STATE OF MARYLAND
DHMH

Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

December 26, 2014

The Honorable Peter A. Hammen
Chairman, Health and Government Operations Committee
Maryland House of Delegates
6 Bladen Street, Room 241
Annapolis, MD 21401

The Honorable Sandy Rosenberg
Delegate, District 41
Maryland House of Delegates
6 Bladen Street, Room
Annapolis, MD 21401

Dear Chairman Hammen and Delegate Rosenberg:

The Department of Health and Mental Hygiene respectfully submits this report on the funding necessary for Cigarette Restitution Fund–eligible programs to implement the actions recommended in the U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, *Best Practices for Comprehensive Tobacco Control Programs — 2014*.

If you have any questions regarding this report, please contact Ms. Allison Taylor, Director of Governmental Affairs, at 410-767-6481.

Sincerely,

Joshua M. Sharfstein, M.D.
Secretary

Enclosure

cc: Allison Taylor, Director, Office of Governmental Affairs
Laura Herrera Scott, Deputy Secretary, Public Health Services
Michelle Spencer, Director, Prevention and Health Promotion Administration
Donna Gugel, Deputy Director, Prevention and Health Promotion Administration
Donald Shell, Director, Cancer and Chronic Disease Bureau
Dawn Berkowitz, Director, Center for Tobacco Prevention and Control

STATE OF MARYLAND
DHMH

Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

February 27, 2014

The Honorable Peter A. Hammen
Chairman, Health and Government Operations Committee
Maryland House of Delegates
6 Bladen Street, Room 241
Annapolis, MD 21401

The Honorable Sandy Rosenberg
Delegate, District 41
Maryland House of Delegates
6 Bladen Street, Room
Annapolis, MD 21401

Dear Chairman Hammen and Delegate Rosenberg:

House Bill 1070, *Department of Health and Mental Hygiene – Cigarette Restitution Fund – Report*, would require the Department of Health and Mental Hygiene (Department) to report to the General Assembly on the funding necessary for Cigarette Restitution Fund–eligible programs to implement the actions recommended in the U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, *Best Practices for Comprehensive Tobacco Control Programs — 2014.*

The Department intends to conduct this study, including a discussion of the most effective means to fulfill those recommendations, and report to the Maryland General Assembly by November 1, 2014.

If you have any questions, please contact Ms. Allison Taylor, Director of Government Affairs, at (410) 767-6480.

Sincerely,

Joshua M. Sharfstein, M.D.
Secretary

MARYLAND
Best Practices in Tobacco Control
A Blueprint for Reducing the Human and Economic Burden of Tobacco-Related Disease in Maryland

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

Martin O'Malley
Governor
State of Maryland

Anthony G. Brown
Lieutenant Governor
State of Maryland

Joshua M. Sharfstein, MD
Secretary
Department of Health and Mental Hygiene

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TABLE OF CONTENTS

Forward

The year 2014 marks the 50th anniversary of the landmark 1964 report of the U.S. Surgeon General warning the public about the health consequences of smoking, and the 15th anniversary of Maryland's participation in the Master Settlement Agreement with the tobacco industry.[1, 2] As such, it is timely that this report examines how Maryland can best position itself to move forward to reduce tobacco-related disease and the human and economic toll that these diseases impose on Maryland residents.

Maryland has made substantial progress in tobacco control. Today a lower percentage of adults and youth smoke than ever before, and more of those who do smoke are quitting, fueled in part by free evidence-based cessation programs available through every local health department and the Maryland Tobacco Quitline, 1-800-QUIT-NOW.[3, 4] Involuntary exposure to secondhand smoke has decreased markedly as smoking is not allowed in public indoor places such as schools, workplaces, restaurants, and bars.

However, a great deal more work needs to be done to protect Marylanders from the avoidable morbidity and mortality caused by tobacco use, as well as the economic toll to the state. "Underage" youth (less than 18 years of age) now smoke cigars as frequently as they smoke cigarettes, and increasingly use multiple types of tobacco products interchangeably – fruit and candy flavored cigars are the most prevalent. While the statewide rate of underage youth using any kind of tobacco may appear relatively low at 15.7%, only three Maryland counties have rates lower than that; the remaining 21 jurisdictions have higher rates. County rates of underage tobacco use range as high as 33.1% with half of Maryland jurisdictions in excess of 20.0%.

A forthcoming report by the Substance Abuse and Mental Health Services Administration will document that during federal fiscal year 2013 Maryland was the only state in the nation where more than 20.0% of licensed tobacco retailers were found to be selling tobacco to underage youth. Overall, 24.1% of licensed tobacco retailers in Maryland were selling tobacco to underage youth, and a number of jurisdictions were selling at rates as high as 50.0%. Furthermore, although federal law requires retailers to check photo identification of people who appear to be under 27 years of age, underage youth report they are not asked for identification 44.0% to 58.2% of the time, depending on the jurisdiction (see Appendix B).

Similar challenges exist with adult tobacco use. Smoking decreased between 2000 and 2008, but rates remained mostly static over the next five years – in 2008, 14.9% of adults smoked cigarettes, as compared to 15.2% in 2010, and 16.4% in 2013 (the increase was not statistically significant). Smoking is most prevalent among low-socioeconomic status populations; for example, 29.1% of adults with less than a high school education smoke as compared to 6.2% among those adults with a college degree. Eighteen of Maryland's 24 jurisdictions have rates of adult cigarette smoking above the state average of 16.4% – ranging from a low of 8.2% to a high of 25.9%.

Before Maryland can significantly reduce the human and economic toll that tobacco-related diseases inflict on state residents and Maryland's economy, efforts to reduce the use of tobacco must be enhanced to match the recommendations of the Centers for Disease Control and Prevention (CDC) for comprehensive tobacco control programs in Maryland.

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[1] Smoking and Health: Report of the Advisory Committee of the Surgeon General of the Public Health Service, http://profiles.nlm.nih.gov/NN/B/B/M/Q/

[2] Master Settlement Agreement (1998), http://publichealthlawcenter.org/sites/default/files/resources/master-settlement-agreement.pdf

[3] In 2013 16.4% of Maryland adults 18 years of age or older smoked cigarettes as compared to 20.5% in 2000.

[4] In 2013 11.0% of underage Maryland public high school youth smoked cigarettes as compared to 23.0% in 2000.

1 THE USE OF TOBACCO PRODUCTS IN MARYLAND

Tobacco products are used by a significant number of Maryland youth, young adults, and older adults. Statewide, general population estimates of tobacco use can be helpful, but it is important to recognize that such estimates are averages, and may conceal much higher use among specific sub-populations and/or geographic regions within the State. In this section, tobacco use across the State and the general population is documented, along with tobacco use by geographic area and select sub-populations.

1.1 THE USE OF TOBACCO BY MARYLAND YOUTH[5]

Persons less than 18 years of age (underage youth) are not permitted to possess, use, or purchase tobacco products in Maryland unless they possess the tobacco products in the course of their employment, and retailers are not permitted to sell or distribute tobacco products to underage youth. Nonetheless, more than 52,000 underage youth report that they currently use one or more types of tobacco products (17.7% of underage high school youth and 6.7% of middle school youth).

Flavored cigars are smoked by almost 84% of the Maryland high school youth who are using flavored tobacco products.

Use of Tobacco Products. Statewide, 16.9% of Maryland high school students currently use one or more types of tobacco products. However, use of any tobacco varies considerably among Maryland's 24 major political jurisdictions – from a low of 11.5% in Howard County to a high of 34.3% in Garrett County. Because the most populous jurisdictions have the lowest rates of tobacco use, the statewide rate of 16.9% does not adequately convey the challenges of tobacco use by youth in Maryland; 20 of Maryland's 24 jurisdictions have rates of high school tobacco use exceeding 16.9% – and fourteen counties had rates exceeding 20.0%.

Concurrent Use of Multiple Types of Tobacco Products. Maryland high school youth use a variety of tobacco products, often interchangeably. Overall, 16.9% used some form of tobacco in the past 30 days – 12.5% reporting smoking a cigar, 11.9% smoking a cigarette, and 7.4% using smokeless tobacco. In the span of just a few years, use of multiple tobacco products during the past 30 days by underage Maryland public high school youth increased from 42.6% (2010) to 47.9% (2013) of current tobacco users.

Over 13.0% of Maryland public high school youth report using flavored tobacco products (see Appendix A for county-level data) and 83.8% of that subset use flavored cigars. Fruit and candy flavors are preferred by the majority of high school youth.

National Ranking by Use. Nationally, 50.0% of the states who reported data in 2013 on current cigar use by high school students had lower rates of cigar smoking than Maryland; 31.7% of states reporting on cigarette smoking had lower rates of cigarette smoking by high school students, and 26.3% of states reporting on smokeless tobacco use had lower rates of smokeless tobacco use. [6]

Attitudes About Tobacco Use Among Maryland Youth. One of the goals of tobacco control is to decrease positive perceptions of tobacco use among underage youth. These perceptions arise from

[5] Unless otherwise specifically noted, all data in sections 1.1 and 1.2 are from the spring 2013 Maryland Youth Tobacco and Risk Behavior Survey conducted by the Maryland Department of Health and Mental Hygiene. Unless specifically noted as being for underage youth, data are for youth of any age in the respective school type, thereby allowing for national and state comparisons to be made.

[6] States reporting 2013 YRBS data for each tobacco product. Source: http://www.cdc.gov/HealthyYouth/yrbs/

portrayals of tobacco use in movies, social media, advertising, as well as by peer and adult role models. Absent health messaging to counter these portrayals of tobacco use, underage Maryland youth are all too often left with only messages delivered about the dangers of tobacco use as part of their school curricula.

Among *non-smokers,* there has been an increase of 63.5% in the proportion of youth believing that smoking helps a youth to 'fit in' or 'look cool' (12.6% in 2000 and 20.6% in 2013) and an 84.4% increase in the proportion of youth believing that youth who smoke have more friends (19.9% in 2000 and 36.7% in 2013).

Among cigarette smokers, there has been an increase of 46.0% in the proportion of youth believing that smoking helps a youth to 'fit in' or 'look cool' (27.4% in 2000 and 40.0% in 2013) and a 52.8% increase in the proportion of youth believing that youth who smoke have more friends (33.9% in 2000 and 51.8% in 2013).

Other Tobacco-Related Youth Issues. Underage high school youth who report smoking cigarettes are also more likely to report drinking alcohol, using marijuana, abusing prescription drugs, or using other illegal drugs compared with non-smoking youth. Approximately 79.4% of underage high school cigarette smokers report that they currently use alcohol (i.e., have had one or more drinks of alcohol in the past 30 days), compared with 23.7% of non-smokers. Similarly, 67.0% of underage high school cigarette smokers reported they currently use marijuana (i.e., have smoked marijuana during the past 30 days), compared with 12.6% of non-smokers. Despite decreased smoking prevalence, the proportion of cigarette smokers who use alcohol has not changed.

E-cigarettes and similar devices are increasingly popular among youth, and are not being used to help them quit smoking. The CDC announced in August 2014 that "[m]ore than a quarter of a million youth who had never smoked a cigarette used [e-cigarettes] in 2013," a three-fold increase between 2011 and 2013.[7] "The data, which comes from the 2011, 2012, and 2013 National Youth Tobacco surveys of middle and high school students, show that youth who had never smoked conventional cigarettes but who used e-cigarettes were almost twice as likely to have intentions to smoke conventional cigarettes as those who had never used e-cigarettes. Among non-smoking youth who had ever used e-cigarettes, 43.9% said they have intentions to smoke conventional cigarettes within the next year, compared with 21.5% of those who had never used e-cigarettes."[8]

1.2 UNDERAGE RETAIL ACCESS TO TOBACCO IN MARYLAND

It is illegal in the United States and under Maryland criminal law to sell any kind of tobacco product to a person less than 18 years of age. Tobacco product retailers are required under federal law to ask for and check photo identification of all persons who reasonably appear to be less than 27 years of age in connection with every attempt to purchase a tobacco product. In addition, Maryland law prohibits persons less than 18 years of age from possessing tobacco products, except as a necessary part of their employment, such as a cashier in a store selling tobacco products.

In Maryland, retailer compliance with restrictions on the sale of tobacco products is monitored in three ways: (1) compliance checks conducted under the auspices of the federal Food and Drug Administration (FDA); (2) local compliance inspections conducted by law enforcement personnel under Maryland law, and local enforcement of existing local restrictions on youth access to tobacco products; and (3) inspections conducted under the auspices of the federal "Synar" amendment.

[7] See http://www.cdc.gov/media/releases/2014/p0825-e-cigarettes.html.
[8] *Id.*

Federal Enforcement of Youth Access Restrictions. Enforcement of federal requirements primarily falls under the jurisdiction of the FDA, which in turn contracts with individual state agencies (in Maryland this is the Department of Health and Mental Hygiene (DHMH) Behavioral Health Administration) to conduct compliance checks of licensed tobacco retailers, and to forward results of those visits to the FDA for action on any violations. Protocols for conducting FDA-based compliance visits were developed by the FDA and are uniform across the nation. Violations may result in warning letters and fines, and in extreme circumstances of multiple offenses, no tobacco sales orders (an order prohibiting the retailer from selling tobacco).

State and Local Enforcement of Youth Access Restrictions. Though Maryland criminal law prohibits the sale and distribution of tobacco products to persons less than 18 years of age, there is not a state requirement that retailers request and check photo identification in connection with tobacco sales. Because the state law restricting access to tobacco is criminal in nature, enforcement is primarily the responsibility of local law enforcement agencies. However, a number of counties (Baltimore, Carroll, Cecil, Garrett, Howard, Kent, Montgomery, Prince George's, and St. Mary's Counties, as well as Baltimore City) have enacted laws that create civil penalties for the sale of tobacco products to underage youth, so that enforcement actions can be taken by local health departments and liquor boards, or other agencies as designated. Every county and Baltimore City is provided funding from the Cigarette Restitution Fund which can be used to enforce either criminal or civil youth access restrictions.

The "Synar" Amendment and Inspections. In 1992 the federal Alcohol, Drug Abuse, and Mental Health Reorganization Act was adopted, including an amendment authored by Congressman Synar of Oklahoma (commonly referred to as the 'Synar Amendment'), requiring every state to enact and enforce laws prohibiting the sale or distribution of tobacco products to persons less than 18 years of age. In Maryland, the DHMH Behavioral Health Administration conducts all Synar inspections. These inspections document compliance with Synar standards. The state tobacco retailer violation rate cannot exceed 20.0%. A Synar compliance inspection itself does not result in a retailer being fined or otherwise disciplined, however, Maryland does combine Synar and FDA inspections in many instances, so if a violation is found, it may result in action by the FDA. Maryland law is not at issue during these inspections as they are federally sanctioned, and the persons conducting them are not law enforcement officers (law enforcement officers are required for enforcement of Maryland statewide youth access restrictions on the sale of tobacco products).

Penalties for Non-Compliance with Synar Standards. Synar imposes significant penalties for states whose tobacco retailers have a violation rate in excess of the 20.0% standard. When the tobacco retailer violation rate exceeds the standard, the State jeopardizes 40.0% of its federal Substance Abuse Prevention and Treatment Block Grant award, risking tens of millions of federal dollars for treating substance abuse. A lesser alternative penalty is available to the state if:

- The state commits additional state funds to youth access enforcement equal to 1.0% of its current Substance Abuse Prevention and Treatment Block Grant award for each percentage point that the state violation rate exceeds 20.0%; and

- The state certifies that the additional funds will supplement and not supplant funds used for tobacco prevention programs and compliance activities in the preceding fiscal year.

Maryland Tobacco Retailer Violation Rate – 24.1% Violation Rate. Based upon Synar inspections conducted in federal fiscal year 2013 (October 2012 through September 2013), Maryland's tobacco retailers have been found in excess of the 20.0% violation maximum. These findings will be published in

the federal fiscal year 2014 Synar Report, anticipated to be released June 2015. Maryland's tobacco retailers are the only tobacco retailers in the nation since 2005 in violation of the Synar compliance standard. Violation rates at the county level ranged from 0.0% to a high of 50.0% (see Appendix E). In an effort to preserve the Substance Abuse Prevention and Treatment Block Grant funded activities, Governor O'Malley has opted for the alternative penalty, a total of nearly $1.4 M. Preliminary projections for compliance rates for federal fiscal year 2014 also appear to be in violation of the 20.0% threshold.

1.3 THE USE OF TOBACCO BY MARYLAND ADULTS AGE 18 AND OLDER[9]

An estimated 20.6% of Maryland adults age 18 or older (949,131 people) currently use one or more types of tobacco products. Unlike high school youth, however, they tend to pick one type of tobacco product, as opposed to using several products concurrently. Additionally, adults prefer cigarettes (16.4%) over cigars (4.6%), smokeless tobacco (2.5%), or pipes and any other type of tobacco product (2.5%) (see Appendix C for state rankings of adult smoking, Appendix D for Maryland county rates of tobacco use).

Disparities in Tobacco Use. Cigarettes are the most popular tobacco product among Maryland adults; cigarette smoking is correlated with lower educational attainment, lower income, poor mental health status, alcohol abuse, and drug abuse. For example, in Maryland just 6.6% of college graduates currently smoke cigarettes as compared to 23.8% of those with only a high school diploma, GED, or less. Among persons diagnosed with a depressive disorder, 30.3% smoke cigarettes as compared to 13.6% of those who never had such a diagnosis. Among persons who are chronic drinkers, 31.7% are cigarette smokers as compared to 15.2% among those who are not chronic drinkers. Among those with a household income of less than $50,000 a year, 23.1% smoke cigarettes as compared to just 9.6% if earning $75,000 or more a year.

Cessation Landscape. When adult Maryland cigarette smokers were asked if they seriously planned on quitting smoking, 78.7% gave time frames for quitting, with 69.0% wanting to quit within the next year. In 2013, 61.7% of current adult Maryland smokers reported a serious quit attempt during the past 12 months. It is important for Maryland to have resources readily available to capture individuals at the point that they are ready to make a quit attempt.

In Maryland, the proportion of adults who are now former smokers to the population of adults who ever smoked cigarettes is increasing. In 2000, 53.5% of adults who ever smoked cigarettes had quit smoking; by 2010 this had increased to 61.0% – a relative increase of 14.0% over 11 years or 1.3% annually. In 2011, 54.2% of adults who ever smoked cigarettes had quit smoking; by 2013 this had increased to 57.7% – a relative increase of 6.5% over three years, or 2.3% annually.

The cessation landscape has changed considerably since 2007. Introduction and implementation of the following initiatives have collectively brought an increased focus on helping smokers quit to the forefront:

- Publication in 2008 of an updated version of the Public Health Services Clinical Practice Guidelines, Treating Tobacco Use and Dependence;
- Enactment of the Patient Protection and Affordable Care Act;
- Implementation of the Meaningful Use initiative;
- Widespread adoption of electronic health records;

[9] Unless otherwise specifically noted, all data in section 1.3 is from the 2013 Maryland Behavioral Risk Factor Surveillance System survey. Data is accessible online at http://MarylandBRFSS.org.

- Creation of the Center for Medicare and Medicaid Innovation;
- Introduction of new voluntary Joint Commission hospital cessation performance measures;
- An increasing shift to managed care plans in state Medicaid programs;
- Changes in the organization of private health care;
- Increased emphasis on establishing linkages between public health interventions and clinical interventions; and
- Introduction of the national tobacco education media campaign, Tips from Former Smokers, conducted by the CDC.

These changes have presented significant new opportunities to expand cessation coverage, institutionalize tobacco use screening and interventions within health care systems, and increase the availability and use of evidence-based cessation treatments.

2 THE BURDEN OF TOBACCO-RELATED DISEASE IN MARYLAND

Tobacco use can lead to disease, disability, and death, and is the single largest cause of preventable death and disease.[10] As a risk behavior, the use of tobacco begins for 90.0% of people before they are 18 years of age, and 99.0% by 26 years of age – at a time when the well-known health risks are greatly discounted by youth and young adults because those risks will not become manifest until far in the future and a youthful belief that nicotine addiction is something that is easily overcome.[11]

For every adult who dies early because of smoking, he or she is replaced by two new, young smokers, one of whom also will die early from smoking.

The relative risk of dying from a smoking-related disease can be extremely high – the risk to current male smokers between the ages of 35 and 64 in the U.S. of dying from lung cancer is 14.3 times greater than it is for non-smokers. And while not everyone who dies from lung cancer is a smoker, almost 89.0% of lung cancer deaths are related to smoking and secondhand smoke. For every adult who dies early because of smoking, he or she is replaced by two new, young smokers, one of whom will also die early from smoking.[12]

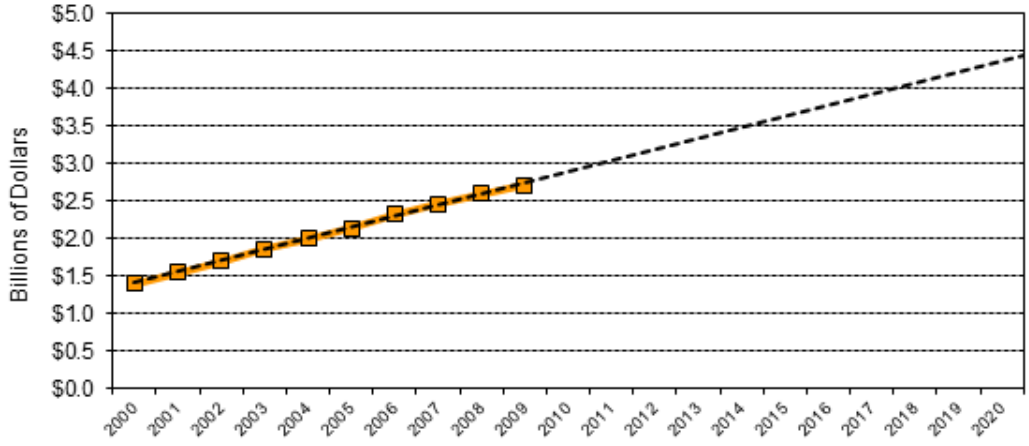
Contrary to what many adolescent and young adult smokers believe, premature death from smoking is not just losing a few years of life when already "old." A substantial percentage (27.7%) of smoking-related

[10] U.S. Department of Health and Human Services. *The Health Consequences of Smoking: A Report of the Surgeon General*. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2004.
[11] U.S. Department of Health and Human Services. Preventing Tobacco Use Among Youth and Young Adults: A Report of the Surgeon General. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention And Health Promotion, Office on Smoking and Health, 2012.
[12] U.S. Department of Health and Human Services. *The Health Consequences of Smoking—50 Years of Progress. A Report of the Surgeon General.* Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014. Printed with corrections, January 2014. See http://www.surgeongeneral.gov/library/reports/50-years-of-progress/consumer-guide.pdf. Last accessed July 23, 2014.

deaths occur between the ages of 35 and 64.[13] However, there appears to be clear benefit of quitting smoking and tobacco use in terms of reduced relative risk. The sooner a smoker quits, the greater the benefits in terms of risk. A person between the ages of 35 and 64 who is a current smoker has a 14.3 times greater risk of lung cancer than a non-smoker, but a former smoker's risk is just 4.4 times greater – a 69.0% improvement.

Though the number of Maryland adults using tobacco and/or suffering from cancers and disease caused by cigarette smoking has decreased, total medical expenditures to treat these conditions has continued to grow (medical costs per case are increasing). The cost of medical treatment in 2000 was estimated at $1.4 B, and at $2.7 B in 2009. This is a 93.0% increase (without adjustment for inflation). By 2015, the cost is estimated to be $3.5 B and, by 2020, $4.5 B.[14]

Figure 2.1
Estimated Maryland Smoking-Related Medical Expenditures, 2000–2009
Projected Maryland Smoking-Related Medical Expenditures, 2010–2020



Source: Maryland Department of Health and Mental Hygiene, Monitoring Changing Tobacco Use Behaviors, 2014.

[13] Centers for Disease Control and Prevention. Smoking-attributable mortality, morbidity, and economic costs (SAMMEC): adult SAMMEC and maternal and child health (MCH) SAMMEC application; 2002. https://apps.nccd.cdc.gov/sammec/methodology.asp.

[14] Maryland Department of Health and Mental Hygiene, *Monitoring Changing Tobacco Use Behaviors*, September 2014.

3 CDC BEST PRACTICES RECOMMENDATIONS FOR MARYLAND

In January 2014 the CDC issued updated recommendations for state comprehensive tobacco control programs (Best Practices), including state-specific recommendations tailored to individual state needs. [15] These recommendations build upon those issued in 1999 and 2007, using what the CDC describes as "a robust evidence base for effective tobacco control interventions" and a two-pronged strategy for each state developed in 2007 by the Institute of Medicine that includes: (1) implementing comprehensive tobacco control programs at the funding levels recommended by the CDC; and (2) creating a regulatory landscape that fosters policy innovations.[16] Maryland's Cigarette Restitution Fund Comprehensive Tobacco Control Program was created by statute in 2000, based on the 1999 CDC Best Practices document – prior to any of the updated CDC recommendations.

Goals for Comprehensive Tobacco Control Programs

- Prevent initiation among youth and young adults.
- Promote quitting among adults and youth.
- Eliminate exposure to secondhand smoke.
- Identify and eliminate tobacco-related disparities among population groups.

The CDC Best Practices describes an integrated programmatic structure for implementing interventions proven to be effective, and provides the recommended level of state investment to reach these goals and to reduce tobacco use in each state. The structure consists of five components. These components constitute a complete checklist that any state implementing a Best Practices Comprehensive Tobacco Control Program must develop, implement, and sustain. The CDC has found that the components of such programs "are most effective when they work together to produce the synergistic effects of a comprehensive statewide tobacco control program" and organize the most effective population-based tobacco control interventions "on the basis of effectiveness documented in the scientific literature and the experiences of state and local programs." [17] These components are:

1. **State and Community Interventions:** Interventions include supporting and implementing programs and policies to influence societal organizations, systems, and networks that encourage and support individuals to make behavior choices consistent with tobacco-free norms.[18]

2. **Mass-Reach Health Communication Interventions:** These interventions deliver strategic, culturally appropriate, and high-impact messages through sustained and adequately funded campaigns that are integrated into a comprehensive state tobacco control program in an effort to reduce or replace tobacco industry sponsorship or promotions.[19]

3. **Cessation Interventions:** Comprehensive tobacco control cessation activities can focus on three broad goals: (1) promoting health systems change; (2) expanding insurance coverage of proven cessation treatments; and (3) supporting state Quitline capacity.[20]

[15] Centers for Disease Control and Prevention. *Best Practices for Comprehensive Tobacco Control Programs – 2014*. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014.
[16] *Id*, page 6.
[17] *Id.*
[18] *Id*, page 7.
[19] *Id*.
[20] *Id*.

4. **Surveillance and Evaluation**: Surveillance is the process of continuously monitoring attitudes, behaviors, and health outcomes over time. Evaluation is used to assess the implementation and outcomes of a program, increase efficiency and impact over time, and demonstrate accountability. A critical infrastructural component of any comprehensive tobacco control program is a surveillance and evaluation system that can monitor and document key short-term, intermediate, and long-term outcomes within populations.[21]

5. **Infrastructure, Administration, and Management**: Sufficient capacity is essential for program sustainability, efficacy, and efficiency, and it enables programs to plan their strategic efforts, provide strong leadership, and foster collaboration among the state and local tobacco control communities.[22]

Figure 3.1
All CDC Best Practices Components are a Necessary Part of the Puzzle

3.1 Implementing CDC Best Practices Recommendations in Maryland

Maryland's current Cigarette Restitution Fund (CRF) tobacco control program was established in fiscal year 2001 based on initial CDC Best Practices recommendations released in 1999.[23] That still-existing statutory framework precludes straightforward adoption of the new CDC Best Practices framework of five primary programmatic components. For example, where the CDC now combines state and community interventions, Maryland maintains separate "local" and "statewide" components. Further, the CDC has a separate component for "cessation" whereas Maryland supports cessation interventions under

[21] *Id*, page 8.
[22] *Id*.
[23] CRF Tobacco Use Prevention and Cessation Program, Subtitle 10, Title 13, Health-General Article.

both the "statewide" and "local" components. Nonetheless, the existing Maryland framework is largely functionally aligned with the CDC Best Practices recommendations.

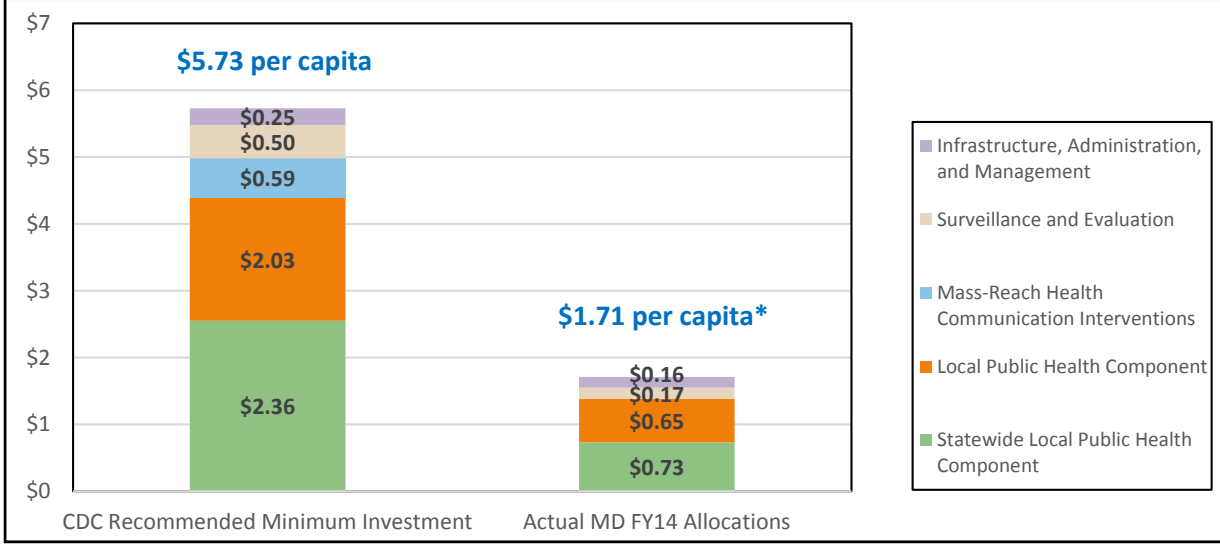
The 2014 CDC Best Practices recommendations for implementation of a comprehensive tobacco control program in Maryland include recommended funding levels for each of the essential CDC program components. For comparative purposes, and to adjust for increases or decreases in each state's population, CDC Best Practices funding recommendations are made on a per capita basis for each state. For both measures, the CDC did not simply utilize population size, but largely considered individual state characteristics including prevalence of tobacco use, socio-demographic, and other factors.

3.2 CDC Investment Recommendations As Applied to Maryland's Tobacco Control Framework

Applying the CDC Best Practices recommendations for Maryland's minimum investment in comprehensive tobacco control to Maryland's existing tobacco control framework results in the allocation among program components as set forth in Figure 3.2. In Figure 3.2, these allocations are contrasted against the most recent funding allocation (fiscal year 2014).[24]

Maryland's investment in comprehensive tobacco control fails to achieve the CDC's minimum recommended investment along two dimensions – first, the overall current investment of $1.71 M per capita is $4.02 M per capita less than the minimum recommendation of $5.73, and second, the current proportional breakdown between and among components is not in line with CDC Best Practices recommendations.

Figure 3.2
CDC Minimum Tobacco Control Per Capita Investment Recommendations Applied to Maryland vs. Actual Fiscal Year 2014 Maryland Tobacco Control Investments



* Note that the per-capita funding of Mass-Reach Health Communications Component in fiscal year 2014 was $0.00 per capita.

[24] Data for fiscal year 2014 is the latest complete year available – fiscal year 2015 funding allocations are expected to be approximately the same.

For comparative purposes, and to adjust for population change, CDC Best Practices funding recommendations are made on a per capita basis for each state. The CDC developed both "minimum" funding levels and "recommended" funding levels for each state. For both measures, CDC did not simply utilize population size, but largely considered individual state characteristics including prevalence of tobacco use, socio-demographic, and other factors. This led to both Maryland's minimum ($5.73 per capita) and recommended ($8.15 per capita) funding levels being the second lowest in the nation, with only Utah measures set lower. However, even though the Maryland measures are among the most achievable, according to data published by The Campaign for Tobacco-Free Kids, a globally recognized tobacco control organization, 22 states invested more in tobacco control than Maryland did in fiscal year 2014.[25]

The funding necessary to comprehensively implement CDC Best Practices recommendations in Maryland can be determined by multiplying the total estimated Maryland population by the relevant per capita funding levels, and is outlined in Table 3.1. Appendix F provides the rationale for the per capita investment for the Statewide and Local Public Health Components.[26]

Table 3.1
Minimum Budget to Support CDC Best Practices Recommendations for Maryland

Program Component	CDC Minimum Investment (in millions)		CDC Recommended Investment (in millions)	
	Per Capita Investment	Budgetary Investment	Per Capita Investment	Budgetary Investment
Statewide Public Health	$2.36	$14.0	$3.36	$19.9
Local Public Health	$2.03	$12.0	$2.88	$17.1
Mass-Reach Health Communications	$0.59	$3.5	$0.85	$5.0
Surveillance and Evaluation	$0.50	$3.0	$0.71	$4.2
Infrastructure, Administration, and Management	$0.25	$1.5	$0.35	$2.1
Total	$5.73	$34.0	$8.15	$48.3

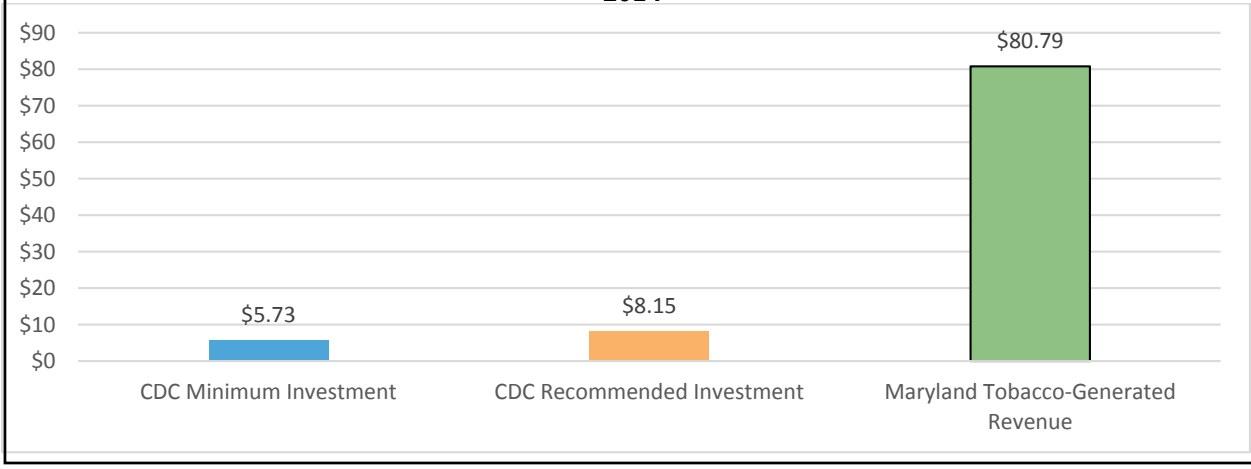
Tobacco-Generated State Revenue. For state fiscal year 2014, Maryland is estimated to have received a total of $479 M in tobacco-related revenue ($384.6 M from State excise taxes on tobacco products and $94.4 M from the 1999 settlement with the tobacco industry),[27] or approximately $80.79 per capita. Nothing in State or federal law requires that states use only revenue generated from tobacco for their investment in comprehensive tobacco control programs. However, funding tobacco control efforts in

[25] See http://Tobaccofreekids.org/research/factsheets/pdf/0176.pdf. Dated June 13, 2014 and last accessed on August 18, 2014.
[26] Estimated Maryland population on July 1, 2013 was 5,928,814. Source: Table 1. Annual Estimates of the Population of the United States, Regions, States, and Puerto Rico: April 1, 2010 to July 1, 2013. U.S. Census Bureau, Population Division, Release Date December, 2013. Available from http://census.gov.

[27] See http://www.tobaccofreekids.org/research/factsheets/pdf/0178.pdf. Dated January 6, 2014 and last accessed on August 20, 2014.

Maryland at the full CDC recommended level would still allow for 90% of tobacco-related revenue to be spent on other efforts. The CDC Best Practices per capita minimum investment in tobacco control for Maryland is 7.1% of Maryland tobacco-generated revenue – and the recommended investment is 10.1%.

Figure 3.3
Maryland – Per Capita, CDC Best Practices Funding Levels and Tobacco-Generated Revenue, 2014



3.3 Current Maryland Tobacco Control Efforts and Recommendations for a Comprehensive Tobacco Control Program

The following information provides an overview of currently funded tobacco control initiatives, as well as recommendations for how DHMH would spend the additional targeted funding outlined in Section 3.2. The interventions summarized in this report draw upon one or more of the following sources.

2014 Centers for Disease Control and Prevention. *Best Practices for Comprehensive Tobacco Control Programs – 2014*. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014.

U.S. Department of Health and Human Services. *Guide to Community Preventive Services*. www.thecommunityguide.org.tobacco/index.html. Last updated: 06/12/2014. Last accessed August 25, 2014.

U.S. Department of Health and Human Services. *The Health Consequences of Smoking – 50 Years of Progress: A Report of the Surgeon General*. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014.

2012 U.S. Department of Health and Human Services. *Preventing Tobacco Use among Youth and Young Adults: A Report of the Surgeon General*. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2012.

The existing funding breakdown that follows includes general funds, federal funds, and funds from the Cigarette Restitution Fund to total the current Maryland statutory requirement of $10 M annual investment in tobacco control.[28]

STATEWIDE PUBLIC HEALTH COMPONENT: $14.0 M CDC MINIMUM INVESTMENT

Current funding: $4.3 M
Increase of: $9.7 M

CURRENT EFFORTS: $4.3 M

DHMH currently funds statewide resource centers, targeted state and local efforts, as well as statewide cessation and health systems change interventions, as outlined below.

Intervention	Description
Maryland Tobacco Quitline, 1-800-QUIT-NOW	Provide phone, web, and text-based services to Marylanders ages 13 and older.
Hospital-based partnerships	Assist with health system interventions for cessation services.
Statewide resource centers Maryland Resource Center for Quitting Use and Initiation of Tobacco, University of Maryland, Baltimore County Legal Resource Center for Public Health Policy, University of Maryland, School of Law	Assist partners, local health departments, and the public with implementing CDC Best Practices interventions.
Pregnancy and Tobacco Cessation Help (PATCH)	Provide targeted local initiatives in partnership with local health departments in the counties with the highest smoking rates among pregnant women and women of childbearing age.
Minority Outreach and Technical Assistance (MOTA)	In low-income and minority communities, assist local health departments with implementing PATCH initiatives, smoke-free multi-unit housing, and youth access enforcement.
State-level responsible retailer initiatives	Develop outreach to retailers addressing youth access and compliance.
Health communication/outreach Targeted initiatives that support and promote statewide and local programmatic efforts.	Cessation support for behavioral health populations, pregnant women, women of childbearing age/members of household. Environmental impact of tobacco litter to the health and safety of communities. Implementation of smoke-free multi-unit housing. "Cigar Trap" awareness and outreach efforts.

[28] Subtitle 10, Title 13, Health – General Article, Annotated Code of Maryland.

TOTAL MINIMUM INVESTMENT: $14.0 M

With an increase of $9.7 M to reach the calculated CDC minimum recommended investment of $14 M for the statewide public health component, DHMH would expand the current efforts listed above, as well as support new efforts that are not currently funded, as outlined below.

Intervention	Description
Statewide cessation interventions	Increase support of the Maryland Tobacco Quitline to expand reach to 5% of Maryland smokers. Expand promotion of health system and insurance cessation coverage and facilitate linkages, especially among disparate populations.
Hospital/health systems partnerships	Engage and assist health care organizations in enhancing the delivery of tobacco dependency care and treatment policies that lead to population-based outcomes.
Tobacco retailer enforcement efforts	Increase state-level efforts to broaden awareness and knowledge of tobacco sales involving minors.
Youth and young adult prevention efforts	Provide community-based outreach coordinated with mass-reach health communication efforts, efforts to restrict youth access to tobacco, survey point-of-sale landscape, addressing all types of existing tobacco products and "new" products, such as e-cigarettes.
Outreach to high-risk populations	Implement and expand targeted efforts to reach vulnerable, high-risk, and disparate populations.
Statewide Resource Centers	Expand reach and training; conduct needs assessment; and provide technical assistance interventions for local health departments, providers, policy makers, and the public.

LOCAL PUBLIC HEALTH COMPONENT: $12.0 M CDC MINIMUM INVESTMENT

Current funding: $3.9 M
Increase of: $8.1 M

CURRENT EFFORTS: $3.9 M

As previously discussed, all 24 local health departments receive funding for local tobacco control programs, divided into four main categories: enforcement, cessation, school-based, and community-based.[29]

Funding is distributed among the 24 local health departments per a formula based on population, and tobacco use prevalence, as outlined in state statute. The majority of these funds are currently dedicated to cessation interventions, followed by school-based, community-based, and then enforcement.

[29] The funding listed includes 7% administrative funding for local health departments.

Intervention	Description
Enforcement	Conduct tobacco retailer compliance checks and vendor education on state and local laws. Implement Tobacco Education Groups (TEGs) for youth cited for possession of tobacco products.
Cessation	Conduct individual and group tobacco cessation counseling, telephone follow-up support, provision of NRT and other cessation aids such as Chantix. Provide limited targeted efforts to support special needs of behavioral health and low income populations.
School-based	Implement tobacco prevention education in classrooms and other settings such as student led support groups/clubs and provide smoking cessation interventions.
Community-based	Maintain community-based coalition activities. Fund community-based prevention grants, activities, and awareness campaigns. Provide outreach and training to minority and low-income communities, coalition members, and community providers.

TOTAL MINIMUM INVESTMENT: $12 M

With an increase of $8.1 M to reach the calculated CDC minimum recommended investment of $12 M for the local public health component, DHMH would increase funding allocated to all local health departments to expand efforts in every category – ensuring programs are adequately funded and sustained. [30]

Intervention	Description
Enforcement	Increase tobacco retailer compliance checks, positive retailer reinforcement, face-to-face vendor education, and other surveillance to reduce Maryland's non-compliance rate. Train partners to broaden educational approaches. Enhance educational component for youth cited for possession of tobacco products. Build additional collaborations with youth, parents, and community to change norms about non-compliance.
Cessation	Expand cessation linkages and services available in low-income and other disparate communities. Connect community members to existing insured cessation resources.
School-based	Re-invigorate collaborations between local school systems and local health departments, strengthen policies, incorporate tobacco prevention/e-cigarette education into health classes, enhance cessation support, student advocacy, and peer education to promote non-smoking norm.
Community-based	Support community participation and increase collaboration with faith-based and/or other organizations. Utilize partnerships in low-income communities to strengthen environmental, policy, system, and attitude change.

[30] *Id.*

Mass-Reach Health Communication Interventions Component: $3.5 M CDC Minimum Investment

Current funding: $0.0
Increase of: $3.5 M

CURRENT EFFORTS: $0

Currently there are no dollars allocated to the Countermarketing and Media Component. However, funds from the statewide component are used to fund some media and communication interventions.

TOTAL MINIMUM INVESTMENT: $3.5 M

The CDC recommends incorporating sustained mass-reach health communications interventions for an effective comprehensive statewide tobacco control program. DHMH would develop initiatives as outlined below.

Intervention	Description
Coordinated Statewide Mass-Reach Health Communications	A state health communications initiative will reach general and special populations with mass media, social media, and/or community-based outreach as appropriate including messaging focusing on: - Prevention of initiation of tobacco use; - Promotion and encouragement of cessation; - Health disparities related to tobacco use; - Prevention of secondhand smoke exposure; and - Forwarding environmental change and shaping social norms.

Surveillance and Evaluation Component: $3.0 M CDC Minimum Investment

Current funding: $0.9 M
Increase of: $2.1 M

CURRENT EFFORTS: $0.9 M

DHMH currently funds statewide surveillance efforts as outlined below.

Intervention	Description
Youth Survey Youth Tobacco and Risk Behavior Survey	Implement school-based paper-and-pencil survey fall of even calendar years with public middle and high school youth. Two fiscal years of funding are required in support of each survey cycle.
Adult Survey Maryland Healthier Communities Survey	Conduct random-digit-dial landline and cell phone survey designed to produce county-specific estimates biennially during even calendar years. Two fiscal years of funding are required in support of each survey cycle.
Adult Survey (BRFSS) Behavioral Risk Factor Surveillance System	Conduct annual survey designed to produce statewide estimates of risk behaviors, partially supported by this component.

TOTAL MINIMUM INVESTMENT: $3.0 M

With an increase of $2.1 M to reach the CDC minimum recommended investment of $3.0 M for surveillance and evaluation, DHMH would sustain the efforts described above, and increase surveillance and evaluation efforts as outlined below.

Intervention	Description
Adult Survey (Enhanced BRFSS)	Transition current BRFSS, with strong technical assistance from the CDC, to an enhanced BRFSS designed to produce annual county-specific estimates as well as statewide estimates for all counties.
Comprehensive Program Evaluation	Evaluate individual program components and tobacco control program overall.
Cessation Evaluation	Create uniform measure of quit rates among local health departments to establish CDC Best Practices standards and measure long-term efficacy of Quitline interventions.

INFRASTRUCTURE, ADMINISTRATION, AND MANAGEMENT COMPONENT: $1.5 M CDC MINIMUM INVESTMENT

Current funding: $0.9 M
Increased funding: $0.6 M

CURRENT EFFORTS: $0.9 M

Current funding allows for staff support for development, implementation, and oversight of programmatic activities.

TOTAL MINIMUM INVESTMENT: $1.5 M

Increased funding will allow for increased staffing to oversee the expansion of programming outlined in the previous four components. Staff would provide fiscal management, accountability, and coordination of state and local initiatives.

APPENDIX A

Percentage of Public High School Youth Using Various Tobacco Products

Jurisdiction	Any Tobacco Use[a]	Cigarettes[b]	Cigars[c]	Smokeless Tobacco[d]	Used Flavored Cigars or Smokeless[e]
United States	22.4%	15.7%	12.6%	8.8%	*No Data*
Maryland	**16.9%**	**11.9%**	**12.5%**	**7.4%**	**13.5%**
Allegany	27.2%	21.3%	14.7%	14.8%	19.5%
Anne Arundel	17.7%	13.7%	12.8%	7.4%	13.6%
Baltimore City	16.6%	10.1%	15.4%	7.5%	15.3%
Baltimore Co.	18.1%	12.6%	12.9%	5.7%	13.6%
Calvert	23.0%	18.3%	14.4%	9.9%	16.9%
Caroline	25.4%	22.2%	14.5%	13.6%	16.3%
Carroll	18.7%	13.6%	11.9%	9.1%	14.6%
Cecil	24.6%	17.7%	14.8%	9.8%	17.7%
Charles	17.6%	12.7%	13.6%	6.9%	15.0%
Dorchester	24.4%	17.7%	13.0%	14.5%	18.1%
Frederick	19.9%	14.3%	12.1%	9.3%	14.1%
Garrett	34.3%	23.6%	17.0%	23.4%	24.8%
Harford	20.2%	14.8%	15.0%	7.7%	16.0%
Howard	11.5%	7.3%	9.3%	4.5%	10.7%
Kent	25.7%	22.2%	13.3%	13.8%	19.1%
Montgomery	12.1%	8.5%	9.5%	5.3%	10.6%
Prince George's	13.3%	7.8%	12.1%	6.6%	11.4%
Queen Anne's	22.5%	17.6%	14.6%	14.2%	16.0%
St. Mary's	19.2%	15.3%	13.5%	7.7%	14.6%
Somerset	23.0%	20.5%	15.4%	13.2%	18.4%
Talbot	20.2%	16.0%	12.7%	10.2%	12.1%
Washington	24.6%	16.5%	13.8%	14.2%	17.9%
Wicomico	22.8%	18.3%	17.6%	9.7%	17.3%
Worcester	27.4%	21.3%	16.3%	12.9%	19.4%

Source: Maryland Youth Tobacco and Risk Behavior Survey – 2013. Data presented as CDC Youth Risk Behavior Survey Results at: http://phpa.dhmh.maryland.gov/cdp/SitePages/youth-risk-survey.aspx

[a] Use of a cigarette, and/or a cigar, and/or smokeless tobacco at any time during the past 30 days.
[b] Use of a cigarette, even if just one puff, at any time during the past 30 days.
[c] Use of a cigar, even if just one puff, at any time during the past 30 days.
[d] Use of smokeless tobacco, even if just a few chews, during the past 30 days.
[e] Use of flavored cigars, or flavored smokeless tobacco, or both during the past 30 days.

APPENDIX B

Percentage of Current Underage Youth Cigarette Smokers Usually Getting Cigarettes from Retail Sources

Percentage of Usual Underage Youth Cigarette Retail Purchasers Being Asked for Photo Identification

Jurisdiction	UNDERAGE YOUTH	
	% Smokers Usually Buying Retail[a]	% Retail Buyers Not Being Asked for Photo ID[b]
United States	18.1%	*No Data*
Maryland	**20.8%**	**52.3%**
Allegany	11.0%	58.2%
Anne Arundel	21.8%	57.7%
Baltimore City	33.3%	57.9%
Baltimore Co.	28.1%	49.3%
Calvert	14.5%	49.6%
Caroline	17.3%	50.0%
Carroll	17.9%	52.1%
Cecil	12.1%	45.0%
Charles	18.2%	53.1%
Dorchester	*Sample too small*	*Sample too small*
Frederick	16.3%	57.1%
Garrett	16.2%	51.9%
Harford	19.7%	52.0%
Howard	20.9%	48.3%
Kent	*Sample too small*	*Sample too small*
Montgomery	16.4%	45.3%
Prince George's	28.6%	52.1%
Queen Anne's	17.8%	44.0%
St. Mary's	15.9%	54.2%
Somerset	*Sample too small*	*Sample too small*
Talbot	24.8%	*Sample too small*
Washington	11.9%	59.0%
Wicomico	14.2%	53.5%
Worcester	13.8%	48.1%

[a] Proportion of current underage cigarette smokers who usually get cigarettes by buying them from retail sources.
[b] Proportion of current underage cigarette smokers who usually get cigarettes from retail sources that were not asked to show photo ID in connection with cigarette purchases made during the past 30 days.

APPENDIX C

Ranking of Adult (Age 18+) Current Cigarette Smoking by State, 2012
Behavioral Risk Factor Surveillance System

Rank	Jurisdiction	% Cigarette Smokers		Rank	Jurisdiction	% Cigarette Smokers
1	Utah	10.6%		21	District of Columbia	19.6%
2	California	12.6%		22	Delaware	19.7%
3	Hawaii	14.6%		-	Montana	19.7%
4	Connecticut	16.0%		-	Nebraska	19.7%
5	**Maryland**	**16.2%**		23	Maine	20.3%
-	New York	16.2%		24	Georgia	20.4%
6	Idaho	16.4%		-	Wisconsin	20.4%
-	Massachusetts	16.4%		25	Alaska	20.5%
7	Vermont	16.5%		26	North Carolina	20.9%
8	Arizona	17.1%		27	North Dakota	21.2%
9	New Hampshire	17.2%		28	Pennsylvania	21.4%
-	Washington	17.2%		29	Wyoming	21.8%
10	New Jersey	17.3%		30	South Dakota	22.0%
11	Rhode Island	17.4%		31	South Carolina	22.5%
12	Colorado	17.7%		32	Michigan	23.3%
-	Florida	17.7%		-	Ohio	23.3%
13	Oregon	17.9%		-	Oklahoma	23.3%
14	Iowa	18.1%		33	Alabama	23.8%
-	Nevada	18.1%		34	Missouri	23.9%
15	Texas	18.2%		35	Indiana	24.0%
16	Illinois	18.6%		-	Mississippi	24.0%
17	Minnesota	18.8%		36	Louisiana	24.8%
18	Virginia	19.0%		37	Tennessee	24.9%
19	New Mexico	19.3%		38	Arkansas	25.0%
20	Kansas	19.4%		39	West Virginia	28.2%
				40	Kentucky	28.3%

Note – 2012 is the latest data available for all states from the CDC at: http://apps.nccd.cdc.gov/brfss/

APPENDIX D

Adult (Age 18+) Current Tobacco Use in Maryland, 2013
Behavioral Risk Factor Surveillance System

Jurisdiction	Any Kind of Tobacco		Cigarettes	Cigars	Smokeless Tobacco	Pipe and Other Types of Tobacco
Maryland	**20.6%**		**16.4%**	**4.6%**	**2.5%**	**2.5%**
Allegany	29.4%		24.4%	11.5%	4.8%	3.3%
Anne Arundel	23.1%		18.0%	5.1%	3.6%	3.8%
Baltimore City	25.8%		22.7%	5.6%	1.6%	2.0%
Baltimore Co.	22.8%		18.4%	5.0%	1.7%	2.3%
Calvert	20.7%		17.2%	7.0%	2.5%	0.8%
Caroline	23.9%		22.5%	2.8%	1.5%	0.0%
Carroll	20.0%		19.4%	3.9%	2.7%	2.3%
Cecil	21.0%		18.0%	3.4%	3.7%	4.4%
Charles	17.3%		13.2%	6.5%	2.6%	0.9%
Dorchester	20.7%		18.4%	2.8%	0.9%	0.4%
Frederick	24.8%		19.8%	3.5%	3.4%	2.2%
Garrett	30.9%		19.9%	10.6%	8.5%	3.4%
Harford	19.9%		16.9%	2.1%	2.9%	0.8%
Howard	19.9%		14.6%	3.7%	2.7%	4.6%
Kent	23.2%		19.6%	4.5%	0.8%	0.6%
Montgomery	11.1%		8.2%	2.6%	1.3%	2.8%
Prince George's	20.3%		14.4%	6.3%	2.1%	2.7%
Queen Anne's	27.5%		19.8%	7.5%	6.1%	3.3%
St. Mary's	29.6%		25.9%	1.6%	2.4%	2.0%
Somerset	16.7%		13.0%	5.8%	2.6%	0.0%
Talbot	20.2%		17.5%	4.1%	2.6%	0.3%
Washington	27.2%		20.0%	3.9%	9.3%	2.0%
Wicomico	18.2%		14.1%	4.5%	3.1%	0.2%
Worcester	20.0%		18.1%	0.4%	3.0%	1.5%

Note – Maryland's 2013 BRFSS data is available at: http://MarylandBRFSS.org/

APPENDIX E

Maryland Synar Violation Rates in Maryland Jurisdictions, by Violation Rate
Maryland Federal Fiscal Year 2014 Synar Report – Inspections May-September, 2013

Rank	Jurisdictions	Number of Inspections	Number of Violations	Violation Rate
1	**Allegany**	**4**	**2**	**50.0%**
2	**Caroline**	**4**	**2**	**50.0%**
3	**Somerset**	**2**	**1**	**50.0%**
4	**Baltimore County**	**85**	**34**	**40.0%**
5	**Prince George's**	**85**	**26**	**30.6%**
6	**Cecil**	**11**	**3**	**27.3%**
7	**Baltimore City**	**158**	**41**	**25.9%**
8	**Talbot**	**4**	**1**	**25.0%**
9	**Worcester**	**16**	**4**	**25.0%**
10	**Charles**	**13**	**3**	**23.1%**
11	**Anne Arundel**	**53**	**11**	**20.8%**
12	**Howard**	**34**	**7**	**20.6%**
13	Montgomery	68	11	16.2%
14	Washington	13	2	15.4%
15	Harford	20	3	15.0%
16	Calvert	7	1	14.3%
17	Dorchester	7	1	14.3%
18	Frederick	18	2	11.1%
19	Wicomico	12	1	8.3%
20	Queen Anne's	13	1	7.7%
21	Carroll	14	1	7.1%
22	Garrett	4	0	0.0%
23	Kent	2	0	0.0%
24	St. Mary's	7	0	0.0%
	Maryland	655	158	24.1%

Note: Jurisdictions whose rates violate the Synar maximum of 20% are in bold.

APPENDIX F

EXPLANATION OF ALLOCATION OF TOBACCO CONTROL INVESTMENT TO MARYLAND'S "Statewide" and "Local" Public Health Components

The 2014 CDC Best Practices tobacco control investment recommendations for Maryland provide for a minimum investment of $4.39 per capita for "Cessation Interventions" ($2.21) and "State and Community Interventions" ($2.18) combined.

Due to the fact that these two components straddle CRF "Statewide Public Health" (SPH) and "Local Public Health" (LPH) Components, as outlined below, a total of $2.35 per capita has been dedicated to SPH and $2.04 per capita to LPH.

Maryland Allocation of CDC Cessation Component Interventions - $2.21 per capita.

CDC Best Practices priorities for cessation interventions include: (1) supporting the Maryland Tobacco Quitline, 1-800-QUIT-NOW which provides free telephone counseling and nicotine replacement therapy; (2) promoting health systems change; and (3) promoting expansion of insurance coverage and utilization of proven cessation treatments.[31] Both the Quitline and insurance coverage priorities are conducted at the state level, and health system change at the state level with local support and involvement. At the same time, maintaining local cessation options through local health departments is necessary to ensure that tobacco users can access cessation programs that work best for them (telephone, group counseling, and/or individual counseling) and local health departments can guide residents to evidence-based services covered by their insurer. The current reach of the Maryland Tobacco Quitline is less than 2.0%; in order to expand the reach of the Maryland Tobacco Quitline to 5.0% of Maryland smokers, as well as to expand health system and insurance coverage promotion, $1.28 per capita will be dedicated to SPH, with the remaining $0.93 per capita designated to the LPH component.

Statewide Public Health Component - Cessation:	$1.28
Local Public Health Component - Cessation:	+$.93
TOTAL PER CAPITA CDC CESSATION ALLOCATION:	$2.21

Maryland Allocation of CDC Statewide and Community Interventions - $2.18 per capita.

Enforcement: Enforcement of youth access restrictions requires both local and statewide activities. These activities also ensure maintenance of a coordinated and effective responsible tobacco retailing environment. Currently, Maryland is the only state in the nation that has less than 80.0% of its tobacco retailers complying with the law and not selling tobacco products to youth less than 18 years of age. To adequately fund each local health department for enforcement efforts, including compliance checks and vendor education, $0.40 per capita will be dedicated to LPH and $0.09 per capita will be dedicated for statewide enforcement efforts.

School-Based: Preventing the initiation of tobacco use among underage youth and young adults requires more than the *school-based* programs supported by the LPH component. Out-of-school and other efforts are essential for prevention that reduces initiation of tobacco use. LPH efforts will be supported with $0.30 per capita and SPH prevention efforts will be funded at $0.16 per capita.

[31] Centers for Disease Control and Prevention. *Best Practices for Comprehensive Tobacco Control Programs – 2014*. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014, pages 40-55.

Community-Based: All funds appropriated to the LPH component are statutorily required be distributed by formula (based on population size and prevalence rates) into 24 specific allocations to each individual county and Baltimore City. The SPH component helps to not only bridge efforts aimed at target populations across jurisdictional borders, but also to address disparities and enhance local efforts when at-risk populations show a greater need. Targeted statewide initiatives addressing gaps and health disparities will be developed, as well as those that support and unify all other program components, including the support of statewide resource centers. LPH community-based efforts will be funded at $0.40 per capita and supplemental community-based efforts will be funded through the SPH component at $0.83 per capita.

Statewide Public Health Component Interventions:	Per Capita
Enforcement Interventions	$0.09
Youth Prevention Interventions	$0.16
Targeted Community Interventions	$0.83
	$1.08

Local Public Health Component Interventions:	Per Capita
Enforcement Interventions	$0.40
School-based interventions	$0.30
Community-based Interventions	$0.40
	$1.10

TOTAL PER CAPITA CDC STATE AND COMMUNITY: $2.18

Combined Cessation and Statewide/Community Interventions

STATEWIDE PUBLIC HEALTH COMPONENT	Per Capita	Budget
CDC Cessation Component	$1.28	$7.6 M
CDC Statewide and Community Component	$1.08	$6.4 M
TOTAL STATEWIDE PUBLIC HEALTH COMPONENT INVESTMENT:	**$2.36**	**$14.0 M**

LOCAL PUBLIC HEALTH COMPONENT	Per Capita	Budget
CDC Cessation Component	$0.93	$5.5 M
CDC Statewide and Community Component	$1.10	$6.5 M
TOTAL LOCAL PUBLIC HEALTH COMPONENT INVESTMENT:	**$2.03**	**$12.0 M**
TOTAL STATEWIDE AND LOCAL PUBLIC HEALTH COMPONENTS:	**$4.39**	**$26.0 M**