.

You must be able to communicate the importance of a short-term investment for long-term savings.

This process will take you a long time and there are a lot of details to manage and communicate! Do not box yourself in to a specific timeline.

Throughout the process you will likely have different people at the table due to turnover. You will need to constantly bring new people up to speed. While this takes time away from implementation, it is a critical step to bringing everyone along.

There are so many internal contracting and budget issues on both sides – some you will be able to anticipate and others you will not.

RESOURCES

Below are links to resources that will prove useful in Medicaid-related partnership efforts, especially as they pertain to securing Federal matching funds for quitline services to beneficiaries.

- **Final CMS Announcement, June 24, 2011**
- **Medicaid Resource Repository:** an electronic collection of documents and links on topic areas such as Medicaid 101, promotion of cessation benefits to beneficiaries, and partnering with Medicaid.
- **Efforts to Claim Federal Financial Participation for Quitline Administrative Expenditures: A Review of the Landscape, December 2011:** a NAQC report highlighting results from an assessment of states' Medicaid-related efforts. The report includes details on state strategies, current challenges and links to helpful resources.
- **Kaiser Family Foundation's Medicaid/CHIP Web page:** a one-stop-shop for Medicaid-related background, updates, reports and fact sheets.

ACKNOWLEDGEMENTS

NAQC would like to acknowledge the author of this case study, **Tamatha Thomas-Haase, MPA**, and the lead contributor, **Sara Wolfe, MS**, Maryland Department of Health and Mental Hygiene. For layout and design of the paper, NAQC would like to acknowledge **Natalia Gromov**. It is also important to acknowledge the work of N**AQC's Medicaid Learning Community** as their lessons-learned are reflected throughout this document.

This report was produced with funding from the Centers for Disease Control and Prevention (CDC), Contract #200-2008-26560. The contents of this publication are under the editorial control of NAQC and do not necessarily represent the official views of the funding organization.

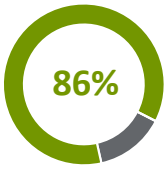
For further details on Maryland's efforts please contact Sara Wolfe, MS, Maryland Department of Health and Mental Hygiene at Sara.Wolfe@maryland.gov.

Maryland Tobacco Quitline Stakeholder Report 2017-2018

were quit 7 months after receiving phone treatment

would recommend the phone program to other tobacco users

were quit 7 months after receiving Web-Only treatment



would recommend the Web-Only program to other tobacco users

What is included in this document?

- This document presents an overview of tobacco cessation services provided to Marylanders through the Maryland Tobacco Quitline (MDQL). It includes national and state-level statistics on tobacco use; research on tobacco control efforts; data on demographics, tobacco use history, and program utilization for MDQL participants; and the results of the 7-month post-registration follow-up survey that assessed outcomes for a random sample of MDQL phone and Web-Only program participants.

What is the Maryland Tobacco Quitline?

- The Maryland Tobacco Quitline (MDQL) provides empirically supported telephone- and web-based tobacco cessation coaching to all Marylanders, including cessation medication support and education, nicotine replacement therapy (NRT), integrated Web Coach®, text messaging support, printed materials, and referral to community resources. Stand-alone Web Coach® (Web-Only) is also offered.

Why is the Quitline needed?

- One in seven adults in Maryland (14%) are current smokers, and three in five (60%) of these smokers make a quit attempt.[1] The MDQL provides an easily accessible, free resource for those trying to quit. The majority (72%) of surveyed MDQL participants report that the MDQL is the only resource they use in a quit attempt, highlighting the importance of the program for Marylanders.

What is the evidence for Quitline effectiveness?

- Tobacco users who use Quitline services are 60% more likely to successfully quit compared to those who attempt to quit without help.[2,3,4] The United States Community Preventative Services Taskforce recommends quitline interventions based on 71 study trials of telephone counseling that show their effectiveness.[5]

How do we ensure continued success of the program in Maryland?

- Maryland currently funds state tobacco control programs at only 27% of nationally recommended levels.[6] The State should consider increasing current funding levels to ensure the success of the Quitline and other tobacco control efforts.

Is the Quitline cost-effective?

- $1.75 was saved in Maryland in medical expenditures, lost productivity, and other costs for every $1 spent on the Quitline and tobacco cessation media.

Who uses the MDQL phone and Web-Only programs?

- 85% enroll in the phone program
- 15% enroll in the Web-Only program
- 62% female
- 46% Black or African American
- 47% White
- 24% do not have a high school diploma
- 47% live with a chronic health condition
- 46% live with a behavioral health condition
- 48% between ages of 41 and 60

"It is very helpful and informative. The checkups are helpful. The supplies are free. I referred it to my friend and she quit for good. It's a good program." —Maryland Tobacco Quitline Participant

In this document

- Tobacco use impacts in Maryland
- Best practices and research evidence for phone-based tobacco cessation
- Description of MDQL services
- Who uses the Quitline services
- Program outcomes and Return On Investment (ROI) findings
- Feedback from Marylanders who received services

Tobacco use in Maryland

"The epidemic of smoking-caused disease in the twentieth century ranks among the greatest public health catastrophes of the century, while the decline of smoking consequent to tobacco control is surely one of public health's greatest successes."

– US Department of Health and Human Services[7]

- In 2017, 13.8% of adults in Maryland were current smokers.[1] This translates to around **648,000 adult cigarette users** in the state.[8] Approximately 7,500 Maryland adults die each year from smoking.[9]
- Approximately 8.2% of youth in Maryland currently smoke. Each year, approximately **1,900 youth in Maryland start smoking.**[9]
- Smoking **costs Maryland over $2.7 billion annually** in health care expenditures.[9] Nationally, it is estimated that each pack of cigarettes sold costs $19.16 in direct health care expenditures and lost workplace productivity.[10]
- Marylanders who do not smoke are impacted by tobacco use. The Centers for Disease Control and Prevention (CDC) estimates that 25.3% of nonsmokers are exposed to harmful secondhand smoke, increasing the risk for smoking-attributable illnesses.[11]
  - While this percentage dropped dramatically between 2000 and 2012, there are notable disparities in exposure. Children, non-Hispanic Blacks, persons living in poverty, and persons living in rental housing still face high exposure rates.[11]
  - In the United States, secondhand smoke costs approximately $1.9 billion each year in healthcare costs for adults.[12]
- The American Lung Association's 2019 State of Tobacco Control Report rated Maryland's policies on tobacco prevention and cessation funding and raising the tobacco purchase age to 21 an 'F', and tobacco taxes a 'D'. The State earned positive grades on smoke free air ('A') and access to cessation services ('B').
  - Maryland's excise tax on cigarettes ($2.00/pack) is the seventeenth highest in the United States, but has not increased since 2008.[10,13] **Raising this tax is one of the most effective ways to reduce smoking, especially among youth.**[14] The Community Preventative Services Task Force recommends tobacco taxes as a method to increase the cost of tobacco as part of a comprehensive tobacco control strategy.[15]

Maryland's smoking prevalence and related costs underscore the importance of smoking cessation programs in improving the lives and health of Marylanders.

Quitline Research – What is the evidence base for state quitlines?

"Tobacco use treatment has been referred to as the 'gold standard' of health care cost-effectiveness."

– US DHHS, Clinical Practice Guideline: Treating Tobacco Use and Dependence[2]

- Quitting smoking reduces a person's risk for numerous chronic health conditions and premature death, with greater benefits the younger a person quits.[16] Quitting smoking by age 50 cuts a person's risk of dying within 15 years in half.[17]

Quitlines

- **Available in every state**
- **Proven to help tobacco users quit**
- **Best outcomes with multiple sessions + NRT**
- **Remove barriers**
- **Cost-effective**

- Extensive research and meta-analyses have proven the efficacy and real-world effectiveness of tobacco quitlines.[2,3,4,5]
  - **Tobacco users who receive Quitline services are 60% more likely to successfully quit** compared to tobacco users who attempt to quit without assistance.[2]
  - **Tobacco users who receive medications and quitline counseling have a 30% greater chance of quitting** compared to using medications alone.[2]

- State quitlines **eliminate barriers** that may be present with in-person cessation interventions because they are free to callers, often available evenings and weekends, convenient, provide services that may not be available locally, and reduce disparities in access to care.[18]

- The Community Preventative Services Taskforce has concluded that quitlines are **cost-effective** based on a review of 27 studies.[5]

- Three strategies have been proven to be especially effective in promoting Quitline use:[5]
  - Wide-reaching health communications campaigns through channels such as television, radio, newspapers, and cigarette pack health warning labels that provide tobacco cessation messaging and the Quitline phone number
  - Offering tobacco cessation medication and nicotine replacement therapy through the Quitline
  - Referral to the Quitline by a health care provider

Assuring Quitline Service Best Practices for Marylanders

The Maryland Tobacco Quitline is **operated and evaluated in line with North American Quitline Consortium (NAQC) best practices**. Since the Quitline's inception in 2006, Maryland has selected Optum as its Quitline service vendor.

Optum specializes in behavioral coaching to help people identify health risks and modify their behaviors so they may avoid or manage chronic illness and live longer, healthier lives. Five large federally and state-funded randomized clinical trials have demonstrated the effectiveness of Optum's tobacco cessation program.[19,20,21,22,23]

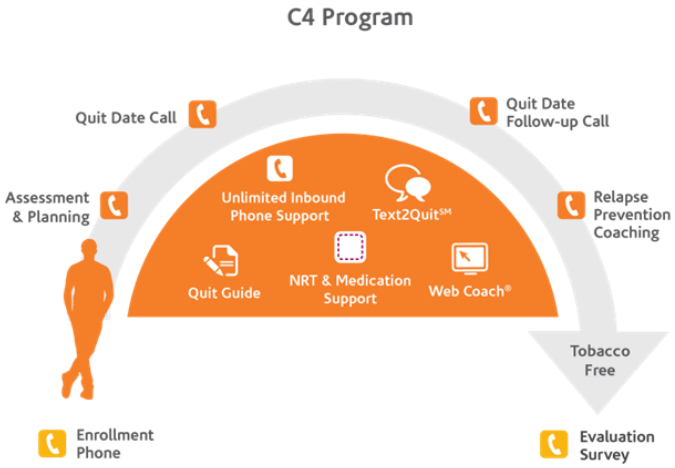
Additional vendor qualifications:

- More than 30 years of experience providing phone-based tobacco cessation services.
- Provision of tobacco cessation services to 27 tobacco quitlines (25 states, Washington DC, and Guam) and more than 750 commercial organizations (76 in the Fortune 500).
- Selected by the American Cancer Society to be its operating partner for quitline services.
- Participant in national tobacco control and treatment policy committees and workgroups.
- Quit Coach® staff complete more than 200 hours of rigorous training and oversight before speaking independently with participants.

What services did the Maryland Tobacco Quitline provide during the evaluation (November 1, 2017 through October 31, 2018)?

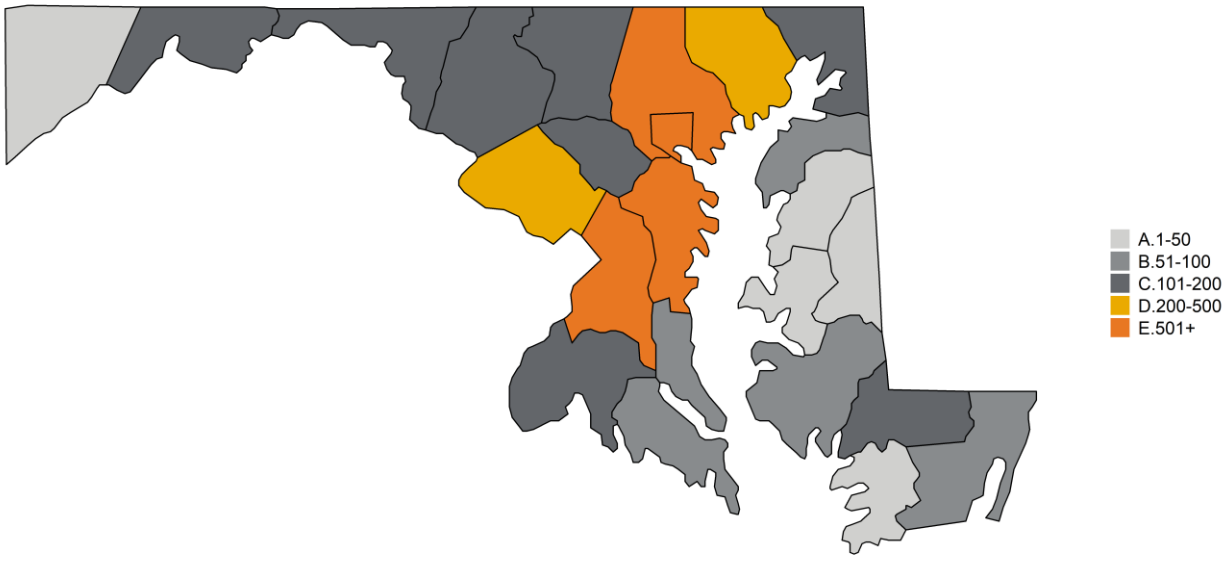
Quitline services are culturally appropriate, available 24 hours per day, 7 days per week, and incorporate evidence-based strategies for tobacco dependence treatment as outlined in the *USPHS Clinical Practice Guideline, Treating Tobacco Use and Dependence: 2008 Update*.

- Phone-based tobacco cessation services:
  - **One-call (C1) tobacco cessation program for all callers**
    - Initial coaching session with Quit Coach® staff
  - **Four-call (C4) tobacco cessation program for all callers ready to quit within 30 days**
    - Initial coaching session and three additional proactive follow-up calls
  - **Intensive 10-call (C10) program for pregnant and postpartum tobacco users**
    - Intensive behavioral support tailored to unique needs during pregnancy and including postpartum contact to prevent relapse



- Web-based tobacco cessation services:
  - **Integrated Web Coach® program**
    - Interactive, web-based cessation tool designed to complement and enhance phone counseling
    - Integrated access with any phone-based Quitline program
  - **Stand-alone Web Coach® program (Web-Only)**
    - Online participant application designed to guide tobacco users through an evidence-based process of quitting tobacco
- Text message-based tobacco cessation services:
  - **Text2Quit** for MDQL participants with cell phones
    - Interactive text messaging cessation aid designed to help guide smokers through the quitting process over a 12-month period
    - Integrated access with any MDQL program
- **Nicotine replacement therapy (NRT)** offering for all participants who are planning to quit in the next 30 days:
  - **For C4 and C10 participants**:
    - November 1, 2017 through December 31, 2017: 12 weeks of patches, gum, or combination therapy (three shipments of a 4-week supply)
    - January 1, 2018 through October 31, 2018: 12 weeks of patches, gum or lozenges, alone or in combination (three shipments of a 4-week supply)
  - **For Web-Only users**:
    - November 1, 2017 through December 31, 2017: 4 weeks of patches or gum (one shipment of a 4-week supply)
    - January 1, 2018 through October 31, 2018: 12 weeks of patches, gum or lozenges, alone or in combination (three shipments of a 4-week supply)

Marylanders Who Enrolled in the MDQL Phone or Web-Only Programs by County of Residence[24]

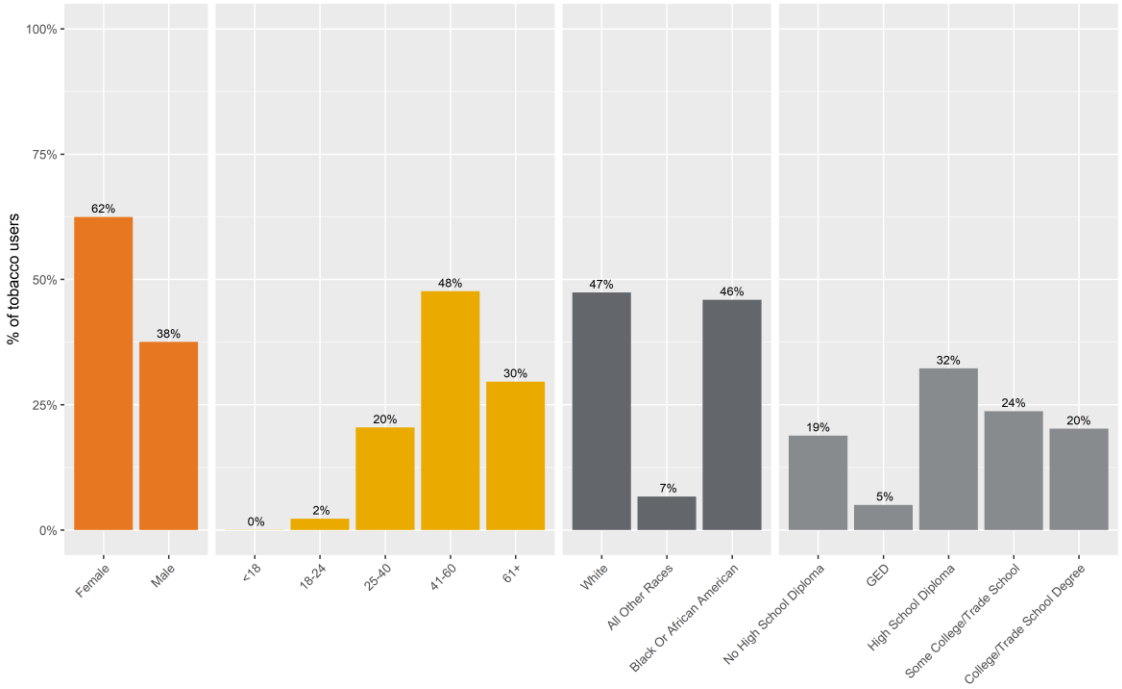


County	Total Served	County	Total Served	County	Total Served
Allegany	111	Charles	160	Prince George's	762
Anne Arundel	730	Dorchester	57	Queen Anne's	34
Baltimore	1468	Frederick	167	Somerset	27
Baltimore City	2571	Garrett	15	St. Mary's	99
Calvert	90	Harford	282	Talbot	35
Caroline	41	Howard	155	Washington	167
Carroll	110	Kent	52	Wicomico	121
Cecil	186	Montgomery	360	Worcester	59

Who uses Maryland Tobacco Quitline phone or Web-Only services?[25]

- During the evaluation timeframe (November 2017 through October 2018), 8,044 (85%) enrolled in a phone-based program and 1,432 (15%) enrolled in the Web-Only program.
- The Quitline serves tobacco users in need who may have limited access to other resources:
  - 54% of enrollees were either uninsured (12%) or Medicaid-insured (42%).
  - 56% did not have education beyond high school.
- About half of participants reported a chronic health condition (47%) and/or a behavioral health condition (46%).
- Services were provided in English (99.5%) and Spanish (0.4%, 41 callers); translation services were also available for callers who speak other languages.
- Most participants sought help to quit cigarettes (94%), but also cigars (4%), smokeless tobacco (1%), pipes (0.4%), and other tobacco products (4%).
- Nearly two fifths of MDQL program participants learned about the Quitline through TV commercials (36%). Other callers learned of the Quitline through a health professional (25%), family or friends (16%), a website (3%), or a brochure/newsletter/flyer (3%).

Demographics of Tobacco Users who Enrolled in MDQL Phone or Web-Only Program Services



Electronic Nicotine Delivery Systems

Electronic nicotine delivery systems (ENDS), also called e-cigarettes, electronic, or vapor cigarettes, are battery operated devices that vaporize nicotine, flavoring, and other chemicals for a user to inhale. A 2018 report released by the National Academies of Science, Engineering, and Medicine concluded that while e-cigarettes are less harmful than cigarettes, they are not without risk.[26] More research is needed to understand the long term effects of e-cigarettes and their utility as a smoking cessation aid.

There is particular concern about e-cigarette use among youth and young adults; in 2018, the Surgeon General declared an epidemic of e-cigarette use among youth.[27] One in five high school students and one in twenty middle school students currently use e-cigarettes, translating to about 3.6 million youth. This rate has increased sharply over the past decade; among high school students, e-cigarette use increased from 1.5% in 2011 to 20.8% in 2018.[28] Research has shown that e-cigarette companies are using tactics to target youth and young adults, such as adding flavorings that appeal to kids and using social media campaigns directed at young people.[29]

In 2017, about 6.9 million adults in the United States were e-cigarette users (2.8% of the adult population).[30] ENDS use is highest among adults aged 18 – 24, and use rates tend to drop off with age. Current cigarette smokers and former smokers who quit within the last year are more likely to use ENDS than the general population.[31,32]

At 7-month follow-up, MDQL participants were asked about current e-cigarette use. Among survey respondents:

- ENDS use was more common among Web-Only users, with 42% of Web-Only respondents reporting having used ENDS compared to 32% of phone program respondents. About one in ten (9%) callers and one in eight (13%) Web-Only users were current ENDS users (used in the last 30 days) at follow-up.
- In both programs, ENDS users most commonly reported that they used ENDS to quit or replace other tobacco products or to cut down on other tobacco products (63% of phone program respondents, 72% of Web-Only respondents).
- Among current ENDS users, most reported that they had been using them for one month or longer (72% of phone program respondents, 82% of Web-Only respondents).

How do we know the Maryland Tobacco Quitline works?

What are the program outcomes?

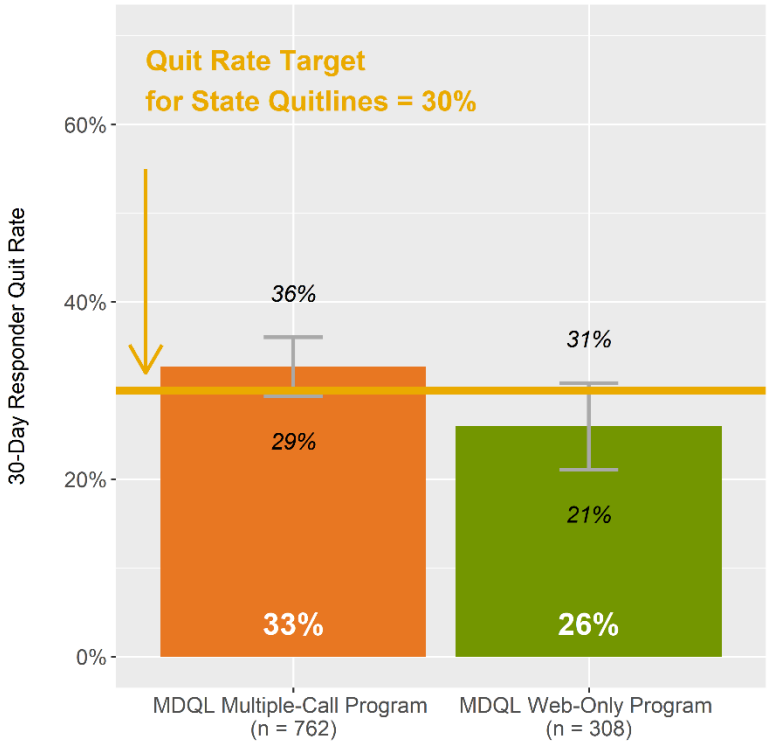
One in three phone program respondents and one in four Web-Only respondents successfully quit; continued tobacco users also made important reductions in their use and dependence, increasing their likelihood of future success.

of phone program participants were quit at the 7-month follow-up evaluation survey (30-day responder quit rate)

30% of phone program respondents were quit from both tobacco and ENDS at 7-month follow-up

of Web-Only program participants were quit at the 7-month follow-up evaluation survey (30-day responder quit rate)

23% of Web-Only program respondents were quit from both tobacco and ENDS at 7-month follow-up



would recommend the phone program to other tobacco users

were satisfied with the phone program

would recommend the Web-Only program to other tobacco users

were satisfied with the Web-Only program

Tobacco Reduction among Continued Users

Although the goal of the Quitline program is to achieve tobacco abstinence, important health improvements were made among continued tobacco users in the phone and Web-Only programs:

- **Quit attempts:** Since enrolling with the MDQL, the majority of participants had stopped using tobacco for 24 hours or longer because they were trying to quit (90% of phone, 84% of Web-Only).
- **Reduction in use:** 74% of phone program and 70% of Web-Only continued tobacco users reduced the number of cigarettes they smoked per day by about half a pack (10 cigarettes for phone respondents, 9 cigarettes for Web-Only respondents), on average.
- **Reduction in dependence level:** There was a 25% decrease for the phone program and a 35% decrease for the Web-Only program in the number of continued smokers who reported smoking their first cigarette within 5 minutes of waking.
- **Reduction in smoking frequency:** There was a 26% decrease for the phone program and 23% decrease for the Web-Only program in the number of continued smokers who reported smoking every day.

Nicotine Replacement Therapy

Nicotine replacement therapy (NRT) is a vital component in a multifaceted approach to tobacco cessation. It is available in several forms, including gum, patches, lozenges, inhalers, and nasal spray. A combination of quitline counseling and medication is particularly effective in treating nicotine dependence. Those who use quitline counseling and medication are 30% more likely to successfully quit than those who use medication alone.[2] Using a combination of medications at the same time has also been shown to aid in quitting tobacco, especially for highly dependent smokers.[2] NRT is often used as an incentive to engage tobacco users with quitline services. Several studies have shown that when quitlines promote free medication for callers, call volume and quit rates increase.[15]

Maryland offered a 12-week supply of patches, gum, lozenges or combination therapy (three shipments of a 4-week supply) to multiple-call program participants and a 4-week supply of patches, gum, or lozenges (one shipment of a 4-week supply) to Web-Only participants.[33] As part of the MDQL evaluation, program outcomes were examined as a function of NRT benefit type (sent no NRT vs. sent one type of NRT vs. sent combination therapy).

Among phone program respondents:

- Phone program respondents who were sent one type of NRT or combination therapy through the MDQL were more likely to report using cessation medication at follow-up compared to those who were not sent NRT (87%, 88% vs. 70%; $p < 0.001$).
- Satisfaction rates were not significantly different as a function of NRT benefit (no NRT: 89%; one type: 93%; combination therapy: 94%; $p > 0.05$).
- 30-day respondent and ITT quit rates were not significantly different between those sent no NRT, those sent a single type of NRT, and those sent combination NRT (respondent: 40%, 32%, 32%, $p > 0.05$; ITT: 13%, 13%, 12%, $p > 0.05$).
    - It is important to note the eligibility criteria for NRT: participants were only eligible for combination therapy if they reported smoking 9+ cigarettes per day, meaning this group was likely more addicted at baseline. Tobacco users who are more addicted tend to have lower quit rates overall; the fact that quit rates were not significantly different is quite positive in this regard.

Pregnancy and Tobacco Use

Reducing tobacco use among pregnant women reduces infant mortality rates, improves birth outcomes, decreases neonatal health care spending in the State, and improves maternal health.[34,35] The Quitline continues to provide the enhanced 10-Call Pregnancy Program (C10) with the goal of reducing health risks for the baby and other children in the household. The program targets cessation during pregnancy and skill development to help women sustain their quit postpartum. C10 participants are eligible to receive incentives for completing calls in the program. For every group of three calls completed prior to delivery, a C10 participant receives a $25 gift card. For every call completed after delivery, the participant receives a $20 gift card. This incentive structure seeks to prevent relapse after delivery.

- 8.8% of women of childbearing age served by the Quitline from November 1, 2017 through October 31, 2018, were pregnant, planning pregnancy in the next 3 months, or breastfeeding.
- For this evaluation (November 1, 2017 – October 31, 2018 registrants), 19 out of 22 C10 respondents reported being satisfied with the services they received, and 17 out of 19 indicated they would recommend the Quitline to a friend in need of similar help.
- About half of respondents who participated in the C10 program had been quit for at least 7 days (10/23) and at least 30 days (9/23) at time of the 7-month follow-up survey.

7-day quit rates **Respondent: 43.5% (10/23)** 95% CI: [23.2% - 63.7%] ITT: 9.2% (10/109) 95% CI: [3.7% - 14.6%]	
30-day quit rates **Respondent: 39.1% (9/23)** 95% CI: [19.2% - 59.1%] ITT: 8.3% (9/109) 95% CI: [3.1% - 13.4%]	

Best practices in quitline evaluation and measurement of outcomes

To encourage quality standards and comparability of findings across state quitlines, the **North American Quitline Consortium (NAQC) has established a series of recommendations and best practices for the evaluation of tobacco cessation quitlines**. These standards include:

- Ongoing evaluation to maintain accountability and demonstrate effectiveness.[36]
- Assessment of outcomes 7 months following callers' enrollment in services, utilizing NAQC methodology and measurement guidelines.[37]
- Reporting of 30-day point prevalence tobacco quit rates (the proportion of callers who have been tobacco-free for 30 or more days at the time of the 7-month follow-up survey) in conjunction with survey response rates.[37]

The Maryland Tobacco Quitline has a strong commitment to evaluation and identifying ways to improve their program to benefit the health of Marylanders. Evaluations are designed utilizing strong methodology and adequate sample sizes for confidence and accuracy in outcome estimates. The findings on page 9 include combined data from the MDQL's **eleventh annual evaluation** and represent 7-month outcome data from a sample of November 2017 through October 2018 registrants who received empirically supported treatment (i.e., completed one or more coaching calls for phone program participants; logged into Web Coach 1+ days or were sent NRT for Web-Only users) through the program (survey response rate was 38% for the phone program, 38% for the Web-Only program).

Is the MDQL cost-effective?

***$1.75 saved* in Maryland in medical expenditures, lost productivity, and other costs *for every $1 spent* on the Quitline program and tobacco cessation media**

Return on Investment (ROI)	
Quit Rate • 30-day respondent quit rate for November 2017 – October 2018 phone program registrants • 30-day respondent quit rate for November 2017 – October 2018 Web-Only program registrants	**32.7%** **26.0%**
# Quit • .327 x 6,729 tobacco users enrolled in the phone program between November 2017 – October 2018 and received phone intervention • .260 x 1,052 tobacco users enrolled in the Web-Only program between November 2017 – October 2018 and received Web-Only intervention	**2,474**
Total $ Saved • Medical expenses (one year):[38] $281 x 2,474 = $695K • Lost productivity: [39] $1,066 x 2,474 = $2.6M • Worker's compensation:[40] $146 x 2,474 = $361K • Secondhand smoke (one year):[41,42,43] $49 x 2,474 = $121K	**$3.8M**
Total $ Spent • MDQL phone and Web-Only program operating ($1,768,406) and tobacco cessation media ($405,642)[44]	**$2.2M**
Return On Investment • Ratio of Total $ Saved / Total $ Spent	**$1.75**

In the Words of Quitline Callers…

"Everybody that I talked to was very friendly, supportive. They answered every question I had. I called every time I needed them."

"It was very effective. The free support and medication options are essential for success."

"It is beneficial, because the text messages remind me why to not smoke and they give helpful tactics to get my mind off it. It is a nice gesture to be offered the nicotine gum, because it did help."

"They helped me successfully. The support via calls and text messages was awesome. I have tried three other times to quit and never succeeded."

"It's beneficial, it's just the way it was presented to me about how you really have to prepare to quit. They gave you a lot of good pointers on keeping [tobacco products] out of sight, they gave you tips on doing a small quit. It really helped, it seems like common sense but it's things I wouldn't have thought about."

"It's a wonderful program. It's nice to know there is help out there when you need it. That you have a lot of support and you are not alone in your struggle. I don't think a lot of people realize how important it is. Thank you so very much for having this program and for all the support. I am truly thankful and happy to say I have been smoke free for 6 months and it really has made a difference."

"It is honestly a great program which afford[s] anyone the opportunity to participate and achieve quit status. I am truly thankful that this program is available to people like myself."

"It is a good way to start to quit and get text messages to remind you. The only problem is when the patches are gone, it is really expensive to buy them."

"The program was simple to enroll in and provided nicotine replacement aides that I was otherwise unable to afford. The website also helped me focus on my motivation and ways to help me increase my success in quitting. I also found the text alerts helpful from time to time—they provided encouragement and motivation (especially when totaling the amount of money I have saved since I have quit). Thank you so much for your program; it has helped me to succeed where I have failed many, many, many, many times before."

References and Notes

[1] Kaiser Family Foundation (2018). State Health Facts: Percent of Adults Who Smoke - 2017. Retrieved from: http://kff.org/state-category/health-status/smoking/

[2] Fiore MC (2008). Treating tobacco use and dependence: 2008 update. Rockville, Md., U.S. Dept. of Health and Human Services, Public Health Service.

[3] Stead LF, Perera R, Lancaster T. (2006). Telephone counseling for smoking cessation. *Cochrane Database of Systemic Reviews*, 3:CD002850.

[4] Lichtenstein E, Glasgow RE, Lando HA, Ossip-Klein DJ, Boles SM. (1996). Telephone Counseling for Smoking Cessation: Rationales and Meta-Analytic Review of Evidence. *Health Education Research*, 11(2):243-57.

[5] Community Preventative Services Task Force. (2015). Reducing Tobacco Use and Secondhand Smoke Exposure: Quitline Interventions. Retrieved from: http://www.thecommunityguide.org/tobacco/quitlines.html.

[6] American Lung Association. (2019). State of Tobacco Control 2019. Retrieved from: http://www.lung.org/our-initiatives/tobacco/reports-resources/sotc/state-grades/

[7] U.S. Department of Health and Human Services. (2014). The Health Consequences of Smoking – 50 Years of Progress. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health.

[8] Calculated from: United States Census Bureau. (2018). Retrieved from: https://www.census.gov/quickfacts

[9] Campaign for Tobacco Free Kids. (2019). Key State-Specific Tobacco-Related Data & Rankings. Retrieved from: https://www.tobaccofreekids.org/assets/factsheets/0176.pdf

[10] Campaign for Tobacco Free Kids. (2019). State Cigarette Excise Tax Rates and Rankings. Retrieved from: http://www.tobaccofreekids.org/research/factsheets/pdf/0097.pdf

[11] Centers for Disease Control and Prevention (2015). Vital Signs: Disparities in Nonsmokers' Exposure to Secondhand Smoke — United States, 1999–2012. Retrieved from: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6404a7.htm?s_cid=mm6404a7_w

[12] Yao T, Sung H, Wang Y, Lightwood J, & Max W. (2018). Healthcare Costs Attributable to Secondhand Smoke Exposure at Home for U.S. Adults. *Preventative Medicine* 2018 March; 108: 41–46. doi:10.1016/j.ypmed.2017.12.028

[13] Campaign for Tobacco Free Kids. (2019). Cigarette Tax Increases by State per Year 2000-2019. Retrieved from: https://www.tobaccofreekids.org/assets/factsheets/0275.pdf

[14] Campaign for Tobacco Free Kids. (2018). Raising Cigarette Taxes Reduces Smoking, Especially Among Kids (and the Cigarette Companies Know It). Retrieved from: http://www.tobaccofreekids.org/research/factsheets/pdf/0146.pdf

[15] Community Preventative Services Task Force. (2014). Reducing Tobacco Use and Secondhand Smoke Exposure: Interventions to Increase the Unit Price for Tobacco Products. Retrieved from: http://www.thecommunityguide.org/tobacco/RRincreasingunitprice.html

[16] Centers for Disease Control and Prevention. (2017). *Smoking and Tobacco Use: Smoking Cessation.* Retrieved from: http://www.cdc.gov/tobacco/data_statistics/fact_sheets/cessation/quitting/index.htm

[17] U.S. Department of Health and Human Services. (1990) *The Health Benefits of Smoking Cessation: A Report of the Surgeon General.* Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. DHHS Publication No. (CDC)90–8416.

[18] Anderson C.M. & S.H. Zhu (2007). Tobacco quitlines: looking back and looking ahead. *Tobacco Control,* 16 (Suppl 1), i81-86.

[19] Orleans C.T., Schoenbach V.J., Wagner E., et al. (1991). Self-help quit smoking interventions: Effects of self-help materials, social support instructions, and telephone counseling. *Journal of Consulting and Clinical Psychology*, 59(3):439-448.

[20] Curry S.J., Grothaus L.C., McAfee T., Pabiniak C. (1998). Use and cost effectiveness of smoking-cessation services under four insurance plans in a health maintenance organization. *New England Journal of Medicine*, 339(10):673-679.

[21] Swan G.E., McAfee T., Curry S.J., et al. (2003). Effectiveness of bupropion sustained release for smoking cessation in a health care setting: a randomized trial. *Archives of Internal Medicine*, 163(19):2337-2344.

[22] Hollis J.F., McAfee T., Fellows J.L., Zbikowski S.M., Stark M. K. R. (2007). The effectiveness and cost effectiveness of telephone counseling and the nicotine patch in a state tobacco quitline. *Tobacco Control*, 16 (Suppl 1), i53-59.

[23] McAfee T.A., Bush T., Deprey T.M., Mahoney L.D., Zbikowski S.M., Fellows J.L., McClure J.B. (2008). Nicotine patches and uninsured quitline callers. A randomized trial of two versus eight weeks. *American Journal of Preventive Medicine*, 35(2):103-10.

[24] Enrollments between November 1, 2017 and October 31, 2018. Map generated using ggmap: D. Kahle and H. Wickham. ggmap: Spatial Visualization with ggplot2. The R Journal, 5(1), 144-161. http://journal.r-project.org/archive/2013-1/kahle-wickham.pdf

[25] All demographics represent tobacco users who requested an intervention through the MDQL (i.e., registered for the phone program or Web-Only program) from November 1, 2017 and October 31, 2018.

[26] National Academies of Sciences, Engineering, and Medicine (NASEM), Public Health Consequences of E-Cigarettes, Washington, DC: The National Academies Press, 2018, http://nationalacademies.org/hmd/Reports/2018/public-health-consequences-of-e-cigarettes.aspx

[27] Office of the Surgeon General, "Surgeon General's Advisory on E-Cigarette Use Among Youth," December 18, 2018, https://e-cigarettes.surgeongeneral.gov/documents/surgeon-generals-advisory-on-e-cigarette-use-among-youth-2018.pdf.

[28] Cullen KA, Ambrose BK, Gentzke AS, Apelberg BJ, Jamal A, King BA. Notes from the Field: Use of Electronic Cigarettes and Any Tobacco Product Among Middle and High School Students — United States, 2011–2018. MMWR Morb Mortal Wkly Rep 2018;67:1276–1277.

[29] Campaign for Tobacco Free Kids. (2019). Electronic Cigarettes: An Overview of Key Issues. Retrieved from: https://www.tobaccofreekids.org/assets/factsheets/0379.pdf

[30] Wang TW, Asman K, Gentzke AS, et al. Tobacco Product Use Among Adults — United States, 2017. MMWR Morb Mortal Wkly Rep 2018;67:1225–1232.

[31] Schoenborn CA, Gindi RM. Electronic cigarette use among adults: United States, 2014. NCHS data brief, no. 217. Hyattsville, MD: National Center for Health Statistics. 2015.

[32] Mirbolouk M et al. Prevalence and Distribution of E-Cigarette Use Among U.S. Adults: Behavioral Risk Factor Surveillance System, 2016. Ann Intern Med. 2018;169(7):429-438.

[33] NRT lozenges were offered starting in January 2018.

[34] DiFranza JR, Lew RA. (1995). Effect of maternal cigarette smoking on pregnancy complications and sudden infant death syndrome. *Journal of Family Practice,* 40(4):385–94.

[35] Adams EK, Miller VP, Ernst C, Nishimura BK, Melvin CL, Merritt R. (2002). Neonatal health care costs related to smoking during pregnancy. *Health Economics,* 11(3):193–206.

[36] Centers for Disease Control and Prevention. (2014). *Best practices for comprehensive tobacco control programs - 2014*. Atlanta, GA, Centers for Disease Control and Prevention.

[37] An L, Betzner A, Luxenberg M, Rainey J, Capesius T, & Subialka E. (2009). *Measuring Quit Rates. Quality Improvement Initiative*. North American Quitline Consortium. Phoenix, AZ.

[38] Medical savings are based on the trend-adjusted one year savings from the Milliman, Inc. research study "Covering Smoking Cessation as a Health Benefit: A Case for Employers" (see Table 5 in the study). The $192 claim cost savings is based on 2006 dollar values. When adjusted to mid-point 2018 dollar values based on Consumer Price Index (CPI), the claim cost savings is $281.

[39] Berman M, Crane R, Seiber E, et al. Estimating the cost of a smoking employee. *Tob Control* 2014; 23(5):428-433

[40] Sherman B, Lynch W. The Relationship between Smoking and Health Care, Workers Compensation, and Productivity Costs for a large Employer. *J Occup Environ Med* 2013 Vol 55 No 8, August 2013

[41] Yao et al 2018. Healthcare Costs Attributable to Secondhand Smoke Exposure at Home for US Adults. *Prev Med*. 2018 March; 108: 41–46. doi:10.1016/j.ypmed.2017.12.028.

[42] Yao et al 2018. Healthcare Costs of Secondhand Smoke Exposure at Home for U.S. Children. *Am J Prev Med*. 2019 Feb; 56(2): 281-287. doi: 10.1016/j.amepre.2018.08.013.

[43] Yao et al. estimates secondhand smoke (SHS) attributable costs to be $1.9 billion for adults in 2010 and $62.9 million for children in 2010. Assuming a 2010 US smoking prevalence of 19.3% and a total adult population of 229.5 million, the total cost per smoker in 2010 was $42.90 in SHS-attributable costs to adults and $1.42 in SHS-attributable costs to children. Adjusted to 2018 dollars using Consumer Price Index (CPI), this totals approximately $49/smoker.

[44] State anti-tobacco media campaign expenditures provided by the State; costs are from November 1, 2017 – October 31, 2018.