SCHAEFER CENTER FOR PUBLIC POLICY

KNOWLEDGE THAT WORKS FOR GOVERNMENT AND NONPROFIT ORGANIZATIONS

Summary of the 2019 Strategic Planning Retreat for the Center for Tobacco Prevention and Control Maryland Department of Health

UNIVERSITY OF BALTIMORE
Schaefer Center for Public Policy

Summary of the 2019 Strategic Planning Retreat for the Center for Tobacco Prevention and Control

Maryland Department of Health

Revised November 15, 2019

Submitted to:

Dana Moncrief, Chief
Statewide Public Health Initiatives
Center for Tobacco Prevention and Control
Maryland Department of Health
201 West Preston Street
Baltimore, MD 21201
410.767.5316
dana.moncrief@maryland.gov

Submitted by:

Dr. Ann Cotten, Director
Schaefer Center for Public Policy
University of Baltimore – College of Public Affairs
1420 N. Charles Street
Baltimore, MD 21201
410.837.6188
acotten@ubalt.edu

UNIVERSITY OF BALTIMORE
Schaefer Center for Public Policy

ABOUT THE SCHAEFER CENTER FOR PUBLIC POLICY

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

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

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

Since its creation more than 30 years ago, the Schaefer Center has completed hundreds of research and professional development projects for various local, state and federal agencies, as well as nonprofit organizations. Through its newest program, the Maryland Certified Public Manager® Program offered in tracks for nonprofit and government managers as well as public safety professionals, the Schaefer Center is building the management capacity in Maryland's public organizations.

CONTENTS

TABLES AND FIGURES

Summary of Strategic Planning Retreat for the Center for Tobacco Prevention and Control

EXECUTIVE SUMMARY

The Center for Tobacco Prevention and Control (CTPC) at the Maryland Department of Health (MDH or the Department) contracted with the Schaefer Center for Public Policy (the Schaefer Center) at the University of Baltimore, College of Public Affairs to conduct an evaluation of Maryland's Tobacco Control Program (MTCP).

The evaluation contract is in place from June 2017 through June 2020. Utilizing process and outcome evaluation frameworks, the evaluation of the Maryland Tobacco Control Program is assessing the progress Maryland is making toward achieving its goals and objectives around reducing the prevalence of cigarette smoking among adults; reducing the prevalence of tobacco use among youth; decreasing youth access to tobacco in the retail environment; reducing exposure of youth to secondhand smoke (SHS); and decreasing exposure to secondhand smoke among Maryland residents by increasing the voluntary household no-smoking rules. Interim findings were submitted in a written report to MDH in June 2018. A draft of the final report was submitted in July 2019. The report will be updated in early 2020 to reflect the most current prevalence data. A final evaluation report is expected in early 2020.

As part of overall evaluation efforts, the research team at the Schaefer Center facilitated two strategic planning retreats in October 2018 and October 2019. This report summarizes the second strategic planning retreat on October 10, 2019 at the Wilde Lake Interfaith Center. The purpose of the retreat was to solicit input to prioritize key strategies for the State's 5-year Tobacco Control Strategic Plan 2020-2025.

In total, 65 people attended the retreat including 33 individuals from the Local Health Departments (LHDs) as well as five staff members from the statewide resource centers (including MDQuit and the Legal Resource Center), 14 staff members from CTPC, two representatives from Red House Communication, and consultant Stephanie Papas. The retreat agenda is included in this report as Appendix 1.

The retreat included an update by Dawn Berkowitz, Director of the Center for Tobacco Prevention and Control; a presentation on *Health Equity, Tobacco and Behavioral Health* by Taslim van Hattum, Director of Practice Improvement for the National Behavioral Health Network for Tobacco & Cancer Control; and facilitated afternoon breakout sessions focused on prioritizing strategies for the new Tobacco Control Strategic Plan. Participants were also invited to discuss

the mission and vision for Tobacco Control during lunch and provide recommended changes via feedback cards.

This document summarizes the events of the day, LHD feedback on the Tobacco Control mission and vision, LHDs' prioritization of strategies for the next strategic plan, LHD feedback on potential performance measures that may be incorporated into the strategic plan, and participant feedback on the retreat.

2019 STRATEGIC PLANNING RETREAT PARTICIPANTS

Sixty-five (65) people attended the retreat, 33 of which were representatives of LHDs. Table 1 below shows the breakdown of attendees by organization type. Representatives from Calvert, Cecil, Howard, Queen Anne's, and Wicomico County LHDs did not attend.

Table 1: Strategic Planning Retreat Attendees by Organization Type

Organization Type	Total Participants
Consultant	1
LHD	33
MDH, MDH-CTPC	14
Media Partner	2
Resource Center	5
Schaefer Center, UB	9
Speaker-Taslim Van Hattum	1
TOTAL	**65**

In subsequent sections, text that has strikethrough font (~~strikethrough~~) was recommended to be deleted or replaced by LHDs. Text that is bolded and blue (**bolded and blue**) is a suggested replacement or new text from LHDs.

MORNING SESSION – MDH UPDATES

Dawn Berkowitz, Director of the Center for Tobacco Prevention and Control kicked off the retreat with an update from CTPC. A copy of the presentation is included in Appendix VII. Her presentation included the following topics:

- An overview of what has happened since the October 2018 retreat including a list of the meetings that were held, links to the new listserv and program reporting and evaluation website, and changes made by CTPC in the grant and site visit processes in response to LHD feedback.
- An update on the most recent data about adult use of tobacco products and electronic smoking devices (ESD).
- An update on lung injury and deaths associated with vaping (nationwide and Maryland), a review of the MDH clinical reporting order, an update on what MDH is doing in response to vaping-associated illnesses and deaths, and a review of MDH resources and outreach on vaping.
- An update on new the Maryland Tobacco 21 legislation, implementation details, and retailer resources.
- An overview of the CTPC goals for the retreat.

MORNING SESSION – HEALTH EQUITY, TOBACCO AND BEHAVIORAL HEALTH

To prepare attendees for their afternoon discussions about strategies for the 2020-2025 strategic plan, Taslim van Hattum, Director of Practice Improvement for the National Behavioral Health Network for Tobacco & Cancer Control delivered a presentation entitled, *Health Equity, Tobacco and Behavioral Health* which is included as Appendix IX to this report. Her presentation included the following topics:

- health equity and determinants of health;
- what is required to address health disparities to achieve health equity;
- tobacco and health equity as it relates to the behavioral health population;
- best practices for addressing tobacco use in the behavioral health population; and
- a review of the tobacco control mission and vision with a health equity lens.

MISSION AND VISION STATEMENTS EXERCISE

Strategic planning retreat participants were given the Mission and Vision Feedback Form (see Appendix II) to evaluate the current Mission and Vision Statements and provide feedback. Following the morning session on health equity, participants were instructed to complete their feedback forms over lunch and return them to the registration table. Four forms were returned. At least one form was a summary of the feedback from an entire table.

A summary of responses from the LHDs regarding the mission statement collected at the retreat is provided in Table 2. Retreat data for vision statement feedback is summarized in Table 3.

MISSION STATEMENT

Participants were provided with the current mission statement and asked to edit it to incorporate a health equity lens:

> *The mission of the Tobacco Use Prevention and Cessation Program is to reduce the use of tobacco products in Maryland thereby reducing the burden of tobacco-related morbidity and mortality on the population.*

Four responses were submitted via the Mission and Vision Feedback Forms at the retreat, but only three forms had feedback on the mission statement. Table 2 summarizes mission statement feedback received during the retreat. Bolded content indicates new or modified text in the mission statement based on suggestions from respondents.

Table 2: Mission Statement Feedback Received at the Retreat

Mission Statement Feedback
The mission of the MD Tobacco Control Program is to change the landscape of Maryland to reduce tobacco and vape product use in Maryland by: 1) improving access to services for those disparately affected by tobacco use; 2) reducing the gaps between the populations with high tobacco use rates and the general population; and 3) partnering with other organizations to broaden the reach of the tobacco program.
The mission of the Tobacco Use Prevention and Cessation Program is to reduce the use of tobacco products in Maryland thereby reducing the burden of tobacco-related morbidity and mortality on the population **to provide leadership, utilize resources, and promote reduction of tobacco product use for all Marylanders, especially priority populations experiencing tobacco-related disparities.**
The mission of the Tobacco Use Prevention and Cessation Program is to reduce the use of tobacco products in Maryland thereby reducing the burden of tobacco-related morbidity and mortality on the population **to all Marylanders and creating equitable access to cessation services for all Marylanders including minority at-risk populations, behavioral health populations, low SES, low education, and others.**

Mission statement feedback was detailed in the three responses received. One respondent provided a new mission statement with three specific responsibilities:

1) Improve access to services for those disparately affected by tobacco use;
2) Reduce gaps between populations with high tobacco use rates and the general population; and
3) Partner with other organizations to broaden the reach of the Maryland Tobacco Control Program.

Two other respondents were comfortable with the first half of the mission statement but felt it should be expanded to include key goals including providing leadership, utilizing resources, promoting reduction of tobacco product use, and creating equitable access to cessation services for several priority populations. At least one of the forms submitted was a summary of feedback from an entire table of respondents.

VISION STATEMENT

Participants were provided with the current vision statement and asked to edit it to incorporate a health equity lens:

> *The Tobacco Use Prevention and Cessation Program envisions a future in which all residents of Maryland can lead healthy, productive lives free from disease and cancer caused by the use of tobacco.*

Four responses were submitted on the Mission and Vision Feedback Form at the retreat, but only three of the forms had feedback for the vision statement. Table 3 summarizes vision statement feedback received during the retreat. At least one of the forms submitted was a summary of feedback from an entire table of respondents.

Table 3: Vision Statement Feedback Received at the Retreat

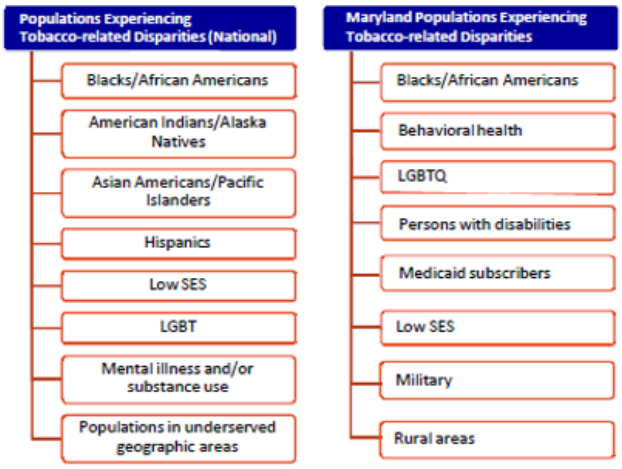
Vision Statement Feedback
The Tobacco Use Prevention and Cessation Program envisions a future in **which all Marylanders** can lead healthy, productive **nicotine-free** lives free from disease and cancer caused by the use of tobacco.
The Tobacco use Prevention and Cessation Program envisions a future in **which all Marylanders have the ability** to lead healthy, productive lives free from disease and cancer **caused by tobacco and ESDs.**

Two of the three respondents specifically suggested that nicotine and nicotine products should be incorporated into the vision statement.

SUMMARY 2: PRIORITY POPULATIONS EXERCISE

Participants were asked to reflect on and document the priority populations in their jurisdiction. To aid their thinking, participants were given the Health Equity in Tobacco Prevention and Control fact sheet included in Appendix III. Figure 1 below includes an excerpt from the fact sheet that shows the populations experiencing tobacco disparities in Maryland and nationwide.

Figure 1: Health Equity Disparities – Priority Populations



Participants were asked to complete a priority populations worksheet (included in Appendix IV) in which they first identify their jurisdiction's priority populations then explain what strategies had been most effective in reducing disparities in their jurisdiction. Participants were instructed to return their completed forms to the registration table. Two forms were returned.

A summary of responses from the LHDs regarding identifying priority populations and strategies collected at the retreat is provided in Table 4.

PRIORITY POPULATIONS AND STRATEGIES

Two priority population forms were submitted during the retreat. Table 4 summarizes feedback received at the retreat. Kent County indicated that youth was a priority population and indicated effective strategies including working with community partners, social media campaigns, and school-wide campaigns. Another form indicated priority populations including low socioeconomic status (SES), behavioral health, rural areas, underserved geographic areas, and youth as priority populations. Strategies and jurisdiction were not included on the second form.

Table 4: Priority Population Disparity Reduction Feedback Received at the Retreat

Priority Populations	Effective Strategies	Jurisdiction
Youth	Community partners, social media, school-wide campaigns	Kent
Low SES, behavioral health, rural areas, underserved geographic areas, youth	*No response*	*No response*

AFTERNOON BREAKOUT SESSIONS

The afternoon breakout sessions provided an opportunity for attendees to provide input into the strategies and performance measures related to the three goals that will be in the Maryland Tobacco Control Strategic Plan: 2020 – 2025. The three goals are: 1) prevent initiation of tobacco use among youth and young adults; 2) promote quitting among adults and youth; and 3) eliminate secondhand smoke exposure. The previous Goal 4, "Identify and eliminate tobacco-related disparities among population groups" has been incorporated into each of the three goals. Per CDC guidance, health equity is now incorporated into each of the three goals.

CTPC developed a chart with proposed strategies, activities, and performance measures for each of the three goals (included as Appendix V) used to incite discussion during the afternoon breakout sessions. The draft strategic plan was based upon the latest CDC guidance, strategies and currently in use by LHDs, and current performance measures. The CTPC staff revised the strategies where appropriate to incorporate a health equity lens, added new strategies where needed, identified activities that specifically address health disparities, and added new performance measures where appropriate.

The three afternoon breakout sessions focused on three tasks for the three goal areas:

- Session 1: Review strategies with equity lens, revise if needed and choose priority populations.
- Session 2: Prioritize strategies by highest likely impact on priority populations.
- Session 3: Select best performance measures for selected strategies, revise and add if needed.

Participants were divided into three groups that rotated through each of the three goal areas. This ensured that each participant was able to provide feedback on each goal area. Figure 2 shows how participants rotated through the sessions.

Figure 2: Breakout Sessions

Session	Room A Goal 1: Prevention (Room 10)	Room B Goal 2: Quitting (Room 14)	Room C Goal 3: Reduce SHS (Room 16)
Session 1 Review strategies with equity lens and choose priority populations	Group A	Group C	Group B
Session 2 Prioritize strategies by impact	Group B	Group A	Group C
Session 3 Review and select performance measures	Group C	Group B	Group A

At the conclusion of the afternoon session, participants reconvened as a large group and prioritized the strategies for each of the three goals by voting on their top three for each goal.

RESOURCE ON ADULT AND YOUTH DISPARITIES IN MARYLAND

To focus their thinking during the afternoon sessions, attendees were given two sets of charts compiled by CTPC that present data on the adult and youth populations in experiencing tobacco-related disparities. The adult charts, included in Figure 3, highlight disparities among racial groups; by disability status, socioeconomic status, military status, and geographic location; and by mental health/substance abuse status. The youth charts are presented in Figure 4 and highlight disparities among racial groups and by mental health status.

Figure 3: Disparities Charts Distributed at 2019 Strategic Planning Meeting

Maryland Populations Experiencing Tobacco-Related Disparities - Adult

Figure 1: Adult Any Product Use* by Race/Ethnicity, Sexual Orientation and Gender Identity, Maryland BRFSS, 2017.

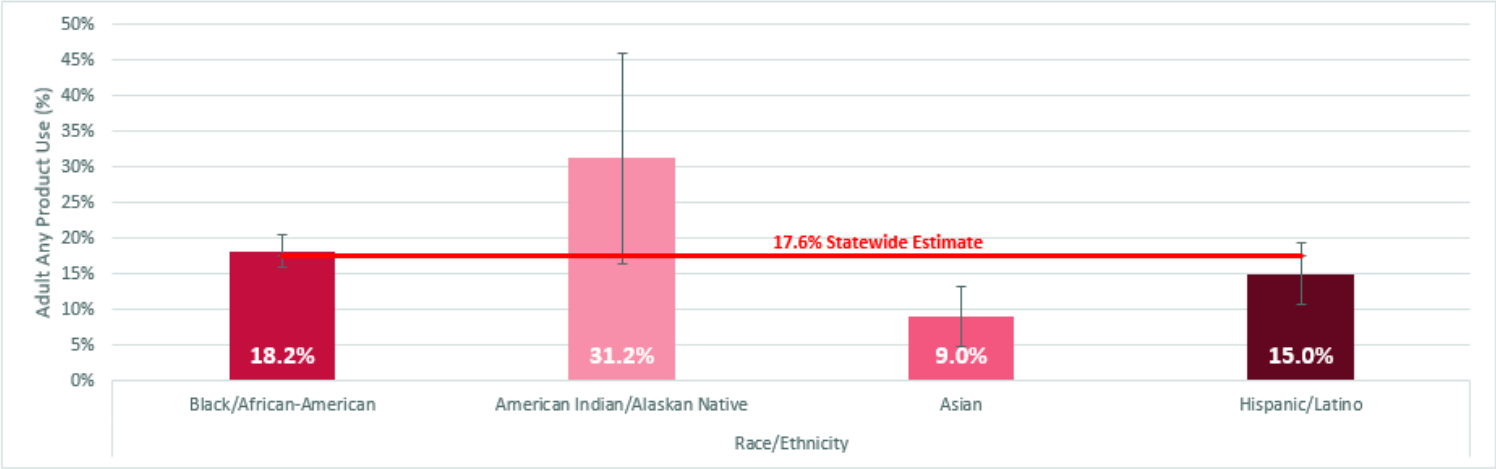


Figure 2: Adult Any Product Use* by Disability Status, Socioeconomic Status, Military Status and Geography, Maryland BRFSS, 2017.

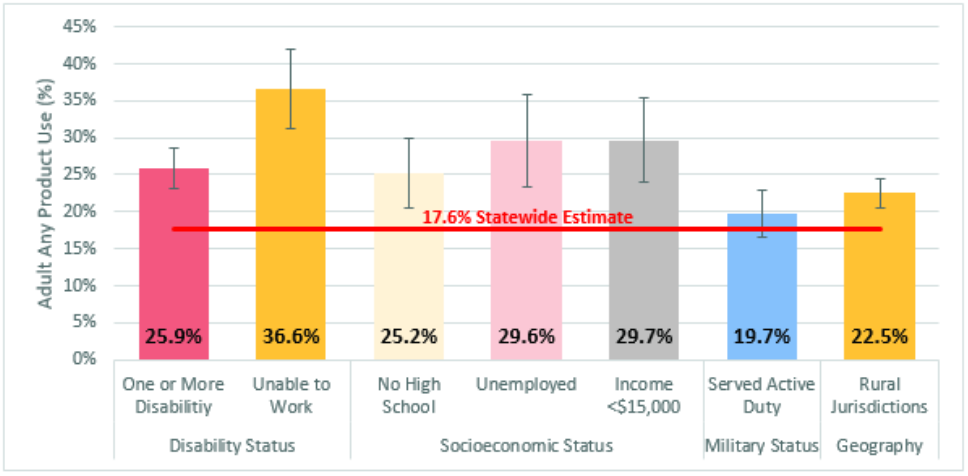
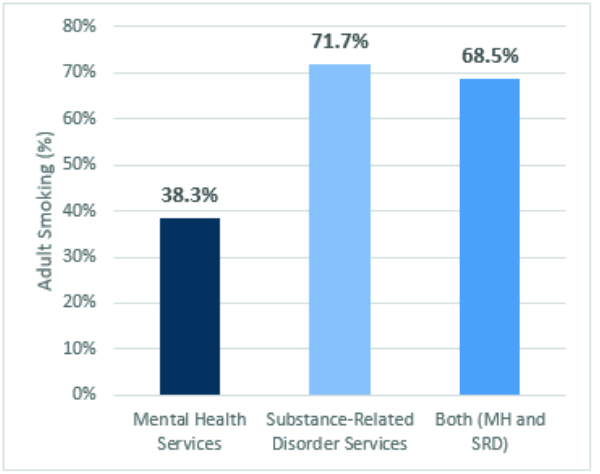


Figure 3: Adult Smoking Among Those Receiving Mental Health and/or Substance-Related Disorder Services, MD OMS Datamart CY 2017.



*Maryland BRFSS, 2017: Combined multiple questions to create "Any Product Use" variable which includes cigarettes, cigars, smokeless, and electronic smoking devices (ESDs)

Figure 4: Disparities Charts Distributed at 2019 Strategic Planning Meeting

Maryland Populations Experiencing Tobacco-Related Disparities - Youth

Figure 1: High School Youth Any Product Use* by Race/Ethnicity, Sexual Orientation and Gender Identity, 2016 MD HS YRBS/YTS

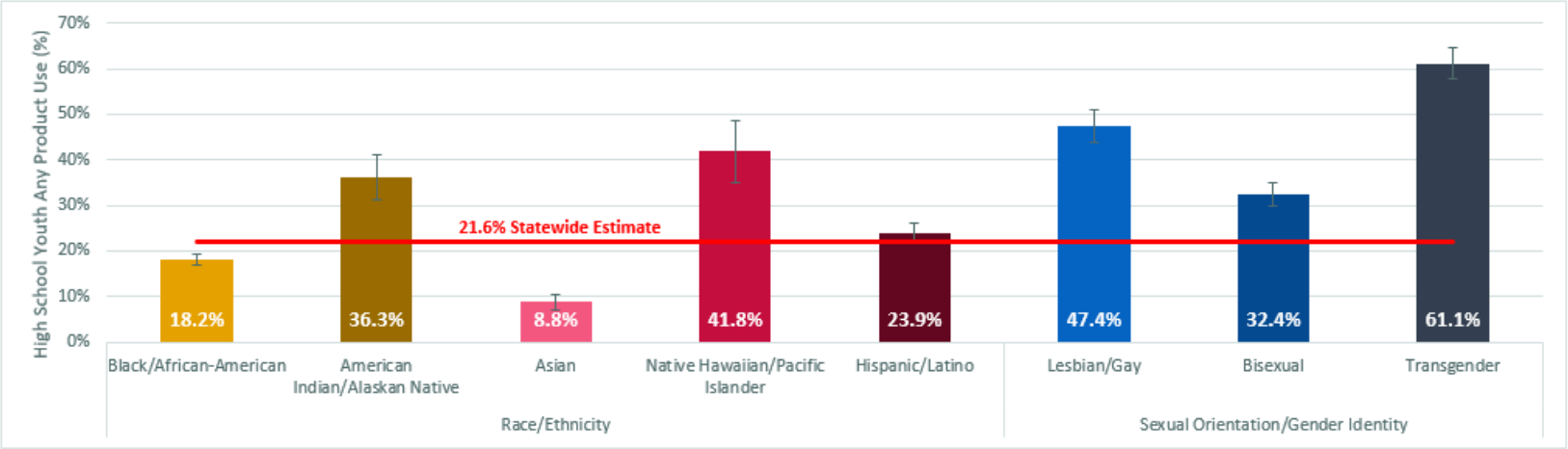
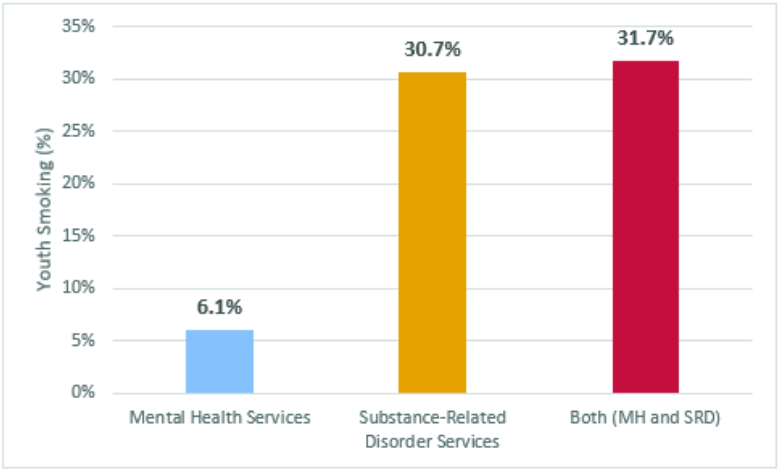


Figure 2: Youth Aged 14-17 Smoking Among Those Receiving Mental Health and/or Substance-Related Disorder Services, MD OMS Datamart CY 2016



*Maryland High School YRBS/YTS, 2016: Any Product Use includes cigarettes, cigars, smokeless, and electronic smoking devices (ESDs)

SUMMARY: BREAKOUT SESSION 1 – PRIORITY POPULATIONS & STRATEGY REVISIONS

Session 1 focused on identifying the priority populations for each of the goals and editing the proposed strategies with a health equity lens. The results of the session 1 discussions are included below organized by goal.

GOAL 1: PREVENTING YOUTH INITIATION

The group identified four priority populations for Goal 1 including:

- Blacks/African Americans;
- LGBTQ youth;
- Low socioeconomic status and Medicaid overlap populations; and
- Military personnel (under 21).

Participants suggested the following revisions to proposed strategies:

1.1 Adopt state and local policies that restrict the sale, advertising, and promotion of tobacco products

1.2 ~~Restrict and enforce minors' access to tobacco products~~ ***Educate, restrict, and enforce sales to minors***

1.3 ~~Implement evidence-based, mass-reach health communication interventions to prevent initiation among disparate youth populations~~

1.4 Provide ongoing training and TA on cultural competency and tobacco-related health disparities to reduce tobacco use among priority youth populations

1.5 Educate and inform stakeholders and decision-makers about evidence-based policies and programs to prevention tobacco use initiation

1.6 ~~Partner with priority youth/young adult groups (and CBOs) to identify new strategies to prevent youth initiation~~

1.7 Implement strategies to reduce tobacco use among ~~rural youth~~ ***hard-to-reach youth***

1.8 Promote school and college based ESD policies and interventions

1.9 ~~Build community capacity to influence social norms and public health policies regarding tobacco products~~

1.10 *(Combine 1.3, 1.6, and 1.9):* ***Adopt state and local policies that restrict the sales, advertising, and promotion of tobacco products and educate retailers of changes in laws and policies***

1.11 ***Partner with priority youth, adult groups, and CBOs to identify new strategies to prevent youth initiation***

GOAL 2: PROMOTING QUITTING

Priority populations identified for Goal 2 included:

- African Americans
- Behavioral health
- Hispanics
- Low socioeconomic status
- Low-income
- Mental health (including youth)
- Pregnant women
- Women of childbearing age
- Youth

Participants suggested the following revisions to proposed strategies:

2.1 Maintain capacity for the Maryland Tobacco Quitline to residents age *13 and older*
Implementation Note: There was significant discussion about adjusting to focus on ages ***18-21***

2.2 Educate the public about the availability of and promote use of comprehensive ***evidence-based*** tobacco treatment services including the Quitline and local programs ***for adults and youth***

2.3 Educate ***healthcare*** payers about the availability of and encourage referrals to tobacco treatment services

2.4 Increase engagement of health care providers and systems to expand utilization of proven tobacco treatment methods

2.5 ***Educate and*** collaborate with health systems to incorporate tobacco treatment and/or referrals to Quitline/local resources

2.6 Provide ongoing training and TA to incorporate evidence-based tobacco treatment and prevention messages into routine clinical care, including facilities that serve populations with higher tobacco use including behavioral health, Medicaid, as well as pregnant women

2.7 Partner with providers to reduce tobacco use among pregnant women and women of childbearing age

2.8 ***Leverage traditional and non-traditional*** ~~Use~~ data to identify disparities in tobacco treatment and inform action

2.9 Cultivate and maintain new and existing partnerships to enhance tobacco treatment outreach

2.10 Increase capacity for health care providers to identify youth tobacco and ESD users ~~at annual visits~~ and provide appropriate tobacco treatment counseling

2.11 Work with schools to support students using/possessing tobacco products by providing interventions and/or services or resources

GOAL 3: REDUCING SECONDHAND SMOKE (SHS) EXPOSURE

The first group brainstormed the following list of priority populations and situations for Goal 3:

- Blacks/African Americans;
- Pregnant women;
- Youth/young children;
- College-aged young adults/college campuses;
- Older adults;
- LBGTQ population;
- Behavioral health population;
- Disabled people;
- Homeless people;
- Multi-unit housing;
- Low SES population;
- Military (including active and veterans);
- Worksites that allow smoking (i.e. construction, waterman, DOT, casinos);
- Entryway and exit smokers (i.e. hospitals entryways, train station entryways/exits);
- Restaurants (i.e. by the front/entrance, outdoor areas); and
- Outdoor events (i.e. Festivals/fairs/auto shows).

When asked to prioritize the populations for addressing SHS from the initial list generated above, the group in the first developed the top five ranking listed below. When asked if anything was missing from the ranking, the second group added low SES family units to the ranking:

1. Youth (under 18), young children (0 – 10), young adults (including college students)
2. Residents in multi-unit housing
3. Behavioral health populations including military (active duty, veterans, those with PTSD)
4. Older adults
5. Worksites that allow smoking (i.e. casinos, cigar bars, outdoor worksites)
6. Low SES family units and extended family

Participants made the following suggestions for revisions to the proposed strategies:

3.1 Reduce SHS exposure and normalization of ESD use through smoke-free multi-unit housing, parks, beaches, college campuses, and/or outdoor areas

3.2 Build community capacity to influence social norms and public health policies regarding tobacco products and **ESDs through current and new/nontraditional partnerships** *[The additions are from Strategy 3.8 which was combined with Strategy 3.2.]*

Note: The priority populations for this strategy are behavioral/mental health, youth, multi-unit housing/low SES, and worksite populations.

Implementation Note: The group recommended targeting management companies for low-income housing properties (non-HUD managed); big event planners and tourism organizations; child care providers; and schools and boys/girls clubs.

3.3 Educate and inform stakeholders and decision-makers about evidence-based policies and program**s** to reduce exposure to SHS **and ESDs** targeted to priority populations

3.4 Implement evidence-based, mass-reach health communication interventions to reduce exposure to SHS and ESD aerosol as well as tobacco litter
Implementation Note: The group suggested targeting pregnant women who smoke, young adult users, and school-age youth for prevention. The group also recommended targeting schools and college campuses about tobacco litter.

3.5 Increase awareness of the health dangers of secondhand and thirdhand smoke and ESD aerosol, and encourage voluntary adoption of smoke-free rules in all households
Note: The priority populations for this strategy are children in multi-unit housing, older adults, and the behavioral health population.

3.6 Support local smoke-free, **ESD-free** policies without exemptions (outdoor dining, casinos, smoking in vehicles, etc.)
Note: The priority populations for this strategy are youth workers, children, and college campuses.

3.7 Use surveillance data to identify disparities in second and thirdhand smoke exposure, inform action, and evaluate policies to eliminate second and thirdhand smoke disparities

~~3.8 Identify new and nontraditional partnerships to support comprehensive SHS protections inclusive of ESD aerosols~~ *[Combined with 3.2]*

3.9. Educate nuclear and extended families to reduce SHS and ESD exposure for young children. [NEW]
Implementation Note: The group recommended focusing on nuclear and extended families at the time of birth maximize impact.

SUMMARY: BREAKOUT SESSION 2 – IDENTIFYING EFFECTIVE STRATEGIES

During the second session, participants were asked to prioritize the strategies based on the expected impact of the strategy. The results are presented in the tables below in order of priority as determined by the small group.

GOAL 1: PREVENTING YOUTH INITIATION

The Goal 1 strategies below are listed in rank order based on LHD, resource center, and CTPC staff member votes.

Table 5: Goal 1 Strategy Rankings

Strategy	Description
1.6 & 1.9	Partner with priority youth/young adult groups (and CBOs) to identify new strategies while building community capacity to influence social norms and public health policies regarding tobacco products
1.8	Promote school and college based ESD polices and interventions
1.1 & 1.2	Adopt state and local policies that restrict the sale, advertising and promotion of tobacco products while restricting and enforcing minor's access to tobacco products
1.3	Implement evidence-based, mass reach health communications interventions to prevent initiation among disparate youth populations
1.7	Implement strategies to reduce tobacco use among disparate youth

GOAL 2: PROMOTING QUITTING

The Goal 2 strategies below are listed in rank order based on LHD votes.

Table 6: Goal 2 Strategy Rankings

Strategy	Description
2.2	Educate the public about the availability of and promote use of comprehensive evidence-based tobacco treatment services including the Quitline and local programs for adults and youth
2.11	Work with schools to support students using/possessing tobacco products providing interventions and/or cessation serves or resources
2.5	Educate and collaborate with health systems to incorporate tobacco treatment and/or referrals to Quitline/local resources
2.1	Maintain capacity for the Maryland Tobacco Quitline for residents age 13 and older
2.4	Increase engagement of health care providers and systems to expand utilization of proven tobacco treatment methods
2.9	Cultivate and maintain new and existing partnerships to enhance tobacco treatment outreach

GOAL 3: REDUCING SHS EXPOSURE

The Goal 3 strategies below are listed in rank order based on LHD votes.

Table 7: Goal 3 Strategy Rankings

Strategy	Description
3.1*	Reduce SHS exposure and normalization of ESD use through smoke-free multi-unit housing, parks, beaches, college campuses, and/or outdoor retreats
3.2* & 3.8* combined	Build community capacity to influence social norms and public health policies regarding tobacco products and **ESDs through current ad new/nontraditional partnerships. [The additions are from Strategy 3.8 which was combined with 3.2.]**
3.6*	Support local smoke-free, **ESD-free** policies without exemptions (outdoor dining, casinos, smoking in vehicles, etc.)
3.9	Educate or focus on nuclear and extended families to reduce SHS for young children (for new parents)
3.5	Increase awareness of the health dangers of secondhand and thirdhand smoke and ESD aerosol, and encourage voluntary adoption of smoke-free rules in all households
3.4	Implement evidence based, mass-reach health communications interventions to reduce exposure to SHS and ESD aerosol, as well as tobacco litter
3.7	Use surveillance data to identify disparities in second and thirdhand smoke exposure, inform action, and evaluate policies to eliminate second and thirdhand smoke disparities

** Strategies 3.1, 3.2 & 3.8, and 3.6 tied for first in terms of expected impact.*

SUMMARY: BREAKOUT SESSION 3 – SELECTING MEANINGFUL MEASURES FOR SELECTED STRATEGIES

Participants in Session 3 were asked to identify the best measures for the selected strategies and provide feedback on the performance measures. The results are presented in subsequent tables.

GOAL 1: PREVENTING YOUTH INITIATION

Performance measures identified for Goal 1 strategies are indicated below.

Strategy	Measure	
1.3 Implement evidence-based, mass-reach health communication interventions to prevent initiation among disparate youth populations	1.1 1.10	# tobacco sales compliance checks # adults (parents/educators) educated on ESD prevention
1.7 Implement strategies to reduce tobacco use among ***hard-to-reach populations***	1.6 1.9 1.14	# students educated on tobacco and vape prevention # individuals educated through community engagement activities # new 100% tobacco free school and college campuses
1.8 Promote school and college-based ESD policies and interventions	1.4 1.5 1.6 1.7 1.8 1.12	# schools funded for youth tobacco prevention activities # teachers/staff trained/educated on tobacco and vape prevention # students educated on tobacco and vape prevention # students educated on tobacco and vaping for school infractions # adults (parents/educators) educated on ESD prevention # orgs supported for tobacco control
1.10 (NEW) Adopt state and local policies that restrict the sales, advertising, and promotion of tobacco products and educate retailers about the changes in laws and policies	1.1 1.3	# tobacco sales compliance checks # tobacco retailers educated
1.11 (NEW) Partner with priority youth, adult groups, and CBOs to identify new strategies to prevent youth initiation	1.10 1.12	# adults (parents/educators) educated on ESD prevention # orgs supported for tobacco control

GOAL 2: PROMOTING QUITTING

Performance measures identified for Goal 2 strategies are indicated below.

Table 8: Goal 2 Performance Measures for Strategies

Strategy	Measure	
2.1 Maintain capacity for the Maryland Tobacco Quitline to residents age 13 and older	2.3 2.4 2.5 2.7 2.9 2.10 2.11	# pregnant participants in smoking cessation # behavioral health participating in smoking cessation # students provided cessation services or resources *# schools educated on cessation resources/options* *# hospital/health systems educated about e-referrals* *# e-referrals to Quitline* *# new behavioral health organizations educated on tobacco cessation*
2.2 Educate the public about the availability of and promote use of comprehensive ***evidence-based*** tobacco treatment services including the Quitline and local programs ***for adults and youth***	2.4 2.5 2.7 2.9 2.11 2.12	# behavioral health participating in smoking cessation # students provided cessation services or resources *# schools educated on cessation resources/options* *# hospital/health systems educated about e-referrals* *# new behavioral health organizations educated on tobacco cessation* *# Quitline campaigns conducted*
2.4 Increase engagement of health care providers and systems to expand utilization of proven tobacco treatment methods	2.1 2.2 2.3 2.6 2.9 2.11	# participants in individual/group cessation (total and priority groups) # pregnant participants in smoking cessation # behavioral health participating in smoking cessation # provider practices/hospitals reached *# hospital/health systems educated about e-referrals* *# new behavioral health organizations educated on tobacco cessation*
2.5 ***Educate and*** collaborate with health systems to incorporate tobacco treatment and/or referrals to Quitline/local resources	2.1 2.2 2.3 2.5 2.6 2.8 2.9 2.10 2.11 2.12	# participants in individual/group cessation (total and priority groups) # pregnant participants in smoking cessation # behavioral health participating in smoking cessation # referrals to Quitline # provider practices/hospitals reached *# providers educated about e-referrals* *# hospital/health systems educated about e-referrals* *# e-referrals to Quitline* *# new behavioral health organizations educated on tobacco cessation* *# Quitline campaigns conducted*
2.9 ***Cultivate and maintain new and existing*** ~~Identify new~~ partnerships to enhance tobacco treatment outreach	2.6 2.7 2.8 2.9 2.11	# provider practices/hospitals reached *# schools educated on cessation resources/options* *# providers educated about e-referrals* *# hospital/health systems educated about e-referrals* *# new behavioral health organizations educated on tobacco cessation*
2.11 Work with schools to support students using/possessing tobacco ***products*** by providing ***interventions and/or*** services or resources	2.4 2.7	# students provided cessation services or resources *# schools educated on cessation resources/options*

GOAL 3: REDUCING SHS EXPOSURE

The group suggested that a mini workgroup be created to determine how best to capture policy work. The group questioned whether it was possible to get a useful measure or if a narrative would be sufficient. The group was concerned about quantifying the activity without penalizing the jurisdiction if the policy is not passed.

Performance measures identified for Goal 3 strategies are indicated below.

Table 9: Goal 3 Performance Measures for Strategies

Strategy	Measure	
3.1 Reduce SHS exposure and normalization of ESD use through smoke-free multi-unit housing, parks beaches, college campuses, and/or outdoor areas	3.1	# individuals educated through community engagement on prevention/SHS **(suggested change, count # of events instead of # of people)**
	3.2	# health communications campaigns conducted ***(suggested clarification: # of resources)***
	3.3	# orgs supported for tobacco control activities
	3.4	# new smoke-free policies enacted at parks, beaches, college campuses, housing, other venues
	3.5	# community leaders trained to support non-smoking norms ***(Comment: What is the definition of community leader?)***
	3.6	# new ***or established*** partnerships to support comprehensive SHS protections ***(suggested clarification: # of new businesses or # of new organizations)***
3.2 & 3.8 Build community capacity to influence social norms and public health policies regarding tobacco products and **ESDs through current ad new/nontraditional partnerships. [The additions are from Strategy 3.8 which was combined with 3.2.]**	3.2	# health communications campaigns conducted ***(suggested clarification: # of resources)***
3.3 Educate and inform stakeholders and decision-makers about evidence-based policies and program***s*** to reduce exposure to SHS targeted to priority populations	***NEW***	***# of meetings/events***
3.4 Implement evidence based, mass-reach health communications interventions to reduce exposure to SHS and ESD aerosol, as well as tobacco litter		*No measure specified*
3.5 Increase awareness of the health dangers of secondhand and third hand smoke and ESD aerosol, and encourage voluntary adoption of smoke-free rules in all households		*No measure specified*

Strategy	Measure	
3.6 Support local smoke-free policies without exemptions (outdoor dining, casinos, smoking in vehicles, etc.)	3.1	# individuals educated through community engagement on prevention/SHS ***(suggested change, count # of events instead of # of people)***
	3.4	# new smoke-free policies enacted at parks, beaches, college campuses, housing, other venues
	3.5	# community leaders trained to support non-smoking norms
	3.6	# new ***or established*** partnerships to support comprehensive SHS protections ***(suggested clarification: # of new businesses or # of new organizations)***
3.9 Educate or focus on nuclear and extended families to reduce SHS for young children (for new parents)		*New strategy – no measure identified*

SUMMARY 6: LARGE GROUP SESSION – VOTING ON STRATEGIES FOR GOALS

Based on the top five to six strategies identified in breakout sessions, participants were asked to vote on top strategies for each goal area at the end of the 2019 Strategic Planning Retreat. The results of those votes are indicated in subsequent sections.

GOAL 1: PREVENTING YOUTH INITIATION

LHDs were asked to vote on the top strategies identified in breakout sessions. The results for Goal 1 are presented in Table 11 below.

Table 10: Goal 1 Large Group Strategy Rankings

Strategy	Description	Small Jurisdiction Votes	Medium Jurisdiction Votes	Large Jurisdiction Votes	Resource Center Votes	Total Votes
S 1.1 & S 1.2	Adopt state and local policies that restrict the sale, advertising and promotion of tobacco products while restricting and enforcing minor's access to tobacco products	3	4	3	2	**12**
S 1.6 & S 1.9	Partner with priority youth/young adult groups (and CBOs) to identify new strategies while building community capacity to influence social norms and public health policies regarding tobacco products	3	3	3	2	**11**
S 1.7	Implement strategies to reduce tobacco use among disparate youth	2	3	2	1	**8**
S 1.8	Promote school and college based ESD polices and interventions	2	2	1	2	**7**
S 1.3	Implement evidence-based, mass reach health communications interventions to prevent initiation among disparate youth populations	2	0	2	0	**4**

GOAL 2: PROMOTING QUITTING

LHDs were asked to vote on the top strategies identified in breakout sessions. The results for Goal 2 are presented in Table 12 below.

Table 11: Goal 2 Large Group Strategy Rankings

Strategy	Description	Small Jurisdiction Votes	Medium Jurisdiction Votes	Large Jurisdiction Votes	Resource Center Votes	Total Votes
S 2.11	Work with schools to support students using/possessing tobacco products providing interventions and/or cessation serves or resources	5	1	4	2	**12**
S 2.2	Educate the public about the availability of and promote use of comprehensive evidence-based tobacco treatment services including the Quitline and local programs for adults and youth	3	1	3	2	**9**
S 2.9	Cultivate and maintain new and existing partnerships to enhance tobacco treatment outreach	2	2	3	0	**7**
S 2.5	Educate and collaborate with health systems to incorporate tobacco treatment and/or referrals to Quitline/local resources	1	1	1	1	**4**
S 2.1	Maintain capacity for the Maryland Tobacco Quitline for residents age 13 and older	3	0	0	0	**3**
S 2.4	Increase engagement of health care providers and systems to expand utilization of proven tobacco treatment methods	0	1	0	1	**2**

GOAL 3: REDUCING SHS EXPOSURE

LHDs were asked to vote on the top strategies identified in breakout sessions. The results for Goal 3 are presented in Table 13 below.

Table 12: Goal 3 Large Group Strategy Rankings

Strategy	Description	Small Jurisdiction Votes	Medium Jurisdiction Votes	Large Jurisdiction Votes	Resource Center Votes	Total Votes
S 3.2 & S3.8	Build a community capacity to influence social norms and public health policies regarding tobacco products by identifying new and nontraditional partnerships to support comprehensive SHS protections inclusive of ESD aerosol	4	1	3	1	**9**
S 3.4	Implement evidence based, mass-reach health communications interventions to reduce exposure to SHS and ESD aerosol, as well as tobacco litter	2	2	4	0	**8**
S 3.5	Increase awareness of the health dangers of secondhand and third hand smoke and ESD aerosol, and encourage voluntary adoption of smoke-free rules in all households	2	0	1	2	**5**
S 3.1	Reduce SHS exposure and normalization of ESD use through smoke-free multi-unit housing, parks, beaches, college campuses, and/or outdoor retreats	2	0	1	1	**4**
S 3.6	Support local smoke-free policies without exemptions (outdoor dining, casinos, smoking in vehicles, etc.)	1	1	1	1	**4**
S 3.9	Educate or focus on nuclear and extended families to reduce SHS for young children (for new parents)	1	1	1	1	**4**

ONLINE SURVEY EVALUATION

The Schaefer Center distributed an online retreat evaluation survey the attendees. The survey first asked respondents to rate the facility and retreat as a whole. Next, the evaluation asked for feedback about the morning session with guest speaker Taslim van Hattum followed by questions about the three afternoon breakout sessions and goal-related priorities. Seventy-two percent of the retreat participants completed the retreat evaluation. The distribution of evaluation responses by respondent affiliation is included in Table 14 below. Overall ratings of the 2019 Strategic Planning Retreat are provided in Table 15 below.

Table 13: Evaluation Participation by Affiliation

Participant Affiliation	# Who attended retreat	# Who submitted an evaluation	Response rate
Local Health Department	33	26	79%
Resource Centers	5	3	60%
Media Partner	3	1	33%
Center for Tobacco Prevention and Control	14	10	71%
Total	**55**	**40**	**72%**

Table 14: Overall Ratings of 2019 Strategic Planning Retreat

How would you rate …					
	Excellent	**Very Good**	**Good**	**Fair**	**Poor**
The Wilde Lake Interfaith Center as a meeting facility	38.5%	46.2%	12.8%	2.6%	0.0%
The location of the Wilde Lake Interfaith Center	33.3%	33.3%	25.6%	7.7%	0.0%
The check in process	53.8%	30.8%	15.4%	0.0%	0.0%
Food	23.1%	17.9%	41.0%	17.9%	0.0%
Audio/Visual	33.3%	35.9%	28.2%	2.6%	0.0%
Time/Length of Meeting	15.4%	33.3%	35.9%	12.8%	2.6%
Effectiveness of how time was used	12.8%	25.6%	38.5%	15.4%	7.7%

The retreat facility, retreat location, and check-in process had “Excellent” or “Very Good” ratings from the majority of participants. Eighty-one percent of participants rated the food as “Good” or better, and 97.4% rated audio/visual as “Good” or better.

Time/length of the meeting and effectiveness of time use were two categories with room for improvement. Approximately half (48.7%) of participants rated the time/length of the meeting as “Excellent” or “Very Good”, 48.7% rated the time/length of the meeting as “Good” or “Fair”, and 2.6% gave a “Poor” rating. For effectiveness of time use, 38.4% rated the retreat as “Excellent” or “Very Good”, 53.9% of participants said the effectiveness of time use was “Good” or “Fair”, and 7.7% said the effectiveness of time use was “Poor”.

MORNING SESSION

The morning session included check in; breakfast with networking time; a welcome, introductions, and Maryland TCP accomplishments from MDH; a review of the retreat and update on evaluation products from SCPP; and a presentation on health equity in tobacco control from guest speaker Taslim van Hattum. Participants' feedback on the morning session is presented in the tables below.

Table 15: Morning Session Participant Feedback

I learned something new and/or enhanced my understanding of health equity from the presentation.	
Strongly agree	56.4%
Somewhat agree	33.3%
Neither agree nor disagree	7.7%
Somewhat disagree	2.6%
Strongly disagree	0.0%

I would like to have invited speakers at future meetings to support professional development on tobacco-related topics.	
Strongly agree	64.1%
Somewhat agree	17.9%
Neither agree nor disagree	15.4%
Somewhat disagree	2.6%
Strongly disagree	0.0%

The presentation helped me identify new resources and/or ways to incorporate health equity in my work.	
Strongly agree	39.5%
Somewhat agree	35.9%
Neither agree nor disagree	15.4%
Somewhat disagree	5.1%
Strongly disagree	2.6%
No Answer	2.6%

Overall, feedback was positive for the morning session. When asked if participants learned something new and/or felt their understanding of health equity had been improved after Taslim van Hattum's presentation, 89.7% said they strongly agreed or somewhat agreed. Most participants (82%) strongly agreed or somewhat agreed that they would like to have invited speakers at future meetings to support professional development on tobacco-related topics. Just over 75% of participants strongly agreed or somewhat agreed that van Hattum's presentation helped them identify new resources and/or ways to incorporate health equity into their work.

AFTERNOON SESSIONS

After a networking lunch, the retreat transitioned to afternoon sessions. Afternoon sessions included three strategic planning breakout sessions; a large group session; and a discussion of next steps and closing remarks presented by MDH. Participant feedback is summarized in tables below.

Table 16: Afternoon Session Participant Feedback

Overall, did you find the afternoon activities successful?	
Very Successful	12.8%
Somewhat Successful	71.8%
Not at all Successful	15.4%

Which session(s) did you not find successful?	
Session 1: Review and revise the strategies with a health equity lens	35.9%
Session 2. Identify the most effective strategies	38.2%
Session 3. Review the performance measures	30.8%

What was not successful about the session(s)?
Additional introduction and clarification before sessions needed
Sessions were not jurisdiction-focused or jurisdiction-sensitive - LHDs struggled to agree on strategies due to diversity of organizations - Groups did not agree with the work of the previous session's group which created challenges for making progress in a session
Sessions were poorly structured - Clearer instructions and tasks for each session (both for participants and for moderators) needed - Not enough time to accomplish goals for each session - Difficult to only work on one part of each goal area - Large groups should have been broken into small groups - Performance measures should have been tied into activities, strategies, and objectives - Additional emphasis on health equity needed
Sessions were facilitated differently by each facilitator

Responses above are summarized and grouped by topic. Overall, 84.6% of participants felt the afternoon sessions were somewhat successful or very successful. Participants provided feedback about improving structure, facilitation, session timing, and instructions for ways to improve the breakout sessions.

OVERALL COMMENTS AND SUGGESTIONS

Participants had common suggestions for improving the strategic planning retreat process including elements such as adjusting the agenda to allow more time or fewer expectations for sessions. Several participants indicated a preference for jurisdiction size-based groups and for each group to work through all activities for one goal rather than rotating through the goals. Several participants requested that information be sent out ahead of the retreat to allow for sufficient preparation beforehand. Table 18 below summarizes comments submitted by participants.

Table 17: Participant Recommendations for Improvement of Strategic Planning Retreat Process

What recommendations do you have to improve the process?
Increase the amount of time or reduce the expectations for sessions
Send out information ahead of time to allow for review and preparation - Strategies, objectives, activities, and performance measures document - Retreat breakout session instructions - Goals for each session in a document participants can refer to throughout the day
Include an additional session or divide groups by jurisdiction size and demographics
Have a state personnel handle the retreat and provide a session to address LHD comments and questions at the end of the retreat
Clearer instructions at the beginning of sessions for facilitators and participants
Increased focus on Enforcement and less on Tobacco Education
Reduce amount of time spent on presentations in the morning session to increase time for breakout sessions
Address status of or progress made on suggestions from previous year
Have one group focus on each goal and complete all related activities
Ensure speakers and sessions start on time

Participants were asked to provide feedback about the strategic planning process overall including questions about having sufficient opportunity to express views, application of views shared, importance of being involved in the strategic planning process, and the frequency of in-person and webinar meetings. Table 19 and Table 20, summarized and grouped by topic, provide participant feedback and general comments.

A majority of participants (71.8%) strongly agreed or somewhat agreed that they had sufficient opportunity to express their views during breakout sessions. Half of participants (56.7%) strongly agreed or somewhat agreed that the input they provided would effectively contribute to the planning process for the five-year strategic plan. When asked if it was important to participants that they be involved in the planning process, 76.9% strongly agreed or somewhat agreed that it is important to them. Participants were satisfied overall with the frequency of in-person and webinar meetings with 89.7% reporting that the frequency of the meetings is “just right.”

Table 18: Participant Feedback about Strategic Planning Process

I had sufficient opportunity to express my views during the breakout sessions.		**I feel that the input I provided will effectively contribute to the planning process for the five-year strategic plan.**	
Strongly agree	41.0%	Strongly agree	23.1%
Somewhat agree	30.8%	Somewhat agree	33.3%
Neither agree nor disagree	20.5%	Neither agree nor disagree	30.8%
Somewhat disagree	2.6%	Somewhat disagree	10.3%
Strongly disagree	2.6%	Strongly disagree	2.8%
No Answer	2.6%		
It is important to me to continue to be involved in planning process for the five-year strategic plan.		**Over the past year, the frequency of in-person meetings and online webinars for the Maryland Tobacco Control Program have been:**	
Strongly agree	53.8%	Too many	7.7%
Somewhat agree	23.1%	Just right	89.7%
Neither agree nor disagree	10.3%	Not enough	2.6%
Somewhat disagree	5.1%		
Strongly disagree	7.7%		
Please explain your answer about the frequency of in-person meetings and online webinars for the Maryland Tobacco Control Program:			
Webinars and meetings are redundant			
Need regularly scheduled Tobacco Coordinators meetings (quarterly)			

Table 19: Additional Comments about the 2019 Strategic Planning Retreat

Additional comments about the 2019 Strategic Planning Retreat
Refreshments should include healthy and environmentally conscientious items
Start earlier in the day
Incorporate a session for LHD discussions after breakout sessions
Participants enjoyed guest speaker Taslim van Hattum's presentation
Participants enjoyed the hospitality
Allow open seating in the main conference room to accommodate vision and hearing needs
Some participants felt the day was productive and informative
Be conscientious of those who are less involved or aware of behind-the-scene meetings and calls so everyone understands what is being discussed
Some participants would be open to more in-person meetings and webinars
Participants enjoyed talking with other counties and hear what they are doing; incorporate more opportunities to provide input
Participants would like to draft and implement a universal plan followed by all counties to streamline processes and goals to increase synergy
Explore a different format for the mission and vision, priority populations, and comment cards; some participants needed more time to complete them

RECOMMENDATIONS FOR NEXT STEPS

The Schaefer Center for Public Policy makes the following recommendations to the Center for Tobacco Prevention and Control. Recommendations are based on suggestions provided by LHDs at the Strategic Planning retreat hosted on October 10, 2019 and the online survey feedback provided by LHDs.

RECOMMENDATIONS ABOUT THE STRUCTURE FOR FUTURE RETREATS

Having staff from LHDs, resource centers, and MDH together for regular retreats have proven to be valuable and has already resulted in meaningful changes in grant and reporting processes. Additionally, participants clearly value having the opportunity for professional education and to hear outside speakers. They also value the opportunity to provide feedback on the Maryland Tobacco Control Program, to hear updates about what is happening at the state level, and to discuss strategies. However, combining these activities makes for a very full agenda in an abbreviated day can be frustrating for participants. The Schaefer Center has the following recommendations about future retreats:

- **Add an additional day for professional development**
  MDH should consider adding an additional day for professional development either as part of a two-day retreat or as part of a pre-retreat planning session or webinar a month or so before the retreat. This will provide more time for participant engagement.

- **Add more self-facilitated groups during the session**
  MDH should consider adding more opportunities for self-facilitated small groups discussions and presentations during the retreat. While this process is more time consuming, it allows for deeper engagement by the participants.

- **Limit retreat objectives**
  MDH should consider limiting the retreat objectives and/or discussion topics which will provide more time for self-facilitated group activities and debriefs to the larger group.

- **Use live online polling or similar tools to solicit input during the retreat**
  MDH should consider using additional tools to collect feedback or voting during the retreat such as live online polling accessible via cellphone. Live online polling allows for feedback or voting to be collected and displayed during the session. This would make it easier and less time consuming for participants to share their input allowing more time for discussion. Using online polling would require the retreat agenda and polling question

topics to be finalized about a week before the retreat. Response options can be added or developed during the retreat based upon the discussion.

- **Assign specific pre-work prior to the retreat**
  If it is not feasible or desirable to limit the retreat objectives, MDH should consider assigning specific pre-work to attendees prior to the retreat so that some of the retreat tasks could be completed prior to the retreat allowing more time for discussion.

- **Expand feedback opportunities through post-retreat surveys**
  To close the loop on the strategic planning sessions, MDH should consider using post-retreat feedback and data collection as a way to share draft work products as a result of the retreat and solicit any additional feedback participants may have.

- **Continue with Columbia location**
  MDH should consider continuing to hold the retreats at the Wilde Lake Interfaith Center or similar location in the Columbia area. The location is centrally located, easily accessible, and offers free parking. The only drawback with the space is that when breakout discussion sessions exceed 15 or so participants, the breakout rooms become cramped. This can be addressed by having more breakout groups with fewer participants or through the use of self-facilitated small groups.

- **Change Menu**
  Participants clearly desired healthier menu options. Switching to box lunches with salads instead of sandwiches will cost approximately 40% more than the sandwich box lunches.

RECOMMENDATIONS FOR STRATEGIC PLAN

Feedback collected during the retreat will be incorporated with CDC guidance to finalize the 2020-2025 strategic plan. Thys Schaefer Center's recommendations for the strategic plan will be included in the strategic plan draft currently in development by the Schaefer Center.

APPENDIX I: AGENDA FOR STRATEGIC PLANNING RETREAT

This page intentionally left blank. See next page for the 2019 Strategic Planning Retreat agenda.

Agenda
Maryland Tobacco Control Program
Strategic Planning Retreat
October 10, 2019 | Wilde Lake Interfaith Center

9:45 am – 10:00 am	**Check in and continental breakfast networking time**
10:00 am – 10:20 am	**Welcome and Introductions** Dawn Berkowitz, Director, Center for Tobacco Prevention and Control
10:20 am – 10:35 am	**Maryland Tobacco Control Program Accomplishments** Dawn Berkowitz
10:35 am – 10:45 am	**Retreat Overview and Update on Evaluation Products** Ann Cotten, Director, Schaefer Center for Public Policy
10:45 am – 11:45 am	**Health Equity in Tobacco Control** Taslim van Hattum, LCSW, MPH Director, Practice Improvement, National Council for Behavioral Health
11:45 am – 12:30 pm	**Networking lunch** *During lunch, complete cards with 1) revised mission/vision and 2) with your response to, "Who are the priority populations in your jurisdiction?* **Afternoon Breakout sessions: incorporating health equity into each goal area** • ROOM 10 – Goal 1 – Prevent Youth Initiation • ROOM 14 – Goal 2 – Promote Quitting • ROOM 16 – Goal 3 – Reduce SHS Exposure
12:35 pm – 1:20 pm	**Strategic Planning Session 1 – *Review strategies with equity lens***
1:20 pm – 1:25 pm	**Rotate to next room** Room 10 → Room 14 → Room 16 → Room 10
1:25 pm – 2:10 pm	**Strategic Planning Session 2 – *Identify the most effective strategies***
2:10 pm – 2:15 pm	**Rotate to next room** Room 10 → Room 14 → Room 16 → Room 10
2:15 pm – 3:00 pm	**Strategic Planning Session 3 – *Review the performance measures***
3:00 pm – 3:10 pm	**Transition to large group**
3:10 pm – 3:50 pm	**Large Group Session – *Vote on the strategies***
3:50 pm – 4:00 pm	**Next Steps and Close** Dawn Berkowitz

APPENDIX II: HANDOUT #1, MISSION AND VISION FEEDBACK FORM

This page is intentionally left blank. See next page for Handout #1.

Maryland Tobacco Control Program
Mission and Vision Feedback Form
Strategic Planning Retreat – October 10, 2019

Please provide your feedback on the Tobacco Use Prevention and Cessation Program mission and vision statement. Feedback can be provided in three ways: 1) by editing the statements; 2) by listing what should be deleted; and 3) listing what should be added. The vision statement is on the back.

Current Mission
The mission of the Tobacco Use Prevention and Cessation Program is to reduce the use of tobacco products in Maryland, thereby reducing the burden of tobacco-related morbidity and mortality on the population.
What, if anything, should be deleted from the mission statement?
What should be added be added to the mission statement?

About you:	
Are you with … (circle one) 1. A Local health Department 2. Resource Center 3. Media Partner 4. CTPC	If you are with a LHD, is your jurisdiction … (circle one) 1. Small 2. Medium 3. Large

Current Vision
The Tobacco Use Prevention and Cessation Program envisions a future in which all residents of Maryland can lead healthy, productive lives free from disease and cancer caused by the use of tobacco.
What, if anything, should be deleted from the vision statement?
What should be added be added to the vision statement?

Please return to the basket at the registration table

APPENDIX III: HANDOUT #2, HEALTH EQUITY DISPARITIES AND PRIORITY POPULATIONS

This page is intentionally left blank, see next page for Handout #2.

FACT SHEET ADAPTED FROM CDC's 2015 BEST PRACTICES USER GUIDE

HEALTH EQUITY IN TOBACCO PREVENTION AND CONTROL

Health Equity in Tobacco Prevention and Control

The opportunity for all people to live a healthy, tobacco-free life, regardless of their race, level of education, gender identity, sexual orientation, the job they have, the neighborhood they live in, or whether or not they have a disability.

TYPES OF TOBACCO-RELATED DISPARITIES

- Differences that exist among populations with regard to key tobacco-related indicators:
  - Patterns, prevention, and treatment of tobacco use
  - The risk, incidence, morbidity, mortality, and burden of tobacco-related illness
  - Capacity, infrastructure, and access to resources
  - Secondhand smoke exposure

Populations Experiencing Tobacco-related Disparities (National)

- Blacks/African Americans
- American Indians/Alaska Natives
- Asian Americans/Pacific Islanders
- Hispanics
- Low SES
- LGBT
- Mental illness and/or substance use
- Populations in underserved geographic areas

Maryland Populations Experiencing Tobacco-related Disparities

- Blacks/African Americans
- Behavioral health
- LGBTQ
- Persons with disabilities
- Medicaid subscribers
- Low SES
- Military
- Rural areas

FACTORS INFLUENCING TOBACCO-RELATED DISPARITIES

- Social determinants of health
- Tobacco industry influence
- Lack of comprehensive policies
- Changing U.S. population

WHAT WORKS → EVIDENCE-BASED INTERVENTIONS

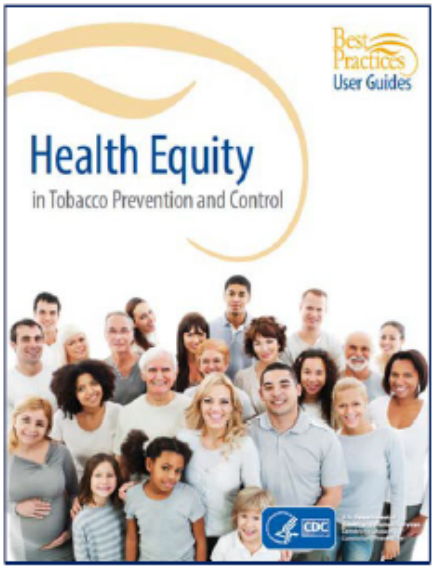
- 100% smoke-free policies
- Sustained funding of comprehensive programs
- Tobacco price increases
- Hard-hitting media campaigns
- Cessation access
- Comprehensive ad restrictions

Page 1

FACT SHEET ADAPTED FROM CDC's 2015 BEST PRACTICES USER GUIDE

HEALTH EQUITY IN TOBACCO PREVENTION AND CONTROL

THE *BEST PRACTICES USER GUIDE* PROVIDES:



- **Overview and history** of why programs should work to achieve health equity and how health equity has become a goal for tobacco prevention and control efforts.
- **Descriptions of populations** experiencing tobacco-related disparities and population-specific resources.
- **Policy interventions** that promote health equity and reduce tobacco-related disparities:
  - Create smoke-free environments
  - Increase the price of tobacco products
  - Reduce exposure to targeted industry advertising, promotion, and sponsorship
  - Promote cessation (tobacco treatment)
- **Strategies to implement the policies**:
  - Conduct a community assessment
  - Partner with the population(s)
  - Design infrastructure to promote health equity
  - Implement mass-reach health communication interventions
  - Connect with other priority issues
  - Monitor tobacco-related disparities and evaluate policies
  - Overcome unintended policy consequences and barriers to success
- **Real world case studies and examples** from a variety of populations.
- **Making the case for investment** and gain support for tobacco control efforts that focus on health equity.
- **How state programs can support efforts** to achieve health equity.
- **Resources** such as publications, toolkits, and websites to help in planning efforts.

RESOURCES

- Best Practices User Guide: Health Equity in Tobacco Prevention and Control
  http://www.cdc.gov/tobacco/stateandcommunity/best-practices-health-equity/index.htm
- OSH Tobacco-Related Disparities
  http://www.cdc.gov/tobacco/disparities/index.htm
- Tips from Former Smokers - For Specific Groups
  https://www.cdc.gov/tobacco/campaign/tips/groups/index.html

October 2019

Page 2

APPENDIX IV: HANDOUT #3, PRIORITY POPULATIONS FORM

This page is intentionally left blank, see next page for Handout #3.

Maryland Tobacco Control Program
Strategic Planning Retreat
October 10, 2019

Instructions: In the space provided below, please identify the priority populations for your jurisdiction and the strategies that have been most effective in reducing disparities in your jurisdiction.

Please return your completed form to the registration desk.

1. Who are the priority populations in your jurisdiction?

_____

_____

_____

_____

_____

_____

_____

_____

2. What strategies have been most effective in reducing disparities in your jurisdiction?

_____

_____

_____

_____

_____

_____

_____

3. Jurisdiction_____

APPENDIX V: HANDOUT #4, PROPOSED 2021 – 2025 OBJECTIVES, STRATEGIES, ACTIVITIES AND PERFORMANCE MEASURES

This page is intentionally left blank, see next page for Handout #4.

Goal 1: Prevent Initiation Among Youth & Young Adults

Proposed Objectives (2021 – 2025) *to be updated with SMART targets*

- By 2025, reduce the prevalence of any tobacco HS tobacco use and use by product type
- By 2025, maintain statewide and jurisdiction-level retailer non-compliance rates for Synar inspections below 20%
- By 2025, reduce prevalence of any HS tobacco use among priority groups

Proposed Strategies (2021 – 2025) – *TO BE VOTED ON*

- 1.1 Adopt state and local policies that restrict the sale, advertising, and promotion of tobacco products (current strategy)
- 1.2 Restrict and enforce minors' access to tobacco products (current strategy)
- 1.3 Implement evidence-based, mass-reach health communication interventions to prevent initiation among disparate youth populations (current strategy; priority - 8 juris)
- 1.4 Provide ongoing training and TA on cultural competency and tobacco-related health disparities to reduce tobacco use among priority youth populations (current strategy)
- 1.5 Educate and inform stakeholders and decision-makers about evidence-based policies and programs to prevention tobacco use initiation (current strategy)
- 1.6 Partner with priority youth/young adult groups (and CBOs) to identify new strategies to prevent youth initiation (priority - 16 juris.)
- 1.7 Implement strategies to reduce tobacco use among rural youth
- 1.8 Promote school and college based ESD policies and interventions (priority - 17 juris)
- 1.9 Build community capacity to influence social norms and public health policies regarding tobacco products (priority - 2 juris)

Activities (current school and community-based activities)

- Implement science-based prevention programs to educate students on dangers of ESDs and vaping (priority, 10 juris.)
- Organize trainings and conferences to engage teachers and student on tobacco prevention strategies and curricula-based interventions
- Implement health communication activities to educate residents on dangers of youth tobacco use (priority, 8 juris.)
- Organize and/or support school-based student organizations that support tobacco-free norms and/or implement evidence-based tobacco control activities within the school
- Engage the faith community on tobacco/ESD prevention and policies
- Provide targeted tobacco prevention messaging in low SES and other priority areas*
- Educate the public and stakeholders about ESDs and work with youth-focused organizations to incorporate youth prevention messaging
- Support grassroots partnerships that promote community dialogue on tobacco-related disparities in low SES populations*

Performance Measures (current; proposed measures are italicized)

- # tobacco sales compliance checks
- # tobacco sales citations issued
- # tobacco retailers educated
- # schools funded for youth tobacco prevention activities
- # teachers/staff trained/educated on tobacco and vape prevention
- # students educated on tobacco and vape prevention
- # students educated on tobacco and vaping for school infractions
- # adults (parents/educators) educated on ESD prevention
- # individuals educated through community engagement activities (prevention/SHS)
- # health campaigns conducted
- # youth educated on ESD prevention/awareness
- # orgs supported for tobacco control
- *# new state and local policies enacted*
- *# new 100% tobacco free school and college campuses*
- *# stakeholders educated on ESDs*
- *# new youth partnerships*

*Addresses disparities

<table>
<tr><td rowspan="3">Goal 2: Promote Quitting</td><td colspan="2">Proposed Objectives (2021 – 2025) to be updated with SMART targets
• By 2025, reduce the prevalence of any HS tobacco use and by product type
• By 2025, reduce prevalence of current cigarette smoking among adults
• By 2025, increase quit attempts by ensuring Quitline infrastructure
• By 2025, reduce the prevalence of tobacco use among adult priority populations</td></tr>
<tr><td colspan="2">Proposed Statewide Strategies (2021 – 2025) – TO BE VOTED ON
□ 2.1 Maintain capacity for the Maryland Tobacco Quitline to residents age 13 and older (current)
□ 2.2 Educate the public about the availability of and promote use of comprehensive tobacco treatment services including the Quitline and local programs (current)
□ 2.3 Educate payers about the availability of and encourage referrals to tobacco treatment services (current)
□ 2.4 Increase engagement of health care providers and systems to expand utilization of proven tobacco treatment methods (current)
□ 2.5 Collaborate with health systems to incorporate tobacco treatment and/or referrals to Quitline/local resources (priority - 4 juris)
□ 2.6 Provide ongoing training and TA to incorporate evidence-based tobacco treatment and prevention messages into routine clinical care, including facilities that serve populations with higher tobacco use including behavioral health, Medicaid, as well as pregnant women (current)
□ 2.7 Partner with providers to reduce tobacco use among pregnant women and women of childbearing age
□ 2.8 Use data to identify disparities in tobacco treatment and inform action (current)
□ 2.9 Identify new partnerships to enhance tobacco treatment outreach
□ 2.10 Increase capacity for health care providers to identify youth tobacco and ESD users at annual visits and provide appropriate tobacco treatment counseling
□ 2.11 Work with schools to support students using/possessing tobacco by providing cessation services or resources</td></tr>
<tr><td>Activities (current cessation activities)
▪ Assist residents ready to quit with evidence-based cessation counseling and resources, especially disparate groups (16 juris)
▪ Provide direct referrals to the Quitline and direct cessation services thru LHDs/partners
▪ Work with community partners and providers to screen, educate and refer to QL/LHDs
▪ Partner with hospitals and health systems to implement and promote policies that support and provide screening and cessation services
▪ Work with hospitals/health systems to add cessation to electronic health records
▪ Increase engagement of health care providers and systems to expand utilization of electronic referrals to the Quitline
▪ Incentivize partners to provide brief tobacco interventions and create a cessation referral system to the Quitline and/or local cessation programs
▪ Educate schools on tobacco cessation services/resources as alternatives to suspension
▪ Implement health communications to increase cessation and/or promote QL/LHDs
▪ Engage partners of pregnant women to promote tobacco-free lifestyles*
▪ Work with behavioral health organizations to address cessation services
▪ Fund community-based tobacco cessation programs where needed</td><td>Performance Measures
▪ # participants in individual/group cessation (total and priority groups)
▪ # pregnant participants in smoking cessation
▪ # behavioral health participating in smoking cessation
▪ # students provided cessation services or resources
▪ # referrals to Quitline
▪ # provider practices/hospitals reached
▪ # schools educated on cessation resources/options
▪ # providers educated about e-referrals
▪ # hospital/health systems educated about e-referrals
▪ # e-referrals to Quitline
▪ # new behavioral health organizations educated on tobacco cessation
▪ # Quitline campaigns conducted</td></tr>
<tr><td>G</td><td colspan="2">Proposed Objectives (2021 – 2025) to be updated with SMART targets</td></tr>
</table>

- By 2025, reduce exposure of HS youth to SHS
- By 2025, reduce exposure to SHS among residents by increasing the number of voluntary household no-smoking policies
- Decrease the percentage of Maryland adults exposed to ESD aerosol indoors and outdoors
- Decrease the percentage of Maryland workers exposed to tobacco smoke at work in past week
- Increase proportion of mental health and substance use treatment centers that have a tobacco-free campus

Proposed Statewide Strategies (2021 – 2025) – *TO BE VOTED ON*

- 3.1 Reduce SHS exposure and normalization of ESD use thru smoke-free multi-unit housing, parks, beaches, college campuses, and/or outdoor areas
- (current; priority – 6 jurisdictions)
- 3.2 Build community capacity to influence social norms and public health policies regarding tobacco products (priority – 2 juris)
- 3.3 Educate and inform stakeholders and decision-makers about evidence-based policies and program to reduce exposure to SHS targeted to priority populations (current)
- 3.4 Implement evidence-based, mass-reach health communication interventions to reduce exposure to SHS and ESD aerosol, as well as tobacco litter
- 3.5 Increase awareness of the health dangers of secondhand and thirdhand smoke and ESD aerosol, and encourage voluntary adoption of smoke-free rules in all households
- 3.6 Support local smoke-free policies without exemptions (outdoor dining, casinos, smoking in vehicles, etc.)
- 3.7 Use surveillance data to identify disparities in second and thirdhand smoke exposure, inform action, and evaluate policies to eliminate second and thirdhand smoke disparities
- 3.8 Identify new and nontraditional partnerships to support comprehensive SHS protections inclusive of ESD aerosol

Activities (current community activities; italicized measures are proposed)

- Reduce SHS exposure, through efforts addressing smoke-free housing; smoke-free parks, beaches, college campuses, and/or otheroutdoor areas
- Provide prevention and cessation resources to housing complexes on smoke-free policies and assist in development
- Support HUD's implementation of smoke-free housing in your jurisdiction*
- Recruit housing partners to Tobacco and Local Health Improvement Coalitions
- Strengthen community capacity to inform social norms regarding tobacco andESD use
- Conduct community engagement activities, such as butt clean-ups and other tobacco litter awareness
- *Train community leaders on benefits of comprehensive smoke-free policies and non-smoking norms*
- *Identify and train new partners on comprehensive SHS protections including ESDs*

Performance Measures

- # indiv educated thru community engagement on prevention/SHS
- # health communications campaigns conducted
- # orgs supported for tobacco control activities
- *# new smoke-free policies enacted at parks, beaches, college campuses, housing, other venues*
- *# community leaders trained to support non-smoking norms*
- *# new partnerships to support comprehensive SHS protections*

APPENDIX VI: HANDOUT #5, COMMENT CARDS

This page is intentionally left blank. See next page for Handout #5.

Maryland Tobacco Control Program
Strategic Planning Retreat
October 10, 2019

Comments about Goals, Strategies, and Performance Measures

If you have any feedback about the goals, strategies or performance measures that you did you get a chance to share during today's sessions, please feel free to share your thoughts below. **Return this from to the registration table.**

Goal 1: Prevent Initiation among Youth & Young Adults

_____

_____

_____

_____

_____

_____

_____

_____

Goal 2: Promote Quitting

_____

_____

_____

_____

_____

_____

_____

Goal 3: Eliminate Secondhand Smoke (SHS) Exposure

_____

_____

_____

_____

_____

_____

_____

_____

_____

Other Comments

_____

_____

_____

_____

_____

_____

_____

_____

_____

Jurisdiction: _____

Please return to the registration table.

APPENDIX VII: POWERPOINT – MDH

This page is intentionally left blank. See next page for a copy of the Maryland Department of Health PowerPoint presentation.

Maryland
DEPARTMENT OF HEALTH

Strategic Planning Retreat
MDH Updates

Dawn S. Berkowitz, MPH, CHES

Director, Center for Tobacco Prevention and Control

October 10, 2019

Looking Back:
Retreat October 11, 2018

Maryland
DEPARTMENT OF HEALTH

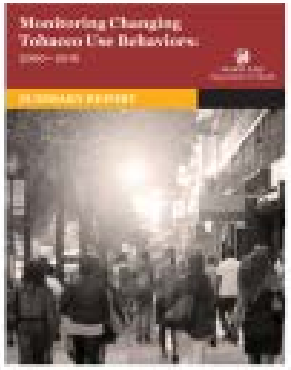
Overall recommendations and improvements since 10/11/18 Retreat

- Additional meetings – in person and virtual
  - 1st Strategic Planning Retreat, October 2018
  - Legal Resource Center (LRC) LHD Meeting, December 2018
  - LRC Legislative Preview Webinar, January 2019
  - Best Practices Conference, January 2019
  - LRC Enforcement Meeting, April 2019
  - LRC Legislative Wrap-up Webinar, May 2019
  - Statewide Tobacco Control Conference, May 2019
  - Tobacco-21 Webinar, July 2019
  - Tobacco-21 Webinar #2, September 2019
- Communication, knowledge management and resource sharing
  - Established listserv: dlcenterfortobaccopreventionandcontrol_mdh@maryland.gov
  - Developed program reporting and evaluation website: https://phpa.health.maryland.gov/ohpetup/pages/Evaluation.aspx
- Grant process
  - Streamlined application
  - Provided essential data to LHDs
  - Developed a list of strategies to select
- Site visit
  - Detailed time-specific agenda shared ahead of time
  - Shorter visit with less duplication of prior report information

Maryland
DEPARTMENT OF HEALTH

Program Evaluation Products Website

https://phpa.health.maryland.gov/ohpetup/pages/Evaluation.aspx



Program Evaluation Products

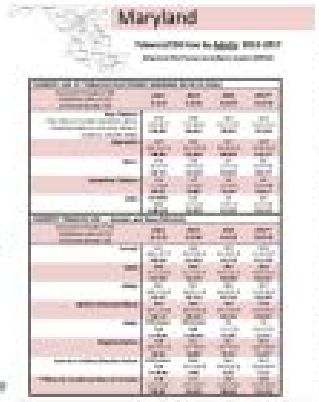
Welcome!

This page is intended for local tobacco programs and partners. Key reports and work products from th ongoing evaluation of the Maryland tobacco control program are available for download below.

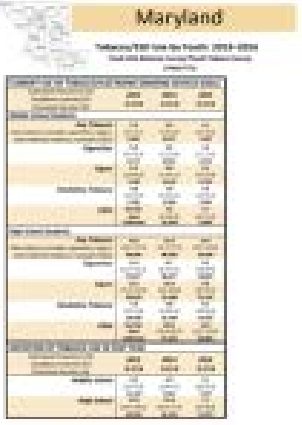
- Interim Evaluation Report - Full Report
- Interim Evaluation Report - Summary
- Program Inventory Report
  - *Detailed inventory of local tobacco control programs*
- Strategic Planning Retreats
  - 2018 Retreat Summary
  - 2019 - *will be posted following the October 10, 2019 Retreat*

Additional data sources

- Maryland Behavioral Risk Surveillance System (BRFSS)
  - *Annual telephone survey of Maryland adults over 18, includes tobacco use*
- Maryland State Health Improvement Process (SHIP)
  - *Data from state and federal partners on 39 measures of health*



- Partner Profiles - Full Report or view below by jurisdiction
  - *Snapshots of FY18 local tobacco control programs*
- Allegany County
- Anne Arundel County
- Baltimore City
- Baltimore County
- Calvert County
- Caroline County
- Carroll County
- Cecil County
- Charles County
- Dorchester County
- Frederick County
- Garrett County
- Harford County
- Howard County
- Kent County
- Montgomery County
- Prince George's County
- Queen Anne's County
- Somerset County
- St. Mary's County
- Talbot County
- Washington County
- Wicomico County
- Worcester County



Maryland
DEPARTMENT OF HEALTH

Additional Recommendations

- Orientation/onboarding for new LHD staff
  - Tobacco 101, CRF requirements, Quitline, other resources
- Develop standards and guidelines for data collection/performance measures and reporting
- Provide reporting template and meeting/webinar with guidance
- Dedicated meeting time to strategize what is/is not working

5

Maryland
DEPARTMENT OF HEALTH

MDH Updates

6

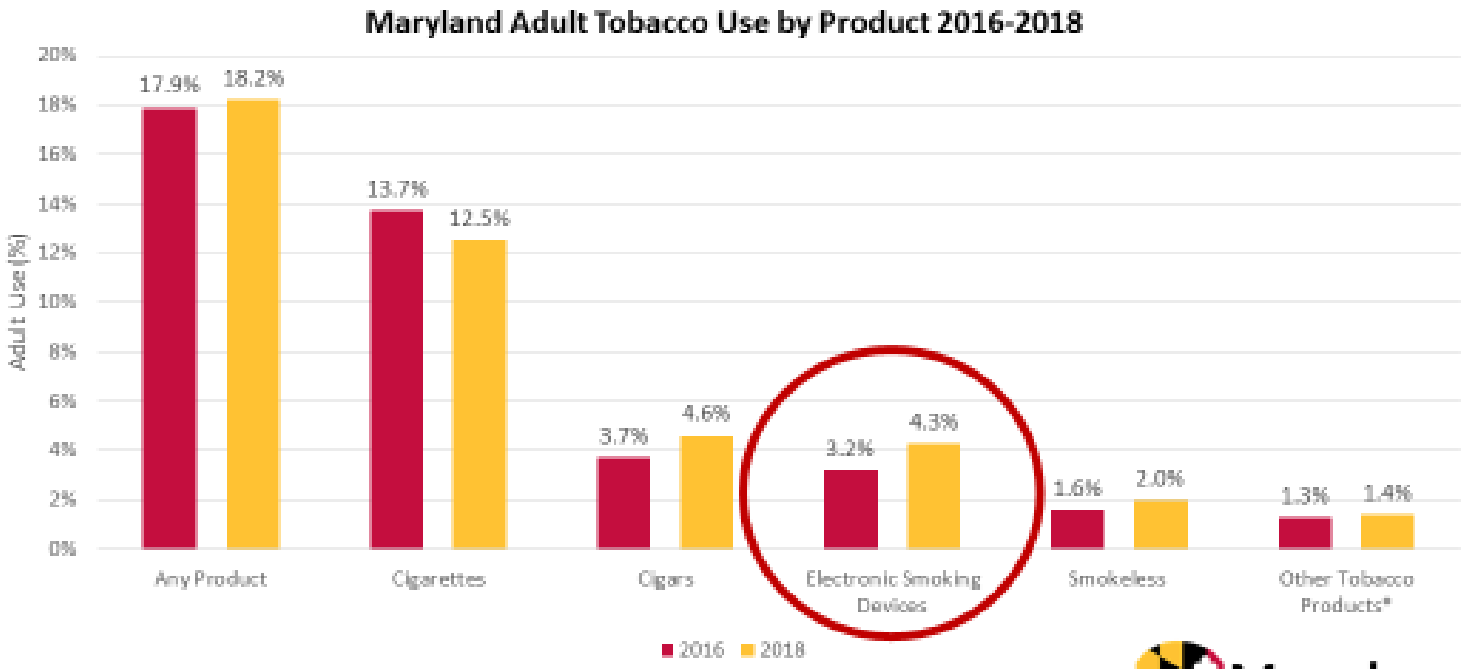
Maryland
DEPARTMENT OF HEALTH

New Adult Data

7

Maryland
DEPARTMENT OF HEALTH

Maryland Data on Current Adult Use, Tobacco Products 2016-2018



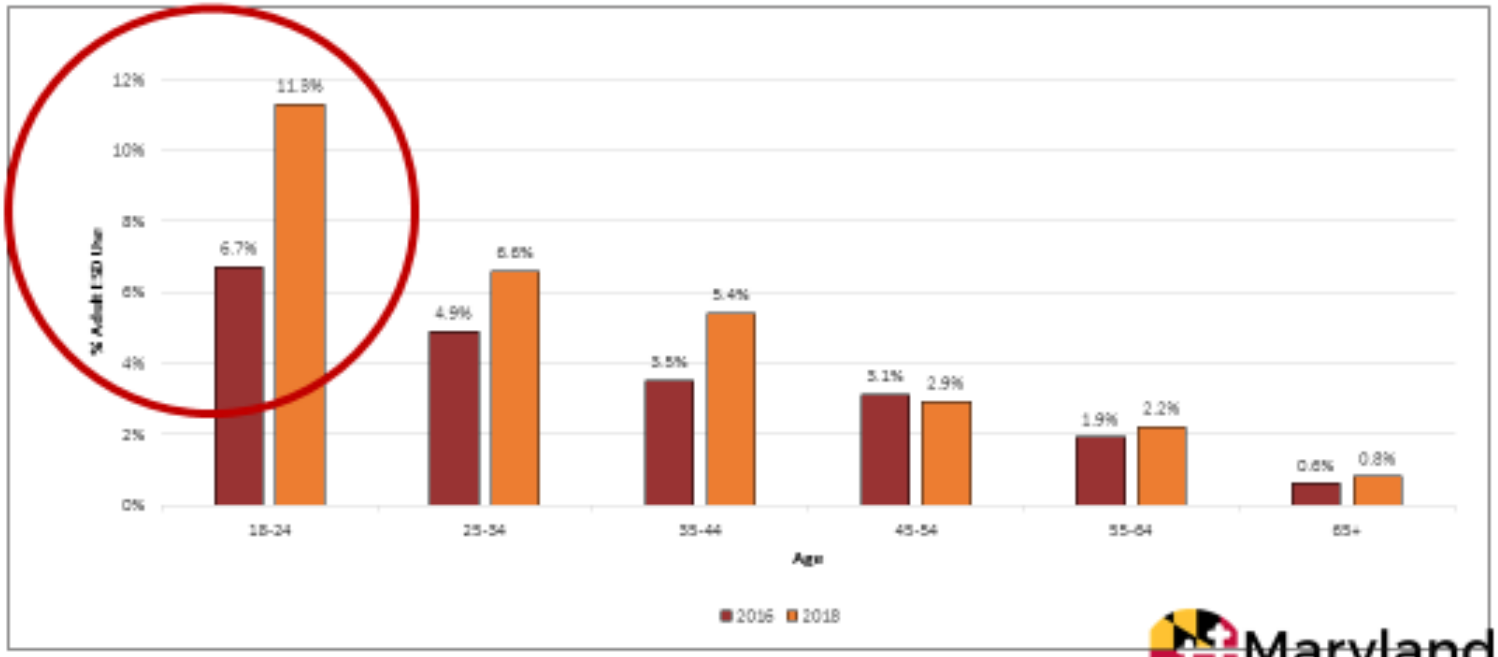
* Other Tobacco Products: Pipes, hookah, bidis, kreteks, or dissolvable tobacco products

Maryland
DEPARTMENT OF HEALTH

8

Source: Maryland Department of Health. Adult BRFSS 2018. Unpublished.

Maryland Data on Current Adult Use of Electronic Smoking Devices, 2016-2018



9

Source: Maryland Department of Health. Adult BRFSS 2018. Unpublished.

Maryland
DEPARTMENT OF HEALTH

In the News

Lung injury and deaths associated with vaping

10

Maryland
DEPARTMENT OF HEALTH

In the News: Severe Lung Illness Linked to E-Cigarettes

Press Release

MARYLAND
Department of Health

Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Robert R. Neal

Aug. 28, 2019

Media Contact
Deidre McCabe, Director, Office of Communications, 410-767-3536 or
Maureen Regan, Deputy Director, Office of Communications, 410-767-8649

Maryland Department of Health investigating cases of severe lung illness in people using e-cigarettes

Baltimore, MD – The Maryland Department of Health (MDH) and the Maryland Poison Center at the University of Maryland School of Pharmacy have identified five individuals who in the last two months developed severe lung illness after using e-cigarettes, often referred to as "vaping."

Respiratory symptoms reported by patients included shortness of breath, pain associated with breathing and cough. Other symptoms reported included fever, nausea, vomiting and diarrhea. The cases displayed no clear infectious cause and all required hospitalization.

To date, none of the cases in Maryland have been fatal. These cases are part of the nearly 200 reported incidents of vaping-related illness in 22 states, resulting in at least one death.

The cause of these illnesses is not yet known and has not been linked to any particular device, substance or brand.

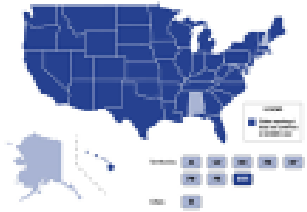
People who became ill reported using a variety of vaping products, including those containing marijuana, THC, and nicotine.

Maryland
DEPARTMENT OF HEALTH

In the News: Severe Lung Illness Linked to E-Cigarettes

CDC Update and Epidemiology

Map of reported cases



- As of October 1, 2019, **1,080* cases** of lung illness associated with the use of e-cigarette products have been reported to CDC from 48 states and the U.S. Virgin Islands.
  - **18 deaths** have been confirmed in 15 states.
  - About **70 percent** of cases are male.
  - Approximately **80 percent** of patients are under 35 years old.
    - 16 percent of patients are under 18 years old
    - 21 percent of patients are 18-20 years old
- The latest findings from the investigation into lung injuries associated with e-cigarette use, or vaping, suggest products containing THC play a role in the outbreak.
  - CDC has received data on substances used in e-cigarettes or vaping products in the 30 days prior to symptom onset among 578 patients.
    - About 78 percent reported using THC-containing products; 37 percent reported exclusive use of THC-containing products.
    - About 58 percent reported using nicotine-containing products; 17 percent reported exclusive use of nicotine-containing products.
- Product testing:
  - FDA conducting broad-spectrum, untargeted testing for contaminants
  - Vitamin E Acetate in many cannabis-derived products used by case patients.
  - Unclear if this is cause (or even one of several causes) of illness

Maryland
DEPARTMENT OF HEALTH

12 *The current number includes only confirmed and probable cases reported by states to CDC after classification.

Source: https://www.cdc.gov/tobacco/basic_information/e-cigarettes/severe-lung-disease.html

Vaping-Associated Lung Illness

Epidemiology in Maryland (10/09/2019)

- As of October 9, 2019: 29 cases
- 26 hospitalizations, 0 deaths
- Earliest hospitalization 06/26/2019; latest 10/03/2019
- 6 female, average age 26, 11 different jurisdictions
- 14 case patients interviewed
  - 14/14 (100%) report vaping nicotine products
  - 12/14 (86%) report vaping cannabis-derived products
  - Zero linked exclusively to medical cannabis
  - No consistent brand, product, or device
  - Nationally, strongest risk factor is vaping pre-filled cartridges containing THC oil

13

Maryland
DEPARTMENT OF HEALTH

MDH Clinical Reporting Order, effective 10/03/19

Maryland
DEPARTMENT OF HEALTH

October 3, 2019

Media Contact:
Desire McCabe, Director, Office of Communications, 410.767.3836 or
Maureen Regan, Deputy Director, Office of Communications, 410.767.6549

Maryland Secretary of Health issues clinical reporting order as severe lung illness investigation continues

All health care providers shall:

- Become familiar with the criteria for a suspected case of vaping associated lung injury, which is as follows:
  - Use of any e-cigarette ("vaping") or dabbing in 90 days prior to symptom onset
  - Pulmonary infiltrate, including opacities on plain film chest radiograph or ground-glass opacities on chest CT
  - No alternative plausible diagnoses (e.g., infectious, cardiac, rheumatologic, or neoplastic process);
- Submit, within one working day, telephonic or written morbidity reports of suspected vaping associated lung injury to the local health department for the jurisdiction in which the health care is located;
- Consult the Maryland Department of Health Vaping Associated Lung Injury website for updated information and additional resources at https://phpa.health.maryland.gov/OEHFP/EH/Pages/VapingIllness.aspx;
- Educate and instruct the patient on appropriate measures to prevent further injury.

All Local Health Departments shall:

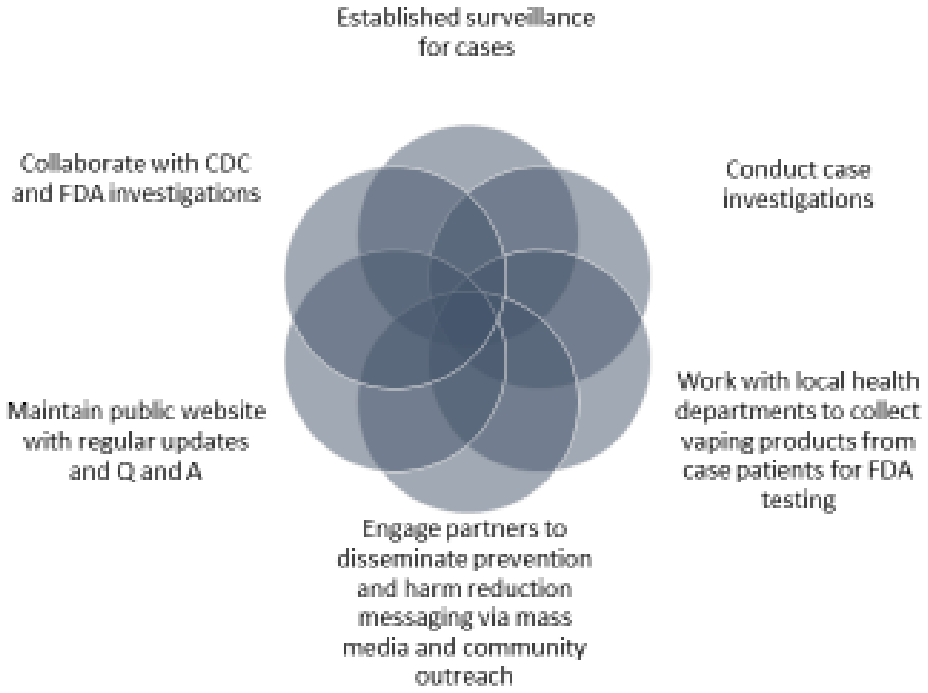
- Immediately notify the MDH PHPA of any suspected vaping associated lung injury cases; and
- Maintain the confidentiality of information collected pursuant to Section 2, above, as required by State and federal law

14

Maryland
DEPARTMENT OF HEALTH

Vaping-Associated Lung Illness

Maryland Department of Health Actions



15

https://phpa.health.maryland.gov/OEHFP/EH/Pages/VapingIllness.aspx

Maryland
DEPARTMENT OF HEALTH

In the News: Severe Lung Illness Linked to E-Cigarettes

Frequently Asked Questions

https://phpa.health.maryland.gov/OEHFP/EH/Pages/VapingIllness.aspx

How can I keep myself safe from vaping-associated lung illness?	The best way to keep yourself safe is to not use e-cigarettes or vapes.
I want to quit using e-cigarettes and vaping but I can't. What should I do?	If you want to stop using e-cigarettes, or any tobacco product, you can call the Quitline at 1-800-QUIT-NOW: Trained professionals are there 24/7 to help you.
I heard this illness is caused by marijuana or THC oils. Is that true?	We do not know yet what causes this illness. Many, but not all, patients who developed this illness report that, in addition to nicotine, they vaped pre-filled cartridges of cannabis-derivative products like THC or CBD. Maryland Department of Health strongly advises against the use of these products.
I heard this illness is caused by Vitamin E. Is that true?	We do not know yet. Testing at several national labs has identified a compound – vitamin E acetate – in some, but not all, of the THC product samples collected from people who became sick. However, we do not know if Vitamin E acetate was the cause, or even one of several causes, of the illness. There is also no way for you to test if a product you purchase contains vitamin E acetate or any other possibly harmful chemical.

Vaping Outreach

MDH Resource Webpage on Vaping

https://phpa.health.maryland.gov/ohpetup/Pages/VapeHelp.aspx

Key Resources on E-Cigarettes and Vaping

What We Know

- E-cigarettes are not safe for youth.[1]
- Between 2017 and 2018, high school use of e-cigarettes/vapes increased 78 percent, leading the U.S. Surgeon General to call youth use an "epidemic".
- Nicotine is the primary agent in both regular cigarettes and e-cigarettes, and there's nicotine in most flavored e-cigarettes.
- Nicotine can harm adolescent brain development, which continues into the early to mid-20s, negatively impacting memory, learning, and attention.[1]
- Young adults who use e-cigarettes are four times more likely to begin smoking regular cigarettes within 18 months compared to those who do not use e-cigarettes.[2]
- E-cigarettes produce a chemical-filled aerosol, *not* "harmless" water vapor.[1]

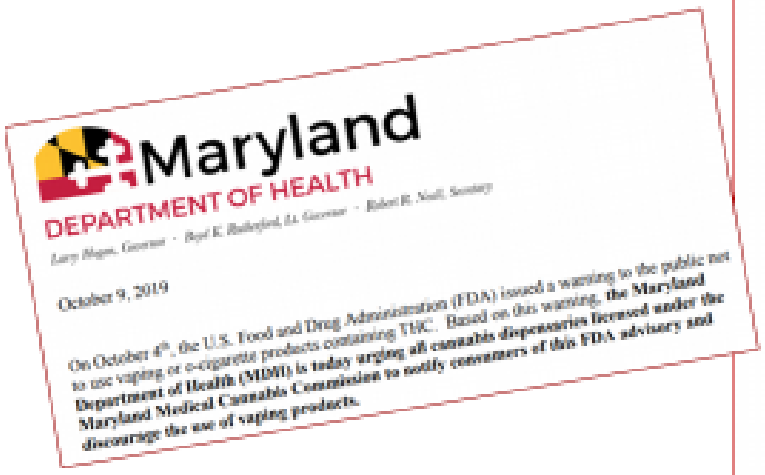
What Resources Are Available

- For Young People
- For Parents
- For Teachers and School Administrators
- For Healthcare Providers

18

Maryland
DEPARTMENT OF HEALTH

Maryland Medical Cannabis Commission – Vaping Warning to dispensaries, providers, and patients – October 9, 2019



Maryland
DEPARTMENT OF HEALTH

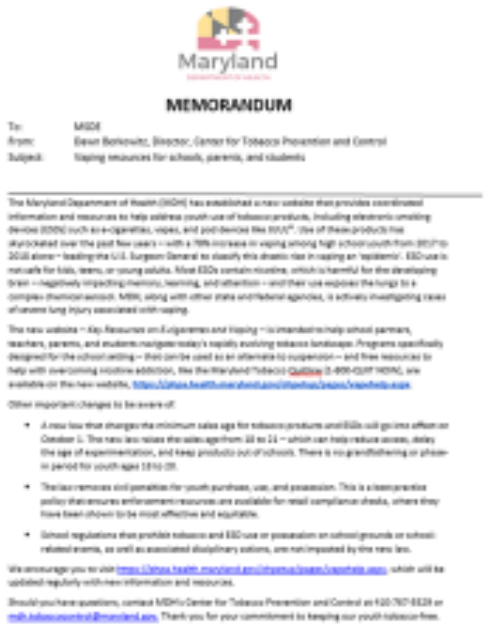
October 9, 2019

On October 4th, the U.S. Food and Drug Administration (FDA) issued a warning to the public not to use vaping or e-cigarette products containing THC. Based on this warning, **the Maryland Department of Health (MDH) is today urging all cannabis dispensaries licensed under the Maryland Medical Cannabis Commission to notify consumers of this FDA advisory and discourage the use of vaping products.**

Consumers should be provided with the following information:

1. **The FDA is warning the public: do not use vaping products containing THC.** More than 1,000 individuals nationwide have developed severe lung injuries after vaping, including at least 23 cases in Maryland. The strongest risk factor identified to date is vaping pre-filled cartridges of cannabis-derived products like THC.
2. **MDH urges medical cannabis consumers to talk to their health care providers about alternatives to vaping THC.** Consumers should discuss alternatives that meet their medical needs. MDH also advises against smoking THC products.
3. **Vaping anything is never safe for adolescents, or for pregnant or breastfeeding women.**
4. **No single product or substance has been linked to all lung injury cases.** While the biggest risk for injury appears to be from THC products not obtained from a licensed dispensary, there are reports in other states of lung injury associated with legally obtained THC products. Vaping products that include nicotine, CBD, and/or other oils and substances have also been linked to injuries.
5. **If you vape cannabis or nicotine products and have shortness of breath or other signs of illness, seek medical attention immediately and tell your provider you have been vaping.**

Coming Soon … MSDE MEMO
Vaping resources for schools, parents, and students



Maryland

MEMORANDUM

To: MSDE
From: Dawn Bohlowitz, Director, Center for Tobacco Prevention and Control
Subject: Vaping resources for schools, parents, and students

The Maryland Department of Health (MDH) has established a new website that provides coordinated information and resources to help address youth use of tobacco products, including electronic smoking devices (ESDS) such as e-cigarettes, vapes, and pod devices like JUUL®. Use of these products has skyrocketed over the past few years – with a 78% increase in vaping among high school youth from 2017 to 2018 alone – leading the U.S. Surgeon General to classify this drastic rise in vaping as 'epidemic'. ESD use is not safe for kids, teens, or young adults. Most ESDs contain nicotine, which is harmful for the developing brain – negatively impacting memory, learning, and attention – and their use exposes the lungs to a complex chemical aerosol. MDH, along with other state and federal agencies, is actively investigating cases of severe lung injury associated with vaping.

The new website – Key Resources on E-cigarettes and Vaping – is intended to help school partners, teachers, parents, and students navigate today's rapidly evolving tobacco landscape. Programs specifically designed for the school setting – that can be used as an alternate to suspension – and free resources to help with overcoming nicotine addiction, like the Maryland Tobacco Quitline (1-800-QUIT NOW), are available on the new website, https://phpa.health.maryland.gov/ohpetup/pages/vapehelp.aspx.

Other important changes to be aware of:

- A new law that changes the minimum sales age for tobacco products and ESDs will go into effect on October 1. This new law raises the sales age from 18 to 21 – which can help reduce access, delay the age of experimentation, and keep products out of schools. There is no grandfathering or phase-in period for youth ages 18 to 20.
- The law removes civil penalties for youth purchase, use, and possession. This is a less punitive policy that ensures enforcement resources are available for retail compliance checks, where they have been shown to be most effective and equitable.
- School regulations that prohibit tobacco and ESD use or possession on school grounds or school-related events, as well as associated disciplinary actions, are not impacted by the new law.

We encourage you to visit https://phpa.health.maryland.gov/ohpetup/pages/vapehelp.aspx, which will be updated regularly with new information and resources.

Should you have questions, contact MDH's Center for Tobacco Prevention and Control at 410-767-6828 or mdh.tobaccocontrol@maryland.gov. Thank you for your commitment to keeping our youth tobacco-free.

The new website – *Key Resources on E-cigarettes and Vaping* – is intended to help school partners, teachers, parents, and students navigate today's rapidly evolving tobacco landscape..

Programs specifically designed for the school setting and free are available on the new website, **https://phpa.health.maryland.gov/ohpetup/pages/vapehelp.aspx.**

Information about Tobacco 21 and enforcement.

Maryland
DEPARTMENT OF HEALTH

Tobacco 21

Maryland Becomes 13th State to Pass Tobacco 21 Legislation

22

MARYLAND
Department of Health

May 15, 2019

Maryland becomes 13th state to raise minimum legal sales age for tobacco products to 21

Baltimore, MD — The Maryland Department of Health applauds the Maryland General Assembly and Governor Larry Hogan for passing legislation (House Bill 1416) increasing the age from 18 to 21 for the sales of tobacco products and electronic smoking devices (ESDs). Over the coming months, MDH will launch a statewide campaign to get the word out to young adults under age 21 and retailers about the new law, which goes into effect Oct. 1, 2019.

MDH Secretary Robert R. Neall said the state has been tracking a troubling increase in tobacco use in recent years among youth and young adults, particularly since the introduction of e-cigarettes, also referred to as vapes and other names. Maryland's Tobacco 21 law covers e-cigarettes, taking the important step of defining them as tobacco products.

"We know most smokers start when they are underage and their brains are still developing," Neall said. "This can quickly lead to nicotine addiction and also make them more susceptible to other addictions. This is a public health crisis that needs to be addressed immediately."

Maryland's new law covers all individuals under the age of 21, with the exception of active-duty military age 18 to 20. Approximately 190,000 Marylanders use tobacco products, most of them starting before age 21. This new law aims to protect the 200,000 Marylanders between ages 18 to 20 from developing a nicotine addiction.

Nationally, from 2017 to 2018, use of tobacco products grew by nearly 48 percent among U.S. high school students, with the use of electronic smoking devices increasing by 78 percent. This increase equates to an additional 1.5 million tobacco users nationwide.

"Maryland data show that electronic smoking devices are by far the most commonly used product among our high school students," said Dawn Bartenwerfer, director of MDH's Center for Tobacco Prevention and Control. "Most of these popular candy- and fruit-flavored products that are attractive to youth contain high levels of nicotine. In addition to addiction, the nicotine in these products leads to reduced impulse control, attention deficit, and other learning and mood disorders in youth and young adults. It's troubling that we often hear of older high school students supplying these tobacco products to their younger peers."

Tobacco 21: Law Overview

TOBACCO
~~eighteen~~ twenty-one

Key Points

- **Effective Date:** October 1, 2019.
- **Raises the minimum sales age to 21 for all tobacco products**, including electronic smoking devices (e.g., e-cigarettes, vapes, pod devices such as JUUL®, e-liquids, and component parts and accessories).
- **"Electronic Smoking Devices" (ESDs)** are now included in the term "tobacco product."
- The **only exemption to this law is for *active duty* military personnel**. These individuals must be 18 or older and present valid military identification.
- **There is no "grandfather," phase-in, or grace period** for individuals who are 18 years of age prior to 10/1/19.

23

Maryland
DEPARTMENT OF HEALTH

Tobacco 21: Law Overview

Frequently Asked Questions

Send additional questions to
MDH.NoTobaccoSalesToMinors@Maryland.gov

Are clerks younger than 21 permitted to sell tobacco products?	Yes, clerks under 21 are permitted to sell tobacco products. If the clerk is under 18 years of age, they must obtain a work permit from the Maryland Department of Labor before starting any job in Maryland.
Does the military exemption apply to personnel in the National Guard or Reserves?	No. The exemption only applies to active duty military with valid military ID (Common Access Card).
How can a retailer tell if a military ID is for active duty versus other status like Reserves or ROTC?	Active duty military are issued the Common Access Card; to verify active duty status, look for "Uniformed Services" printed on the front of the ID card under "Affiliation." No other forms of military ID are acceptable.
Can retailers refuse all sales under 21, including eligible military?	Retailers have discretion in whom they choose to sell age-restricted products to, regardless of whether the individual may meet an exemption. Retailers should contact their legal counsel for any further guidance.

24

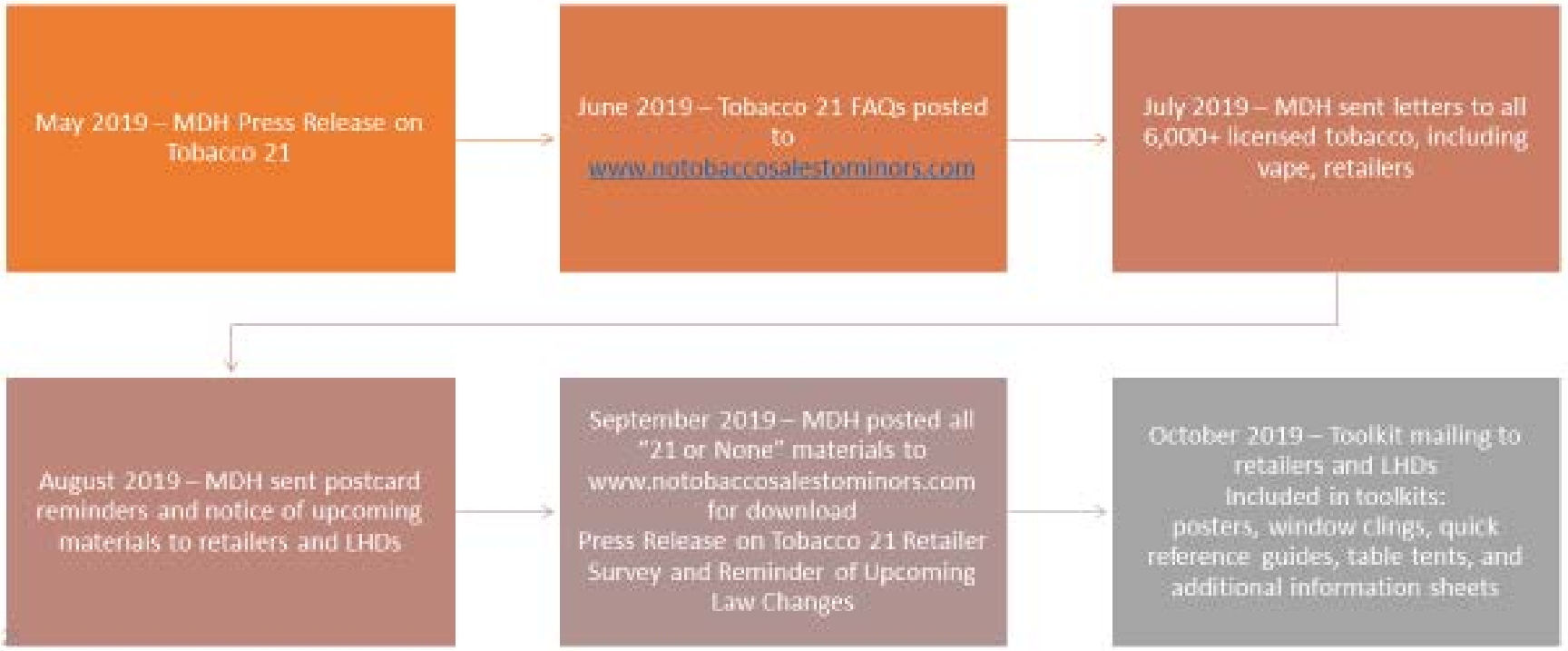
Visit www.notobaccosalestominors.com for updated Frequently Asked Questions

Maryland
DEPARTMENT OF HEALTH

Source: Maryland Department of Health, Tobacco 21 FAQs

Tobacco 21: Retailer Outreach

Tobacco 21 Outreach



Tobacco 21: 21 or None

21 or None Materials

- Materials are available for download and free to order at www.notobaccosalestominors.com
- Toolkits to be mailed directly to Retailers

26

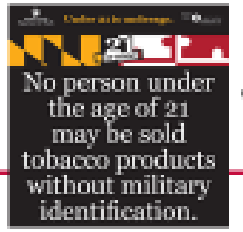
Maryland
DEPARTMENT OF HEALTH

Tobacco 21: 21 or None

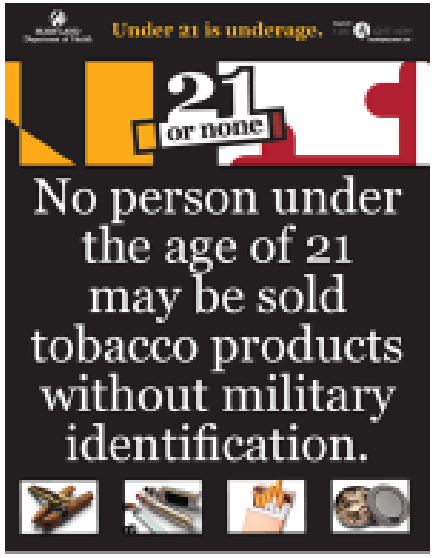
Signage for Retailers

- Posters and window clings include the **required language** for retailers to display in stores
- Table tents to be placed near cash registers
- Available for download

www.notobaccosalestominors.com



Window Cling



Poster

Table Tent

Maryland
DEPARTMENT OF HEALTH

27

Tobacco 21 Retailer Survey

MARYLAND
Department of Health

Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Robert R. Neall, Secretary

September 25, 2019

Media Contact:

Deidre McCabe, Director, Office of Communications, 410-767-3536 or

Maureen Regan, Deputy Director, Office of Communications, 410-767-6649

Maryland Health Department reaches out to retailers across the state preparing for change in tobacco sales law

- 4,000 retailers across the state were invited at random to participate in an online survey to assess readiness and awareness of Tobacco 21
- The survey closed September 30
- More than 400 retailers responded, exceeding the 10% target
- A follow up survey is planned for spring 2020

28

Maryland
DEPARTMENT OF HEALTH

Tobacco 21: Colleges and Universities

How is MDH supporting colleges and universities?

- Letter to alert college administrators of T21
- Frequently Asked Questions document for colleges/universities

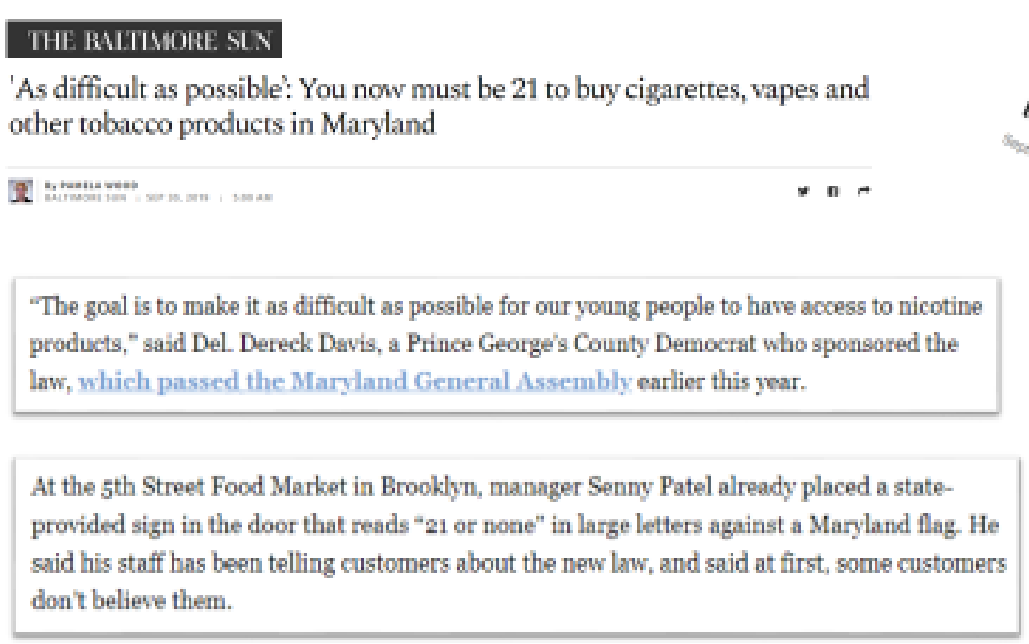
How can colleges and universities best support their students?

- Educate and inform the campus community, including **out-of-state students**, starting now on how the new law may impact them and resources available to help with quitting tobacco use. Incorporate messaging at existing campus events or in campus announcements.
- Promote tobacco treatment options, such as cessation classes and the Maryland Tobacco Quitline (1-800-QUIT-NOW), for all students, faculty, staff, and visitors.
- Support a Tobacco-Free Generation by becoming a Tobacco-Free Campus.

29

Maryland
DEPARTMENT OF HEALTH

Tobacco 21 in the News


THE BALTIMORE SUN

'As difficult as possible': You now must be 21 to buy cigarettes, vapes and other tobacco products in Maryland

"The goal is to make it as difficult as possible for our young people to have access to nicotine products," said Del. Dereck Davis, a Prince George's County Democrat who sponsored the law, which passed the Maryland General Assembly earlier this year.

At the 5th Street Food Market in Brooklyn, manager Senny Patel already placed a state-provided sign in the door that reads "21 or none" in large letters against a Maryland flag. He said his staff has been telling customers about the new law, and said at first, some customers don't believe them.


Maryland law curbing nicotine sales to youths takes effect amid vaping concerns

You must be 21 years old to buy tobacco products in Maryland

30

Maryland
DEPARTMENT OF HEALTH

Looking Ahead:
Retreat October 10, 2019

Maryland
DEPARTMENT OF HEALTH

The Day Ahead

What we hope to accomplish with today's retreat

- Gain input from our partners to guide our next 5-year plan (2020-2025)
- Review/select strategies that will make the greatest impact with the limited resources that we have

Maryland
DEPARTMENT OF HEALTH

32

Questions

Dawn Berkowitz, MPH, CHES

Director, Center for Tobacco Prevention and Control

dawn.berkowitz@maryland.gov

33

Maryland
DEPARTMENT OF HEALTH

APPENDIX VIII: POWERPOINT – SCHAEFER CENTER

This page is intentionally left blank. See next page for a copy of the Schaefer Center for Public Policy PowerPoint presentation.

2019 STRATEGIC PLANNING RETREAT

Center for Tobacco and Prevention Control
Maryland Department of Health

Wilde Lake Interfaith Center
October 10, 2019

UNIVERSITY OF BALTIMORE
Schaefer Center for Public Policy

Welcome & Introductions

Dawn Berkowitz, Director
Center for Tobacco Control and Prevention

Tobacco Control Accomplishments

Dawn Berkowitz,
Director, Center for Tobacco Prevention and Control

Retreat Overview and Evaluation Update

Ann Cotten,
Director
Schaefer Center for Public Policy

AGENDA

- Maryland Tobacco Control Accomplishments
- Evaluation Update
- Presentation on Health Equity and Tobacco Control (mission & vision discussion)
- Lunch
- Breakout Sessions (Strategies for 3 goal areas)
- Reporting on breakout sessions
- Closing

UNIVERSITY OF BALTIMORE
Schaefer Center for Public Policy

EVALUATION UPDATE

- Final draft of CDC report was delivered in July, will be updated with new data before resubmission in the spring of 2020.
- Work products
  - Tobacco Control Program Inventory
  - Local Health Department Profiles
  - Application Inventory Reporting System (AIR) (In progress)

Program Inventory Summary Report
What do other jurisdictions do?

- Submitted in March 2019
- Data presented statewide and jurisdiction
- Topics covered
  - Organizational Structure
  - Staffing
  - Coalitions
  - Cessation Activities
  - School-based Training
  - Community Campaigns and Programs
  - Innovative Programs Summary
  - Effective Programs Summary
  - Program Accomplishments
  - Priorities for upcoming year

UNIVERSITY OF BALTIMORE

FY 2018 LHD Profiles
The view at the jurisdiction level.

Topics

- County strategies
- County demographics
- Key Tobacco related health statistics
- Listing of partners
- Listing of partner activities
- Key performance data (enforcement, cessation, and SHS)
- Innovations
- Accomplishments
- Most effective programs

Data sources

- 2018 LHD Program Inventory
- Census 2017 Population Estimates
- 2016 Behavioral Risk Factor Surveillance System
- 2016 Youth Risk Behavior Survey and Youth tobacco Survey
- FY17 Cigarette Restitution Fund Grantee Reports
- FY17 Enforcement Grantees Reports
- FY18 MD Tobacco Quitline Reports
- FFY18 Synar Report
- FY18 Cigarette Restitution Fund Grantee Reports
-

UNIVERSITY OF BALTIMORE
Schaefer Center for Public Policy

Application Inventory Reporting System (AIRS)

Qualtrics based program is in development

Long term goals for the system

- Accept grant applications
- Allow for report on activities
- Support creation of statewide inventory reports

Healthy Equity in Tobacco Control

Taslim van Hattum, LCSW, MPH

Director, Practice Improvement, National Council for Behavioral Health

Afternoon Breakout Sessions

- Reviewing strategies and performance measures with a healthy equity lens to identify statewide plan to address health equity.
- Closing session, group voting to prioritize strategies.

Networking Lunch

Assignments

- **Mission Vision Review**
  - Review the mission and vision with health equity lens and document changes/ comments on form.

- **Priority populations:**
  - What are the priority populations for your jurisdiction?
  - What strategies have been most effective in reducing disparities in your jurisdiction?

Afternoon Breakout Sessions

Tasks

- Examine/revise strategies with a health equity lens to identify most impactful.
- Identify the most appropriate performance measures.

Product

- Input to the statewide 5 year plan to address health equity in tobacco control

3 Goal Areas

Goal 1: Prevent initiation among youth and young adults

Goal 2: Promote quitting

Goal 3: Eliminate Secondhand smoke (SHS) exposure

Breakout Sessions

Session 1:Review strategies with equity lens. Revise if needed.

Session 2: Prioritize strategies by highest likely impact on priority populations.

Session 3: Select best performance measures for selected strategies, revise and add if needed.

Breakout Sessions Assignments (also in folder)

Session	Room A Goal 1: Prevention (Room 10)	Room B Goal 2: Quitting (Room 14)	Room C Goal 3: Reduce SHS (Room 16)
Session 1 Review strategies with equity lens and choose priority populations	Group A	Group C	Group B
Session 2 Prioritize strategies by impact	Group B	Group A	Group C
Session 3 Review and select performance measures	Group C	Group B	Group A

UNIVERSITY OF BALTIMORE

Definitions

- **Goals:** A broad statement of the long-term expectation of what will be achieved by a program.
- **Objectives:** A statement of specific results that will be achieved. Objects are SMART.
- **Strategies:** The general plan of activities for achieving objectives
- **Activities:** Specific steps that will be taken in the next year or two to achieve objectives.

Large Group Session
Prioritizing Strategies

DIRECTIONS

- Using your dots, vote for the **3** most impactful strategies for each goal area.

- Each LHD has **2** sets of **9** dots

  (*color coded by jurisdiction size or resource center*)

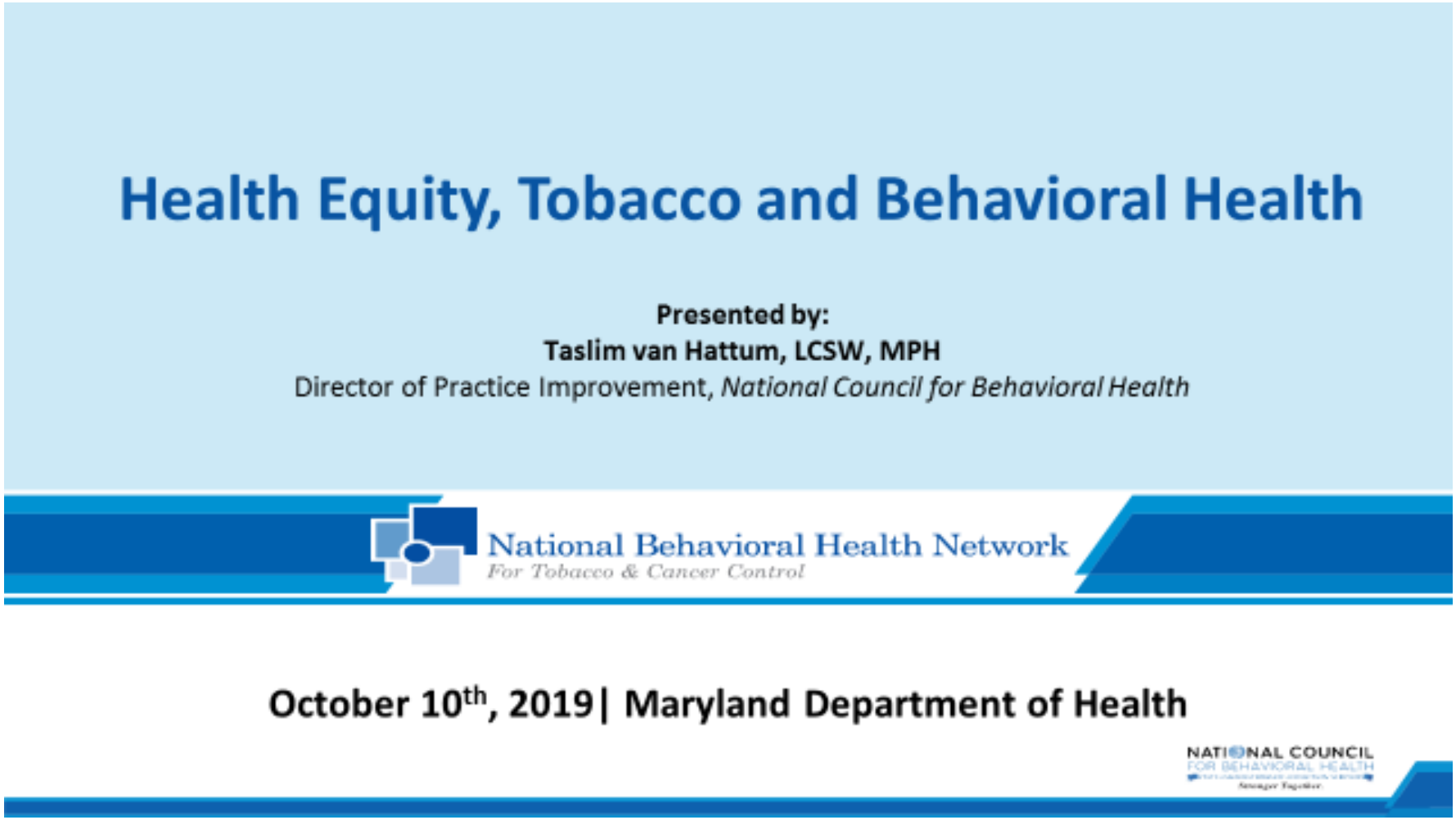
- Each resource center has **2** sets of 15 dots

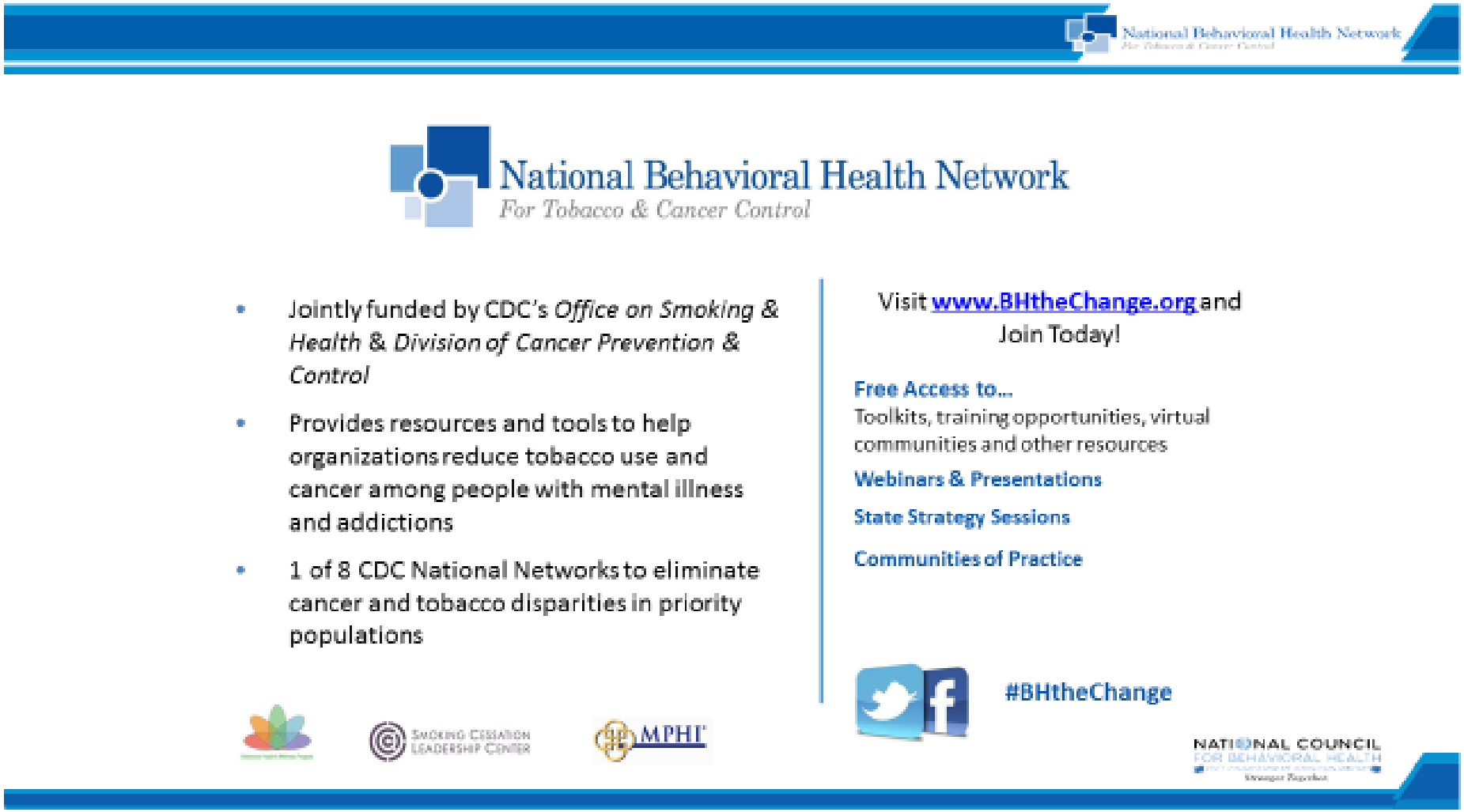
Closing

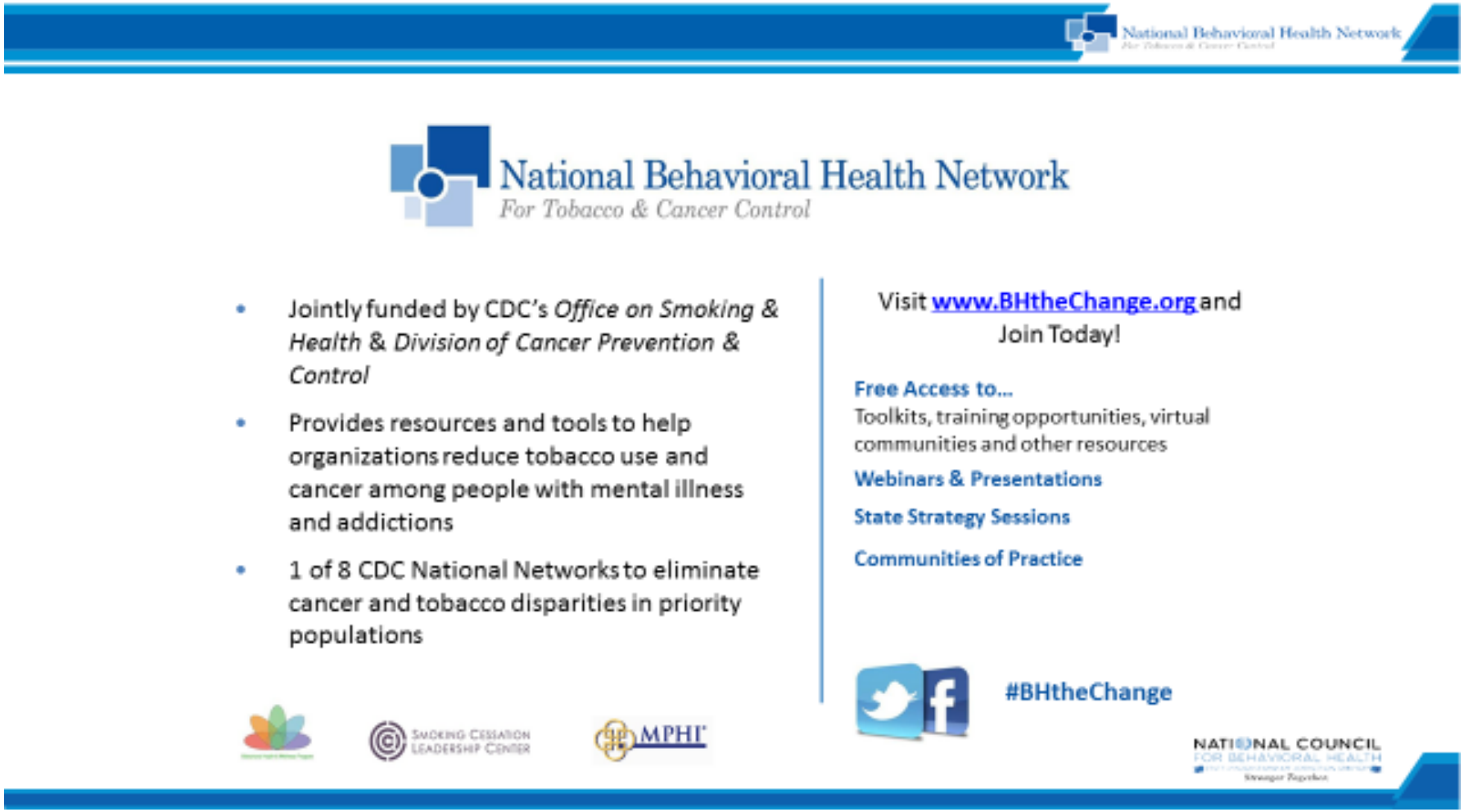
Dawn Berkowitz,
Director, Center for Tobacco Prevention and Control

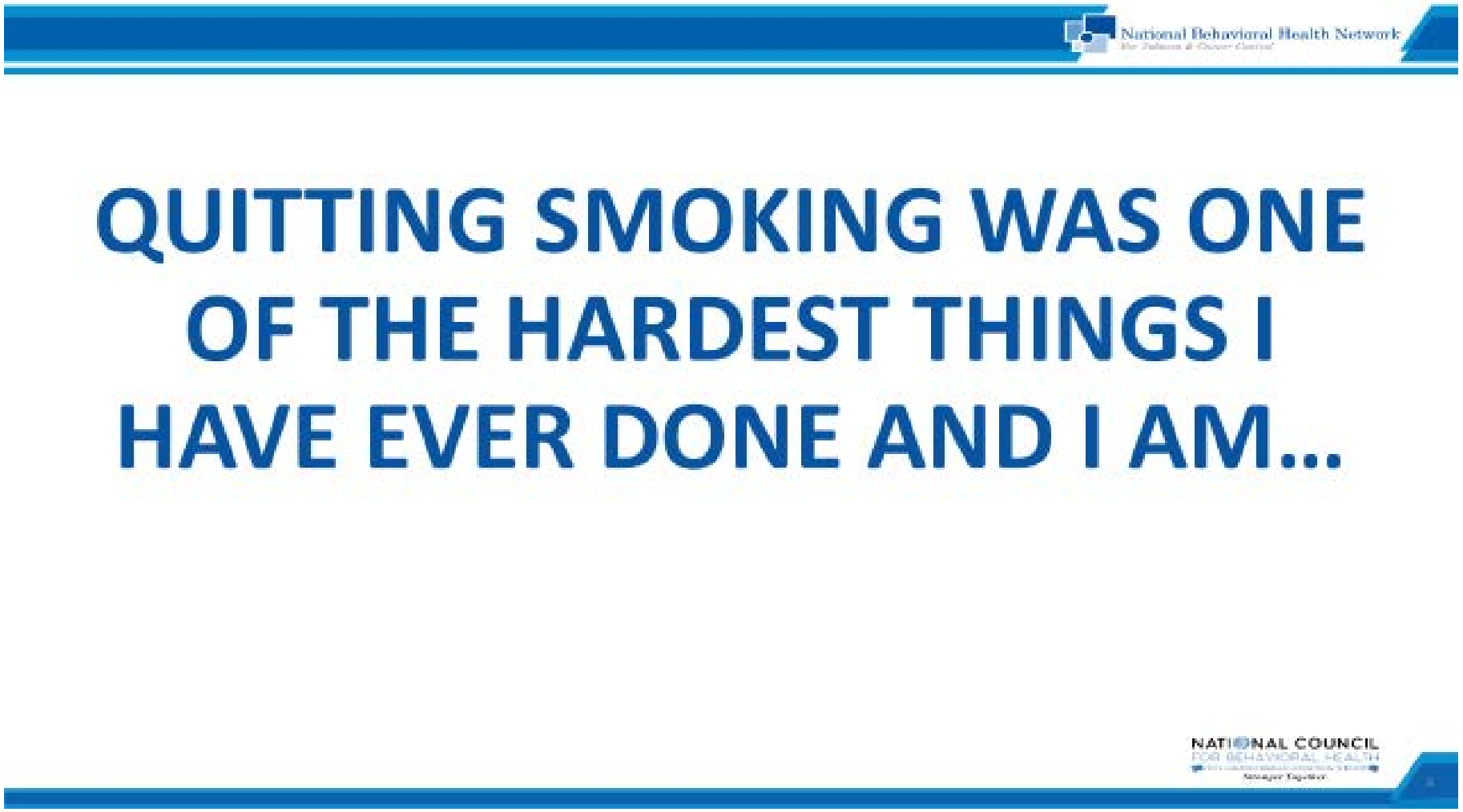
APPENDIX IX: POWERPOINT – GUEST SPEAKER TASLIM VAN HATTUM

This page is intentionally left blank. See next page for copies of guest speaker Taslim van Hattum's PowerPoint presentation.


Health Equity, Tobacco and Behavioral Health
Presented by:
Taslim van Hattum, LCSW, MPH
Director of Practice Improvement, National Council for Behavioral Health
National Behavioral Health Network
For Tobacco & Cancer Control
October 10th, 2019| Maryland Department of Health
NATIONAL COUNCIL FOR BEHAVIORAL HEALTH


National Behavioral Health Network
For Tobacco & Cancer Control
• Jointly funded by CDC's *Office on Smoking & Health* & *Division of Cancer Prevention & Control*
• Provides resources and tools to help organizations reduce tobacco use and cancer among people with mental illness and addictions
• 1 of 8 CDC National Networks to eliminate cancer and tobacco disparities in priority populations
Visit www.BHtheChange.org and Join Today!
Free Access to...
Toolkits, training opportunities, virtual communities and other resources
Webinars & Presentations
State Strategy Sessions
Communities of Practice
#BHtheChange
SMOKING CESSATION LEADERSHIP CENTER
MPHI
NATIONAL COUNCIL FOR BEHAVIORAL HEALTH


National Behavioral Health Network
For Tobacco & Cancer Control
Jointly funded by CDC's Office on Smoking & Health & Division of Cancer Prevention & Control
Provides resources and tools to help organizations reduce tobacco use and cancer among people with mental illness and addictions
1 of 8 CDC National Networks to eliminate cancer and tobacco disparities in priority populations
Visit www.BHtheChange.org and Join Today!
Free Access to...
Toolkits, training opportunities, virtual communities and other resources
Webinars & Presentations
State Strategy Sessions
Communities of Practice
#BHtheChange
Smoking Cessation Leadership Center
MPHI
National Council for Behavioral Health


National Behavioral Health Network
QUITTING SMOKING WAS ONE OF THE HARDEST THINGS I HAVE EVER DONE AND I AM…
NATIONAL COUNCIL FOR BEHAVIORAL HEALTH

National Behavioral Health Network

What is Health?

"A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."

- World Health Organization

NATIONAL COUNCIL FOR BEHAVIORAL HEALTH

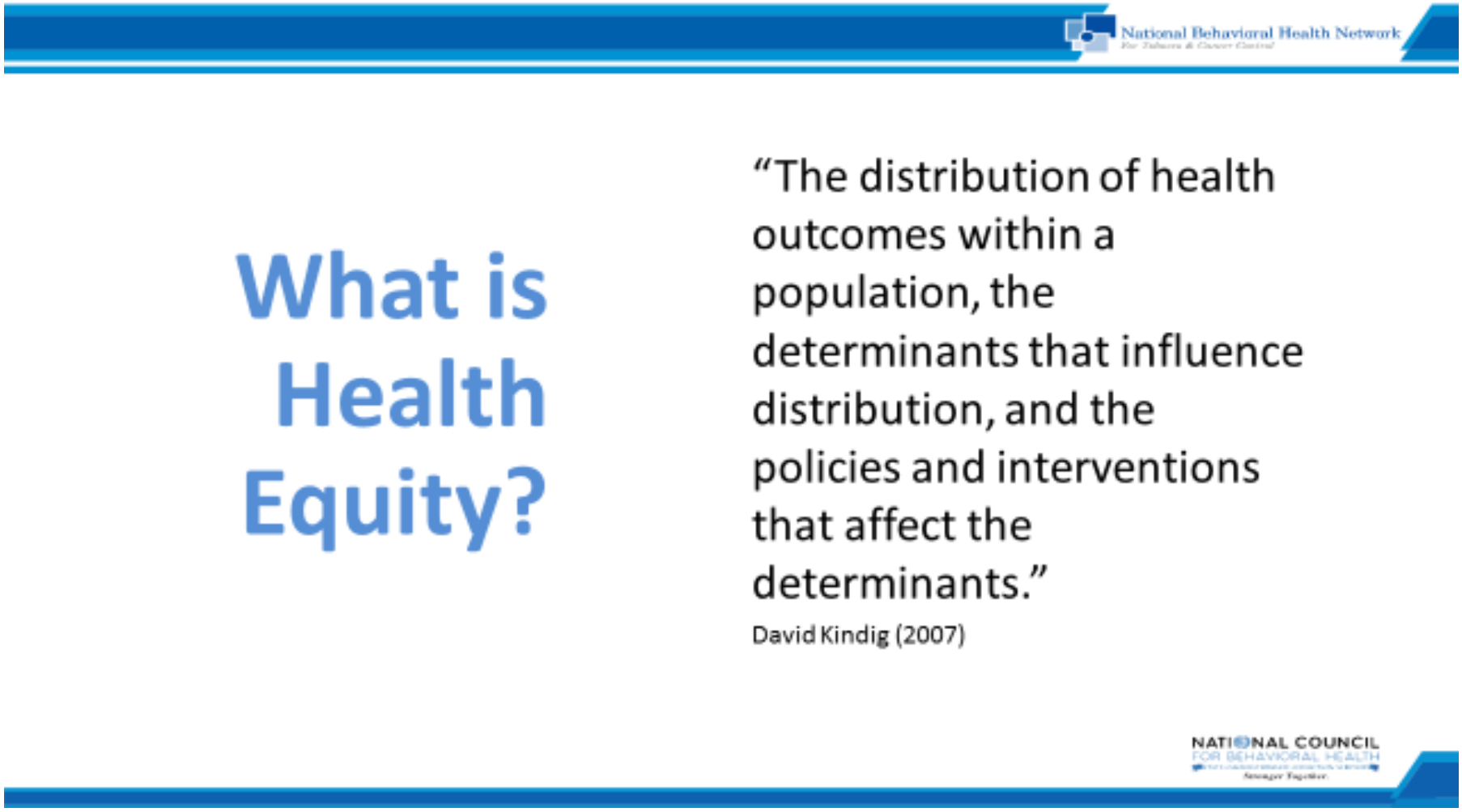
National Behavioral Health Network

What is population health?

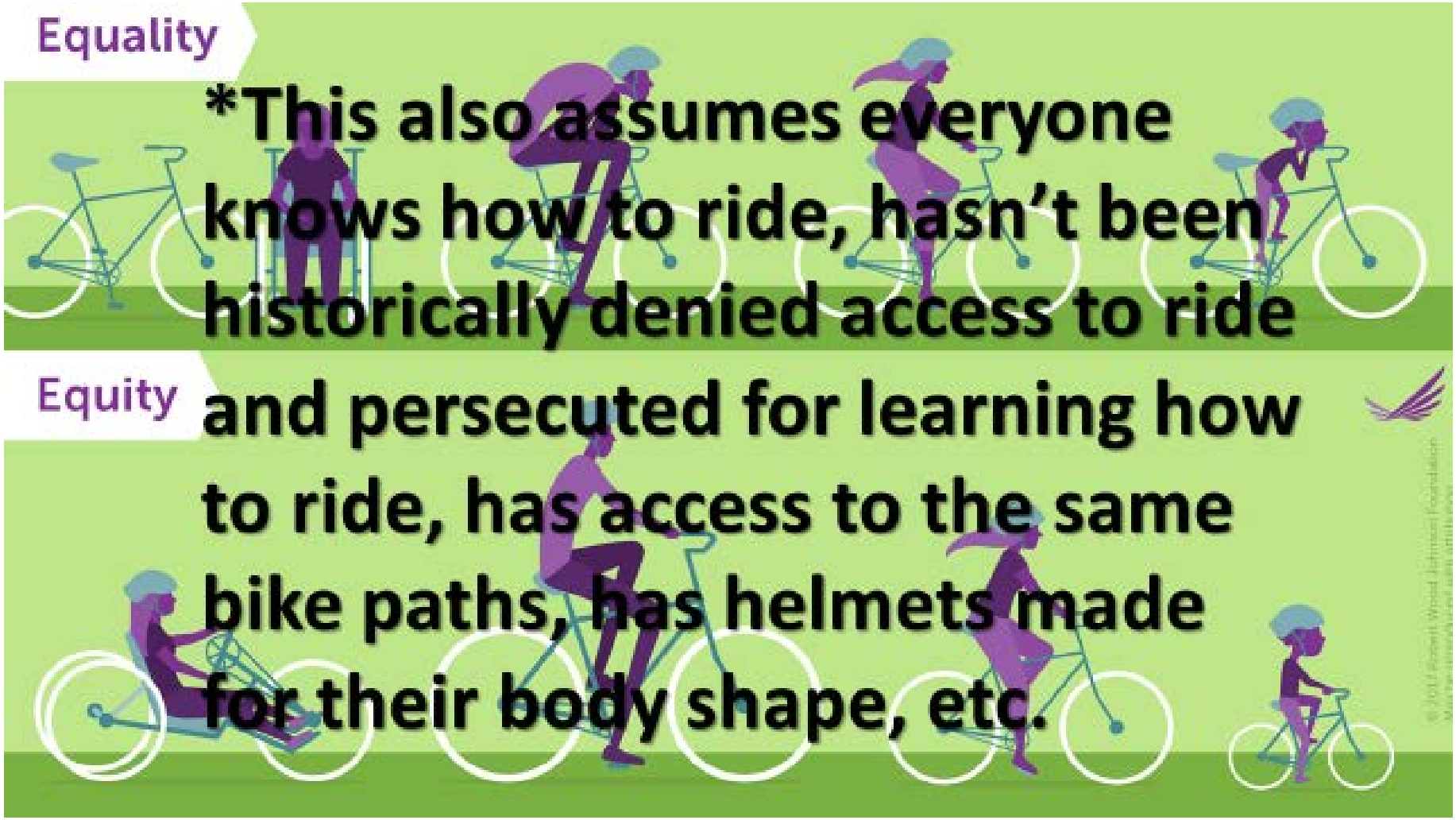
"The distribution of health outcomes within a population, the determinants that influence distribution, and the policies and interventions that affect the determinants."

David Kindig (2007)

NATIONAL COUNCIL FOR BEHAVIORAL HEALTH


National Behavioral Health Network
What is Health Equity?
"The distribution of health outcomes within a population, the determinants that influence distribution, and the policies and interventions that affect the determinants."
David Kindig (2007)
NATIONAL COUNCIL FOR BEHAVIORAL HEALTH


Equality
Equity


Equality
*This also assumes everyone knows how to ride, hasn't been historically denied access to ride
Equity
and persecuted for learning how to ride, has access to the same bike paths, has helmets made for their body shape, etc.

National Behavioral Health Network

Definitions of Health Equity

- "**Health equity** means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care." -RWJF
- "**Health equity** is achieved when every person has the opportunity to "attain his or her full health potential" and no one is "disadvantaged from achieving this potential because of social position or other socially determined circumstances." –CDC
- "**Health equity**" or "**equity in health**" implies that ideally everyone should have a fair opportunity to attain their full health potential and that no one should be disadvantaged from achieving this potential. -WHO

NATIONAL COUNCIL FOR BEHAVIORAL HEALTH

9

National Behavioral Health Network

10

Health Inequities

"The unjust distribution of health conditions"

(Whitehead and Dahlgreen, 2007)

NATIONAL COUNCIL FOR BEHAVIORAL HEALTH


National Behavioral Health Network
Do you have a different definition?
Did those definitions leave something out?
NATIONAL COUNCIL FOR BEHAVIORAL HEALTH

National Behavioral Health Network
For Tobacco & Cancer Control

Health Equity in Tobacco

Health Equity in Tobacco Prevention and Control: The opportunity for all people to live a healthy, tobacco-free life, regardless of *their race, level of education, gender identity, sexual orientation, the job they have, the neighborhood they live in, or whether or not they have a disability. –CDC

* *Or behavioral health condition*

NATIONAL COUNCIL FOR BEHAVIORAL HEALTH
Stronger Together.

WHAT DETERMINES OUR HEALTH?

Where we live, work, play and pray

National Behavioral Health Network

Determinants of health include:

- Conditions of birth (prenatal care/resources/healthcare education & support/positive parenting)
- Nutrition (access to healthy food, costs)
- Safe and habitable housing
- Environmental exposures
- Biological/genetic influences
- Historical factors and systems
- Psychosocial behaviors (tobacco, alcohol, illicit drugs)
- Stress/hopelessness/deprivation
- Education (duration & quality)
- Financial security
- Occupational opportunities & conditions
- Politics (influence, voice, advocacy) [Brunner, Marmot, 2008

NATIONAL COUNCIL FOR BEHAVIORAL HEALTH

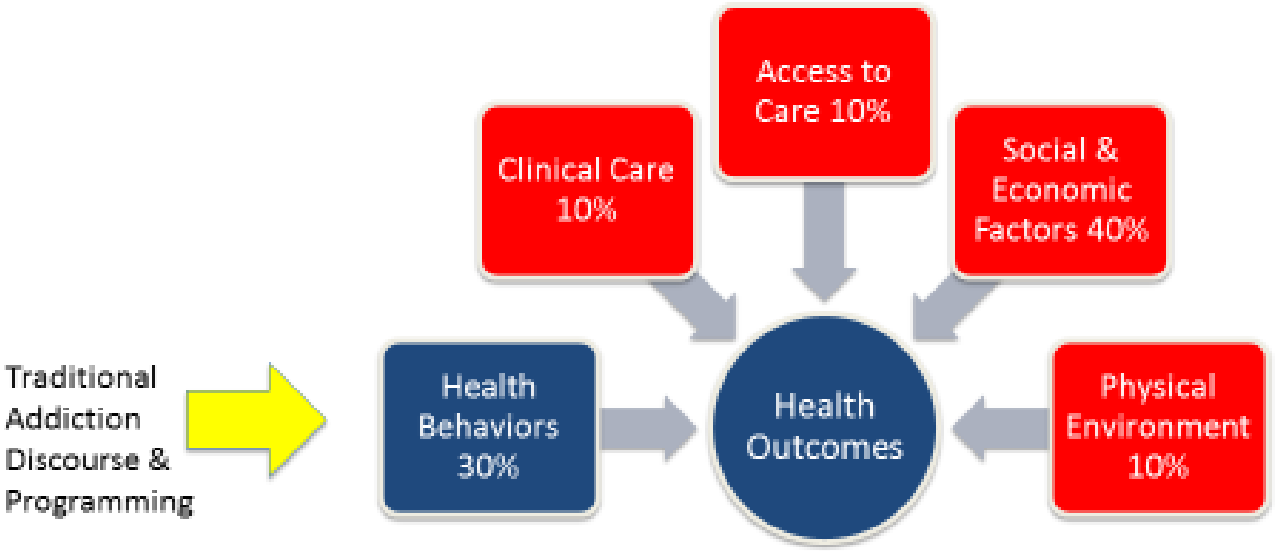
National Behavioral Health Network

Determinants of Health

NATIONAL COUNCIL FOR BEHAVIORAL HEALTH

National Behavioral Health Network

Determinants of Health



NATIONAL COUNCIL FOR BEHAVIORAL HEALTH

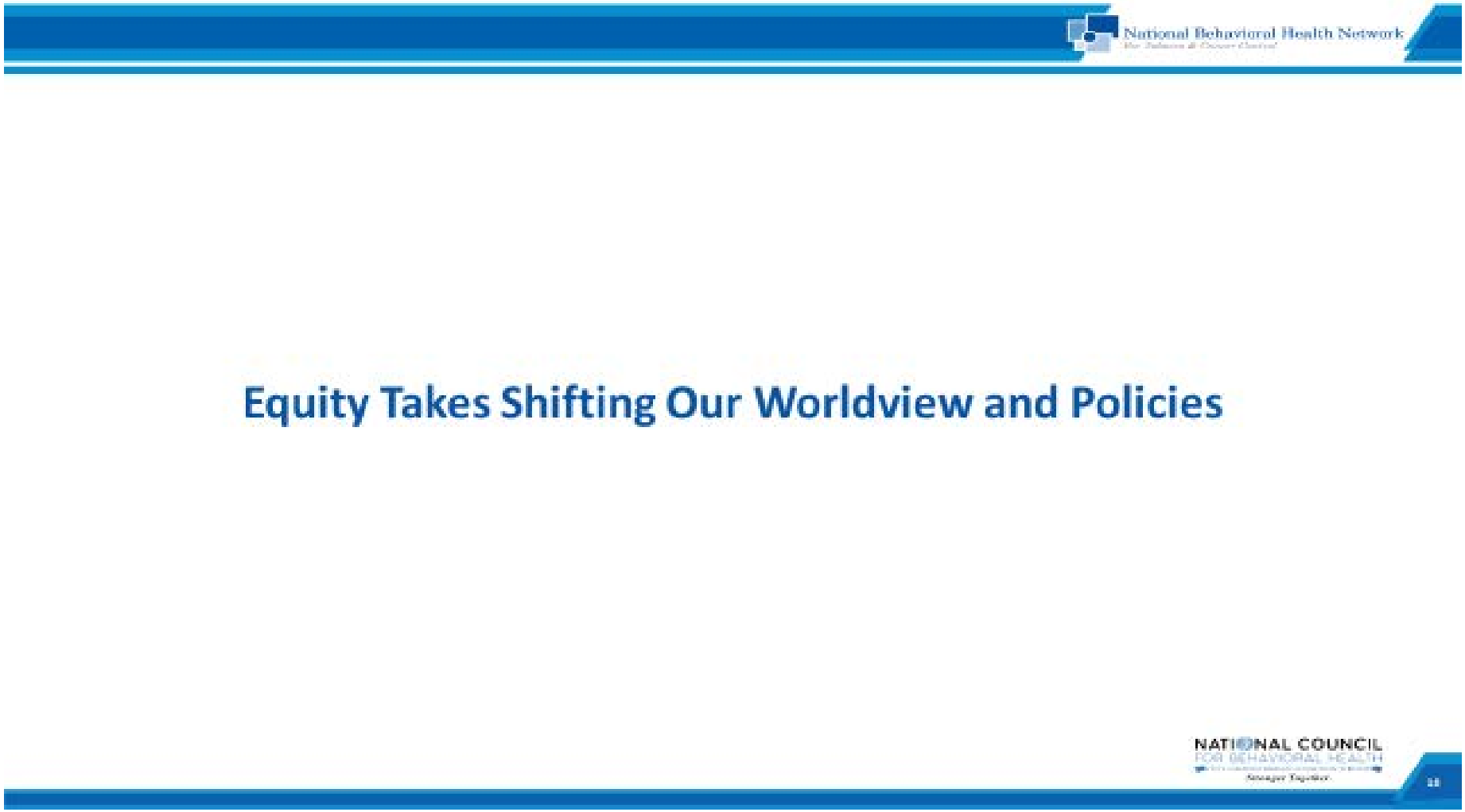
National Behavioral Health Network For Tobacco & Cancer Control

…so why do we only focus on tobacco cessation and traditional interventions?

- Conditions of birth (prenatal care/resources/healthcare education & support/positive parenting)
- Nutrition (access to healthy food, costs)
- Safe and habitable housing
- Environmental exposures
- Biological/genetic influences
- Historical factors and systems
- Psychosocial behaviors (tobacco, alcohol, illicit drugs)
- Stress/hopelessness/deprivation
- Education (duration & quality)
- Financial security
- Occupational opportunities & conditions
- Politics (influence, voice, advocacy) [Brunner, Marmot, 2008

NATIONAL COUNCIL FOR BEHAVIORAL HEALTH

17


National Behavioral Health Network
Equity Takes Shifting Our Worldview and Policies
NATIONAL COUNCIL

Why are Tobacco Use and Equity Still a Problem?

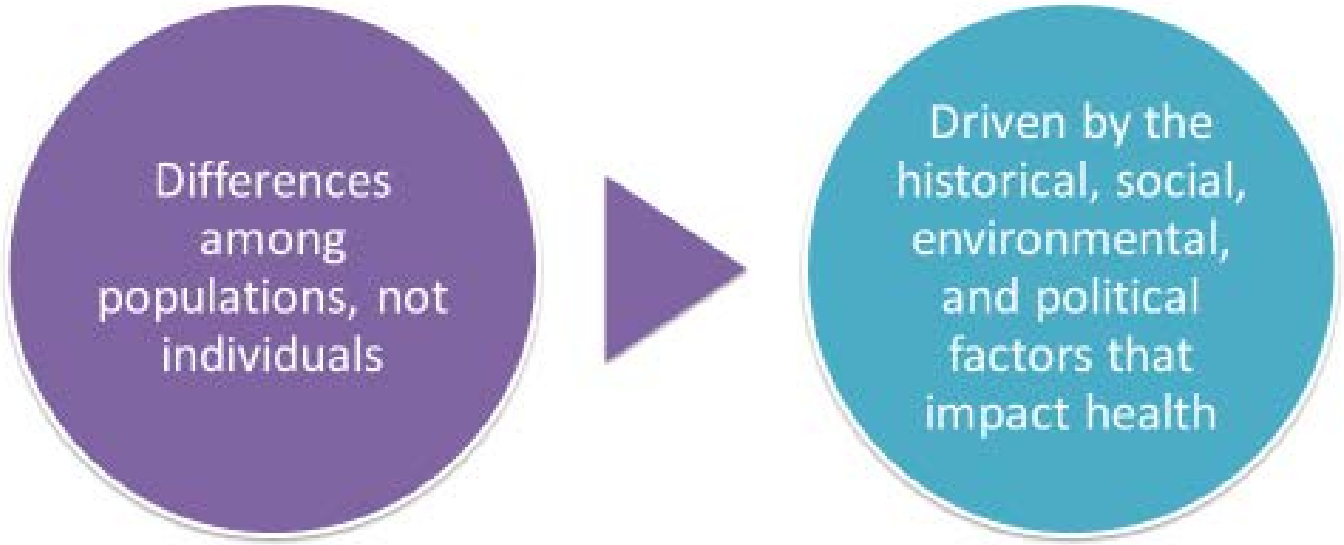
Predominant Narrative

Change the Narrative about What Creates Health

Alternative Worldview

National Behavioral Health Network

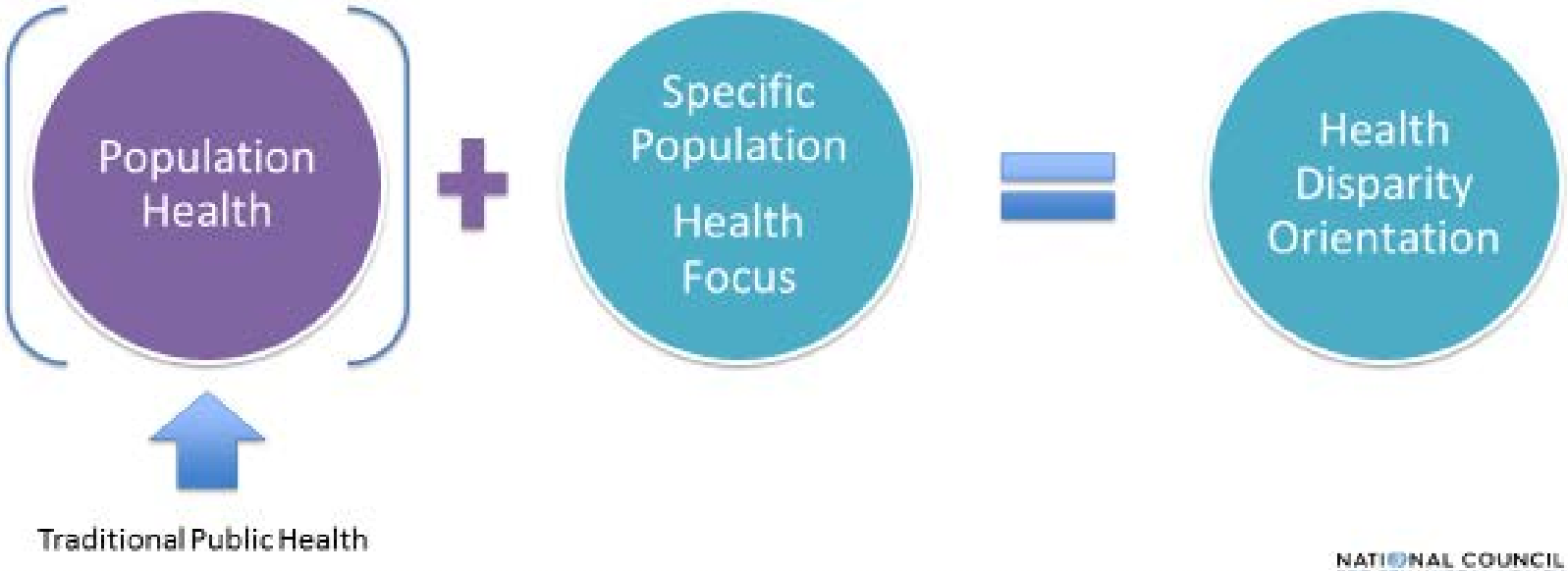
Health Disparities
Equity Takes Shifting Our Worldview and Policies



NATIONAL COUNCIL FOR BEHAVIORAL HEALTH

National Behavioral Health Network

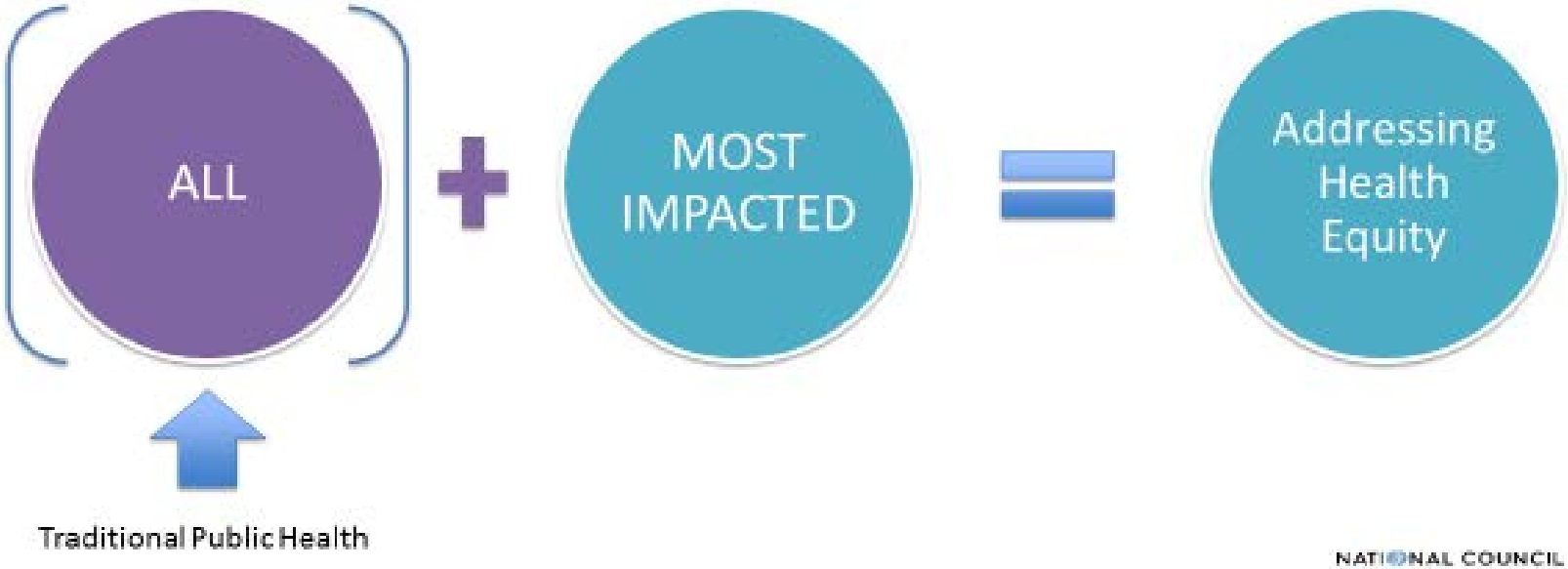
Philosophical Bridging in Public Health



NATIONAL COUNCIL FOR BEHAVIORAL HEALTH

National Behavioral Health Network

Philosophical Bridging in Public Health



NATIONAL COUNCIL FOR BEHAVIORAL HEALTH

National Behavioral Health Network

Things to Consider: Health Equity Operationalized

Operationalizing your tobacco cessation efforts within a health equity framework requires tobacco control practices and policies to meet the needs of different patients and populations in ways that reduce inequities and do not further cause disparities among the public.

- Identify and address barriers to prevention and care
- Base policies and practices on evidence-based research and interventions
- Ensure that actions can be evaluated and are measurable
- Understand that patients are people and come with unique living conditions and social situations (social determinants of health matter!)
- Act beyond your tobacco program, health inequities are part of a system-wide issue

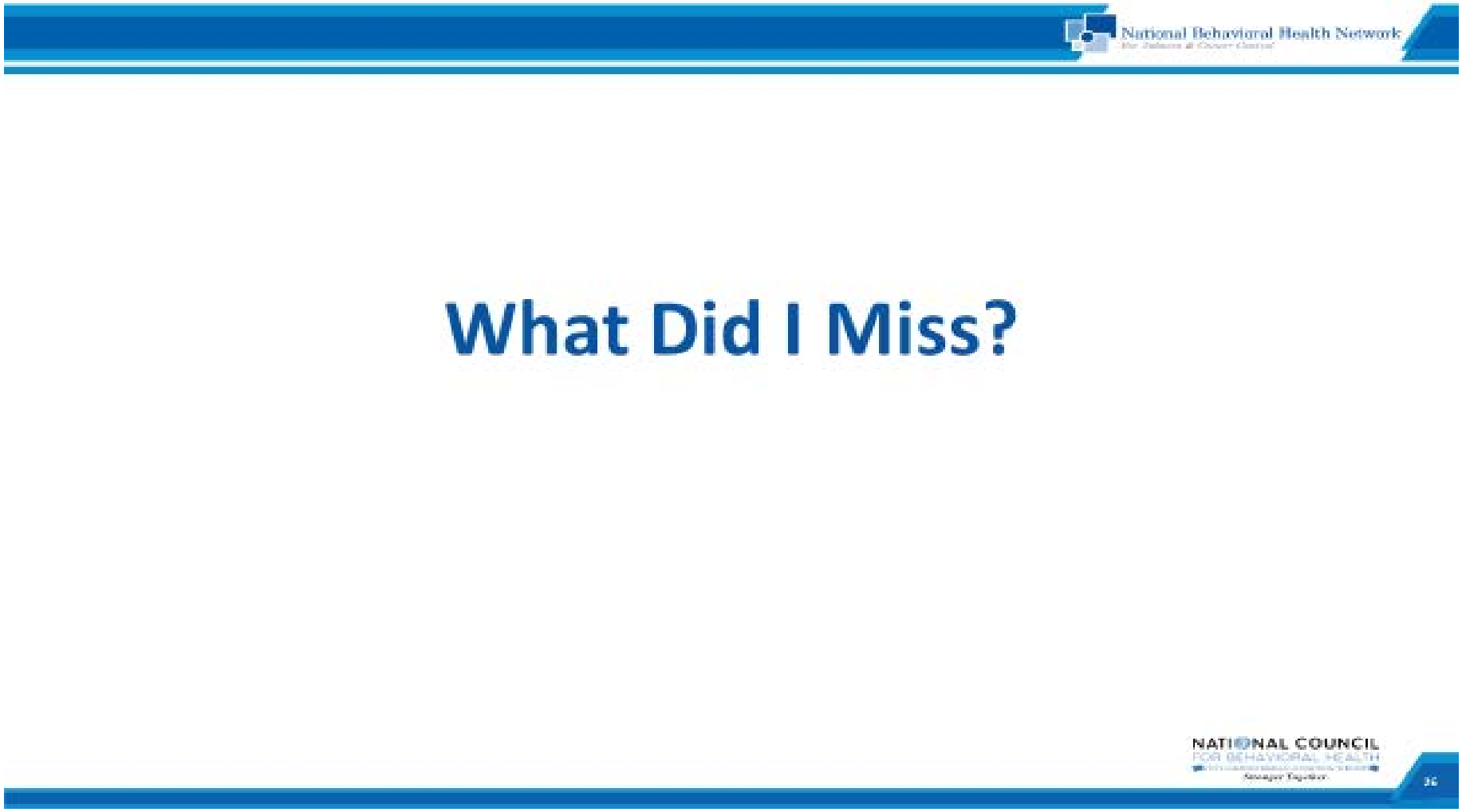
NATIONAL COUNCIL FOR BEHAVIORAL HEALTH

34

Implement a Health in All Policies Approach with Health Equity as the Goal

- Minimum Wage
- Paid Leave
- Ban the Box
- Transportation Policy
- Broadband connectivity
- E-Health Policies
- Affordable Housing
- Food Security
- Marriage Equity
- Payday Lending
- Minimum legal Age
- Smoke Free Air
  - Parks
  - Child Care/Foster Care
  - Automobiles
  - Behavioral Health Settings
  - Prisons
- Tobacco Tax
- Ban: Couponing; flavors; sponsorship/Marketing/ Promotion

Slide Source: Edward P. Ehlinger, MD, MSPH, Former Commissioner, Minnesota Department of Health, January 25, 2017


National Behavioral Health Network
What Did I Miss?
NATIONAL COUNCIL
FOR BEHAVIORAL HEALTH

National Behavioral Health Network

Impact of discrimination and racism on health

A FEW of the ways discrimination AND racism impact health include:

- Unequal treatment by medical system (e.g., implicit bias)
- Unequal access to medical services
- Unequal access to safe housing, employment, education, and social and economic opportunities (e.g., harmful social determinants of health)
- Increased toxic stress due to exposure to discrimination and racism, including implicit biases and microaggressions
- Increased exposure to environmental toxins and natural disasters

National Behavioral Health Network
For Tobacco & Cancer Control

Tobacco & Behavioral Health

The overall rate of cigarette smoking among adults has been falling steadily over the decades, but people with mental illnesses have been neglected. About 20% of American adults have a mental illness, but they smoke more than 30% of the cigarettes smoked by adults in the United States (CDC, 2013). **This disparity can be attributed to predatorial practices by tobacco companies which included:**

- Targeted advertisements
- Providing free or cheap cigarettes to psychiatric clinics
- Blocking of smoke-free policies in behavioral health facilities
- Funding research that perpetuates the myth that cessation would be too stressful and negatively impact overall behavioral health outcomes

And limited access to high quality care (delays in care, lower quality of care, and more)

NATIONAL COUNCIL FOR BEHAVIORAL HEALTH
Stronger Together.

Targeting by the Tobacco Industry

- Making financial contributions to organizations that work with mentally ill clients.
- Funding research to foster the myth that cessation would be too stressful because persons with mental illness use nicotine to alleviate negative mood
- Providing free or cheap cigarettes to psychiatric facilities.
- Supporting efforts to block smokefree psychiatric hospital policies
- Creating marketing plans that target marginalized populations, including mentally ill, homeless, and LGBT individuals (e.g., "Project SCUM").

Sources: CDC. Vital Signs: Current Cigarette Smoking Among Adults Aged ≥18 Years With Mental Illness—United States, 2009–2011. MMWR 2013;62(05):81-7; CDC. Best Practices User Guide: Health Equity in Tobacco Prevention and Control. Atlanta: U.S. Department of Health and Human Services, CDC, NCCDPHP, Office on Smoking and Health, 2015.

National Behavioral Health Network

NATIONAL COUNCIL FOR BEHAVIORAL HEALTH

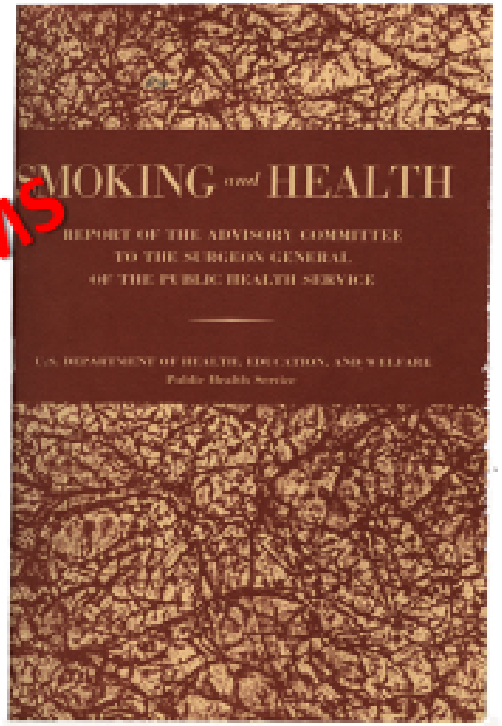
National Behavioral Health Network

What Changed in the General Population?

The 1964 the U.S. Surgeon General released the first report to examine the health consequences of tobacco use. This report changed the American perception, health care and public health attitudes towards tobacco use. From this report tobacco use was found to be….

- The most important cause of chronic bronchitis
- A cause of lung cancer and laryngeal cancer in men
- A probable cause of lung cancer in women

ACCESS
EDUCATION
SOCIAL NORMS
POLICIES
FUNDING



NATIONAL COUNCIL FOR BEHAVIORAL HEALTH

11

National Behavioral Health Network

50 Years Later…New Findings Emerged

Today we know that tobacco use can lead to many more types of cancers and chronic conditions other than those directly related to the lung thanks to the 2014 Report of the Surgeon General on Smoking and Health. Key findings from this report included:

- Smoking harms nearly every organ in the body
- Quitting smoking has both short- and long-term benefits for health
- Exposure to secondhand smoke causes cancer, respiratory and heart disease, and adverse health effects among children
- The list of diseases caused by smoking continues to grow

Yet for individuals with behavioral health conditions, prevention of smoking related illnesses often takes a back seat to the individual's mental illness leading to delayed diagnosis.

NATIONAL COUNCIL FOR BEHAVIORAL HEALTH

National Behavioral Health Network

Let's Finish the Sentence

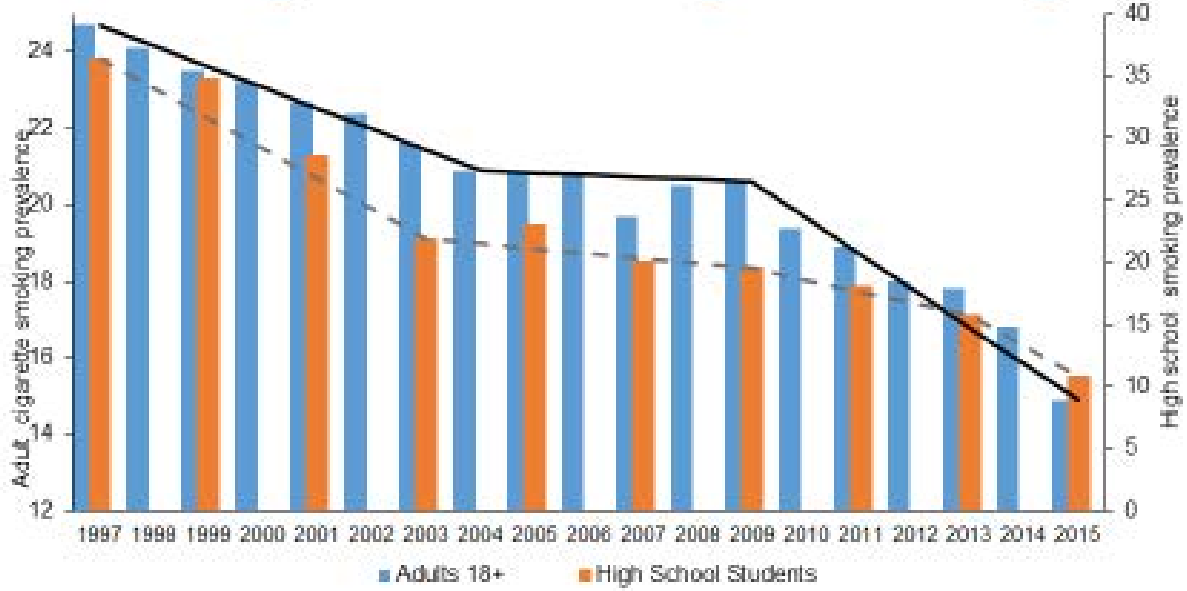
People with mental illness die on average 15 to 25 years earlier than those without mental illness...

due to complications from smoking-related illnesses.

NATIONAL COUNCIL FOR BEHAVIORAL HEALTH

National Behavioral Health Network

Overall Cigarette Smoking Is Trending Down

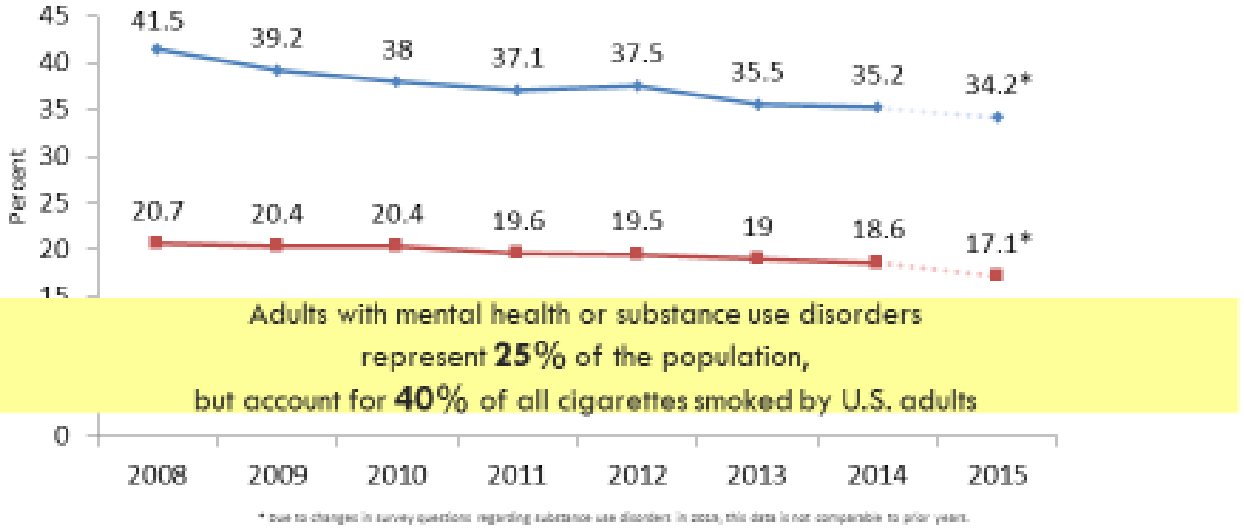


Source: slide courtesy of CDC; Adult cigarette smoking prevalence data are from the National Health Interview Survey (NHIS); 2015 data based on NHIS Early Release data for January-June; High
Source: data are from the National Youth Risk Behavior Survey.

NATIONAL COUNCIL FOR BEHAVIORAL HEALTH

National Behavioral Health Network

Current smoking among adults (age≥18) with past-year behavioral health (BH) condition: NSDUH, 2008–2015



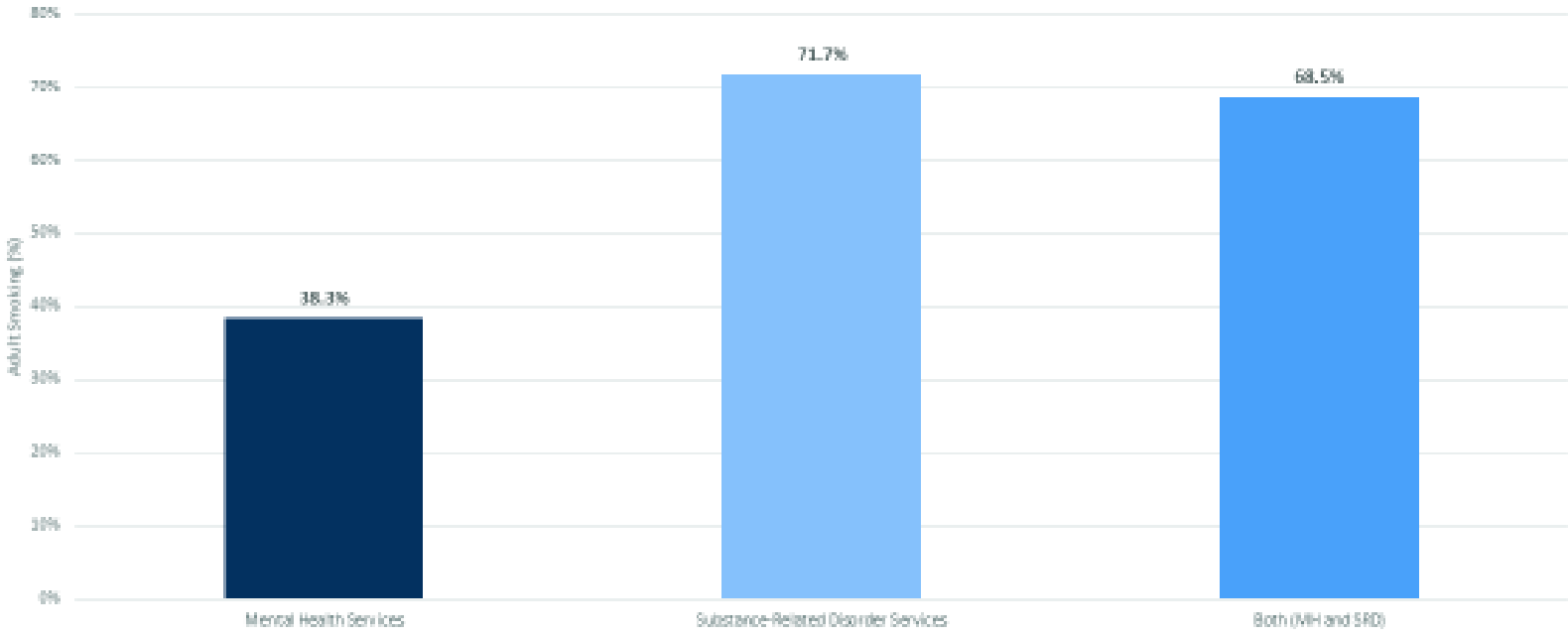
Adults with mental health or substance use disorders represent **25%** of the population, but account for **40%** of all cigarettes smoked by U.S. adults

* due to changes in survey questions regarding substance use disorders in 2015, this data is not comparable to prior years.

Sources: slide courtesy of SAMHSA. Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health (NSDUH), 2008-2015; SAMHSA, Center for Behavioral Health Statistics and Quality. The NSDUH Report: Adults With Mental Illness or Substance Use Disorder Account for 40 Percent of All Cigarettes Smoked [PDF–563 KB]. March 20, 2013. Rockville, MD [accessed 2016 May 18].

NATIONAL COUNCIL FOR BEHAVIORAL HEALTH

Figure 3: Adult Smoking Among Those Receiving Mental Health and/or Substance-Related Disorder Services, MD OMS Datamart CY 2017.



36

National Behavioral Health Network

Race/Ethnicity

31.8% American Indians/Alaska Natives

16.6% White

Education Level

40.6% GED

4.5% Graduate degree

Poverty Status

25.3% Below poverty

14.3% At or above poverty

Health Insurance

28.4% Uninsured
25.3% Medicaid
11.8% Private

Disability/limitation

21.2% Yes

14.4% No

Sexual orientation

20.5% Lesbian/Gay/Bisexual

15.3% Heterosexual

Serious Psychological Distress

35.8% Yes

14.7% No

Source: slide courtesy of CDC; Jamal A, Phillips E, Gentzke AS, et al. Current Cigarette Smoking Among Adults — United States, 2016. MMWR Morb Mortal Wkly Rep 2018;67:53–59.

NATIONAL COUNCIL FOR BEHAVIORAL HEALTH

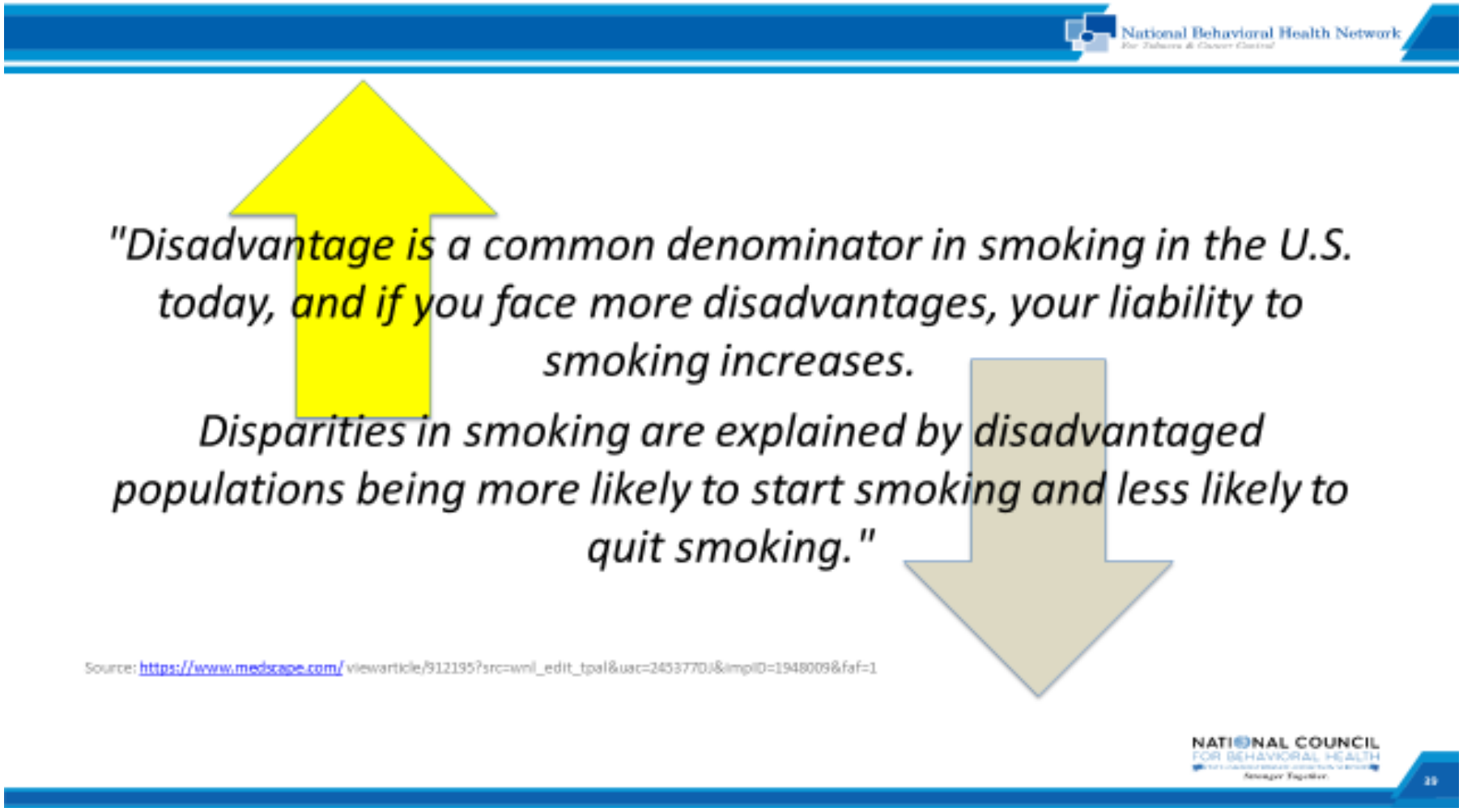
National Behavioral Health Network

Examining Risk

- The more adversities individuals face, the more likely they are to start smoking and the less likely they are to quit.
- Researchers examined data from 278,048 adults who were asked about smoking and six socioeconomic/health-related disadvantages: unemployment, poverty, low education, disability, serious psychological distress and heavy drinking.
  - > **About 14 percent of individuals without any of these forms of adversity smoked**
  - > **With each added disadvantage, smoking rates increased, rising to 58 percent among individuals with all six forms of adversity**

Source: https://www.medscape.com/viewarticle/912195?src=wnl_edit_tpal&uac=245377DJ&impID=1948009&faf=1

NATIONAL COUNCIL FOR BEHAVIORAL HEALTH


National Behavioral Health Network
"Disadvantage is a common denominator in smoking in the U.S. today, and if you face more disadvantages, your liability to smoking increases.
Disparities in smoking are explained by disadvantaged populations being more likely to start smoking and less likely to quit smoking."
Source: https://www.medscape.com/viewarticle/912195?src=wnl_edit_tpal&uac=245377DJ&impID=1948009&faf=1
NATIONAL COUNCIL FOR BEHAVIORAL HEALTH
19

National Behavioral Health Network

Tobacco Interventions by Behavioral Health Facilities

Intervention	Mental Health Tx Facilities	Substance Abuse Tx Facilities
	2017	2017
Tobacco Use Screening	51.5%	66.0%
Cessation Counseling	39.1%	49.5%
Nicotine Replacement Therapy	25.6%	27.1%
Non-nicotine Cessation Medications	22.8%	21.3%
Smokefree Building/ Grounds	49.9%	34.8%

Sources: National Mental Health Services Survey (N-MHSS): 2017. Data on Mental Health Treatment Facilities; National Survey of Substance Abuse Treatment Services (N-SSATS): 2017. Data on Substance Abuse Treatment Facilities.

NATIONAL COUNCIL FOR BEHAVIORAL HEALTH

National Behavioral Health Network

Tobacco Cessation in BH Populations– The Facts

- The majority of persons with mental illness and substance use disorders want to quit smoking [1,2]
- **Smokers are more than 2x likely to quit for good with the help of tobacco cessation medications and counseling services.**
- Persons with mental illness and substance abuse disorders can successfully quit using tobacco at rates similar to the general population. [3]
- **Smoking cessation can enhance long-term recovery for persons with substance use disorders.** For example, if someone quit smoking at the same time they are quitting drinking, they can have a 25% greater chance of staying clean and sober. [4]

Sources: [1] Acton et al. Depression and stages of change for smoking in psychiatric outpatients. Addictive Behaviors. 2001; 26(5):621-31. [2] Prochaska et al. Return to smoking following a smoke-free psychiatric hospitalization. Am J Addiction. 2006; 15(1):15-22. [3] Heiligenstein E, Smith SS. Smoking and mental health problems in treatment-seeking university students. Nicotine & Tobacco Research. 2006;8(4):519-23 [4] Prochaska, Judith J; Delucchi, Kevin; & Hall, Sharon M. A meta-analysis of smoking cessation interventions with individuals in substance abuse treatment or recovery.. Journal of consulting and clinical psychology. 2004; 72(6), 1144 - 1156. Retrieved from: http://escholarship.org/uc/item/0r8673wv

NATIONAL COUNCIL FOR BEHAVIORAL HEALTH

National Behavioral Health Network
For Tobacco & Cancer Control

Tobacco Disparities By the Numbers in BH Populations

Compared to the general population, smoking is 3-5X more common among people with a behavioral health diagnosis

- Drug use disorder: 65-85%
- Alcohol use disorder: 55-65%
- Bipolar and unipolar depression: 36-80%
- Schizophrenia: 62-90%
- Chronic anxiety: 30-46%

NATIONAL COUNCIL FOR BEHAVIORAL HEALTH
Stronger Together

National Behavioral Health Network
For Tobacco & Cancer Control

"INCLUSION IS THE MUSCLE OF DIVERSITY, AND EQUITY IS IT'S CONSCIENCE AND SOUL."

So we know not all groups continue to smoke at the same rate, and we know there are emerging needs that are growing disparities too…**how can we change all of these outcomes?**

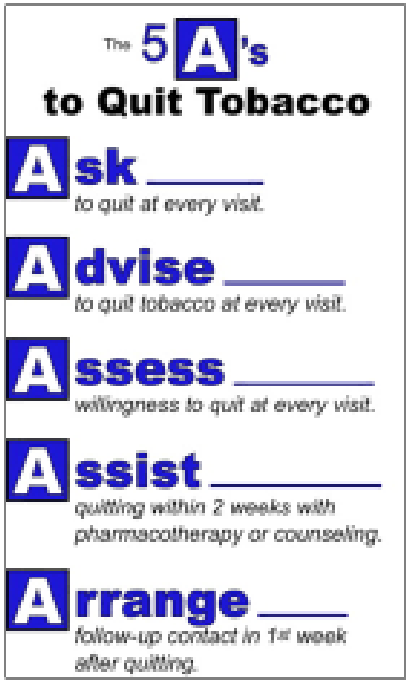
NATIONAL COUNCIL FOR BEHAVIORAL HEALTH

43

Source Slide Courtesy of SAMHSA: Substance Abuse and Mental Health Services Administration. "Tobacco and Behavioral Health: The Issue and Resources." https://www.samhsa.gov/sites/default/files/topics/alcohol_tobacco_drugs/tobacco-behavioral-health-issue-resources.pdf [accessed 2018 May 11].

National Behavioral Health Network
For Tobacco & Cancer Control

Best Practices, What Works, and How Can We Make What Works Even Better?



De-mystify tobacco use in behavioral health populations and increase provider education.

- Train behavioral health providers in the tobacco addiction process, diagnosis, and evidence-based tobacco addiction management.
- Require staff responsible for treating tobacco dependence to demonstrate competency in providing evidence-based tobacco treatment.
- Provide ongoing continuing education opportunities for tobacco treatment training

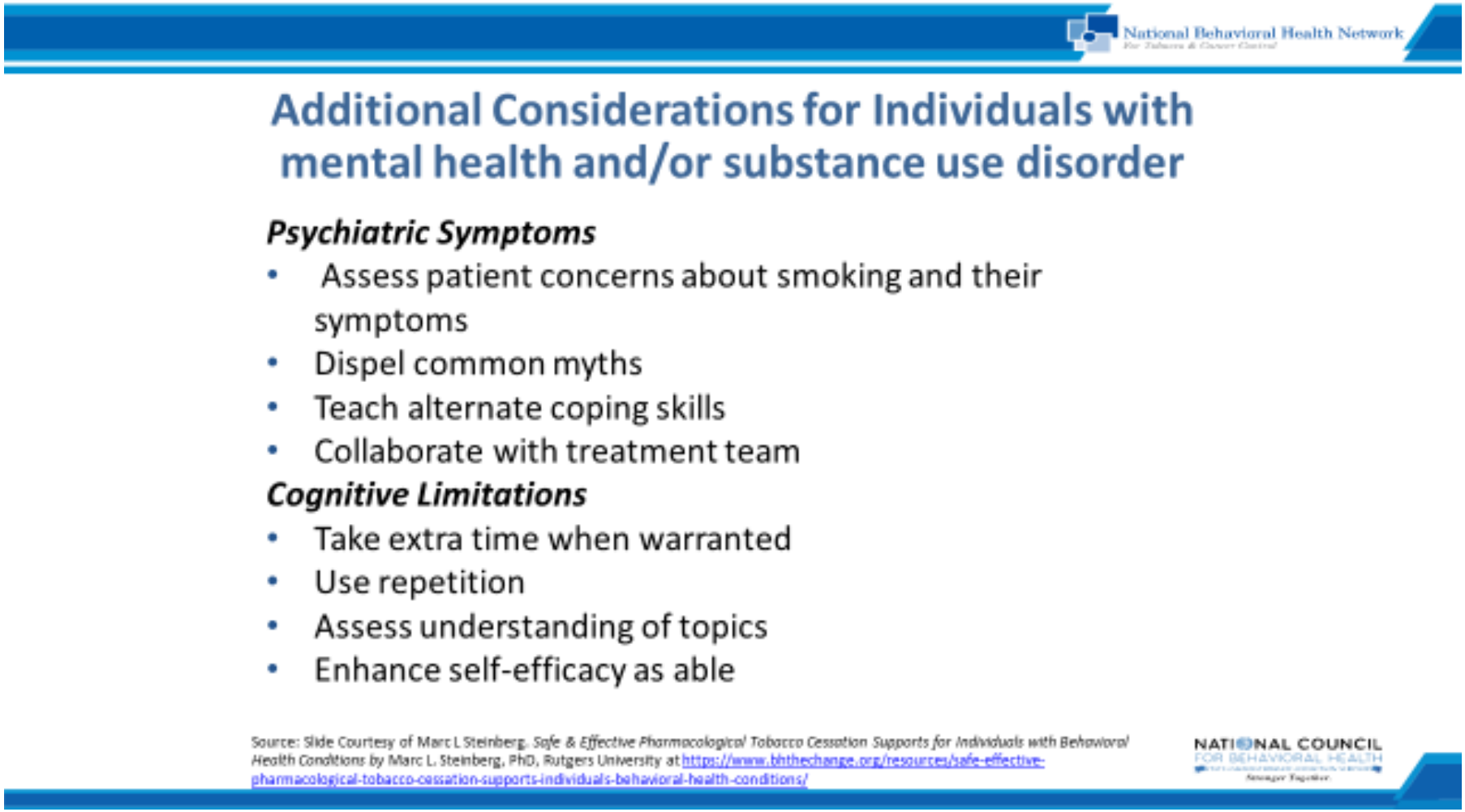
NATIONAL COUNCIL FOR BEHAVIORAL HEALTH

National Behavioral Health Network

Strategies for Co-Treatment of Tobacco and Other Substances

- Screen for tobacco use and dependence at treatment intake, concurrent with assessment for other chemical dependencies.
- Develop and implement tobacco treatment plans for tobacco users that address both behavioral and pharmaceutical treatment.
- Document tobacco diagnoses in client charts using DSM or ICD criteria.
- Use available billing procedures and codes to maximize reimbursement and sustain services.
- Provide discharge plans to facilitate transitions in care and provide referrals for continued support.
- Promote use of the quitline.

NATIONAL COUNCIL FOR BEHAVIORAL HEALTH


National Behavioral Health Network
Additional Considerations for Individuals with mental health and/or substance use disorder
Psychiatric Symptoms
Assess patient concerns about smoking and their symptoms
Dispel common myths
Teach alternate coping skills
Collaborate with treatment team
Cognitive Limitations
Take extra time when warranted
Use repetition
Assess understanding of topics
Enhance self-efficacy as able
Source: Slide Courtesy of Marc L Steinberg. Safe & Effective Pharmacological Tobacco Cessation Supports for Individuals with Behavioral Health Conditions by Marc L. Steinberg, PhD, Rutgers University at https://www.bhthechange.org/resources/safe-effective-pharmacological-tobacco-cessation-supports-individuals-behavioral-health-conditions/
NATIONAL COUNCIL FOR BEHAVIORAL HEALTH

RECOVERY Orientation

The Quality of Recovery is Up To and Individual
AND
PROVIDERS CAN SUPPORT INDIVIDUALS IN LIVING THIS RICHER HEALTHIER LIFE

-Understand the difference between a treatment plan (basic, cognitive, clinical) and a recovery plan (self determination, goal development and a plan to enhance recovery, holistic and addresses overall wellness)

- **Empower** individuals to make their own decision about health and wellness and actively encourage it with all the tools and resources possible to make those decisions and the support to reach those goals.

National Behavioral Health Network

Health Equity in Tobacco Prevention and Control: The opportunity for all people to live a healthy, tobacco-free life, regardless of their race, level of education, gender identity, sexual orientation, the job they have, the neighborhood they live in, or whether or not they have a disability. -CDC

What is Missing?

MARYLAND

MISSION

The mission of the Tobacco Use Prevention and Cessation Program is to reduce the use of tobacco products in Maryland, thereby reducing the burden of tobacco-related morbidity and mortality on the population.

VISION

The Tobacco Use Prevention and Cessation Program envisions a future in which all residents of Maryland can lead healthy, productive lives free from disease and cancer caused by the use of tobacco.

NATIONAL COUNCIL FOR BEHAVIORAL HEALTH


National Behavioral Health Network
THANK YOU!
Want to learn more about tobacco and behavioral health?
Visit www.BHtheChange.org
NATIONAL COUNCIL
FOR BEHAVIORAL HEALTH