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2009 Independent Evaluation Report for the New York Tobacco Control Program

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Executive Summary

New York State has established itself as a leader in tobacco control with strong tobacco control policies, evidence-based interventions, and innovative strategies to reduce the burden of tobacco use. In 2008, New York State had the highest cigarette excise tax in the country, nearly all workplaces were smoke-free, and per capita funding for the New York Tobacco Control Program (NY TCP) was higher than the national average. Data on key outcome indicators illustrate that these interventions are having their intended effects: youth and adult smoking rates have declined faster in New York than in the United States as a whole. In addition, as of 2008, a greater percentage of smokers in New York made a quit attempt in the past year and had intentions to quit in the next 30 days than smokers in the rest of the United States. Finally, daily cigarette consumption is lower in New York than in the rest of the United States. New York has accomplished these changes despite countervailing forces that undermine the state's efforts. In 2008, nearly half of smokers in New York reported purchasing low or untaxed cigarettes, and a greater proportion of cigarettes were sold under a price promotion in New York than in the country as a whole.

Despite this progress, NY TCP's budget was reduced by nearly one-fifth as a result of the statewide fiscal crisis. This budget reduction was more than twice as large as the reduction for the New York State Department of Health as a whole, excluding Medicaid. Given that tobacco use remains the leading preventable cause of disease, disability, and death in the United States and arguably has a more extensive set of evidence-based interventions compared with other public health threats, preserving the state's tobacco control infrastructure should be a priority. The NY TCP budget reduction threatens continued progress and virtually guarantees that the program will not achieve its 2010 goal of 1 million fewer smokers.

RTI's key programmatic recommendations are as follows:

Overall

- Increase NY TCP funding by $9 million to a minimum of $77 million per year.
  - Allocate the additional funds to health communication.

Health Communication

- Achieve at least an annual average of 60% confirmed awareness of NY TCP television advertisements.
- Avoid unplanned gaps in media activities.
- Increase funding for core campaigns (e.g., cessation, secondhand smoke) by $5 million.
- Allocate an additional $4 million for campaigns to more support state and community action.

Cessation Interventions

- Maintain current funding for the New York State Smokers' Quitline.
  - Explore ways to provide nicotine replacement therapy (NRT) more cost-effectively.
- Eliminate support for NRT distribution outside of the Quitline.

Statewide and Community Action

- Eliminate NY TCP financial support for the Asthma Coalitions.
- Reduce funding for enforcement of youth access.
- Reduce funding for community contractors and direct these funds to the creation of new tobacco control demonstration projects aimed at new opportunities that result from the Food and Drug Administration authority over tobacco.
- Develop a core theme or message for each community contractor initiative and incorporate the theme into all strategies for that initiative.
- Develop guidelines for mobilizing community members in support of selected community initiatives.

Introduction

Tobacco use imposes a significant health and economic burden on New York State. Each year, an estimated 25,432 New Yorkers die as a result of smoking, resulting in 339,646 years of life lost (CDC, 2007a). The smoking-related health care costs and lost productivity in New York total $14.2 billion each year. However, this significant burden can be reduced with evidence-based tobacco control program and policy interventions. A considerable evidence base for tobacco control has demonstrated that state tobacco control programs are effective in reducing youth and adult smoking prevalence and overall cigarette consumption (Farrelly et al., 2008; Tauras et al., 2005; Farrelly, Pechacek, and Chaloupka, 2003; USDHHS, 2000). Specifically, a wide range of effective interventions are available, including mass media campaigns, smoke-free air laws, cigarette excise taxes, health care provider reminder systems, telephone-based smoking cessation counseling, and reductions in out-of-pocket costs for cessation therapies.

The New York Tobacco Control Program's (NY TCP's) mission is to reduce tobacco-related morbidity and mortality and the social and economic burden caused by tobacco use, with a long-term vision of creating a tobacco-free New York. In addition, the program established an interim goal of reducing the number of smokers from approximately 3 million in 2005 to 2 million in 2010. To accomplish these goals, the program employs three key evidence-based strategies: health communication, cessation interventions, and statewide and community action. This approach is consistent with the framework for tobacco control presented in the Centers for Disease Control and Prevention's (CDC's) (2007b) *Best Practices for Comprehensive Tobacco Control Programs* and supported by available evidence reflected in *Reducing Tobacco Use: A Report of the Surgeon General* (USDHHS, 2000), the *Task Force on Community Preventive Services: Tobacco Use Prevention and Control* (Zaza, Briss, and Harris, 2005), and *The Role of the Media in Promoting and Reducing Tobacco Use* (NCI, 2008).

Previous Independent Evaluation Reports (IERs) have demonstrated that smoking rates among youth and adults are lower and have declined faster in New York than in the United States as a whole. In addition, in recent years, daily cigarette consumption among current New York smokers has decreased and interest in quitting and the percentage of adult smokers making quit attempts each year has increased. Although the comprehensive approach to tobacco control in New York makes it challenging to isolate which factors have contributed to this success, we can note several potentially significant contributing factors:

- above national average cigarette excise taxes,
- a comprehensive statewide smoke-free air law since 2003,
- increasing resources for tobacco control through 2008,
- growing awareness of statewide public health communication, and
- statewide and community action leading to policy change.

Since the 2008 IER, significant events have occurred that will shape current and future trends in tobacco use. On June 3, 2008, the State's cigarette excise tax became the highest in the United States at $2.75. As of July 1, 2009, Rhode Island now has the highest state excise tax at $3.46. Higher excise taxes lead to higher prices, reduced smoking initiation and cigarette consumption, and increased quitting. Some of these effects will be reflected in data presented below. However, the global financial crisis and economic recession have led to significant reductions in the 2008–2009 and 2009–2010 NY TCP budgets. The budget has been cut from $84 million in fiscal year (FY) 2008–2009 to $68 million in FY 2009–2010. The estimated revenue from tobacco taxes in 2008–2009 totaled $1.34

billion, while the annual payment from the Master Settlement Agreement (MSA) between cigarette companies and states was $834.5 million in 2008. Therefore, annual funding for tobacco control in FY 2009–2010 represents 3% of the annual revenue from tobacco taxes and MSA payments. Although the effects of these budget reductions are not reflected in the available key outcome indicators presented through 2008 below, they will likely slow future progress and threaten the program's ability to achieve its goal of 1 million fewer smokers by 2010.

In this report, we describe how the program has responded to the funding reductions and make recommendations for how best to allocate funds in light of NY TCP's reduced budget. We also assess progress by examining trends in key programmatic and outcome indicators in New York over time and, where available, in comparison with national data. By comparing key indicators in New York and the United States as a whole, we can illustrate how New York's outcomes compare with the average state experience.

The New York Tobacco Control Program—Programmatic Approach and Context

In this section, we describe the program's approach to tobacco control, the tobacco control context in which the program operates, and NY TCP's response to the budget reductions.

Program Administration and Support

NY TCP's programmatic efforts are supported by administration, training and technical assistance, and surveillance and evaluation. NY TCP administration focuses on driving overall programmatic strategy, building and maintaining an effective tobacco control infrastructure, providing technical assistance and guidance, and managing the effective and efficient investment of state tobacco control funding. NY TCP funds a contractor to provide technical assistance and training to enhance the skills of funded community contractors. The training sessions emphasize skill-building for policy advocacy. RTI International is contracted to provide surveillance and evaluation activities to monitor program progress and impact by working in collaboration with the Tobacco Surveillance and Evaluation Team within NY TCP.

Health Communication

NY TCP invests in paid advertising on television, radio, print, Internet, and other venues to motivate tobacco users to stop, promote smoke-free homes, expose tobacco industry propaganda, deglamorize tobacco use, and educate community members and decision makers about tobacco control. Paid advertising is also the key driver of calls to the New York State Smokers' Quitline. NY TCP employs other strategies, such as public relations and media advocacy, to increase coverage and discussion of tobacco control issues and events in the news media.

Mass Media

Evidence from population-level studies and controlled experiments indicates that mass media campaigns can be effective in discouraging tobacco use (Farrelly, Crankshaw, and Davis, 2008; USDHHS, 2000). For tobacco countermarketing messages to be persuasive, they must be fully attended to by the viewer and the message content must be processed. In tobacco control, the creative strategies used to promote behavior change have varied in content and stylistic approach. Common messages have highlighted the short- and long-term health effects of tobacco use, the consequences of tobacco use for friends and family, difficulties in trying to stop smoking, the benefits of smoking cessation, the dangers of exposure to secondhand smoke, and deceptive tobacco industry marketing. These messages also differ stylistically in that some rely

on strong emotions or the use of graphic images to grab the viewer's attention, whereas others do not. The quantity of message features aimed at eliciting higher arousal and stronger emotions is often referred to as message sensation value. A growing body of research, including findings from this evaluation, indicates that messages with high sensation value are more effective in promoting behavior change than messages with low sensation value.

However, a mix of messages with high and low sensation value is likely warranted because ads are processed and attended to differently by different types of smokers. For example, smokers who are ready and willing to quit may be more receptive to low sensation ads that provide them with information, support, and encouragement in the quitting process. Conversely, ads that graphically depict the health consequences of smoking and/or include emotional narratives of personal losses due to smoking may be more appropriate for smokers who are less open to quitting and need stronger motivation to quit. NY TCP uses both strategies in its paid advertising efforts, and we assess NY TCP's implementation of those strategies in this report.

Earned Media

Media advocacy in tobacco control involves the strategic use of the media to shape public views, frame the issue/debate, and ultimately influence tobacco control policy (NCI, 2008). Media advocacy has been shown to significantly increase reporting of tobacco control and other public health issues in the news. News coverage of tobacco issues has the potential to influence attitudes, beliefs, and other tobacco-related outcomes, although the evidence for this is currently limited (NCI, 2008).

NY TCP–funded community contractors work to increase the impact of their efforts by making them public, including getting newspaper, radio, and television news coverage. Partners send out press releases about tobacco control achievements, write letters to the editor about the issues they address, alert media sources of upcoming community events, and correspond with media contacts about the importance of keeping tobacco control issues in the news. The Public Affairs Group within the New York State Department of Health (NYSDOH) has also supported the program by regularly issuing tobacco control–related press releases. These releases are often associated with recurring events, such as the International Day of Action for smoke-free movies, the release of new scientific data, and new project initiatives.

Cessation Interventions

To promote cessation, NY TCP takes a multistrategy, evidence-based approach that includes health systems change, telephone-based smoking cessation counseling, and health communication. Examples of health systems change include promoting written policies or standards of care, updating systems in health care provider organizations (e.g., reminder systems, electronic medical records) to ensure that patients are asked about tobacco use and provided assistance, supporting the transition to smoke-free substance abuse treatment facilities, expanding Medicaid support for smoking cessation, and reaching out to private health plans to expand tobacco cessation coverage. To increase access to nicotine replacement therapy (NRT) and cessation counseling, NY TCP offers the New York State Smokers' Quitline.

Cessation Centers

The program funds 19 Cessation Centers to increase the number of health care provider organizations that have a system to screen all patients for tobacco use, provide brief advice to quit at all visits, and provide assistance to help patients quit successfully. Evidence demonstrates that brief advice to quit smoking by a health care provider significantly increases the odds that a smoker will quit. Cessation Centers use the Public Health Service clinical practice guideline *Treating*

Tobacco Use and Dependence to guide their work. Cessation Centers partner with health care organizations across New York State and offer provider training, guidance on system improvement, and technical assistance to bring new organizations on board, including providing continuing education credits for tobacco cessation training. Cessation Centers are beginning to reach out to health plans to offer assistance to their member practices if they need to improve cessation-related performance measures, as well as collaborate with other chronic disease programs to integrate their approach.

Given the challenge of reaching all of the many hospitals and medical practices in New York, in February 2008, the Cessation Centers launched a media campaign ("Don't Be Silent about Smoking") aimed at health care providers to extend the reach of their message.

New York State Smokers' Quitline

The New York State Smokers' Quitline was established in 2000 and currently provides individualized phone counseling from 9:00 a.m. to 12:00 a.m. Monday through Wednesday, 9:00 a.m. to 9:00 p.m. Thursday and Friday, and 9:00 a.m. to 1:00 p.m. Saturday and Sunday; prerecorded messages covering a range of stop-smoking topics; a Fax-to-Quit health care provider referral program; the Quitsite Web site; and the distribution of free 2-week NRT starter kits to eligible callers. Quitlines and Web-based quitsites serve a number of purposes in a tobacco control program, including (1) providing an effective, evidence-based service for helping smokers quit smoking; (2) serving as a clearinghouse of information on smoking cessation for smokers, health care providers, and the general public; (3) providing a call to action in mass media messages designed to promote cessation; and (4) enhancing the ability of health care providers to refer their patients to a helpful resource.

The core service of the Quitline is to provide support to those who call. The support is provided by a Quitline specialist who works with the smoker to develop a quit smoking plan, assess eligibility for and provide NRT, and send the smoker a packet of quit smoking information. The specialist contacts the caller again to offer encouragement, provide additional tips, and determine quit progress. The Quitline also offers additional coaching calls and NRT for Medicaid recipients and the uninsured.

Reduced Patient Costs for Treatment

NY TCP has implemented two initiatives to increase support for cessation coverage through policy and systems change: one focuses on working with the Medicaid program to expand coverage for smoking cessation counseling and pharmacotherapy, and the other involves reaching out to New York–based health plans to encourage them to provide greater support for smoking cessation. Medicaid will reimburse for two 90-day courses of smoking cessation medication (i.e., nicotine inhalers and nasal sprays, medication such as Zyban [bupropion] and Chantix [varenicline], and over-the-counter nicotine patches and gum). Beginning in January 2009, pregnant smokers also can receive up to six counseling sessions annually. The goal of these initiatives is to provide increased support to smokers for smoking cessation statewide.

The other strategy for reducing out-of-pocket costs for effective cessation treatment is to provide free NRT starter kits. In addition to distributing NRT through the New York State Smokers' Quitline and Quitsite, NY TCP has distributed NRT through substance abuse treatment programs, local health departments, and Cessation Centers. The distribution of NRT through substance abuse treatment programs

began in September 2007 to help facilitate substance abuse treatment programs' transition to smoke-free facilities and grounds that was required by the Office of Alcoholism and Substance Abuse Regulation 856, implemented in July 2008. Therefore, in this setting, NY TCP is the payer of last resort for NRT. In addition, NY TCP began supporting the distribution of NRT through local health departments in January 2008. Support for NRT distribution through local health departments ended on March 31, 2009, because of budget constraints.

Statewide and Community Action

State and community interventions have long been an integral part of a comprehensive tobacco control program (CDC, 2007b). NY TCP funds organizations across the state to work in three modalities: Community Partnerships for Tobacco Control, Youth Action Programs, and Tobacco-Free School Policy Programs. A fourth modality, Advocacy in Action, is set to begin in July 2009 and focuses on engaging young adult leaders to work on and off college campuses to advance local and statewide policy to denormalize and reduce tobacco use.

In FY 2008–2009, the community contractors were structured in such a way that every county falls within the coverage area of one Community Partnership, one Youth Partner, one Cessation Center, and one School Policy Partner. These contractors are charged to effect policy change in multiple settings, including health care provider organizations; schools; licensed tobacco retailers; multi-unit housing; and public spaces, such as parks, beaches, and building entranceways. A key indicator for this strategy is the adoption and effective implementation of local and statewide policies that permanently change society's acceptance of tobacco use (Gerlach et al., 2005). CDC recommends that tobacco control programs emphasize tobacco regulation and policy over individually focused clinical or education interventions because policy changes potentially have the greatest reach (CDC, 2007b). For this strategy to have a meaningful effect on population-based measures of smoking initiation and cessation, two conditions must be met. First, the targeted policies must cover a significant proportion of the state's population. Second, the policies must either provide meaningful support for smoking cessation (e.g., encourage health care providers to more systematically support smoking cessation with their patients) and prevention or constraints on the tobacco industry (e.g., reduce cigarette price promotions).

Community contractors conduct three types of activities (or strategies). They use paid and earned media and other strategies to raise awareness and educate the community and key community members about the tobacco problem and tobacco control policies; educate government policy makers about the tobacco problem to build support for tobacco control policies; and advocate with organizational decision makers, such as tobacco retailers, health care organizations, school boards, and community organizations, for policy changes and resolutions.

Community Partnerships for Tobacco Control

In FY 2008–2009, 29 Community Partnerships across the state conducted activities to meet the following objectives:

- Increase the number of retail tobacco stores that have a written policy prohibiting tobacco company or tobacco product advertising.
- Increase the number of sporting, cultural, entertainment, art, and other events in the community, region, and state that have a written policy prohibiting the acceptance of tobacco company corporate giving, commercial sponsorship, or product promotion.
- Increase the number of local laws, regulations, and voluntary policies that prohibit tobacco use in outdoor areas (e.g., public parks, beaches, outdoor areas of businesses).
- Increase the percentage of adult smokers and youth who live in households where smoking is

Community Partnerships advocate directly with tobacco retailers to request that they voluntarily reduce, rearrange, or eliminate tobacco advertising in their stores, and they contact local municipalities to request that they adopt resolutions of support for eliminating tobacco advertising in the retail environment. Each of the Community Partnerships targets a handful of retailers for policy change annually.

In addition, Community Partnerships work with businesses, organizations, and municipalities to implement policies prohibiting tobacco use on their grounds or near building entranceways. Community Partnerships also advocate with landlords and property management representatives to introduce smoke-free policies in multi-unit housing.

Youth Action Programs

In FY 2008–2009, 46 Youth Action Programs engaged youth leaders to challenge and change community norms regarding tobacco use through policy advocacy and community education efforts. These Youth Action Programs engage middle and high school aged youth in actions aimed at deglamorizing and denormalizing tobacco use in their communities and exposing the manipulative and deceptive marketing practices of the tobacco industry. Their specific objectives for the past year are to

- eliminate smoking and tobacco imagery from movies rated G, PG, and PG-13;
- increase the number of magazine and newspaper publishers that have a written policy prohibiting acceptance of tobacco company, retailer, or product advertising; and
- increase the number of retail tobacco stores that have a written policy prohibiting tobacco company or tobacco product advertising.

Youth Partners promote smoke-free movies by obtaining smoke-free movie resolutions from organizations throughout the state and collecting petition signatures in support of smoke-free movies. These are sent to the Motion Picture Association of America and major movie studios to encourage them to eliminate smoking in movies rated G, PG, and PG-13. Youth Partners participate in an International Day of Action regarding smoke-free movies, conducting activities at the same time as other groups in other states and countries to protest the presence of tobacco products and smoking in youth-rated movies. In 2008, NY TCP released a request for proposals to identify a contractor to work with NY TCP and Youth Partners to develop strategies to advance the Smoke-Free Movies Initiative.

Youth Partners have advocated for magazine publishers to send magazine editions to schools and libraries that are free of tobacco advertisements. They have had some success in the past in this area and continue to work to increase the number of magazines (i.e., *Essence, Field and Stream, Outdoor Life,* and *Popular Science*) that prohibit tobacco advertising or produce editions that are free of tobacco advertisements. They do this by obtaining signed resolutions supporting the tobacco advertisement–free magazine initiative from parent groups, school boards, and community organizations. These resolutions are sent to the New York State Attorney General and magazine publishers.

Tobacco-Free School Policy Programs

In FY 2008–2009, 33 School Policy Partners worked with schools and school districts to implement and enforce tobacco-free school policies that meet standards developed by NY TCP. These standards include

- prohibiting tobacco use among students, staff, and visitors in school buildings and on school grounds, in all school vehicles, and at school functions away from school property;
- requiring that appropriate tobacco-free school signage be posted in school buildings, in school vehicles, and on school grounds;

- prohibiting the sale of tobacco on school property and at school functions;
- prohibiting tobacco advertising in school buildings, on school grounds, and at school functions;
- requiring enforcement statement or enforcement procedures for student, staff, and visitor violations;
- requiring that access and referrals to tobacco cessation resources be provided to students and staff; and
- requiring that all students receive instruction on avoiding tobacco use.

School Policy Partners provide technical assistance to schools and school districts to implement comprehensive tobacco-free school policies. School Policy Partner activities include obtaining buy-in from school administrators, recruiting a committee to develop an updated policy, providing technical assistance for policy development and review, and providing assistance for policy implementation.

School tobacco policies can affect the prevalence and intensity of student tobacco use through numerous pathways. Such policies can reduce students' opportunities to smoke, decrease exposure to adult modeling of smoking, change norms regarding the acceptability of smoking, and reduce access to tobacco products. Studies of worksite policy (Fichtenberg and Glantz, 2002; Bauer et al., 2005; Farrelly, Evans, and Sfekas, 1999; Brigham et al., 1994) and school policy (Rohde et al., 2001; Kumar, O'Malley, and Johnston, 2005; Evans-Whipp et al., 2004; Leatherdale and Manske, 2005; Wakefield et al., 2000; Turner and Gordon, 2004) demonstrate positive effects of smoke-free sites on smoking rates. These studies also indicate that nuances in implementation of school policies, such as strictness of monitoring, allowances for staff smoking, closed campus policies, and provision of cessation services for students and staff, can enhance or reduce program effectiveness.

Program Context

NY TCP has established a comprehensive tobacco control infrastructure, including health communication, cessation interventions, and statewide and community action. To better understand the context within which these activities are implemented, we present data on several key factors that influence tobacco use: cigarette excise taxes, funding for tobacco control programs, the percentage of the population covered by smoke-free air laws, and tobacco sponsorships and promotions (Table 1). With respect to indicators of tobacco control environment, New York compares favorably with the average state: New York's cigarette excise taxes are more than double the U.S. average; all New Yorkers are covered by a comprehensive smoke-free air law, compared with 40% nationally; and average per-capita funding for tobacco control over the past 3 years is higher in New York ($3.81) than in the average state ($2.21). In 2008, per capita funding across all states ranged from $0.25 in Missouri to $13.67 in Maine. In contrast, the tobacco industry promotes tobacco more aggressively and engages in more sponsorships and charitable donations in New York than in the average state.

Table 1. Pro- and Anti-Tobacco Control Environmental Influences in New York and the United States

Indicator	New York	U.S. Average
State cigarette excise tax (July 1, 2009)	$2.75	$1.27
Percentage of the state population covered by comprehensive[a] smoke-free air laws (April 20, 2009)	100%	39.6%
Average annual per capita funding for tobacco control (2006–2008)	$3.81	$2.21
Percentage of cigarette sales sold under a price promotion (2007)	13.2%	3.3%
Sponsorships and charitable donations from tobacco companies (2007)	$11.3 million total	$0.54 million per state ($27.0 million total)

[a] "Comprehensive" refers to laws that create smoke-free bars, restaurants, and workplaces.

Program Response to the Fiscal Crisis

As a result of the state fiscal crisis, the NY TCP budget was cut significantly from $84.3 million at the beginning of FY 2008–2009 to $68.0 million at the beginning of FY 2009–2010, a decline of 19.2%. NY TCP originally proposed a budget of $85.49 million for FY 2008–2009 that was reduced at the start of the year with a number of programmatic and administrative line changes; the $84.3 budget presented in Table 2 represents the budget that the program operated under at the start of the fiscal year and is used in the report because it better illustrates the decisions the program made in response to the budget reductions. Table 2 presents line item budgets for FY 2008–2009 prior to midyear reductions and FY 2009–2010. This reduction occurred in two phases: a midyear reduction from $84.3 million to $80.4 million (−4.6%) in FY 2008–2009 and a reduction from $80.4 million to $68.1 million (−15.3%) in FY 2009–2010. Some of the changes in the budget reflect previous strategic decisions, such as reducing the number of Youth Action Programs and not renewing the Promising Tobacco Interventions, whereas other changes reflect responses to the budget crisis.

The Program had several rationales to its approach to the budget adjustments:

- Preserve essential Program capacity and infrastructure because it represents a long-term investment that is not easily restored once eliminated.
- Support new initiatives seen as critical for the future of the program (e.g., Tobacco Policy Center of Excellence and new multimedia countermarketing projects), while eliminating other new initiatives (e.g., Tobacco Free Tribal Communities, Mental Health Initiative).
- Delay new initiatives in FY 2008–2009 until the next fiscal year.
- Reduce funding for other initiatives, with relatively larger reductions for activities that can be reduced more easily without losing Program capacity, such as media placement and NRT distribution.

The largest percentage reduction is for statewide and community action (−32.3%), followed by health communication (−24.9%), research and evaluation (−23.1%), enforcement (−9.9%), and cessation (−2.0%). Program administration, which includes cancer surveillance, increased by 11.5% after remaining flat for several years.

Table 2. NY TCP Budgets, Original FY 2008–2009 and FY 2009–2010

Program Component	Original FY 2008–2009 ($)	FY2009–2010 Revised ($)	% Change
State and Community Action			
Community Partnerships	8,788,240	8,691,572	−1.1%
Youth Action Program	5,845,000	3,621,900	−38.0%
Young Adult Advocacy in Action	—	656,250	—
School Policy Partners	3,535,000	3,322,900	−6.0%
Asthma Coalitions	550,000	517,000	−6.0%
Tobacco Policy Center of Excellence	275,000	343,040	24.7%
Smoke-Free Movies	62,500	63,600	1.8%
Training and Other Services	857,000	780,000	−9.0%
Promising Tobacco Interventions	4,368,500	—	−100.0%
Women in Government/Consultant Services	50,000	—	−100.0%
Mental Health Initiative	1,119,864	—	−100.0%
Tobacco Free Tribal Communities	192,500	—	−100.0%
Community Resource Center	500,000	—	−100.0%
Public Relations Resource Center	425,000	—	−100.0%
State and Community Action Subtotal	**26,568,604**	**17,996,262**	**−32.3%**
Enforcement			
Enforcement Subtotal	**5,800,000**	**5,225,650**	**−9.9%**
Cessation			
Cessation Centers	6,757,337	6,350,283	−6.0%
Tobacco Dependence Treatment Programs	2,000,000	1,255,350	−37.2%
Quitline	2,938,157	3,969,080	35.1%
Nicotine Replacement Therapy	6,610,902	6,370,000	−3.6%
Cessation Subtotal	***18,306,396***	**17,944,713**	**−2.0%**
Health Communication Campaigns			
Media Placement	22,050,000	15,273,875	−30.7%
Multimedia Countermarketing Campaigns	—	850,000	—
Multimedia Research Project	—	637,500	—
Misc Media Development and Placement	900,000	350,000	−61.1%
Health Communication Campaigns Subtotal	**22,950,000**	**17,237,500**	**−24.9%**
Research and Evaluation			
Research and Evaluation Subtotal	**6,500,000**	**5,000,000**	**−23.1%**
Administration			
Administration Subtotal	**4,238,000**	**4,724,700**	**11.5%**
Total	84,363,000	68,128,825	−19.2%

Health Communication

The most tangible and significant budget reduction with concrete short-term implications is the 31% reduction in media placement for FY 2009–2010. Our previous evaluations have shown that the Program's television advertisements have influenced antitobacco attitudes; driven calls to the Quitline; and, most importantly, promoted smoking cessation. However, the Program is taking actions to minimize the impact of the budget reduction on smoking cessation. It is doing this by maintaining level funding for television advertisements, increasing the budget for radio advertisements, and reducing funding for other media channels. Media placement will be reduced in other venues, such as the Internet, sports venues, malls, transit, and newspapers. Although research indicates that reaching target audiences through multiple communication channels is more effective than a single outlet, we believe that the adjustments to the media placement strategy are a reasonable response to the budget reduction. In addition, the Program is shifting more of the messaging toward cessation and away from secondhand smoke. The latter strategy is based on evaluation findings showing that although secondhand smoke television advertisements are associated with changes in attitudes and increases in Quitline call volume, they are not associated with behavior change (i.e., smoking cessation and 100% smoke-free home rules). However, cessation-focused advertisements, particularly those with high sensation value, are associated with increases in Quitline call volume, quit attempts, and intentions to quit.

Cessation Interventions

Although the budget for cessation interventions appears to be the least affected, the changes in the budget from the beginning of FY 2008–2009 to FY 2009–2010 mask changes that happened in the interim during FY 2008–20009. For the Quitline, there was no change in the budget during FY 2008–2009 and a 6% reduction for tobacco dependence treatment programs and Cessation Centers. However, the budget for NRT distribution increased sharply from $6.6 million to $10 million as a result of the greater than expected demand for NRT at substance abuse treatment facilities and local health departments.

Statewide and Community Action

Although statewide and community action has the largest reduction, funding for the core programs (i.e., Community Partnerships, Youth Action Programs, School Policy Partners, and training) was largely preserved, with the exception of the aforementioned planned reduction in the number of Youth Action Programs. Other initiatives concluded in FY 2008–2009 and will not be renewed (i.e., promising tobacco interventions, mental health initiative) and several other planned initiatives have been postponed indefinitely (i.e., tobacco-free tribal communities, community resource center, public relations resource center, women in government). Support for Asthma Coalitions continues in the FY 2009–2010 budget, although it is not clear how this contributes to NY TCP goals and objectives because there does not appear to be explicit coordination between these Asthma Coalitions and the Community Partnerships. To date, the Asthma Coalitions have not been part of the independent evaluation.

Other new initiatives, such as the Tobacco Policy Center of Excellence, may prove to be quite useful to NY TCP in light of the recent passage of the Family Smoking Prevention and Tobacco Control Act that gives the Food and Drug Administration (FDA) authority over tobacco and creates tobacco control policy options at the state level, such as regulating the time, place, and manner (but not the content) of cigarette advertising. In addition, the new Smoke-Free Movies Initiative would build on previous activities by the Youth Partners by providing overall coordination within the state and with national organizations as noted above. The purpose of the Advocacy in Action modality is to engage young adult leaders to work on and off college campuses to promote policy change that

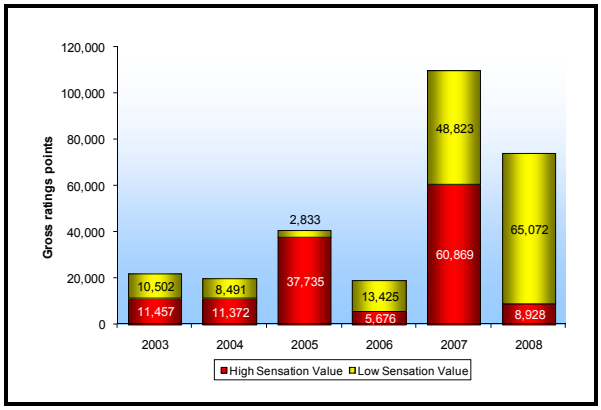
limits where and how tobacco products are promoted, advertised, and sold. This initiative is intended to combat the significant amount of tobacco industry marketing aimed at young adults (Sepe, Ling, and Glantz, 2002; Gilpin, White, and Pierce, 2005), reduce industry sponsorships, and to promote smoke-free multi-unit housing.

Program Implementation

Health Communication

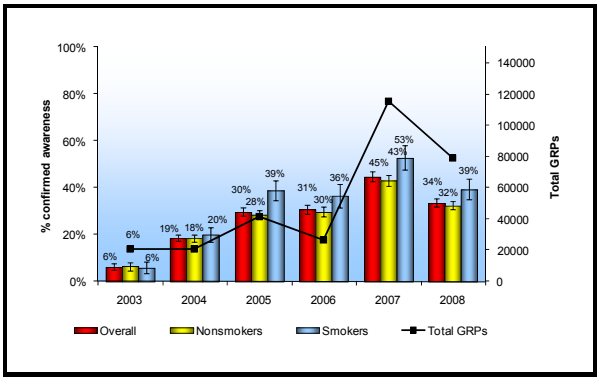
Over the past 5 years, the Program's overall budget was doubled and an increasing share was dedicated to mass media efforts, including high sensation value television advertisements. Gross rating points (GRPs) represent a standardized measure of a television audience's potential exposure to a media campaign. Overall, advertising increased fivefold from 2003 (21,959 GRPs) to 2007 (109,692 GRPs) (Figure 1). However, overall GRPs declined by 32.5% between 2007 and 2008, and the proportion of GRPs devoted to high sensation value ads declined substantially. Administrative delays contributed to the reduction in advertising activity in 2008. Approval and certification of NY TCP's overall budget was delayed in 2008, which in turn delayed the amendments to the media purchasing contract, compounding delays in launching media campaigns.

Figure 1. Market-Level Gross Rating Points for Paid Television Advertisements by Ad Sensation Value in New York, 2003–2008



NY TCP's increased investment in mass media translated into significant increases in New Yorkers' awareness of advertisements over time. Figure 2 shows trends in confirmed awareness of countermarketing ads from 2003 to 2008. Confirmed awareness of NY TCP–sponsored advertisements among New York smokers increased from 6% in 2003 to 39% in 2008. Similar significant increases occurred among nonsmokers (6% to 32%). Although confirmed awareness increased significantly since 2003, there was a pronounced decline in awareness among smokers from its peak of 53% in 2007 to 39% in 2008. The decline in awareness coincides with the decline in advertising GRPs in 2008. The GRP data shown in Figure 2 illustrate the relationship between paid ad placements and confirmed awareness over time.

Figure 2. Confirmed Awareness of NY TCP Tobacco Countermarketing Television Advertisements and Annual Advertising Gross Rating Points, ATS 2003–2008



Note: Statistically significant upward trend from 2003–2008 among smokers, nonsmokers, and adults overall.

In 2008, NY TCP's television media plan focused exclusively on cessation-focused advertisements. Table 3 lists advertisements that were aired in 2008, when they were aired, our qualitative sensation value rating (high or low), and the total number of GRPs for the year. Prior to being aired, nearly all of these advertisements were assessed in an online media tracking survey to gauge smokers' receptivity to the advertisements. Eighty-eight percent of the GRPs were for low

sensation value advertisements. The majority of these advertisements focus on the benefits of calling the Quitline (e.g., "Food," "Mood," "Call it Quits," "Time to Quit"). Other low sensation advertisements include the American Legacy Foundation's "Become an EX" campaign, which featured three ads that show smokers re-learning how to perform everyday activities (i.e., drinking coffee, driving, and getting ready for work) without having to smoke.

Table 3. NY TCP Television Advertisements Aired in Calendar Year 2008

Ad Name	Months Aired in 2008	Ad Type	Sensation Value	Total GRPs
Skip Park	1	Cessation	Low	8235
The Wait	12	Cessation	High	6848
Didn't Listen	1	Cessation	High	1040
Gangrene	1	Cessation	High	1040
Time to Quit	1, 2, 3, 4	Cessation	Low	16474
Call it Quits	2, 3, 4	Cessation	Low	10011
Wall	1, 2, 3, 4	Cessation	Low	7943
Food	4, 5	Cessation	Low	7378
Mood	4, 5	Cessation	Low	7378
Coffee	10, 11	Cessation	Low	2551
Driving	10, 11	Cessation	Low	2551
Start Your Day	10, 11	Cessation	Low	2551

Note: GRPs = gross rating points.

The high sensation value advertisements included ads with strong emotions (e.g., "The Wait") and graphic images (e.g., "Gangrene" and "Didn't Listen"). "The Wait" shows a patient anxiously waiting in an examining room, imagining all of the possible tobacco-related diagnoses he may receive from his doctor. "Didn't Listen" shows a doctor performing surgery on a diseased lung and noting how most patients express regret for not deciding to quit sooner.

As a result of delays in the contract amendment for the media buyer, the program was off the air for 6 months during 2008. Secondhand smoke–focused advertisements and additional high sensation value cessation advertisements were delayed until 2009.

Cessation Interventions

Cessation Centers

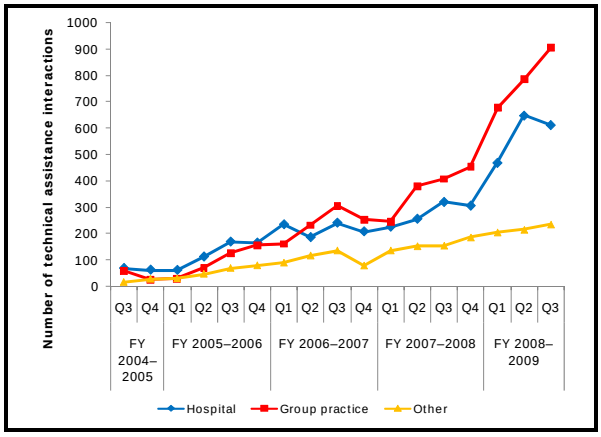
Cessation Centers establish relationships with health care organizations and offer technical assistance with changes to systems and practices related to identifying and treating patients who use tobacco. They also conduct provider training and provide materials and information on cessation interventions.

Cessation Center interventions initially focused on hospitals. However, Cessation Centers have worked with the majority of hospitals in New York State and recognize that most patient interactions occur in outpatient settings. As Cessation Centers have reached out to group practices, they have encountered new challenges. Group practices have more limited time, fewer

formal incentives to implement changes than hospitals (which must meet specific requirements for accreditation), and less formalized means of documenting their protocol and practices in general. Cessation Centers have adapted their approach to try to appeal to group practices in a more targeted way.

Cessation Centers have increased the number of technical assistance interactions with health care organizations each year, especially among group practices, indicating enhanced Cessation Center capacity and greater reach across the state (Figure 3).

Figure 3. Number of Cessation Center Technical Assistance Interactions by Type of Health Care Organization, CAT System, FY 2004–2005 to FY 2008–2009

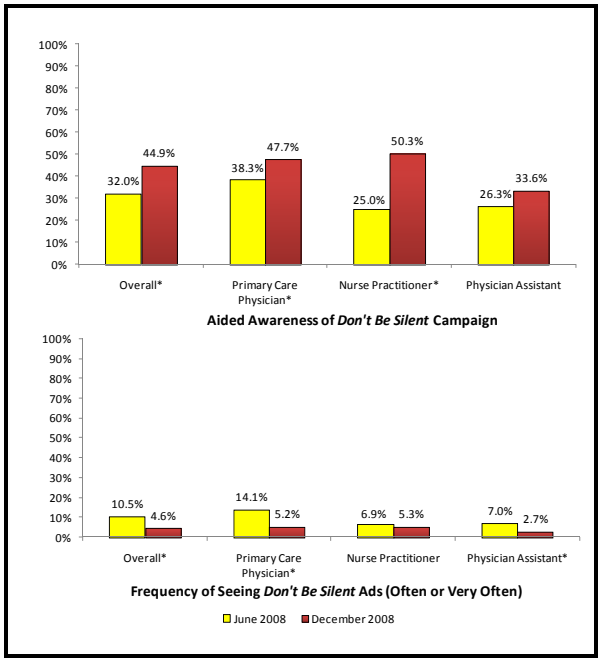


In 2008, the "Don't Be Silent About Smoking" health care provider media campaign consisted of two phases of print advertisements in various periodicals, including the *Journal of the American Medical Association* and *New England Journal of Medicine*; Internet banner advertisements; and a Web site, talktoyourpatients.org. The first phase of the "Don't Be Silent" campaign ran from February to June 2008 and primarily targeted primary care physicians, nurse practitioners, and physician assistants. The Program invested approximately $1.1 million in the first phase. The follow-up phase for the "Don't Be Silent" campaign ran from October to December 2008 and included print and Internet banner ads similar in style and format to the original ads, but targeted primarily to nurses and nurse practitioners. Advertisements for this phase of the campaign were also placed in nursing-specific publications, such as *American Nurse* and *Nursing Spectrum*. The budget for this phase of the campaign was $120,000.

To assess the "Don't Be Silent" campaign, we conducted an initial survey (N = 1,205) and a follow-up survey (N = 602) of primary care physicians, physician assistants, and nurse practioners using an online panel of health care providers. The first survey was conducted in June 2008, and the follow-up survey was conducted in December 2008. The survey measures awareness of and receptivity to the campaign and targeted outcomes, such as asking patients about tobacco use and advising and assisting them with quitting.

By June 2008, a few months after the launch of the "Don't Be Silent" campaign, approximately one-third of health care providers had seen at least one of the advertisements, with higher awareness among primary care physicians—the target of the first phase of the campaign (Figure 4). By the December 2008 follow-up survey, overall awareness increased to 45% and doubled among nurse practitioners (from 25% to 50%), the target of the second phase of the campaign. Despite reasonably high levels of awareness by December 2008, a small percentage of health care providers reported seeing the "Don't Be Silent" advertisements "often" or "very often," and this percentage decreased over time, consistent with a smaller media buy for fall 2008.

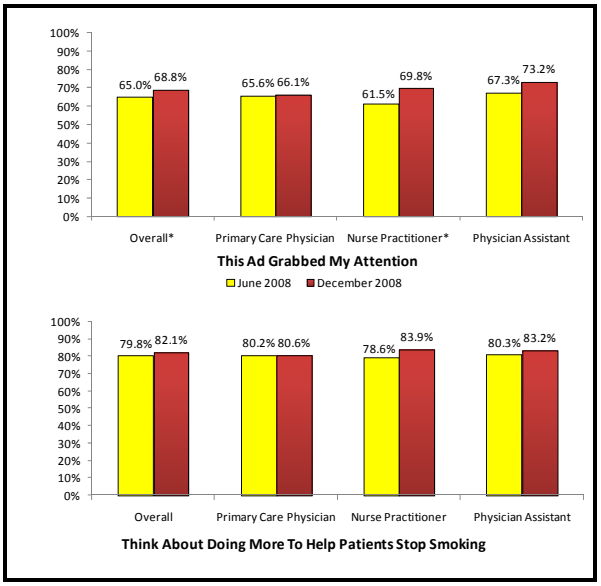
Figure 4. Percentage of Health Care Providers Who Reported Seeing the "Don't Be Silent" Campaign Advertisements at Least Once and "Often" or "Very Often," June 2008 and December 2008 Health Care Provider Online Survey



*Statistically significant difference between June and December surveys ($p < 0.05$).

The "Don't Be Silent" campaign appears to be well received by providers. A high percentage of health care providers agree that the advertisements grabbed their attention and made them think about doing more to help patients stop using tobacco (Figure 5). However, to date, we do not have strong evidence that the campaign has influenced targeted outcomes, such as health care providers asking, advising, and assisting patients about smoking and smoking cessation and related attitudes. Although the purpose of the campaign is to contribute to the overall efforts of the Cessation Centers to promote system-level changes, providers' response to the campaign serves as a proxy of the campaign's ability to influence support for such system-level changes. Given the positive appraisals of the campaign, the lack of a behavioral impact may result from insufficient resources to expose providers frequently enough to the campaign. The limitations of the evaluation may have also influenced the results of the analysis. The limitations include relying on a convenience sample of health care providers from the online survey and conducting the initial survey several months after the launch of the campaign.

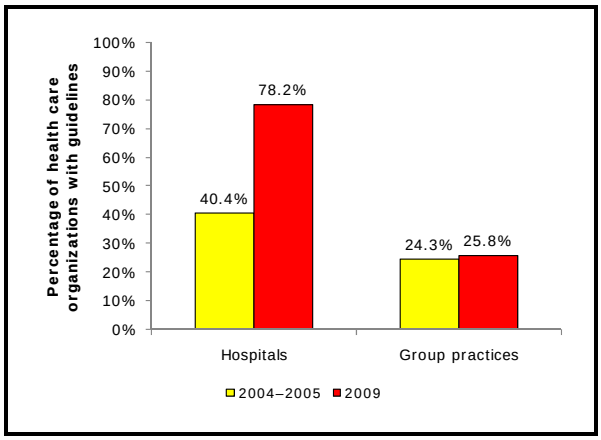
Figure 5. Percentage of Health Care Providers Who Reported That the "Don't Be Silent" Advertisements Grabbed Their Attention and Made Them Think About Doing More to Help Patients Stop Using Tobacco, June 2008 and December 2008 Health Care Provider Online Survey



*Statistically significant difference between June and December surveys ($p < 0.05$).

To assess the impact of the Cessation Centers initiative on health systems change, we conducted the Health Care Organization and Provider Study (HCOPS). From this study, we found that the percentage of hospitals in New York that have written guidelines regarding tobacco use identification and treatment has increased, whereas the percentage of group practices remains unchanged (Figure 6).

Figure 6. Health Care Organizations with Written Guidelines Regarding Tobacco Use Identification and Treatment in New York State, HCOPS 2004–2005 and 2009

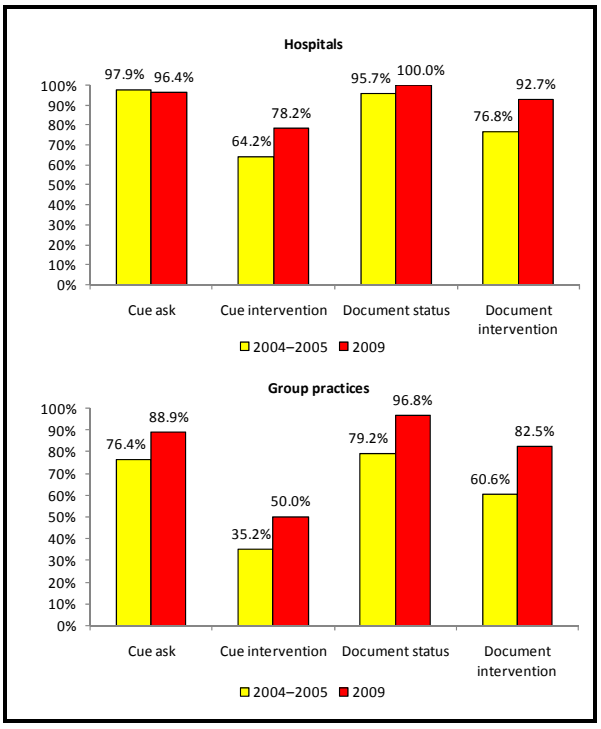


Note: Preliminary, unweighted data

The percentage of hospitals in New York State that have systems in place to cue providers to ask patients about tobacco use and document tobacco use status remained very high, and the percentage of group practices appears to have increased (Figure 7). Among both hospitals and group practices, there appears to have been an increase in systems to cue providers to conduct cessation interventions and document those interventions.

Since 2005, there has been an increase in the percentage of hospitals in New York State that require their providers to ask new patients about their tobacco use status, ask all patients about tobacco use at every visit, strongly advise tobacco users to quit, and offer NRT or other stop smoking medications unless contraindicated (Figure 8). There appears to be an increase in the percentage of group practices that require providers to offer NRT or other stop smoking medications, but a decrease in the percentage of group practices that require their providers to ask new patients about tobacco use.

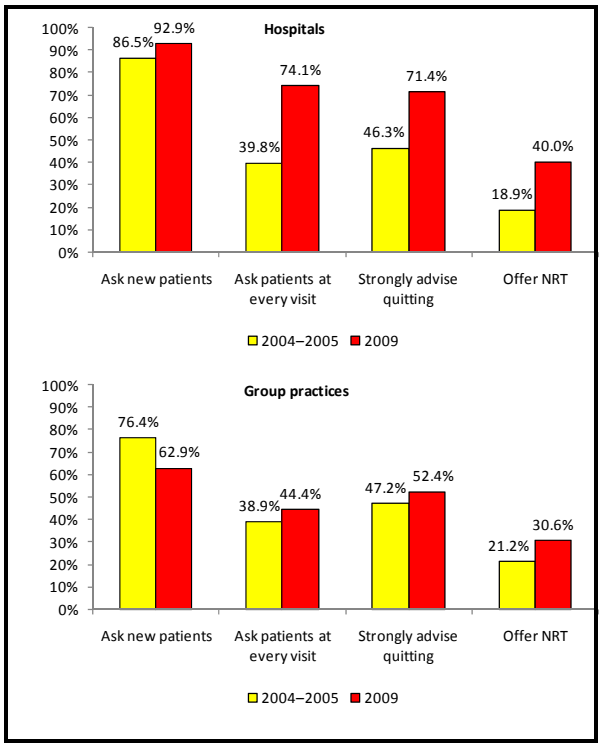
Figure 7. Health Care Organizations with Systems Regarding Tobacco Use Identification and Treatment in New York State, HCOPS 2004–2005 and 2009



Note: Preliminary, unweighted data

For the next contract period, Cessation Centers will continue to promote the Public Health Service guideline, reaching out primarily to group practices for organization-level changes and provider training. Cessation Centers will target federally qualified health centers, which provide services to low-income populations.

Figure 8. Health Care Organizations that Require Providers to Conduct Specific Tobacco Use Identification and Treatment Practices in New York State, HCOPS 2004–2005 and 2009

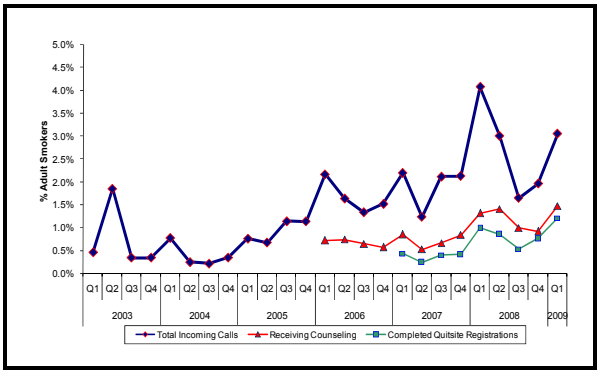


Note: Preliminary, unweighted data

New York State Smokers' Quitline

Use of the New York State Smokers' Quitline has increased steadily over the years. In 2008, 116,479 current and former smokers (4.6% of adult smokers in New York State) received telephone counseling and 78,633 (3.2%) registered to receive free NRT through the Quitsite (Figure 9). Customer satisfaction with the Quitline has remained high over the years, and after the introduction of free NRT starter kits the percentage of clients who are quit 6 months after using the Quitline increased.

Figure 9. Reach of the New York State Smokers' Quitline, Q1 2003–Q1 2009

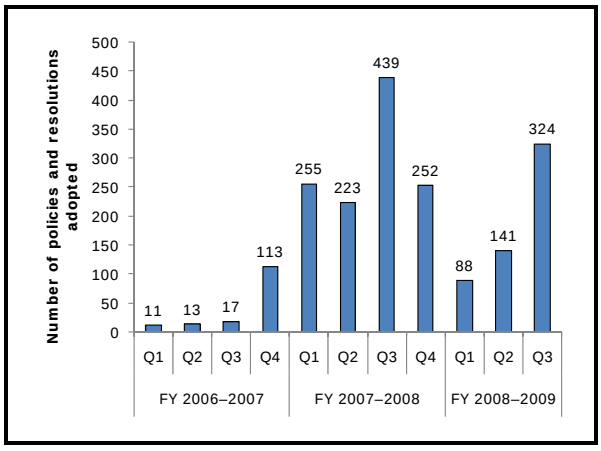


Statewide and Community Action

Community Partnerships for Tobacco Control

In FY 2008–2009, Community Partnerships have focused primarily on reducing tobacco advertising in the retail environment, limiting tobacco company sponsorship and promotion, implementing effective tobacco-free policies in the outdoor environment, and promoting access to evidence-based cessation services. Figure 10 illustrates the number of tobacco retailer policies and municipality resolutions reported by Community Partnerships and Youth Partners. Many retail policy and resolution advocacy efforts were joint strategies across contractors. More than three-fourths (76%) of policies reported during FY 2008–2009 represented changes in the way the organization operates, and 24% were policies formalizing current practice. The number of policies and resolutions reported during the first three quarters of FY 2008–2009 is lower than the same period of the previous fiscal year. However, during FY 2007–2008, one-third of reported policies resulted from a single contractor's mass mailing effort.

Figure 10. Policies and Resolutions Reducing Tobacco Advertising in Retail Environments Reported by Community Partnerships and Youth Partners, CAT System, FY 2006–2007 to FY 2008–2009

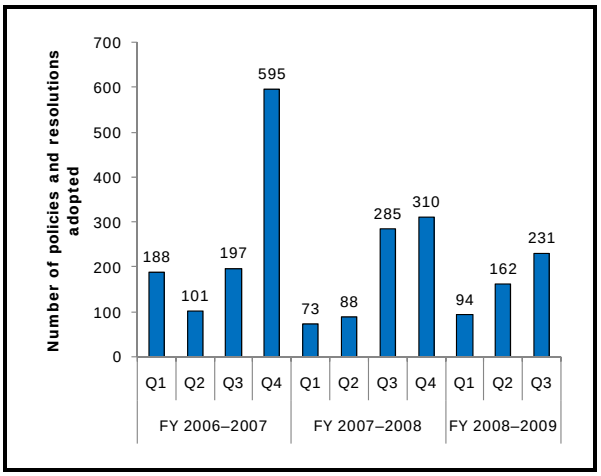


One major policy change in the retail environment occurred in January 2008 when Wegman's supermarket chain announced that it would stop selling tobacco products in all of its stores. Additionally, Price Chopper stores agreed to stock tobacco products out of sight of customers. Community Partnerships are encouraging other retailers to adopt similar policies. Community Partnerships have used newspaper ads to raise awareness of efforts to eliminate tobacco sales in grocery stores and pharmacies and to encourage customers to pressure stores to make this change. Contractors also advocate directly with store managers and owners. The most commonly reported barriers regarding the retail initiative include challenges with needing local stores' policies to be approved by management higher up the organizational chain, lack of support or interest by retailers, restrictions of retailers' contracts with tobacco companies, and not finding store owners present during visits.

Community Partnerships also focused a significant proportion of their work on trying to limit tobacco industry sponsorship and promotion. Activities included asking community organizations, venues, fairs, and businesses to adopt policies prohibiting acceptance of tobacco industry sponsorship. Additional activities included sending mailings to organizations, sponsoring events with tobacco-free messages, running paid media advertisements, and conducting recognition events to bring positive attention to organizations that do adopt policies.

Figure 11 illustrates the number of policies and resolutions to limit tobacco industry sponsorships and promotions adopted over time by community organizations, event committees, and businesses. Approximately three-fourths (74%) of policies reported during FY 2008–2009 were policies formalizing current practice, whereas one-fourth (26%) were changes in the way the organization operates. Contractors are on track to reach a similar number of sponsorship policies and resolutions in FY 2008–2009 as in FY 2007–2008. Contractors reported facing barriers in their advocacy efforts, including legal or bureaucratic hurdles and organizations' competing priorities.

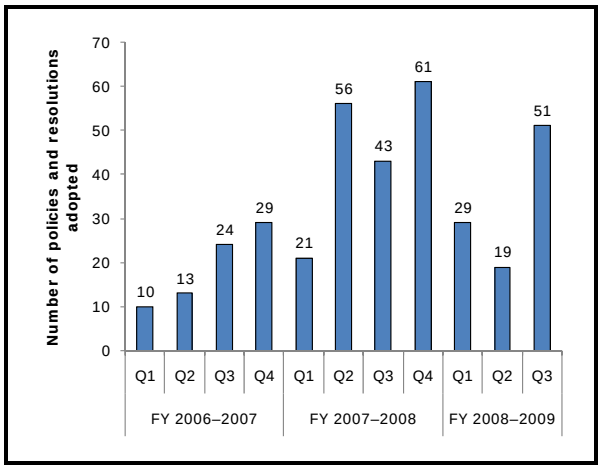
Figure 11. Policies and Resolutions Prohibiting Tobacco Industry Sponsorship and Promotion Reported by Community Partnerships and Youth Partners, CAT System, FY 2006–2007 to FY 2008–2009



Community Partnerships also worked to restrict outdoor smoking. Community Partnerships contacted government officials and decision makers at businesses/workplaces, community organizations, municipalities, and health care

organizations to promote policies that restrict smoking in outdoor areas, including building entranceways and parks. Three-fourths (75%) of policies reported during FY 2008–2009 were changes in the way the organization operates, whereas one-fourth (25%) were policies formalizing current practice. Contractors are on track to reach a similar number of outdoor policies and resolutions in FY 2008–2009 as FY 2007–2008 (Figure 12). Challenges reported by Community Partnerships included resistance to adopting outdoor tobacco use policies, concern about alienating or inconveniencing tobacco users, and difficulty placing signs and cigarette receptacles in locations that effectively communicate the policy.

Figure 12. Policies and Resolutions Prohibiting Tobacco Use in Outdoor Areas Reported by Community Partnerships and Youth Partners, CAT System, FY 2006–2007 to FY 2008–2009



Community Partnerships also advocated with apartment complex managers and landlords for smoke-free multi-unit housing. Early Community Partnership efforts involved encouraging individuals to adopt smoking bans in their homes and cars. This individual-level approach was de-emphasized and replaced with efforts to encourage adoption of smoking bans in multi-unit housing, which have the potential to reach more people. In FY 2007–2008, obtaining multi-unit housing tobacco use policies became a required strategy for Community Partnerships. Partners reported the adoption of 65 smoke-free multi-unit housing policies in the first three quarters of FY 2008–2009.

To ensure the long-term sustainability of NY TCP, Community Partnerships (and other community partners) are required to conduct a core set of activities to educate decision makers, the media, and the general public about the importance of tobacco control and of the program. The number of partners reporting corresponding monthly with legislators, making in-person legislative visits, submitting letters to the editor, and meeting with media representatives has increased every year.

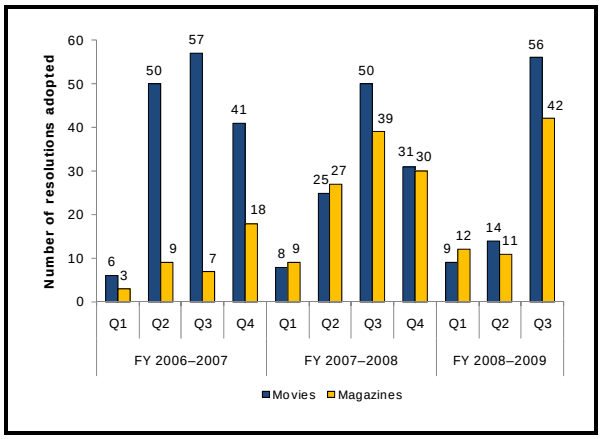
The key activities for Community Partnerships in the next fiscal year will be retail and outdoor policy initiatives. Retail efforts will primarily focus on eliminating sales of tobacco products rather than reducing tobacco advertisements. Smoke-free multi-unit housing policy efforts will only be conducted by contractors in high population areas. Sponsorship and promotion efforts will not be part of Community Partnership efforts because of budget reductions.

Youth Action Programs

In addition to supporting Community Partnership efforts on retail and sponsorship initiatives, Youth Partners focused on smoke-free movies and reducing the amount of tobacco advertising in magazines sent to schools. In FY 2008–2009, Youth Partners reported obtaining smoke-free movie resolutions from more than 80 organizations, which were sent to the Motion Picture Association of America and major movie studios, and they also gathered more than 8,000 petition signatures in support of smoke-free movies. Activities to increase the number of schools receiving tobacco advertisement–free magazines and efforts to obtain signed resolutions supporting the tobacco advertisement–free magazine initiative continued throughout FY

2008–2009 (Figure 13). Youth Partners indicated that the most common barriers they encountered on the Smoke-Free Movies Initiative were a lack of interest in the issue and logistical challenges in getting on organizations' agendas. With magazine resolution efforts, Youth Partners also encountered some logistical challenges and competing priorities among target organizations.

Figure 13. Resolutions Focused on Tobacco-Free Magazines and Movies Reported by Youth Partners, CAT System, FY 2006–2007 to FY 2008–2009



For the next contract period, Youth Partners will focus on smoke-free movies and retail initiatives, as well as either outdoor policies or magazine advertising efforts. Their retail activities will focus on supporting Community Partnership activities by obtaining resolutions and conducting community education.

Tobacco-Free School Policy Programs

Since April 2006, School Policy Partners have built relationships with 873 schools and 562 school districts—representing more than 80% of the school districts in New York State. A total of 134 districts have updated their tobacco policies.

In 2008, RTI assessed existing school policies in 254 school districts (out of a selected sample of 365) to gain a better understanding of the comprehensiveness of school policies. This review indicated that prohibitions on student tobacco use are prevalent in buildings (97%), on school grounds (95%), and in district vehicles (85%). Staff use is also prohibited in school buildings and on school grounds in 85% of district policies and in vehicles in 70% of districts. However, enforcement is not commonly specified in these policies, with explicit mentions of enforcement of policy for students in 63% of the district policies and only 21% for staff.

Where there is a more considerable gap in the school policies and the NY TCP minimum requirements is in prohibition of tobacco use among staff (44%) and visitors (43%) at school-sponsored events. The primary benefit of such policies at school events is to contribute to the NY TCP goal of denormalizing tobacco use. Our evaluation also indicated that school districts working with School Policy Partners had stronger policies than school districts that did not, suggesting that the Partners were influencing policy.

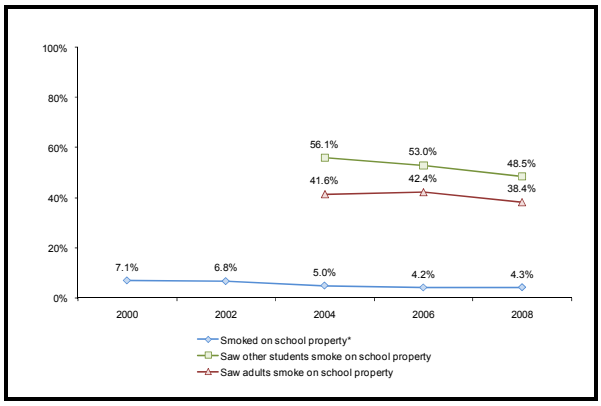
These results suggest that although there are opportunities to strengthen school policies regarding school events, the central policy elements of prohibiting tobacco use among students and staff is very common. What is not clear is how consistently these policies are communicated and enforced and what benefits greater communication and enforcement would yield in terms of student or staff tobacco use.

The most common barriers that School Policy Partners reported encountering in their efforts included a lack of school or district staff interest or follow through, competing priorities (e.g., nutrition, obesity prevention, school budget drafting), lack of policy enforcement, and staffing and turnover issues within the school system.

Data from the New York Youth Tobacco Survey (YTS) paint a puzzling picture of the school environment. Self-reported smoking on school grounds is uncommon (4% of youth in 2008) and declining over time (Figure 14). However, in 2008, approximately half of youth reported seeing at least one other student smoking on school

grounds in the past month and 38% reported seeing at least one adult smoking. There has been no change in either of these measures from 2004 to 2008. However, because these questions do not capture how common smoking is on school grounds, it is possible that smoking could be declining, with no change in these measures.

Figure 14. Percentage of Youth Who Reported Smoking on School Property or Seeing Others Smoking on School Property in the Past 30 Days, YTS 2000–2008



*Significant downward trend from 2000 to 2008.

Trends in Key Outcome Indicators

NY TCP is built on the social norm change model, which posits that reductions in tobacco use are achieved by creating a social environment and legal climate in which tobacco becomes less desirable, less acceptable, and less accessible. This section addresses progress by NY TCP in achieving its statutorily mandated outcomes of reducing tobacco use and strengthening antitobacco attitudes from 2003 to 2008. Data are presented for the United States where available to allow comparisons with New York. In addition to key tobacco use indicators, we examine key outcome indicators for exposure to secondhand smoke and tobacco control policies and related beliefs and attitudes.

Cigarette Use and Smoking Cessation Indicators

The key outcome indicators for this section include the

- percentage of adults who currently smoke in New York and the United States,
- number of cigarettes smoked per day by current adult smokers,
- percentage of adults who currently use smokeless tobacco and smoke cigars,
- percentage of adult smokers who intend to make a quit attempt in the next 30 days,
- percentage of adult smokers who made a quit attempt in the past 12 months, and
- youth smoking prevalence as measured by the New York and National Youth Tobacco Surveys.

From 2003 to 2008, New York Behavioral Risk Factor Surveillance System (BRFSS) and National Health Interview Survey (NHIS) data show a statistically significant downward trend in the percentage of adults who smoke (Figure 15). However, the percentage decline over this period was much greater in New York (22%) than in the rest of the United States (5%). Between 2007 and 2008, the prevalence of smoking decreased in New York, while increasing nationally. Over this same period, self-reported daily cigarette consumption declined by 25% (from 14.7 to 11.0 cigarettes). In 2008, average cigarette consumption was lower in New York (11.0) than nationally (13.1) (Figured 16).

With respect to other tobacco use, there has been a statistically significant downward trend in smokeless tobacco use from 2003 to 2008. In 2008, the prevalence of use is lower in New York (0.9%) than in the United States (3.5%) (Figure 17). Cigar use in New York has remained stable over time, but the prevalence of use was lower in New York (5.3%) than in the United States (7.7%) in 2008.

Figure 15. Percentage of Adults Who Currently Smoke in New York (BRFSS) and Nationally (NHIS), 2003–2008

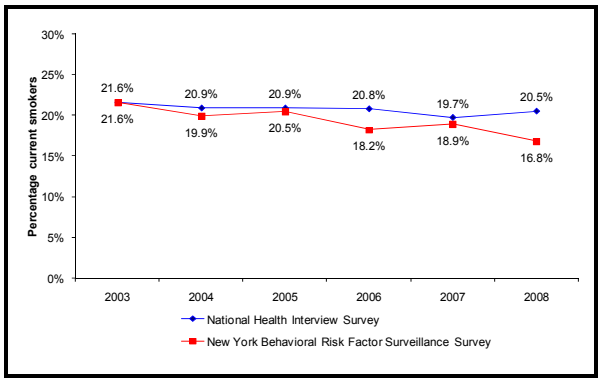
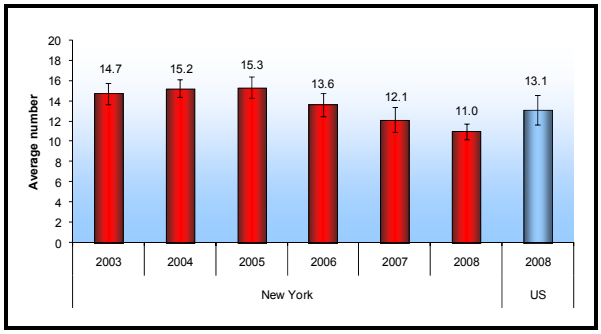
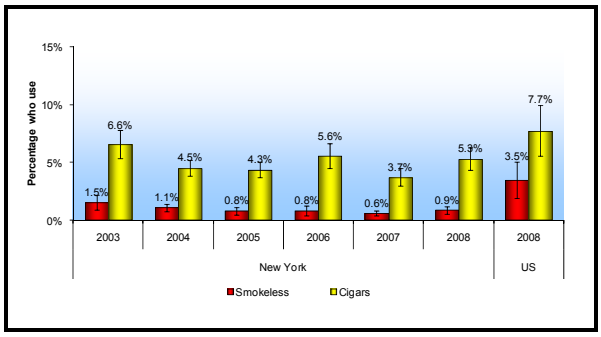


Figure 16. Average Daily Cigarette Consumption by Current Smokers, ATS 2003–2008 and NATS 2008



Note: Statistically significant downward trend in New York from 2003 to 2008. Difference between New York and the United States is statistically significant.

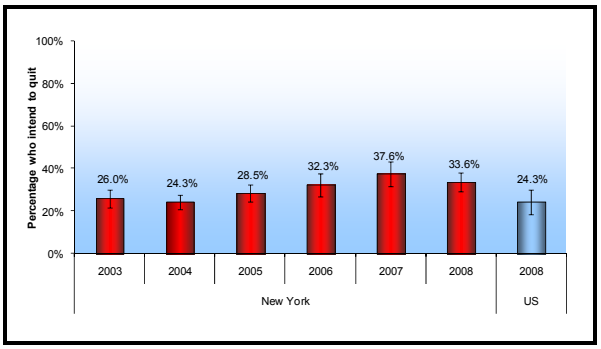
Figure 17. Percentage of Adults Who Currently Use Smokeless Tobacco and Smoke Cigars, ATS 2003–2008 and NATS 2008



Note: Statistically significant downward trend in smokeless tobacco use from 2003 to 2008. Difference between New York and the United States is statistically significant for smokeless tobacco use.

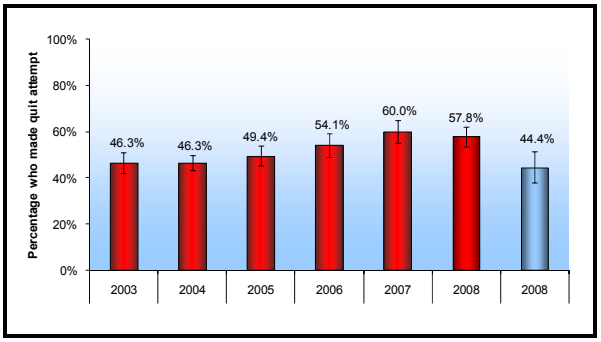
Consistent with the declines in the prevalence of smoking and cigarette consumption, there were significant upward trends from 2003 to 2008 in the percentage of current smokers who intend to make a quit attempt in the next 30 days (Figure 18) and who made a quit attempt in the past year (Figure 19). All four measures show a similar pattern, with very little change from 2003 to 2005, followed by changes thereafter.

Figure 18. Percentage of Adult Smokers Who Intend to Make a Quit Attempt in the Next 30 Days, ATS 2003–2008 and NATS 2008



Note: Statistically significant upward trend in New York from 2003 to 2008. Difference between New York and the United States is statistically significant.

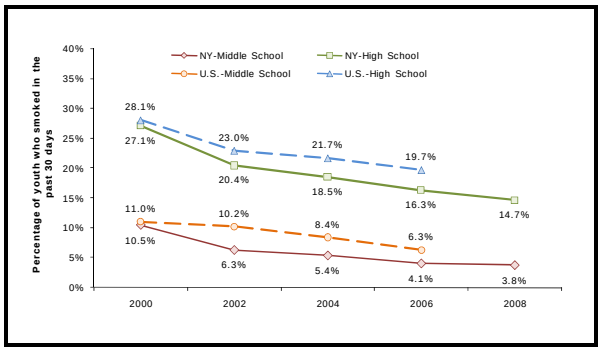
Figure 19. Percentage of Adult Smokers Who Made a Quit Attempt in the Past 12 Months, ATS 2003–2008 and NATS 2008



Note: Statistically significant upward trend in New York from 2003 to 2008. Difference between New York and the United States is statistically significant.

From 2000 to 2008, the percentage of middle and high school students who smoked in the past 30 days declined substantially—by 64% and 46% for middle and high school, respectively (Figure 20). From 2000 to 2006, the rate of decline in New

Figure 20. Percentage of Middle and High School Students Who Currently Smoke in New York and the United States, Youth Tobacco Survey 2000–2008



Note: Statistically significant downward trend from 2000 to 2008.

York was faster than the decline nationally for both middle and high school students (there are no national data for 2008). From 2006 to 2008, there were no statistically significant declines.

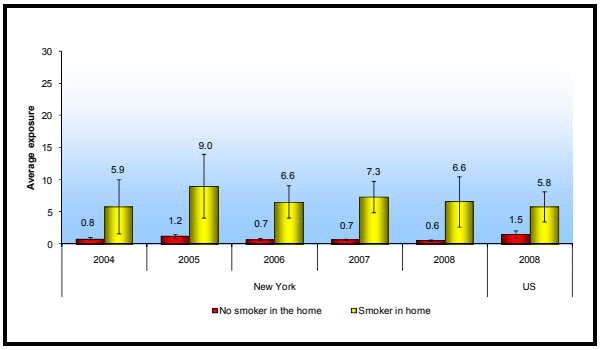
Exposure to Secondhand Smoke

Since the 2003 amendment to the New York Clean Indoor Air Act (CIAA), exposure to secondhand smoke has declined in bars and restaurants and remained at low levels in other workplaces. With this law in place, the last significant source of exposure to secondhand smoke for most New Yorkers is in the home. We present data on three related key outcome indicators below:

- hours of exposure to secondhand smoke among adult nonsmokers who do and do not live with a smoker
- percentage of middle and high school students who report being in a room where someone else was smoking on at least 1 day in the past week
- percentage of smokers who report that their home is 100% smoke-free

From 2004 to 2008, there has been a statistically significant decline in average exposure to secondhand smoke among nonsmokers who do not live with a smoker, while there has been no change for nonsmokers who live with a smoker. In 2008, nonsmokers in New York who do not live with a smoker were exposed to less secondhand smoke than their counterparts nationally (0.6 versus 1.5 hours per week) (Figure 21). Exposure to secondhand smoke among nonsmokers who live with a smoker was comparable in New York and the United States in 2008.

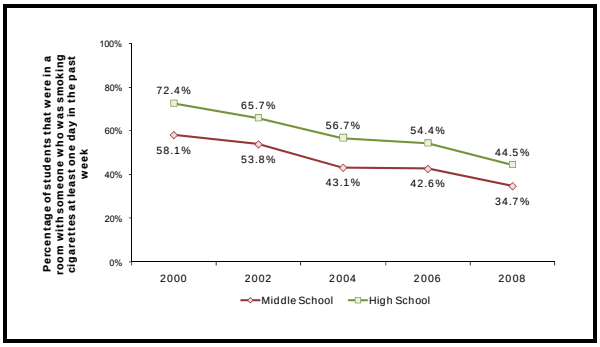
Figure 21. Number of Hours Nonsmokers Spent in a Room Where Someone Was Smoking by Presence of a Smoker in the Home, ATS 2003–2008 and NATS 2008



Note: Statistically significant downward trend from 2004 to 2008 in homes with no smokers. Difference between New York and the United States is statistically significant for homes with no smokers.

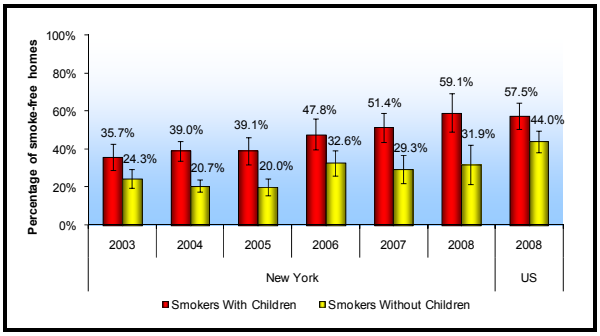
The percentage of middle and high school students reporting that they were in a room where someone else was smoking on at least 1 day in the past week has declined by approximately 40% from 2000 to 2008 (Figure 22). This decline is likely explained by declines in youth smoking, the CIAA amendment in 2003, and an increasing trend in the percentage of adult smokers with children under 18 who report that their homes are 100% smoke-free. From 2003 to 2008, there was a statistically significant upward trend in the percentage of adult smokers with children and without children in their homes who reported that their homes were smoke-free (Figure 23). This percentage increased from 36% to 59% for smokers with children and from 24% to 32% for smokers without children.

Figure 22. Percentage of Middle and High School Students Who Were in a Room Where Someone Was Smoking on at Least One Day in the Past Week, Youth Tobacco Survey 2000–2008



Note: Statistically significant downward trend from 2000 to 2008.

Figure 23. Percentage of Adult Smokers Who Report That Their Homes Are 100% Smoke-Free by Presence of Children Under Age 18, ATS 2003–2008 and NATS 2008



Note: Statistically significant upward trend from 2003 to 2008 among smokers with and without children. Difference between New York and the United States is statistically significant among smokers without children.

Tobacco Control Policies and Related Beliefs and Attitudes (Intermediate Outcome Indicators)

As noted above, changing the social and legal environment to discourage tobacco use and support smoking cessation is a key strategy for NY TCP. We measure progress in changing the environment and social norms about tobacco for several key areas: health care provider support for cessation; cigarette tax evasion and cigarette prices; and support for tobacco control, including support for restrictions on smoking in outdoor public places, attitudes and beliefs about limiting exposure to smoking in the movies, and cigarette advertising at the point-of-sale.

Health Care Provider Support for Smoking Cessation

Approximately 9 in 10 New York smokers reported that their health care provider asked them if they used tobacco (Figure 24). This percentage has been steady from 2003 to 2008 and is comparable to the national average. The percentage of smokers in New York reporting that their provider advised them to quit has also remained steady over time and is similar to the national average (Figure 25). In contrast, over the past 5 years, an increasing percentage of smokers in New York reported that their health care provider assisted them with smoking cessation, and this percentage is significantly greater than the national average (Figure 26).

Figure 24. Percentage of Adult Smokers Who Were Asked by Their Health Care Provider if They Smoked in the Past 12 Months, ATS 2003–2008 and NATS 2008

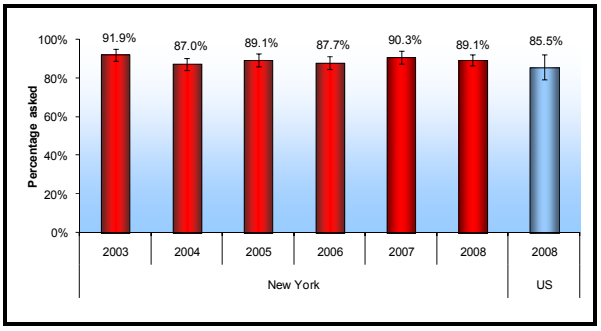


Figure 25. Percentage of Adult Smokers Who Were Advised by Their Health Care Provider to Quit Smoking in the Past 12 Months, ATS 2003–2008 and NATS 2008

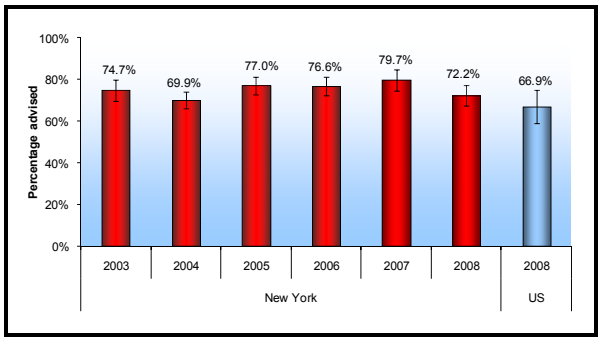
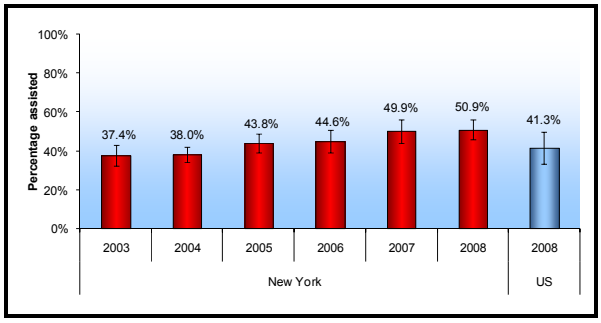


Figure 26. Percentage of Adult Smokers Who Report That Their Health Care Provider Assisted Them with Smoking Cessation in the Past 12 Months, ATS 2003–2008 and NATS 2008

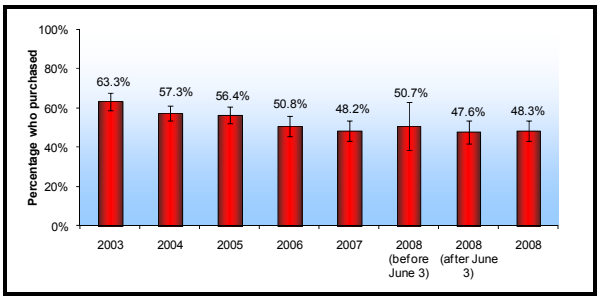


Note: Statistically significant upward trend from 2003 to 2008. Difference between New York and the United States is statistically significant.

Cigarette Tax Evasion and Prices

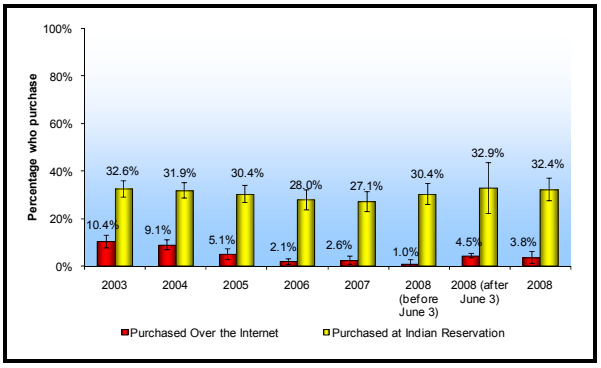
Higher cigarette taxes are associated with higher retail cigarette prices, lower cigarette consumption among adult smokers, and reduced smoking prevalence. However, smokers' efforts to avoid paying higher taxes by purchasing cigarettes from low or untaxed sources can diminish the effects of cigarette tax increases. On June 3, 2008, the tax on a pack of cigarettes in New York increased by $1.25 to $2.75, at the time the highest state excise tax in the country. Figures 27 through 29 present data on smokers' efforts to avoid the tax and the prices they paid per pack for their last pack or carton purchased.

Figure 27. Percentage of Adult Smokers Who Purchased from Low or Untaxed Sources in the Past 12 Months, ATS 2003–2008



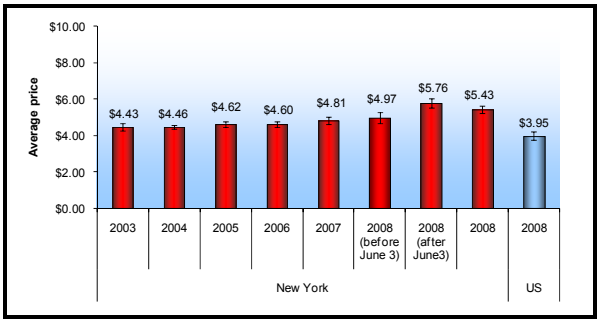
Note: Statistically significant downward trend from 2003 to 2008.

Figure 28. Percentage of Adult Smokers Who Purchased Cigarettes at an Indian Reservation or on the Internet in the Past 12 Months, ATS 2003–2008



Note: Statistically significant downward trend from 2003 to 2008 for cigarette purchases over the Internet. Difference before and after the June 3, 2008, tax increase is statistically significant for cigarette purchases over the Internet.

Figure 29. Price Per Pack of Cigarettes for Most Recent Purchase, ATS 2003–2008 and NATS 2008



Note: Statistically significant upward trend from 2003 to 2008. Difference before and after the June 3, 2008, tax increase is statistically significant.

Overall, there has been a gradual downward trend in the percentage of smokers who purchased cigarettes from low or untaxed sources over the past 12 months, and so far there does not appear to be any shift in this behavior following the tax increase in 2008 (see Figure 27). With respect to purchases from Indian reservations, there has been no change over time or after the tax increase. Approximately one-third of smokers reported that they made purchases from this locale in the past 12 months (see Figure 28). Although purchases of low or untaxed cigarettes from the Internet are less common and have decreased over time, there was a statistically significant increase following the tax increase—from 1% to 4.5% (see Figure 28).

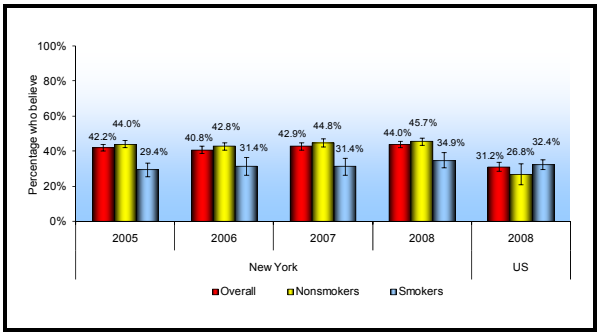
Following the tax increase, smokers reported paying $5.76 per pack, compared with $4.97 per pack—a difference of $0.79, less than the $1.25 increase (see Figure 29). In addition, on average across the country cigarette prices usually increase by 125% of the value of the tax. Therefore, tax evasion appears to have an impact on the average prices that smokers are paying in New York State.

Support for Tobacco Control

Because changing the tobacco control environment and denormalizing tobacco are central objectives of NY TCP, we present data that illustrate New Yorkers' support for tobacco control in general and for specific policies. For example, in 2008, addressing health problems associated with tobacco use is a higher priority in New York than in the United States among adults overall and among nonsmokers (Figure 30). However, support has not changed over time in New York.

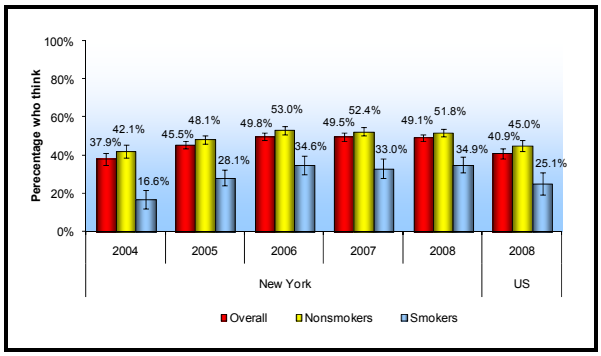
Two issues that are particularly salient now that the FDA has the authority to regulate tobacco have to do with restricting tobacco advertising at the point of sale and placing graphic warning labels on cigarette packs. The passage of the Family Smoking Prevention and Tobacco Control Act allows the possibility of regulating the place, timing, and manner (but not the content) of cigarette advertising. Figure 31 illustrates that a growing percentage of New Yorkers believe that tobacco advertising should not be allowed in stores. In addition, a greater percentage of smokers, nonsmokers, and adults overall in New York support banning store advertising compared to their counterparts in the United States. These data suggest that there is significant support for community contractors' efforts to encourage tobacco retailers to reduce point-of-sale tobacco advertising. More than three-fourths of New Yorkers support the use of graphic warning labels, and support has increased over time among smokers, nonsmokers, and adults overall (Figure 32). As of 2008, there is more support for graphic warning labels in New York than in the United States. Figures 31 and 32 suggest that there is more support for aggressive tobacco control interventions (i.e., banning cigarette advertising in stores and placing graphic warning labels on cigarette packs) in New York than in the United States on average.

Figure 30. Percentage of Adults Who Believe That Tobacco Use Is Among the Most Important Health Problems in Their Community, ATS 2005–2008 and NATS 2008



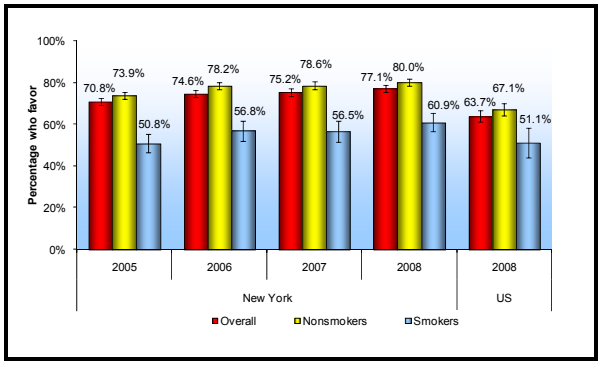
Note: Statistically significant difference between New York and the United States among nonsmokers and adults overall.

Figure 31. Percentage of Adults Who Think Tobacco Advertising in Stores Should Not Be Allowed, ATS 2004–2008 and NATS 2008



Note: Statistically significant upward trend from 2004 to 2008 among smokers, nonsmokers, and adults overall. Difference between New York and the United States is statistically significant.

Figure 32. Percentage of Adults Who Are in Favor of Graphic Warning Labels on Cigarette Packs, ATS 2005–2008 and NATS 2008

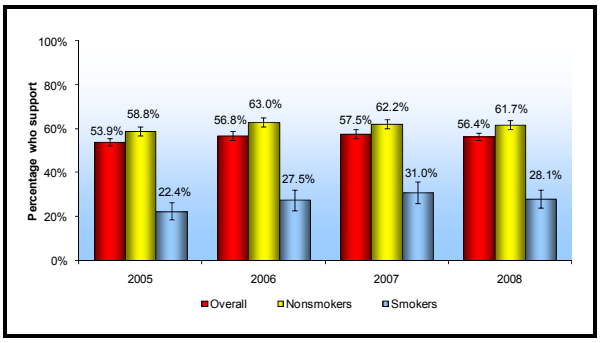


Note: Statistically significant upward trend from 2005 to 2008 among smokers, nonsmokers, and adults overall. Difference between New York and the United States is statistically significant.

Three additional measures gauge support for other community contractor policy initiatives: banning smoking in outdoor places and building entranceways and eliminating smoking in movies rated G, PG, and PG-13. Although the majority of New Yorkers support a ban on smoking in outdoor public places (e.g., beaches and parks), support among nonsmokers has not changed from 2005 to 2008, whereas support among smokers gradually increased (Figure 33). There is greater support for a ban on smoking in building entranceways than for outdoor public places, and support has increased over time among smokers.

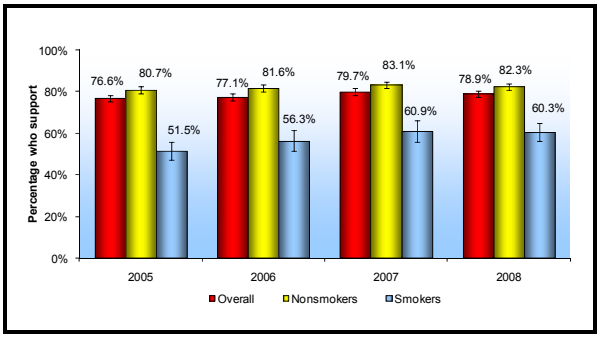
As of 2008, nearly 8 in 10 New Yorkers favor a ban on smoking in building entranceways (Figure 34).

Figure 33. Percentage of Adults Who Support a Ban on Smoking in Outdoor Public Places, ATS 2005–2008



Note: Statistically significant upward trend from 2005 to 2008 among smokers.

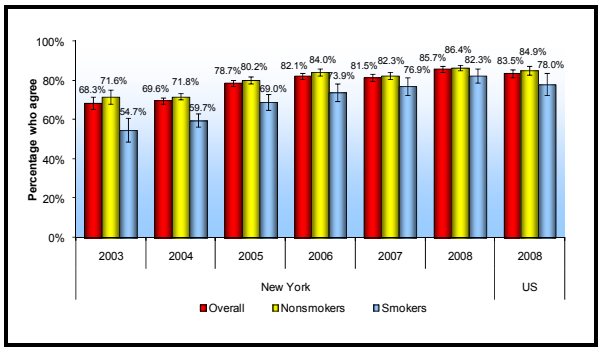
Figure 34. Percentage of Adults Who Support a Ban on Smoking in Building Entranceways, ATS 2005–2008



Note: Statistically significant upward trend from 2005 to 2008 among smokers, nonsmokers, and adults overall.

An increasing percentage of New Yorkers believe that movies rated G, PG, and PG-13 should not show actors smoking. The most marked increase was among smokers—increasing from 55% in 2003 to 82% in 2008, a level similar to that of nonsmokers (Figure 35). Attitudes toward smoking in the movies are similar in New York and the United States.

Figure 35. Percentage of Adults Who Agree That Movies Rated G, PG, and PG-13 Should Not Show Actors Smoking, ATS 2003–2008 and NATS 2008



Note: Statistically significant upward trend from 2003 to 2008 among smokers, nonsmokers, and adults overall.

Discussion

Overview

As a result of a strong tobacco control environment, sustained funding for tobacco control, and a strategy grounded in evidence-based interventions and complemented by innovative new interventions, NY TCP has emerged as a leader among state tobacco control programs. All of the key outcome indicators for tobacco use and smoking cessation in New York compare favorably with national averages in 2008, following several years of favorable trends. The prevalence of adult smoking and daily cigarette consumption in New York are lower than the national averages by 18% and 16%, respectively. Indicators of adult smoking cessation follow a similar pattern—intentions to quit in the next 30 days and making a quit attempt in the past year have both increased over time and are higher than the national level in 2008. Although there is no national comparison for youth smoking in 2008, youth smoking has declined considerably among middle school (64% decline) and high school (46% decline) students from 2000 to 2008 and was lower than the national average in 2006. In addition, adults' current smokeless tobacco and cigar use is lower in New York than in the United States in 2008, and there has been a downward trend in smokeless tobacco use in New York.

Several other key outcome indicators reflect NY TCP's progress in achieving program goals—exposure to secondhand smoke has declined and antitobacco attitudes have strengthened over time. Exposure to secondhand smoke has declined by approximately 40% from 2000 to 2008 among youth. However, although nonsmokers' exposure to secondhand smoke has declined over time for adults who do not live with a smoker, it has not changed for nonsmokers living with other smokers. Finally, New Yorkers' attitudes toward tobacco control indicate that there is more support for tobacco control in New York than in the United States on average.

The differences in key tobacco use outcome indicators between New York and the United States are likely explained by strong tobacco control policies that have been shown to reduce tobacco use: currently the second highest state cigarette tax, a comprehensive smoke-free air law that covers virtually all workplaces, and above-average funding for tobacco control. These differences exist despite countervailing forces that may also affect the progress of NY TCP—cigarette tax evasion is fairly widespread in New York State with nearly half of smokers reporting some form of tax evasion in the past year, especially from Indian reservations; cigarette price promotions are considerably more common in New York than the national average; and tobacco company sponsorships and charitable donations are greater in New York than the national average.

New York's leadership in and support for tobacco control is commendable as it reflects an understanding that, although knowledge of the negative health effects of tobacco use is widespread, it requires a sustained effort to undo decades of imagery that glamorizes smoking in the movies and in the media, billions in cigarette advertising, and entrenched political forces. It also recognizes that, because smoking is highly

addictive, it takes time for smokers to effectively kick the habit despite the availability of effective treatments.

However, the progress NY TCP has made in recent years is at risk as a result of a nearly 20% cut in program funding as a result of the state fiscal crisis. In light of the state's fiscal realities, it is reasonable that all health programs face a reduction in resources. Excluding the costs of Medicaid, the overall budget for NYSDOH declined by 8.3% from FY 2008–2009 to FY 2009–2010. Given that tobacco use remains the leading preventable cause of disease, disability, and death in the United States and arguably has a more extensive set of evidence-based interventions compared with other public health threats, preserving the state's tobacco control infrastructure should be a priority.

In the sections below, we discuss each of the program's major components and end with programmatic recommendations.

Health Communication

Our analyses have consistently shown a strong link between NY TCP paid television advertising and New Yorkers' awareness of these advertisements and other related key outcome indicators. Specifically, as awareness of cessation messages has increased over time, so too have intentions to quit smoking, quit attempts, and calls to the New York State Smokers' Quitline. Although greater advertising highlighting the dangers of secondhand smoke is associated with calls to the Quitline and secondhand smoke–related attitudes and beliefs, it is not associated with increases in voluntary restrictions on smoking in the home. In 2008, as a result of delays in the renewal of the media placement contract, NY TCP spent less on media placement than planned, was off the air for 6 months, and aired fewer high sensation value cessation advertisements and no secondhand smoke advertisements. The drop in television advertising spending is reflected in an approximate 25% decline in awareness of NY TCP advertisements overall and among smokers. Because we have demonstrated a link between awareness of television advertisements and key outcome indicators, such as quit attempts and intentions to quit, the delays in the media contract likely resulted in fewer smokers making quit attempts in 2008 than there would have been with more timely execution of the contract amendment.

Although the decline in media placement was unplanned, it illustrates the potential consequences of the 30% reduction in the media placement budget for FY 2009–2010. In an effort to lessen the impact of the budget reduction, NY TCP has made several significant changes to its media plan. First, it is slightly increasing television advertising spending. Second, television advertising will emphasize cessation over secondhand smoke messages. Third, NY TCP is increasing radio advertising and decreasing or eliminating spending in several other media outlets, including sports venues (e.g., football, hockey), malls, transit, print, Internet, and one sheets (e.g., movie posters).

These decisions are largely supported by the available data. Although there is evidence that media campaigns can be more effective by using multiple media outlets than relying on a single outlet, it is difficult to know what the balance should be across multiple outlets. Our previous analyses have suggested that radio and print advertising may be more cost-effective than television in driving calls to the Quitline; however, the impact of these outlets on broader measures of cessation, such as population measures of quit attempts and quit intentions, is less clear. Given that NY TCP is maintaining a presence in multiple media channels, it is reasonable to change the media mix when reducing the overall budget. The overall budget reduction likely will have an impact on key outcome indicators, but it is difficult to quantify the extent of this impact at this time. The thematic shift toward cessation television advertisements over secondhand smoke advertisements is

supported in the available evidence—that cessation advertisements, especially high sensation value advertisements, have been linked to a range of key outcome indicators, whereas the link between secondhand smoke advertisements and key outcomes is less consistent. Therefore, in light of the budget constraints and available evidence, we agree with NY TCP's strategic decisions.

That said, we encourage NY TCP to examine its strategy for secondhand smoke media carefully and consider alternative approaches that may be more successful in encouraging smokers to restrict smoking in their homes, especially in the presence of children. To date, the only implicit call to action included in the secondhand smoke television advertisements has been to call the Quitline, implying that smokers should quit to protect others from secondhand smoke. An alternative approach that we have previously suggested is to include a specific call to action tied to limiting smoking in the home, such as "Take it Outside" or "Create a Smoke-free Zone Around Your Children," as other states have done.

Our recent analyses also suggest that for cessation-related television advertising a greater reliance on high sensation value messages is warranted because they have a greater influence on smokers' intentions to quit and quit attempts than low sensation value messages. In addition, the New York Media Tracking Surveys indicate that smokers subjectively rate high sensation value messages higher than low sensation messages.

Finally, we suggest that health communication campaigns be developed to more explicitly support statewide and local community action. CDC's *Best Practices for Comprehensive Tobacco Control Programs* recommends mass media campaigns combined with other community interventions as "an effective strategy to decrease the likelihood of tobacco initiation and promote smoking cessation" (p. 33). For example, a campaign could be developed to support reducing point-of-sale cigarette advertising. These campaigns support policy issues addressed by community contractors by raising awareness of the issues among decision makers and the community at large.

Cessation Interventions

The evidence base indicates that a combination of system change and provider education is effective in promoting cessation in health care settings. Although the first of its kind, the inclusion of the provocative "Don't Be Silent" media campaign to encourage providers is also consistent with the evidence base. What is not clear in the literature is how best to promote system-level change. Cessation Centers have built relationships with hospitals on the merit of the intervention and by leveraging the benefits of helping hospitals become more compliant with accreditation standards and helping integrate systems to support the transition to smoke-free campus policies. However, it is challenging to effect change broadly throughout the state because of the sheer number of medical practices in New York State and the fact that they are less likely to have written policies in general. Cessation Centers have taken a slightly different approach with group practices, focusing more on systems and training, including a Performance Improvement Project that offers health care providers at group practices continuing education credits for participating in a training program.

Hospitals are making changes in guidelines, systems, and required provider practices that appear to be related to Cessation Center efforts. The impact of Cessation Centers on group practices at the state level is not yet clear. Given the large number of group practices and their resistance due to limited time, cost concerns, low prevalence of written policies in general, and limited incentives for providers to make systems-level changes, Cessation Centers face a significant challenge in effecting change. Their upcoming focus on federally qualified health centers will likely help reach a greater proportion of low-

income smokers, which will raise their potential for population impact.

Tobacco control programs face a trade-off in terms of interventions that have a larger reach versus those that offer more direct services to a smaller fraction of smokers. CDC's *Best Practices for Comprehensive Tobacco Control Programs* calls for quitlines and free NRT distribution through quitlines, but also urges programs to focus on interventions that lead to changes in social norms that have larger reach and thus the potential for population-level impact.

In New York, the Quitline and NRT are important proven interventions offering direct services to smokers that increase quit rates, but their reach is limited (2% to 3% of smokers annually). Given budget constraints, NY TCP must explore opportunities to provide NRT in the most cost-effective manner possible. The Quitline is currently conducting a study to determine whether 2-, 4-, or 6-week NRT starter kits are most cost-effective in promoting quitting. Finally, there may be an opportunity to enhance online quit counseling services and more actively encourage online services over telephone counseling for interested smokers as a way to reduce costs. To date, there has been no difference in outcomes for smokers who receive NRT via the Quitsite and the follow-up call and smokers who use NRT and telephone counseling.

Although NRT is an evidence-based strategy for the general population, it is not clear from available studies whether NRT distribution in substance abuse facilities is justified given its limited reach and in the context of limited resources. A meta-analysis of smoking cessation in substance abuse treatment facilities found short-term effects for smoking cessation, but not long-term (≥ 6 months) effects (Prochaska, Delucchi, and Hall, 2004). Given the current budget constraints faced by NY TCP, continuing to provide NRT to substance abuse facilities is probably not an optimal use of program resources.

Statewide and Community Action

CDC's best practices in state and community tobacco control recommend that comprehensive tobacco control programs prioritize activities that have the potential for the greatest impact. Activities focused on policy change that creates a social environment providing persistent and inescapable cues to discourage smoking are recognized as having the potential for the greatest impact (NCI, 1991). Consistent with these recommendations, the New York community contractor initiatives are overwhelmingly focused on policy change. However, as currently implemented, the potential reach of these efforts is limited.

The potential reach of contractor efforts is limited for several reasons. In the past, some contractors focused on obtaining written policies from organizations that already practiced that policy. These contractors met their goals, but the policies they recorded changed nothing in the social environment.

Another limitation stems from the fact that contractor efforts—and their associated goals—may be too modest to yield a measurable change in the social environment. For example, during FY 2007–2008, Community Partnerships made individual contact with 639 of the 22,950 licensed tobacco retailers in New York and mass mailed letters to 6,339 of them. As a result, 747 tobacco retailers (3% of all those in the state) adopted policies to reduce tobacco advertising in their stores. To date, the evaluation has been unable to demonstrate that these activities have had any effect on either the amount of tobacco advertising in the retail environment or on public attitudes toward tobacco advertising in the retail environment (Crankshaw, Pais, and Schmitt, 2008). Because the evaluation does not currently monitor the primary target of contractor activities—tobacco retailers—we cannot determine whether these activities have been effective. For example, they may have changed

retailer attitudes toward adopting policies to reduce or eliminate advertising in their stores.

As of July 1, 2009, one beach and six parks in New York State were smoke-free (http://www.no-smoke.org/goingsmokefree.php?id=519#outdoor). Partners are required to have one municipality in each of New York's 62 counties adopt an ordinance requiring smoke-free parks, playgrounds, areas around schools, and beaches during FY 2009–2010. If this goal is met, smoking will still be allowed at county parks outside of municipalities (there are 21 in Monroe County alone) and in New York State's more than 200 state parks (which include more than 300 beaches), historical sites, and golf courses.

Partner policy efforts are also limited because they are not supported by a consistent media message and their advocacy efforts are not sufficiently magnified by the support of other like-minded organizations and mobilized citizens.

Sustained media interventions, including media campaigns and media advocacy, are considered essential to gain the broad base of support essential for advocacy efforts to succeed (NCI, 2005). Although some partner initiatives, such as the Cessation Centers' "Don't Be Silent" campaign, have a coordinated media message, there is no planned, sustained, and coordinated media campaign to build public and policy maker support for the majority of partner efforts. For example, Community Partnerships and Youth Partners are required to engage in media advocacy activities and, many are quite successful in getting earned media. However, although earned media raises the public profile of an issue and is responsible for defining it as a legitimate community concern, a media campaign informs and makes a direct appeal to support or change a behavior or policy (Finnegan and Viswanath, 1999). Without a media campaign to augment and support contractor activities and earned media, it has been difficult to build the broad base of public and policy maker support that is needed for successful policy change.

Collaborations among community organizations have been a core component of comprehensive tobacco control programs since their inception (Thompson et al., 1995; Anderson et al., 2005; IOM, 2007), and both the tobacco control and wider health promotion literatures consistently show that when advocates successfully build relationships with and coordinate the efforts of influential community members and organizations, they are more likely to achieve their goals (Florin et al., 2006; Lempa et al., 2006; Provan and Milward, 1995; Ross and Stover, 2001; Wickizer et al., 1998; Zakocs and Edwards, 2006). The School Policy Partner grants, beginning in 2010, will integrate with nutrition and physical activity efforts. The community contractors are strongly encouraged to collaborate with each other, and many implement their activities through a coalition model. However, their work plans do not require them to develop ongoing collaborations with other allied or influential organizations in their catchment areas. As a result, some partners shoulder the full burden of local tobacco control activities and subsequently limit the potential reach of those activities because they are not leveraging the influence and resources of other organizations in their catchment areas.

It is important to remember that "strong tobacco control policies are an outcome of hundreds of local and state citizen campaigns" (Sparks, 2007, p. 6) and that case studies of effective local tobacco control initiatives describe a clear role for community mobilization in well-coordinated initiatives to change local policy (Malek et al., 2005). CDC's best practices recommend that local community members be mobilized to take actions that support policy change and counter pro-tobacco influences (CDC, 2007b). While collaborative partners are a component of community mobilization, a mobilized community more broadly involves individual citizens in promoting tobacco control policies and organizations that may only have a limited interest or role in tobacco control. For example, many

early community-level efforts to pass smoke-free policies were not successful until citizens pressured local businesses and leaders to adopt and implement them (Malek et al., 2005). Similarly, New York community contractors who have mobilized community members to communicate their disapproval of tobacco advertising and sales to their local grocery stores have had success in some local chains. While community contractor work plans include activities to educate the public and gain their support for initiatives, there is no requirement that contractors develop and maintain a list of grassroots supporters they can quickly mobilize for high-profile events and to contact media, decision makers, and policy makers when a tobacco control policy is under discussion at the local or state level. Unlike mobilizing public support for tobacco control, a grassroots campaign is of limited duration and best targeted at a limited number of influential decision makers.

Programmatic Recommendations

NY TCP has established itself as a leader in tobacco control, and the data through 2008 indicate that key outcome indicators have changed significantly over time and in many cases compare favorably with the nation as a whole. Despite this progress, however, the reduction in NY TCP's budget threatens continued progress and virtually guarantees that the program will not achieve its 2010 goal of 1 million fewer smokers. In the sections below, RTI offers some overall and specific program component recommendations.

Overall Recommendations

- Increase NY TCP funding by $9 million to a minimum of $77 million per year; this level of funding reflects an 8.3% reduction from FY 2008–2009, in line with the overall reduction in NYSDOH funding.
- Use the additional funds to increase funding for health communication in the following ways:
  - Increase funding for core campaigns (e.g., cessation, secondhand smoke) by $5 million.
  - Allocate an additional $4 million to develop and implement campaigns to more explicitly support state and local community action.
- Eliminate NY TCP financial support for the Asthma Coalitions.
- Reduce funding for Community Partnerships, Youth Action Programs, and School Policy Partners and direct these funds to the creation of new tobacco control demonstration projects aimed at new opportunities that result from the FDA authority over tobacco.
  - Specific reductions in funding would include a 10% reduction for Community Partnerships and Youth Action Programs.

Health Communication Recommendations

- Invest sufficient funds in health communications to achieve at least an annual average of 60% confirmed awareness of NY TCP television advertisements.
- Avoid unplanned gaps in health communication activities that result from delays in contract executions and amendments.
- For cessation-related advertising, increase focus on high sensation value messages.
- Consider a new approach to messages that highlight the dangers of secondhand smoke to encourage more smokers to limit smoking in their homes.
- Develop new campaigns to support ongoing statewide and community action.
  - Increase support for the "Don't Be Silent" media campaign.

Cessation Intervention Recommendations

- Maintain current funding level of Cessation Centers.
  - Continue to advocate for improvements in tobacco dependence assessment and treatment systems.

  - Increasingly target group practices and clinics that serve a high proportion of patients who smoke.
  - Continue to promote the health care provider media campaign to add salience and reach to Cessation Centers' efforts and increase awareness.
  - Assess the amount or percentage of Cessation Center effort spent on more time-intensive efforts, such as the Performance Improvement Project, which is largely provider-oriented and thereby limited in its reach. Concurrently, assess opportunities for interventions that are potentially more efficient in creating incentives for group practices to implement systems change (such as getting health plans to refer group practices to Cessation Centers when Healthcare Effectiveness Data and Information Set measures related to tobacco issues need to be improved).
- Maintain current funding for the New York State Smokers' Quitline.
  - Explore ways to more efficiently deliver NRT.
- Eliminate support for NRT distribution outside of the Quitline.

Statewide and Community Action Recommendations

- Some contractors work collaboratively with allied organizations and individuals in their catchment areas. Others could benefit from more structured requirements to collaborate with other organizations in their community and thereby increase the reach of their efforts.
- Build community support for future state legislation of tobacco advertising and sales at the point-of-purchase made possible by the recent bill giving FDA authority over tobacco. Once a determination is made about the potential components of such state legislation, the community contractor point-of-sale initiative should be modified to be consistent with those components.
- Develop a core theme (or message) for each community contractor initiative and incorporate the theme into all partner strategies for that initiative. This will ensure that the same message reaches all target audiences for a specified initiative.
- Enhance and coordinate media advocacy efforts within each community contractor initiative so that all contractors are supporting activities with the same message during the same time period.
- Develop guidelines for contractors to develop and maintain a list of grassroots advocates who can be mobilized quickly by action alerts to support selected tobacco control events and policies.
- Reduce funding for enforcement of youth access laws as the level of compliance is not associated with youth smoking rates.

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