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2010 Independent Evaluation Report for the New York Tobacco Control Program

Prepared for

New York State Department of Health
Corning Tower, Room 710
Albany, NY 12237-0676

Prepared by

RTI International
3040 Cornwallis Road
Research Triangle Park, NC 27709

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Executive Summary

New York State has developed and implemented a multifaceted tobacco control program that has produced a number of notable successes from 2003 to 2009, the time frame for the independent evaluation. New York is a leader in tobacco control with a program built on evidence-based interventions, supported by strong tobacco control policies, and complemented by forward-looking next-generation initiatives that keep the New York Tobacco Control Program (NY TCP) at the forefront in tobacco control. From 2003 to 2009, the prevalence of smoking declined faster in New York (17% decline) than in the United States as a whole (6% decline). Trends in other key programmatic outcome indicators are consistent with this trend: the prevalence of smokers making quit attempts has increased; the prevalence of youth smoking has declined and outpaced the national decline; and cigar, smokeless tobacco, and cigarette consumption have all decreased. Key influences have also changed over this period, including increases in awareness of NY TCP public health marketing; health care provider assistance of smokers' attempts to quit smoking; cigarette prices; and use of cessation counseling, medications, and nicotine replacement therapy (NRT). New York has accomplished these changes despite countervailing forces that undermine the state's efforts. In 2009, more than half of smokers in New York reported purchasing low or untaxed cigarettes, a greater proportion of cigarettes were sold under a price promotion in New York than in the country as a whole, and sponsorships and charitable donations from tobacco companies remain more common in New York than in the rest of the country. However, although the overall trends in smoking are positive, we find that not all sociodemographic groups experienced the same declines. From 2003 to 2009, smoking prevalence declined by 20% for whites but only 9% for African Americans and 11% for Hispanics. In addition, the prevalence of smoking declined more slowly for adults with less than a high school degree (−3%), with annual incomes less than $25,000 (−5%), and those with poor mental health (−5%) than for adults overall (−17%).

Despite a consistent record of success, NY TCP's budget has been cut severely over the past 2 years, declining by 35%—a proportionate decline significantly larger than that for the New

York State Department of Health (NYSDOH) as a whole. 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 over the past 2 years has also virtually guaranteed that NYSDOH will not achieve its goal of 1 million fewer smokers by 2010. In addition, the reduced resources will make it very difficult to address the disparities in smoking noted above.

RTI's key programmatic recommendations are as follows:

Overall Recommendations

- Increase NY TCP funding to a minimum of $77 million per year; this level of funding reflects a restoration of funds so that budget reductions for tobacco control are 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 cessation-focused campaigns.
  - Fully fund the media contract that would create campaigns that explicitly support state and local community efforts to effect policy change.
- Eliminate NY TCP financial support for the Asthma Coalitions given the reduced funding for core tobacco control interventions.
- Further investigate possible explanations for the relatively slow declines in smoking prevalence for specific populations, such as African Americans, Hispanics, and adults with low incomes and/or education.

Health Communication Recommendations

- Invest sufficient funds in health communication to increase annual average confirmed awareness of NY TCP television advertisements from 45% in 2009 to at least 60%.
- Avoid unplanned gaps in health communication activities that result from delays in contract executions and amendments.

  - Ensure that a minimum amount of funds ($3 million to $5 million) are available to NY TCP for media placement for the first quarter of every fiscal year to avoid disruptions to the Program's media plan that result from annual delays in expenditure plan approvals and contract renewals.

- Develop new campaigns to support ongoing statewide and community action.

Cessation Intervention Recommendations

- Eliminate support for NRT distribution in Office of Alcoholism and Substance Abuse Services addiction treatment centers.
- Encourage the New York State Office of Mental Health to adopt tobacco-free regulation for their facilities. This would reinforce their focus on improving the health and well-being of their consumers. Such a policy change would be consistent with the recent Office of Alcoholism and Substance Abuse Services' tobacco-free regulation.
- The New York State Medicaid Program should take a more active role in promoting tobacco cessation Medicaid benefits to Medicaid recipients and providers.
- Continue to promote the health care provider media campaign to add salience and reach to Cessation Centers' efforts and increase awareness.

Statewide and Community Action Recommendations

- Continue to maintain community contractors' current emphasis on the point-of-sale initiative.
- Develop a core theme (or message) for all community contractor initiatives, and incorporate the theme into all contractor strategies for that initiative (as the Program is currently doing with the point-of-sale initiative).
- Provide structured requirements to community contractors to collaborate with other organizations in their communities to increase the reach of their efforts.

Introduction

In New York each year, an estimated 25,432 people die prematurely as a result of smoking, resulting in 339,646 years of life lost (CDC, 2007a). 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; Farrelly, Pechacek, and Chaloupka, 2003; Tauras et al., 2005; 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.

A recent study of the California Tobacco Control Program highlights the long-term impact of tobacco control on human health. This study concluded that the California Tobacco Control Program's comprehensive approach to tobacco control resulted in decreased rates of smoking initiation and increased rates of smoking cessation that led to dramatic improvements in the health of Californians over the long run (through 2079) (Miller et al., 2010). Specifically, these authors found that the California program will ultimately result in more than 700,000 years of life saved as a result of changes in smoking. Using relatively conservative estimates of the value of these additional life years, the California Tobacco Control Program saved more than $22 billion in net health care expenditures and the value of life years. This study highlights the significant human health impact potential of investment in tobacco control.

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 New York State Department of Health (NYSDOH) 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 California Tobacco Control Program's approach and 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).

The 2009 Independent Evaluation Report noted that NY TCP made significant progress across a range of key Program outcome indicators from 2003 to 2008. For example, we found that smoking rates among youth and adults are lower and have declined faster in New York than in the United States as a whole over this period. 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.

However, as illustrated below, the significant reductions in funding for NY TCP are having an impact on the Program's key outcome indicators, eliminating the Program's ability to achieve the NYSDOH goal of 1 million fewer smokers by 2010. The budget has been cut from $84 million in fiscal year (FY) 2008–2009 to $68 million in FY 2009–2010 originally, and then to $55 million as a result of the midyear deficit reduction plan. That represents a staggering 35% reduction in a short period of time—much larger than the budget reduction for NYSDOH as a whole.

These severe budget reductions not only threaten to slow or reverse recent gains, they have the potential of slowing NY TCP's efforts to fully leverage historic national policy changes, such as the Family Smoking Prevention and Tobacco Control Act (Tobacco Control Act hereafter), which enables state and local governments to enact laws that restrict the time, place, and manner of cigarette advertising, consistent with the First Amendment.

In this report, we describe the Program's approach to tobacco control and response to national tobacco control events and opportunities. 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 national average.

The New York Tobacco Control Program—Programmatic Approach and Context

In this section, we describe the Program's approach to tobacco control and the tobacco control context in which the Program operates.

Program Leadership in Tobacco Control

Comprehensive tobacco control programs like New York's have been responsible for the significant declines in smoking seen since the mid-1980s (Farrelly et al., 2008). However, in recent years, earlier declines in youth smoking initiation have slowed, and cessation rates among smokers have not been robust (IOM, 2007). If we expect continued declines in tobacco use, tobacco control programs need to adopt the two-pronged approach recommended by the Institute of Medicine: immediately strengthen traditional tobacco control interventions and pursue aggressive next-generation regulatory changes to control the marketing and content of tobacco products.

Since the 2009 Independent Evaluation Report, NY TCP has had several significant opportunities to strengthen existing interventions and develop new approaches:

- In the fall of 2009, CDC issued a call for proposals for states and communities under the American Recovery and Reinvestment Act's Communities Putting Prevention to Work Initiative. The initiative prioritizes support for high-impact policy, environmental, and system change strategies; media to promote healthy behaviors; and support for quitlines.
- On June 22, 2009, the federal Tobacco Control Act was signed into law and gave the U.S. Food and Drug Administration the power to regulate the tobacco industry. Of direct relevance to state governments, this new law permits state and local governments to enact laws that restrict the time, place, and manner of cigarette advertising, consistent with the First Amendment.

- On April 1, 2009, the federal excise taxes on tobacco products increased, including a $0.62 per pack increase on cigarettes.
- In March 2010, the federal Prevent All Cigarette Trafficking Act was signed into law. Some of the key provisions of this law include requiring Internet sellers to pay all federal, state, local, or tribal tobacco taxes; mandating that the age of purchasers be verified at purchase and at delivery; and banning the delivery of tobacco products through the U.S. mail.

For the past two decades, comprehensive tobacco control programs have focused on "creating a social environment that provides persistent and inescapable cues to smokers to stop smoking and to nonsmokers not to start" (NCI, 1991, p. 205) through policy change. More recently, interventions that change the environmental context (e.g., smoke-free air laws, cigarette excise taxes) have become the gold standard of all public health programs because they affect the greatest number of people for a sustained period of time (Frieden, 2010). The Communities Putting Prevention to Work Initiative, the Tobacco Control Act, and the two federal legislative changes (federal tobacco excise tax increase and the Prevent All Cigarette Trafficking Act) are policies that modify, or have the potential to modify in the future, the context of day-to-day living to support healthier behaviors. Together, they demonstrate the tension between implementing a policy at the national level, which affects virtually all Americans (federal tobacco excise tax increase), and implementing a policy at the state or local level that affects fewer people but that may not currently have the requisite political support for adoption at the national level (regulating tobacco industry marketing at the point of sale).

Although reducing tobacco industry marketing at the point of sale is recommended as an important policy goal (IOM, 2007), no single set of policy components is considered to effectively accomplish this. For example, the California Tobacco Control Program has developed model ordinances to regulate the location and density of tobacco retailers and, like New York, has invested in advocating with tobacco retailers to adopt voluntary policies to reduce or eliminate tobacco advertising in stores. Although CDC recommends community mobilization with a policy focus as a core component of a comprehensive tobacco control program (CDC, 2007b), little research or guidance exists about the community-level activities that will successfully

lead to policy change (O'Dougherty et al., 2008; Sparks, 2007). Furthermore, 50 years of research has provided substantial evidence that advertising in traditional media channels, such as magazines and television, affects children's behaviors (including tobacco use), but far less research has been conducted on the effects of advertising through other channels (Wilcox et al., 2004). As a result, there is a limited research base on which to develop messages that support the more aggressive regulation of tobacco industry marketing practices recommended by the Institute of Medicine (2007); and in fact promoting policies aimed at reducing cigarette advertising at the point of sale and countering other tobacco industry influences may prove more challenging than smoke-free air policies where exposure to secondhand smoke is a more tangible and credible threat to health than pervasive advertising or availability of tobacco products (Howard et al., 2000).

As a result, tobacco control programs that address next-generation tobacco control policies, such as curbs on tobacco marketing and sales, must not only define the core components of those policies, but they must also develop strategies that have the potential to influence tobacco use and can affect a sufficient percentage of the population to lead to changes in statewide indicators of tobacco use. This shift in focus requires a fundamental shift in strategies by community coalitions/ partnerships—a decreased emphasis on localized community health education in favor of policy advocacy with organizational decision makers and education of public officials.

New York has built a strong tobacco control program that is well-positioned to address these challenges and gaps, but this will require more than having the sufficient resources that are a critical component for success in tobacco control. Strong program leadership is equally important to ensure that those resources are deployed effectively. That leadership must develop a strategic plan that is grounded in evidence-based strategies and leverages emerging opportunities. The Program must also embrace promising practices that address important public health priorities and provide the requisite guidance and training to funded partners so that they can faithfully implement the Program's vision. In the months since the Tobacco Control Act was signed and the Communities Putting Prevention to Work Initiative was announced, NY TCP has made impressive progress to meet these challenges.

NY TCP was one of the first state tobacco control programs to aggressively address ubiquitous tobacco industry marketing with next generation policies. This transition began with a new strategic plan in 2003 that set the groundwork for the 2005 Advertising, Sponsorship, and Promotion initiative. This initiative was aimed at curbing tobacco industry influences at the point of sale and more broadly in communities (e.g., tobacco industry–sponsored community events). Community contractors advocated with tobacco retailers for voluntary policies to reduce or eliminate tobacco advertising in stores and with potential recipients of tobacco industry largesse for voluntary policies to reject tobacco industry sponsorships. NY TCP also began formally training community contractors on how to implement the Program strategies in 2005. Additional policy change efforts have since included smoke-free outdoor spaces, smoke-free multi-unit housing complexes, comprehensive tobacco-free schools, and health system changes.

Advocating directly with tobacco retailers and retail chains has been challenging in light of well-funded and entrenched tobacco industry influence, but these experiences have positioned NY TCP and its community contractors to leverage the Tobacco Control Act. Following its passage, NY TCP began developing new policy goals and strategies to achieve them. As a result of a successful Communities Putting Prevention to Work grant application to CDC, NY TCP is receiving additional support to implement the refocused initiative to decrease tobacco industry marketing at the point of sale. Although the new strategy is still in development, its core element involves advancing local ordinances and statewide laws that (a) restrict the number, location, and type of tobacco retailers; and (b) keep tobacco products out of view in the retail setting.

The community contractors' new policy approach to tobacco industry marketing at the point of sale puts NY TCP at the cutting edge of regulatory changes to control the marketing of tobacco products and will reach a much larger proportion of the New York population than previous activities focused on voluntary retailer policies. In a relatively short period of time, the Program has successfully leveraged new legislation and newly available funding and has implemented major changes to an initiative that has been in place since 2005. The Program understands the challenges posed by such aggressive policy

goals and recognizes its obligation to contribute to the science and practice of tobacco control.

To address these challenges and provide leadership to the greater tobacco control community, NY TCP conducted the following activities during FY 2009–2010:

- Contracted with the Center for Public Health and Tobacco Policy at New England Law | Boston to develop and support policy initiatives that will reduce tobacco-related morbidity and mortality in New York. The Center has developed model policies for the point-of-sale initiative.
- Worked with RTI to test messages and solicit input from the general public, retailers, and local elected officials about point-of-sale objectives.
- Worked with RTI to build the evidence base for point-of-sale policy objectives. In this capacity, RTI has analyzed the relationships between tobacco industry advertising, the density of tobacco retailers, and indicators of current and predicted tobacco use among youth. These analyses will be used to support the goals of the point-of-sale initiative and disseminated through peer-review publications and presentations at professional conferences, such as the American Public Health Association.
- Convened multiple trainings to prepare contractors to educate the public about the impact of retail tobacco marketing on youth and to better understand policy goals and how to achieve them. These trainings integrated input from the Center for Public Health and Tobacco Policy, RTI, and the Center for Tobacco Free New York.
- Identified a media contractor that can develop statewide media campaigns to support the point-of-sale initiative and other policy initiatives. Unfortunately, due to budget cuts, this contract has not been funded yet.

NY TCP is one of the first state tobacco control programs to systematically implement activities to change local policies that will in turn reduce the level of tobacco industry marketing that New Yorkers are exposed to on a daily basis. The activities planned are based on best practices in community tobacco control and, where there were no best practices, the Program has utilized available information, resources, and conducted formative research. The evidence base they are building in support of point-of-sale policy effectiveness and the activities

that result in policy change will guide other tobacco control programs as they incorporate the Institute of Medicine (2007) recommendations and leverage policy opportunities provided by the 2009 Food and Drug Administration legislation.

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 and effective communication. RTI is contracted to provide surveillance and evaluation activities to monitor program progress and impact by working in collaboration with the Tobacco Surveillance, Evaluation and Research Team within NYSDOH.

Health Communication

NY TCP invests in paid advertising on television, radio, print, Internet, and other venues to motivate tobacco users to stop using tobacco, promote smoke-free homes, 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 public health marketing 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. A growing body of research, including findings from this evaluation, indicates that messages that elicit strong negative emotions are more effective in promoting behavior change than messages without these elements. As a result, NY TCP has increasingly relied on this style of television advertisements.

Historically, NY TCP has relied primarily on existing television, radio, and print advertisements to execute its public health marketing plans. However, the Program recently solicited proposals from media contractors to develop new advertisements in preparation for an increased emphasis on state and local policy change efforts. Statewide media can help frame the tobacco control agenda, educate the public and decision makers, and legitimize and energize local community mobilization efforts to build support for policy change. Although a media contractor has been selected, the recent significant cuts to the Program's budget have indefinitely delayed the award of this new contract.

NY TCP has also used a variety of media outlets to disseminate these messages. The Program's paid advertising efforts were implemented quite well during the first half of 2009 with consistent airing of ads with strong negative emotions primarily focused on cessation. However, the Program's budget for media implementation was reduced significantly (from $15.2 million to $4.4 million) in response to ongoing state fiscal crises. Coupled with delays in approval of remaining media funds in 2009, the Program's ability to implement media was effectively eliminated during the second half of the year. We illustrate the results of this reduction in the Program Implementation section below.

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 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 Great American Smokeout, 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. Health systems change approaches include updating health care provider reminder systems to ensure that patients are asked about tobacco use and provided assistance, expanding Medicaid support for smoking cessation, and encouraging private health plans to expand tobacco cessation coverage. The New York State Smokers' Quitline provides tobacco cessation counseling and access to nicotine replacement therapy (NRT) and serves as an information clearinghouse for cessation.

Cessation Centers

The Program funds 19 Cessation Centers to increase the number of health care provider organizations that have systems 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 2008 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 to help with changes to improve tobacco cessation intervention, offer provider training, provide guidance on system improvement, and provide technical assistance. To extend the reach of their message, the Cessation Centers launched a media campaign ("Don't Be Silent About Smoking") aimed at health care providers.

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 9:00 p.m. Monday through Thursday and 9:00 a.m. to 5:00 p.m. Friday through Sunday. In addition, the Quitline offers prerecorded messages covering a range of stop-smoking topics, a Fax-to-Quit health care provider referral program, the Quitsite Web site, and 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 smoking cessation coaching and support to those who call. The support is provided by Quitline specialists who work with smokers to develop quit smoking plans, assess eligibility for and provide NRT, and send smokers packets of quit smoking information. The specialists contact callers again to offer encouragement, provide additional tips, and determine quit progress.

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). Medicaid also provides reimbursement for up to six counseling sessions annually for pregnant and postpartum smokers and adolescents.

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 addiction treatment programs, local health departments, and Cessation Centers. The distribution of NRT through addiction treatment programs began in September 2007 to help facilitate a transition to smoke-free facilities and grounds that was required by the Office of Alcoholism and Substance Abuse Services 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.

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 five modalities: Community Partnerships for Tobacco Control, Youth Action contractors, School Policy contractors, Cessation Centers, and Colleges for Change contractors.

Community contractors are structured in such a way that every county falls within the coverage area of one Community Partnership, one Cessation Center, and one School Policy contractor. In addition, there are 16 Youth Action contractors and seven Colleges for Change contractors (working with 18 colleges) throughout the state. All community contractors are charged with effecting 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 (Frieden, 2010). 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.

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 the tobacco control environment, New York compares favorably with the national average: 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 41% nationally; and average per-capita funding for tobacco control over the past 3 fiscal years is higher in New York ($4.12) than in the average state ($2.23). 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, although this has declined following the departure of Altria from New York City in 2008.

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

Indicator	New York	U.S. Average
State cigarette excise tax (July 1, 2010)	$2.75	$1.41
Percentage of the state population covered by comprehensive[a] smoke-free air laws (April 1, 2010)	100%	41.0%
Average annual per capita funding for tobacco control (2006–2009)	$4.12	$2.23
Percentage of cigarette sales sold under a price promotion (2008)	10.5%	2.3%
Sponsorships and charitable donations from tobacco companies (2009)	$4.6 million total	$1.3 million per state ($63.6 million total)

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

Program Implementation

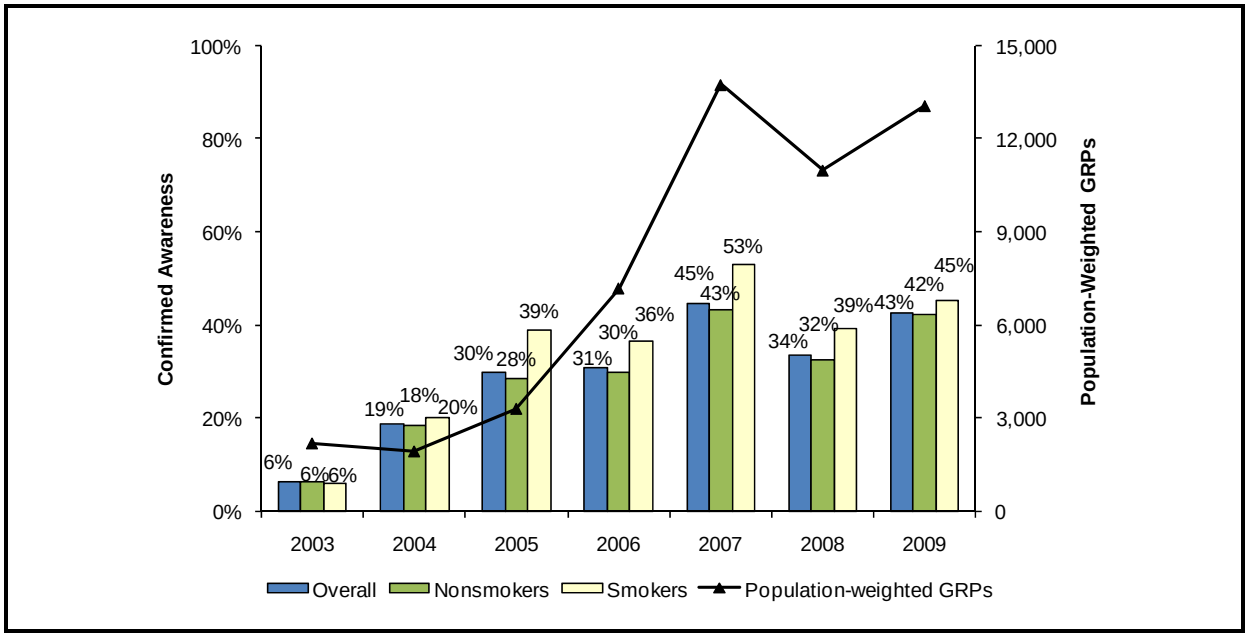
Health Communication

As part of the deficit reduction plan, NY TCP cut nearly $11 million from the media placement budget of FY 2009–2010, leaving only $4.4 million. This is a dramatic reduction from the peak media placement budget of $25 million in FY 2006–2007. 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. As a result, media placement originally planned for 2008 occurred in early 2009. Similar delays occurred in the second half of 2009. The unplanned absence of media during the second half of 2009 was primarily the result of the midyear state government deficit reduction plan, which resulted in significant cuts to the Program's media placement budget. In addition, the Program's remaining funds were not available for media buys until

December 3, 2009, when an amendment to the NYSDOH media buyer's contract was approved. Finally, because the media buyer's contract expired on January 1, 2010, the Program had only 28 days to develop and place a $3 million media campaign.

The implication of the budget cuts and administrative delays can be seen in Figures 1 and 2 that plot New Yorkers' awareness of NY TCP's public health communication efforts and gross rating points—a measure of media delivery. Figure 1 shows the long-term trend in awareness of media from 2003 to 2009. Smokers' awareness of television advertisements peaked in 2007 at 53%, fell to 39% in 2008, and then increased to 45% in 2009. The media that was placed in late 2009 occurred after the completion of the Adult Tobacco Survey; as a result, this survey did not capture awareness of the advertisements that launched December 28, 2009.

Figure 1. Confirmed Awareness of NY TCP Television Advertisements and Annual Gross Rating Points (GRPs), Adult Tobacco Survey 2003–2009



Note: Statistically significant upward trend from 2003–2009 among smokers, nonsmokers, and adults overall.

To explore possible differences in the reach of NY TCP health communication, we tested for differences in average awareness among smokers across the entire 2003–2009 period by demographic groups. The overall average level of awareness

among smokers during this period is 35.9%. Notable differences in awareness include

- higher average awareness among African Americans (45.9%) than whites (34.7%) and Hispanics (31.9%),
- lower awareness among smokers aged 65 or older (27.7%) compared with smokers aged 40 to 64 (35.9%) and 25 to 39 (39.0%), and
- higher awareness among smokers enrolled in Medicaid (41.4%) compared with smokers with private insurance (34.6%) or Medicare (32.8%).

The approximately 30% higher awareness among African Americans compared with whites and Hispanics is likely explained by comparable differences in weekly differences in television watching (Bureau of Labor Statistics, 2009). According to the 2008 American Time Use Survey, average weekly hours of television watching is higher for African Americans (25.0 hours) than whites (18.7) and Hispanics (17.9). However, older smokers have lower awareness despite watching television more frequently than younger smokers. These differences may be due to the media buyer's effort to target NY TCP advertisements to smokers younger than age 65.

Figure 2 shows quarterly trends in confirmed awareness of advertising among smokers, plotted against quarterly data on total ad gross rating points from 2005 to 2009 (the time period for which quarterly gross rating point data are available). The Program achieved the highest rate of awareness observed to date at 70% in Q2 2009 but declined precipitously to 14% in Q4 following the budget cuts and contract delays.

Consistent with evaluation findings indicating that advertisements that elicit strong negative emotions and/or portray graphic images may be more effective in promoting behavior change, NY TCP's media plan for 2009 emphasized these advertisements (Table 2). Five of the six cessation advertisements that aired in 2009 included graphic images or

Figure 2. Quarterly Population-Weighted Gross Rating Points (GRPs) for Paid Television Ads and Confirmed Awareness among Smokers, 2005–2009

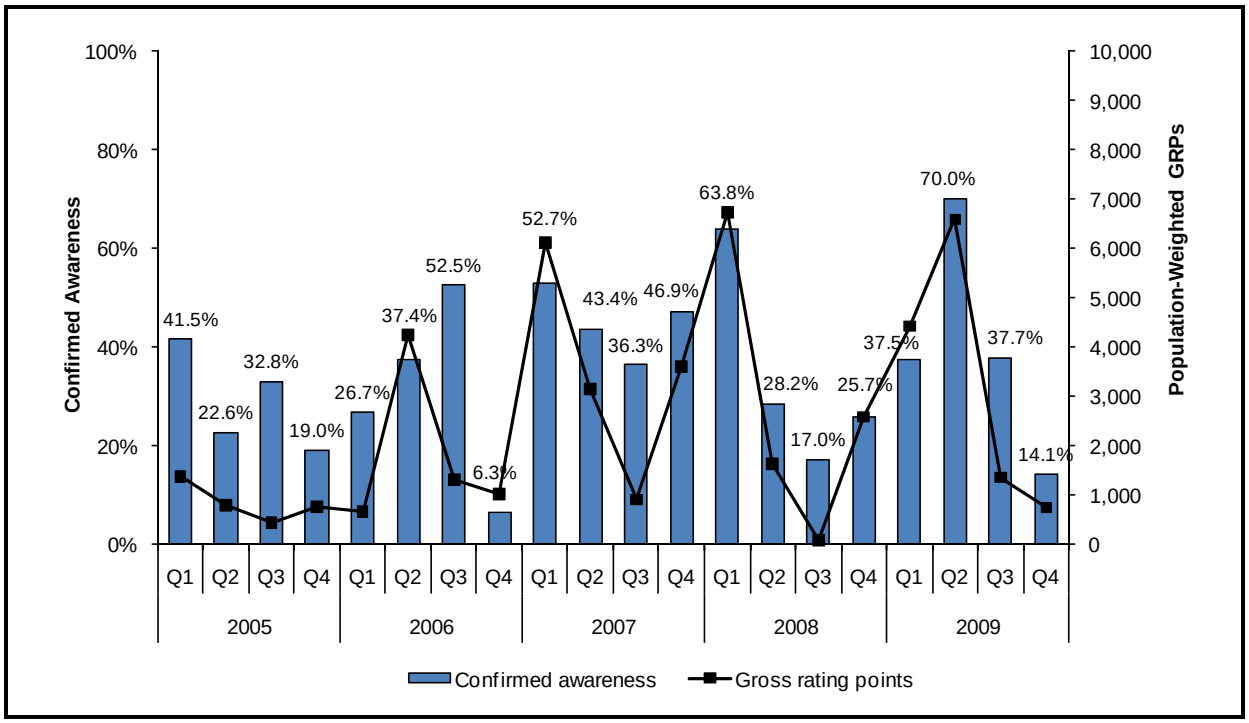


Table 2. NY TCP Television Advertisements Aired in Calendar Year 2009

Ad Name	Months Aired in 2009[a]	Ad Type	Strong Negative Emotions and/or Graphic Images	Statewide Average GRPs
Bronchoscopy	1, 2	Cessation	Yes	750
The Wait	1, 6, 7, 8, 9, 10	Cessation	Yes	1,140
Homesick	2	Secondhand smoke	No	763
Cigarettes Eating You Alive (SHS)	2, 3	Secondhand smoke	Yes	631
Cigarettes Eating You Alive	2, 3	Cessation	Yes	631
Family Room	3, 4	Secondhand smoke	No	455
Sponge	4	Cessation	Yes	270
Stairway	4, 5	Cessation	Yes	308
Down the Aisle	4, 5, 6	Cessation	No	356

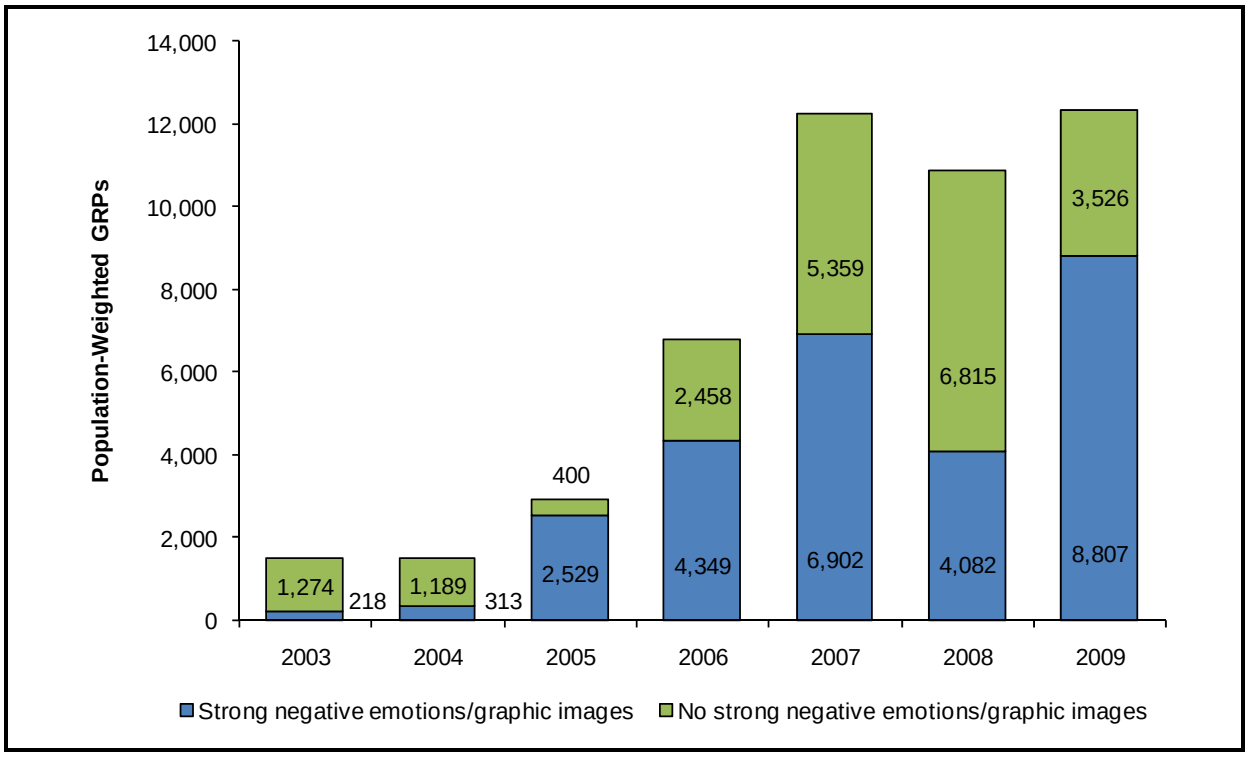
Note: GRPs = gross rating points; SHS= secondhand smoke.

[a]January through December, indicated by months 1 through 12.

elicited strong negative emotions. Figure 3 shows that the proportion of media delivered that featured strong negative emotions and/or graphic images increased considerably in 2009 (to 70%) compared with recent years. These included ads with strong graphic images of the health consequences of smoking (e.g., "Bronchoscopy" and "Sponge") and ads with strong emotional content (e.g., "The Wait"). "Sponge" shows how the lungs absorb tar and other harmful chemicals in cigarettes and the amount of tar that could be squeezed from the lungs of a 1 pack-a-day smoker. "The Wait" portrays an anxious patient waiting in his doctor's examining room, contemplating the possible tobacco-related diagnoses he may receive from his doctor.

The secondhand smoke ads "Family Room" and "Homesick" both illustrate the impact of children's exposure to secondhand smoke. "Cigarettes are Eating You Alive (SHS)" shows graphic images of the effects of inhaled secondhand cigarette smoke on human lungs—one of the few secondhand smoke advertisements to use graphic images.

Figure 3. Statewide Average Gross Rating Points (GRPs) for Paid Television Ads With and Without Strong Negative Emotions and/or Graphic Images in New York, 2003–2009



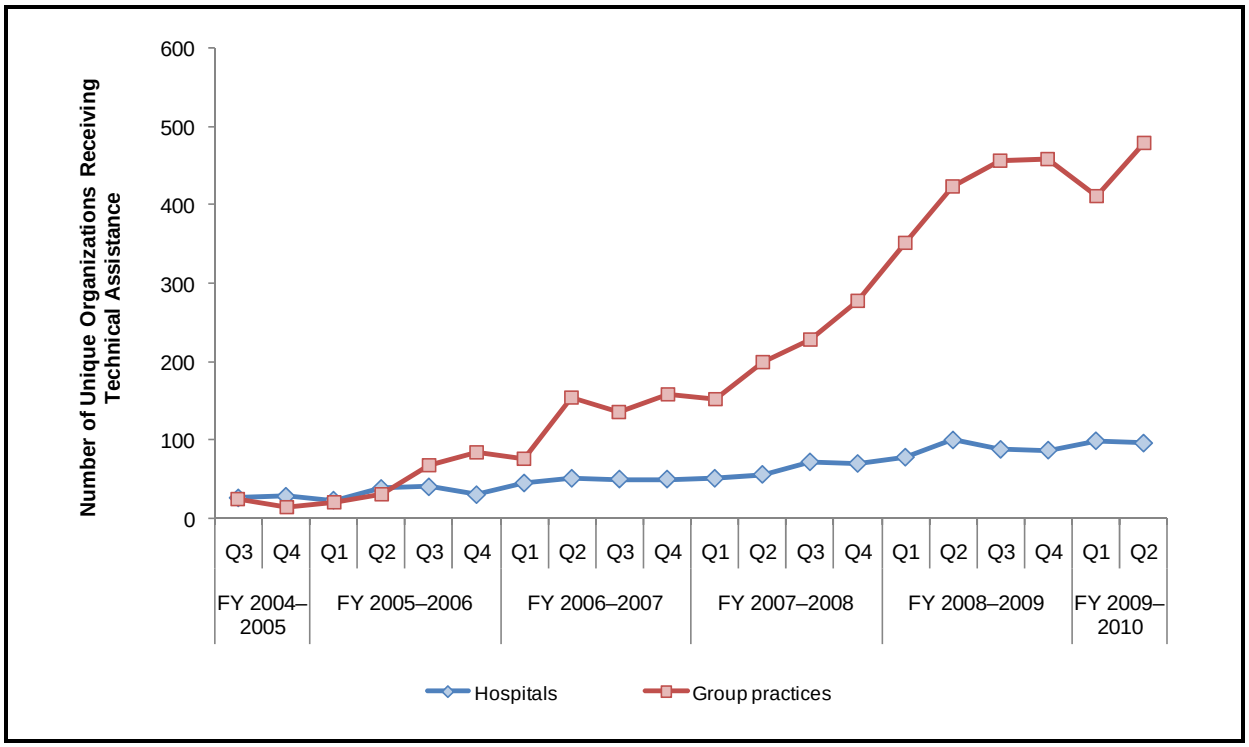
Cessation Interventions

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 distribute materials and information on cessation interventions.

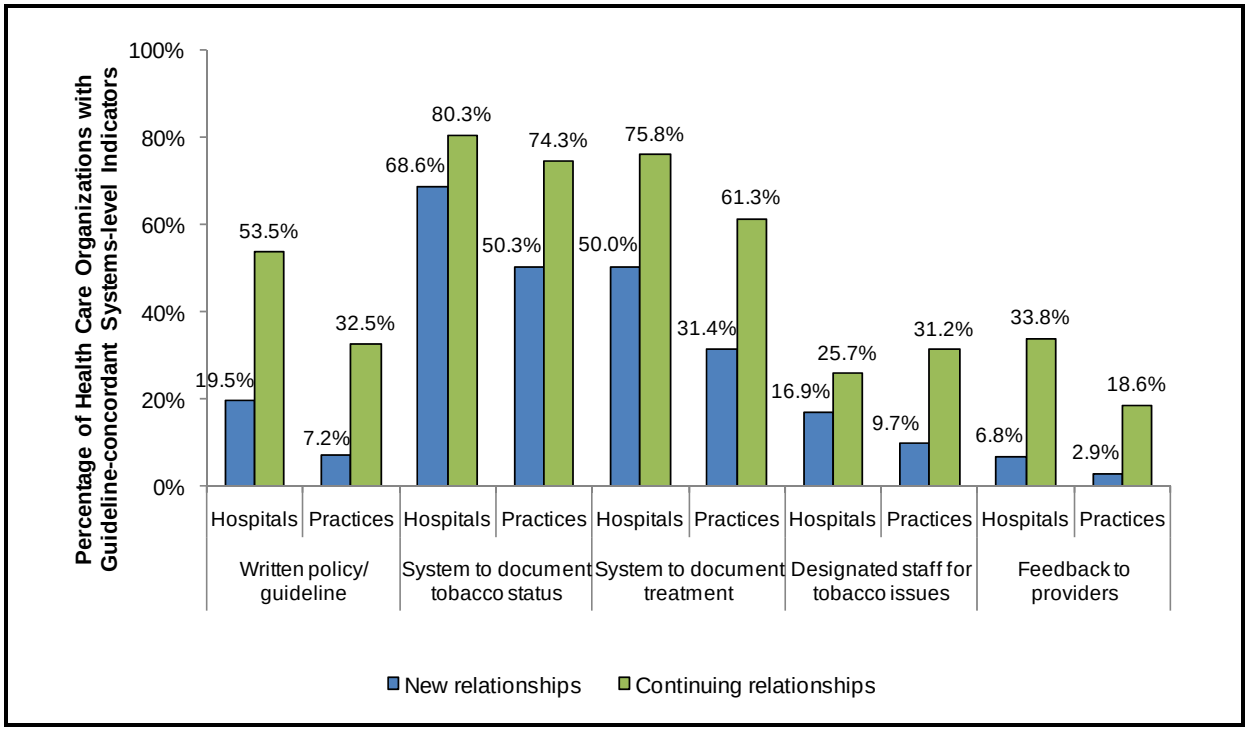
The number of hospitals with which Cessation Centers work has remained fairly steady, while the number of group practices has increased over time (Figure 4). Cessation Centers interact with multiple departments and units within hospitals in addition to higher-level committees and leaders that oversee hospital administration. In 2010, Cessation Centers across New York State report working with 660 hospitals or hospital departments or units, 1,588 group practices, and 176 other organizations. Approximately 30% of these organizations are new relationships as of the current reporting period.

Figure 4. Number of Health Care Organizations Receiving Cessation Center Technical Assistance Per Quarter by Type of Health Care Organization, Community Activity Tracking System, FY 2004–2005 to FY 2009–2010



Cessation Centers report higher use of key systems-level indicators among health care organizations with which they have been in continuing relationships over time (Figure 5).

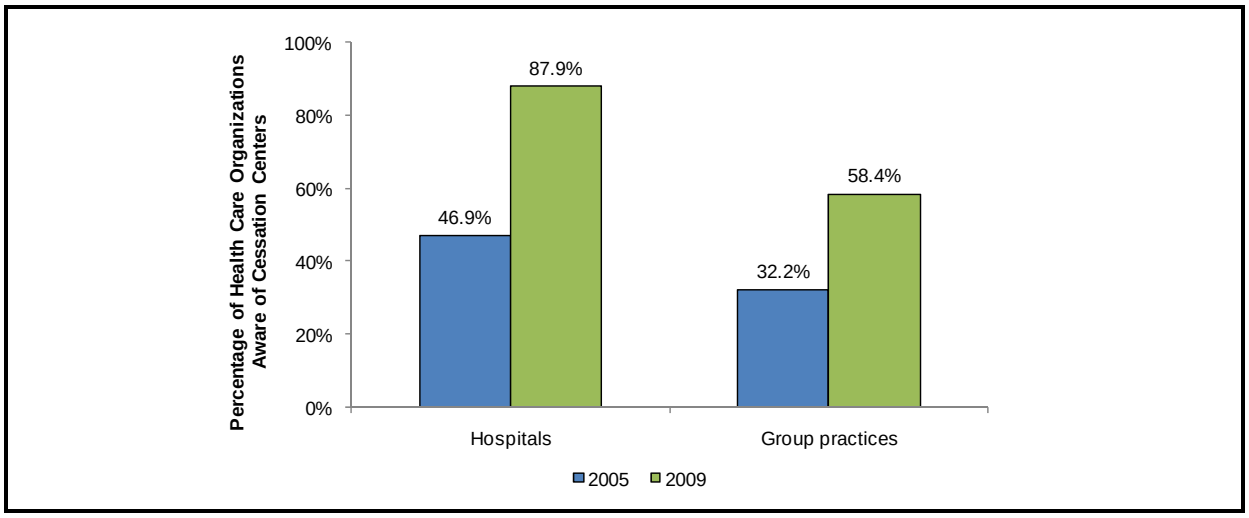
Figure 5. Percentage of Health Care Organizations with Guideline-Concordant Systems-Level Indicators by Type of Organization and Whether their Cessation Center Relationship is New or Continuing, Community Activity Tracking System, 2009–2010



We also measured guideline concordance from the perspective of health care organizations. To document the systems, policies, and practices in place among health care organizations in New York State and assess the impact of the Cessation Center initiative on health systems change, we conducted the Health Care Organization and Provider Study. Health care organizations' awareness of Cessation Centers nearly doubled from 2005 to 2009, among both hospitals and group practices (Figure 6). Nearly all organizations were aware of the New York State Smokers' Quitline (97.1% of practices and 100.0% of hospitals).

Implementation of written policies or guidelines is one way to standardize screening and treatment expectations regarding patient tobacco use. The use of such written policies or

Figure 6. Health Care Organization Awareness of Cessation Centers, Health Care Organization and Provider Study 2004–2005, and 2009



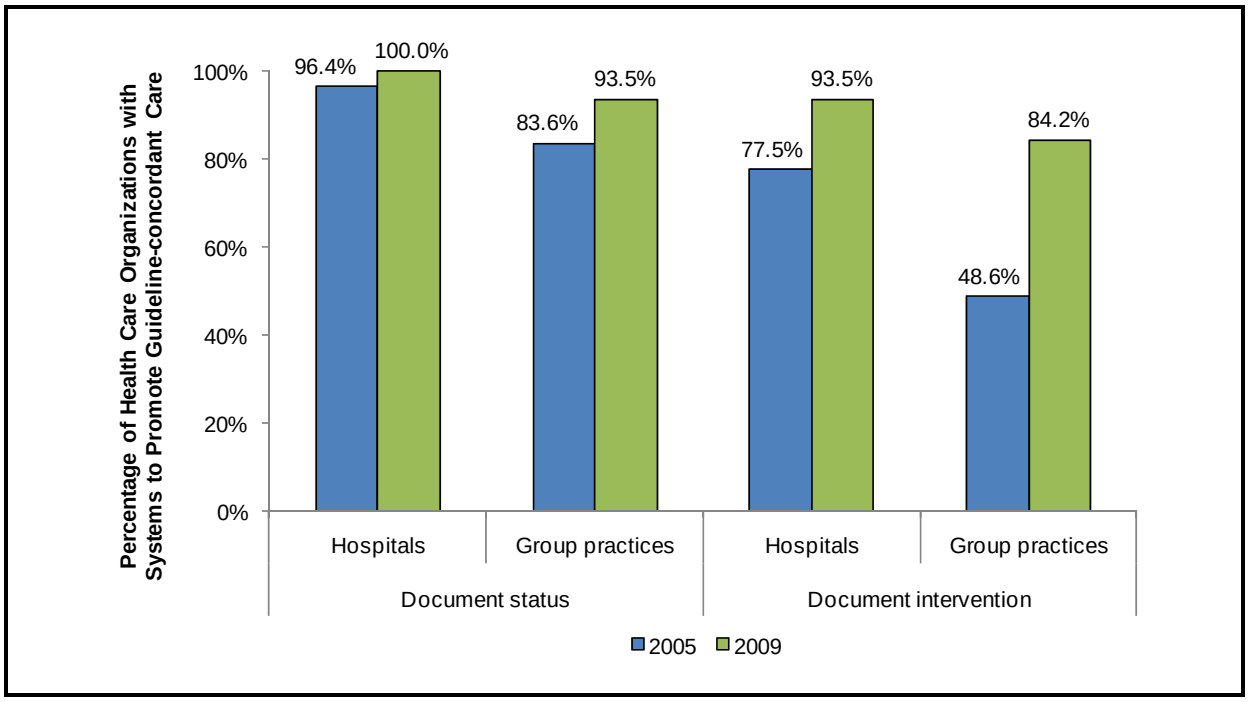
Note: Statistically significant difference between 2005 and 2009 for hospitals and group practices.

guidelines increased among hospitals in New York State from 37.5% in 2005 to 67.5% in 2009.

One of the main systems-level strategies recommended by the Public Health Service guideline is use of provider reminder systems to cue and document tobacco screening. More than 90% of hospitals and group practices reported having such systems to document tobacco use status. The percentage of hospitals and group practices that reported having systems to document tobacco dependence intervention increased from 2005 to 2009 (Figure 7).

Even though most hospitals and group practices reported having systems to document tobacco cessation interventions, consistent use of these systems is critical—as well as ongoing feedback to reinforce intervention and documentation. The majority of hospitals (89.8%) and 36.2% of group practices reported conducting audits that assess tobacco-related documentation. There was no statistically significant change in these percentages since 2005. Of those organizations that conduct tobacco-related audits, 80.8% report that feedback on the audits is given to providers or managers.

Figure 7. Health Care Organizations with Systems to Document Patient Tobacco Status and Tobacco Dependence Treatment in New York State, Health Care Organization and Provider Study 2004–2005 and 2009

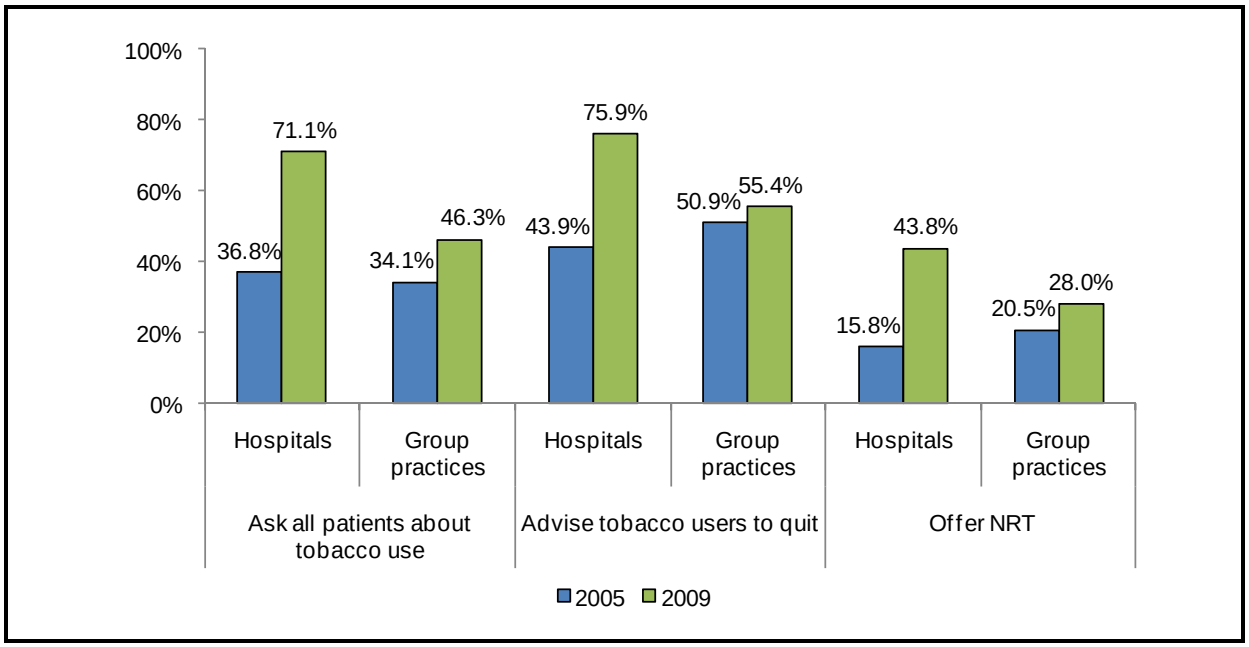


Note: Statistically significant difference between 2005 and 2009 for systems to document intervention among hospitals and group practices.

Greater percentages of hospitals reported that they require their providers to ask all patients about tobacco use, advise tobacco users to quit, and offer NRT or other stop-smoking medications (Figure 8). More than 70% of hospitals reported that their providers are required to ask all patients about tobacco use, up from 36.8% in 2005. Nearly 76% of hospitals require providers to advise tobacco users to quit, up from 43.9% in 2005. The percentage of hospitals requiring providers to offer tobacco users NRT or other stop-smoking medications (unless contraindicated) nearly tripled from 2005 (15.8%) to 2009 (43.8%).

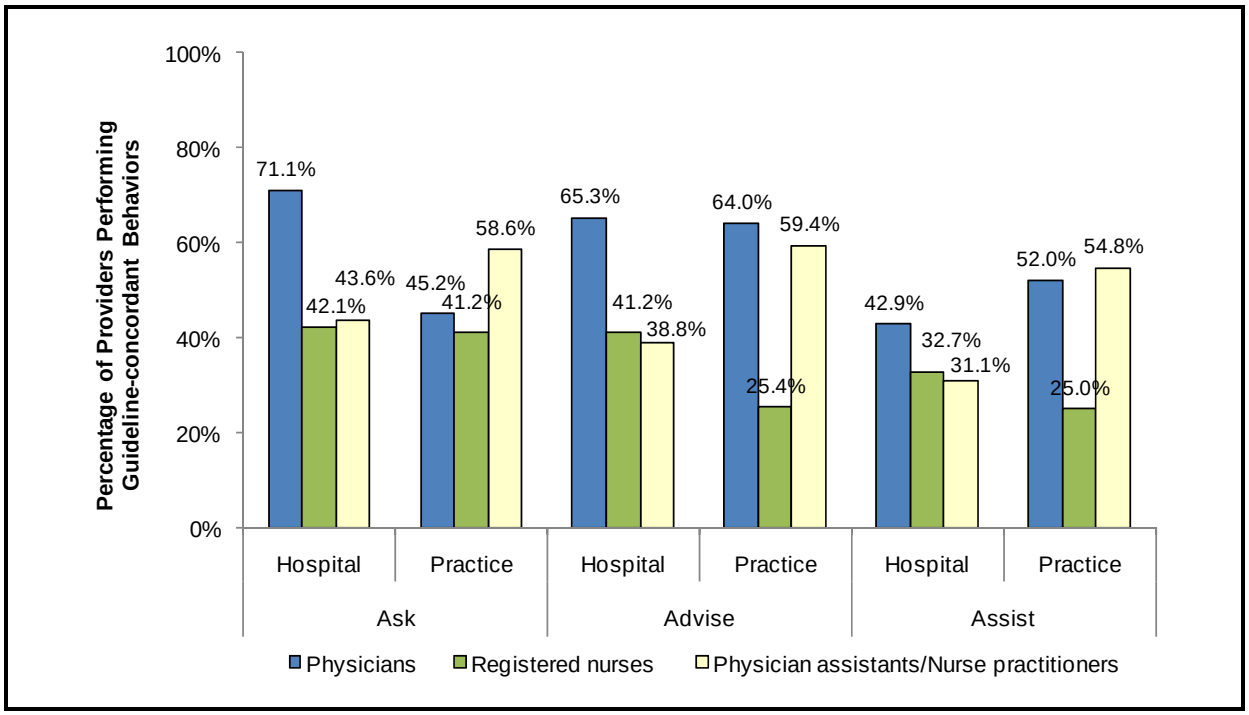
The health care providers who most commonly reported asking patients about tobacco use were hospital physicians (71.1%) and group practice physician assistants and nurse practitioners (58.6%); approximately 40% of other surveyed providers reported asking all or most patients about tobacco use (Figure 9). Advice to quit is most often conducted by hospital physicians and group practice physicians and physician assistants and nurse practitioners. Assistance with quit

Figure 8. Percentage of Health Care Organizations that Require Guideline-Concordant Care, Health Care Organization and Provider Study 2004–2005 and 2009



Note: Statistically significant difference between 2005 and 2009 for hospitals for requiring providers to ask all patients about tobacco use, advise tobacco users to quit, and offer NRT.

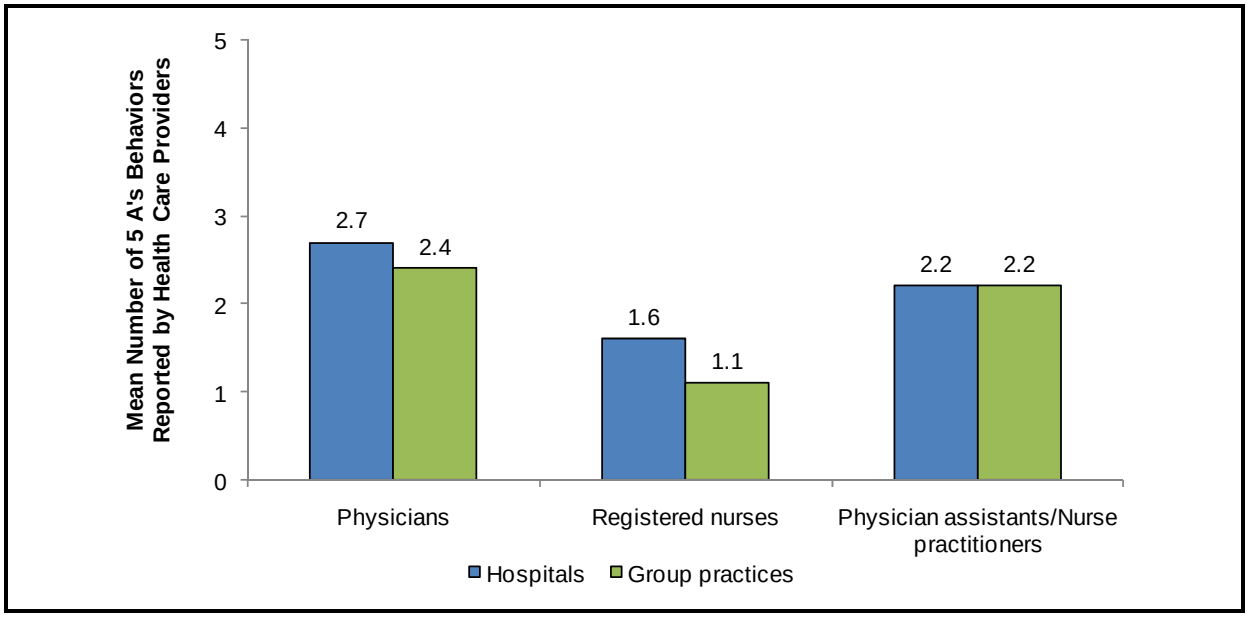
Figure 9. Percentage of Health Care Providers Reporting That They Ask Patients about Tobacco Use, Advise Tobacco Users to Quit, and Assist with a Quit Attempt, Health Care Organization and Provider Study 2009



attempts was higher among physicians, physician assistants, and nurse practitioners in group practices than hospitals.

In 2009, the mean number of 5 A's (Ask, Advise, Assess, Assist, Arrange) reported by health care providers ranged from 1.1 to 2.7, with no significant changes since 2005 (Figure 10). The least commonly reported was Arrange—scheduling a follow-up contact with the patient to discuss smoking cessation.

Figure 10. Mean Number of 5 A's Reported by Health Care Providers, Health Care Organization and Provider Study 2009



In the 2009 Independent Evaluation Report, we recommended that Cessation Centers target health care sites that serve a high population of patients who smoke. In response to this, NY TCP launched an initiative during 2009 offering free NRT to Federally Qualified Health Centers that agreed to establish relationships with Cessation Centers and institute tobacco cessation systems change. NY TCP set aside funds to allow 57 Federally Qualified Health Centers to participate, but only 11 umbrella organizations with 34 clinic sites applied. Cessation Centers found that many Federally Qualified Health Centers were reluctant to sign Memoranda of Understanding and that the free NRT was not a significant enough incentive. As with all types of health care organizations, Cessation Centers found it challenging to recruit sites that are not ready to change their policies, practices, and systems.

Also in response to a recommendation in the 2009 Independent Evaluation Report, NY TCP has required Cessation Centers to reach out to health plans in an attempt to gain access to primary care practices. Cessation Centers reported that they have started working with nine health care organizations that were referred through health plans. Cessation Centers have extended a focused effort specifically toward Medicaid Managed Care health plans.

"Don't Be Silent About Smoking" Media Campaign

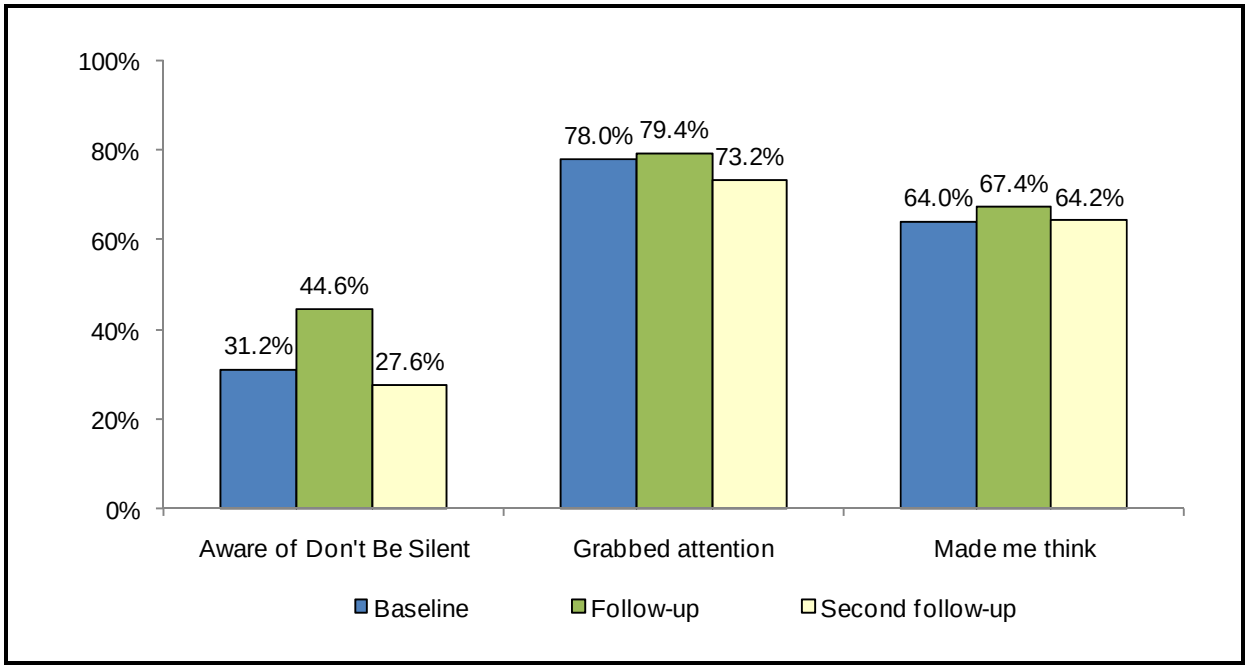
In 2008, the Cessation Center's "Don't Be Silent About Smoking" health care provider media campaign consisted of two phases of print advertisements targeting primary care physicians, physician assistants, and nurse practitioners. These advertisements ran in various periodicals, including the *Journal of the American Medical Association*, *New England Journal of Medicine,* and nursing-specific publications such as *American Nurse* and *Nursing Spectrum*; Internet banner advertisements; and a Web site, talktoyourpatients.org. In 2009, the "Don't Be Silent" campaign ran from March through June, continuing to target physicians, nurse practitioners, and physician assistants. The 2009 advertisements included full-page ads in *The New York Times—Science Times*, *Albany Times Union*, and *Buffalo News*; billboards near Albany hospitals; print ads in periodicals, including *Wall Street Journal*, *Newsday*, and *Golf Digest*; Internet banner ads; a campaign Web site; and regional and local press events. NY TCP planned to launch a new phase of print advertisements in 2009, but the new campaign was delayed until fall 2010 due to the midyear deficit reduction plan.

To assess the "Don't Be Silent" campaign, we conducted an initial survey (N = 1,205) and two follow-up surveys (N = 602 and N = 598) of primary care physicians, physician assistants, and nurse practitioners using an online panel of health care providers. The baseline survey was conducted in June 2008, the first follow-up survey was conducted in December 2008, and the second follow-up survey was conducted in June 2009. The survey asks all respondents whether they recall seeing the campaign advertisements and whether the advertisements grabbed their attention and/or made them think about doing more to help their patients quit. The survey also measures targeted campaign outcomes, such as asking patients about

tobacco use, advising them to quit, 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 11). 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. We found significant associations between recall of ads and cessation counseling behaviors and awareness of cessation resources. The strongest effects were on assistance with counseling and referral to cessation resources.

Figure 11. Awareness of and Reactions to *Don't Be Silent* Campaign, Health Care Provider Online Baseline and Follow-up Surveys

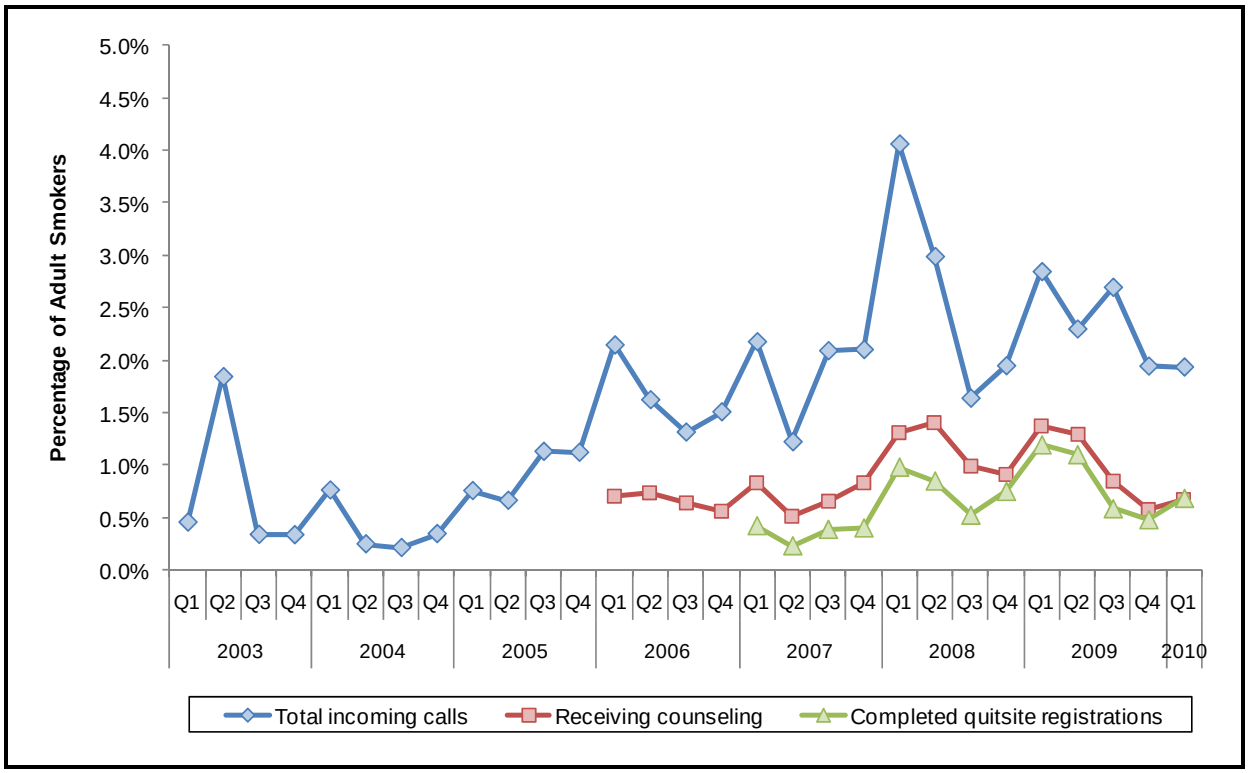


New York State Smokers' Quitline

Use of the New York State Smokers' Quitline has increased steadily over the years. In 2009, 110,724 current and former smokers (4.1% of adult smokers in New York State) received telephone counseling and 90,966 (3.4%) registered to receive

free NRT through the Quitsite (Figure 12). The reach of the Quitline and Quitsite is comparable to 2008; however, the number who registered at the Quitsite increased by 15% between 2008 and 2009.

Figure 12. Reach of the New York State Smokers' Quitline, Q1 2003–Q1 2010



Statewide and Community Action

Community Partnerships for Tobacco Control

In FY 2009–2010, the Program initiated significant changes to the focus and objectives of Community Partnership activities at the point of sale. Contractors advocated with individual store owners for policy changes under the Advertising, Sponsorship, and Promotion initiative, and the Program recognized that if they continued this practice, they would never reach a significant proportion of the more than 19,000 licensed tobacco retailers in the state. Currently, Community Partnerships advocate for voluntary policies only with grocery store chain management, and their efforts are coordinated and focused on a small set of grocery store chains. By focusing on chain store

management, contractors can effectively advocate for policy change in multiple stores with one contact.

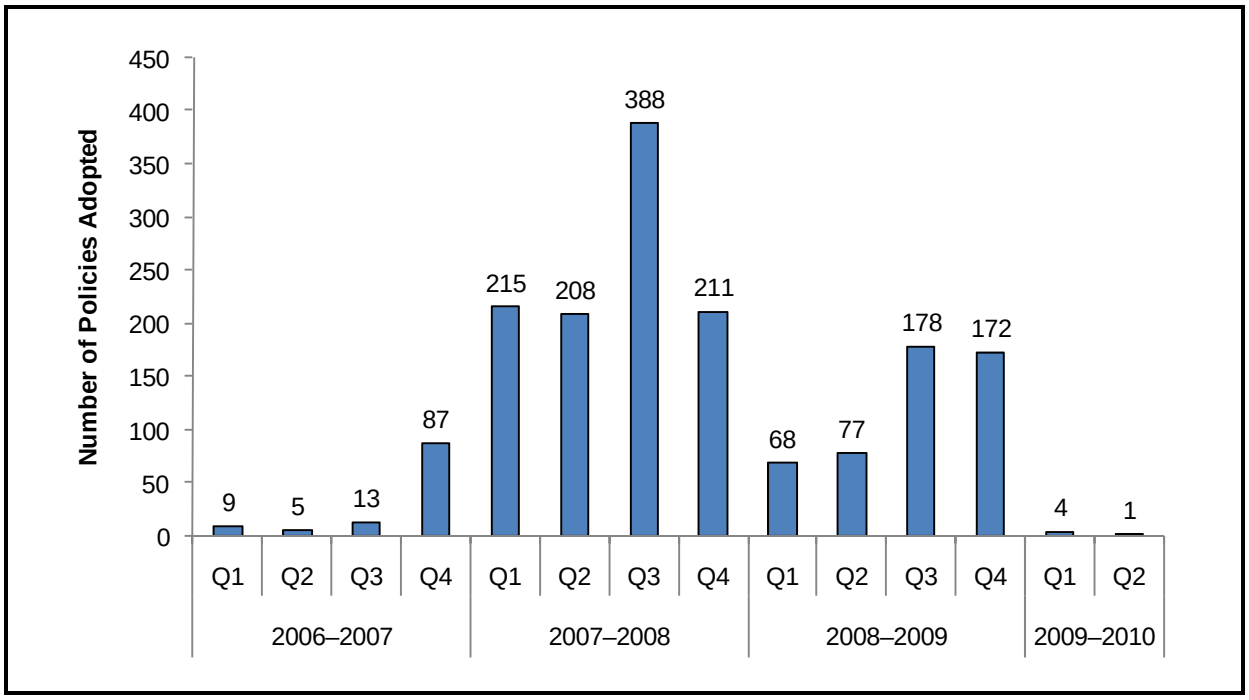
NYSDOH's successful application for funds under the American Recovery and Reinvestment Act of 2009 has provided resources needed to support the change in policy focus. These funds have been used to hire a Policy Coordinator and support a contract with the Center for Tobacco-Free New York. These additional resources combined with in-kind support from existing state-funded contracts have been used to develop model policies, a media campaign to educate the public about tobacco industry marketing at the point of sale, and training materials for contractors to successfully meet the following point-of-sale objectives:

- restrict the number, location, and type of tobacco retailers; and
- keep tobacco products out of view in non-adult–only retail settings.

Figure 13 illustrates the number of tobacco retailer policies reported by Community Partnerships during the first two quarters of FY 2009–2010. The drop in the number of policies and resolutions to reduce tobacco advertising in retail environments reflects the change in focus of Community Partnership efforts in the retail environment from voluntary policies adopted by individual stores to voluntary policies adopted by chain store management that affect multiple stores. Of the five policies passed during the first two quarters of FY 2009–2010, four chain stores agreed to stop selling tobacco products, and the fifth chain agreed to reduce the visibility of tobacco products in its stores. To illustrate the potential impact of this approach compared to advocating with individual stores, one of the policy changes recorded was adopted by a chain with more than 25 stores in 19 New York cities. This chain agreed to stop selling tobacco products, and this one policy will result in a change in all of its stores.

In addition to activities focused on the retail environment, 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, parks, playgrounds, and beaches in support of the following objective:

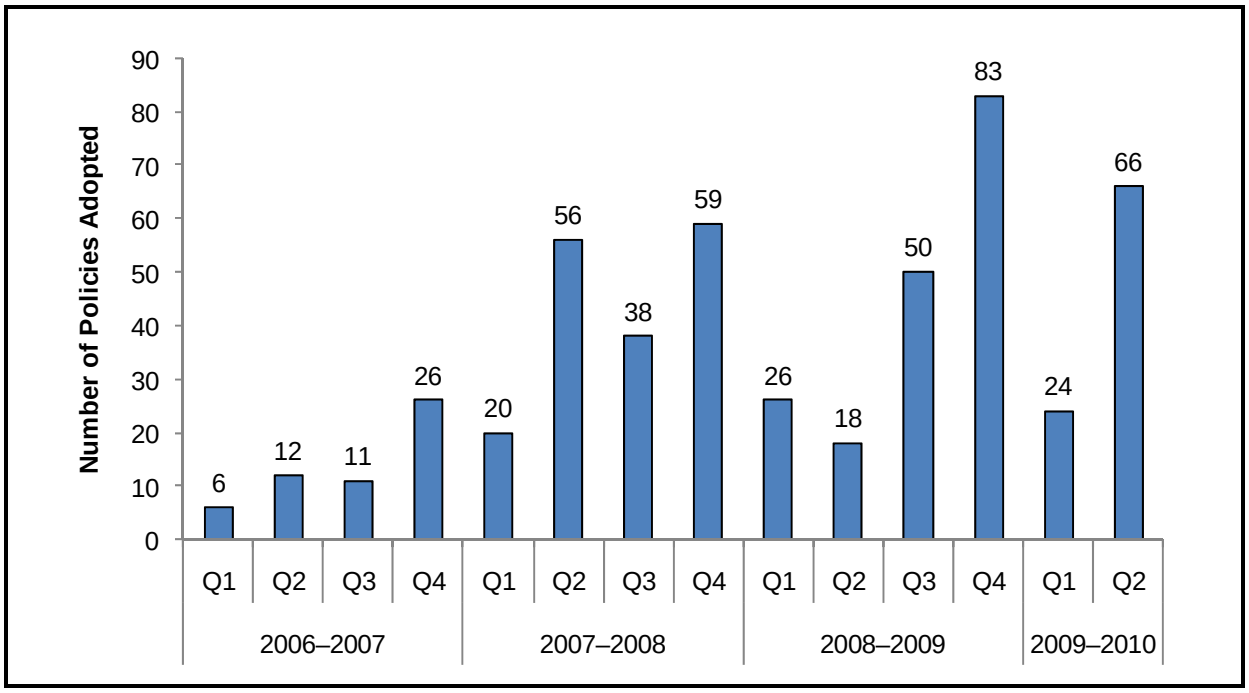
Figure 13. Policies Reducing Tobacco Advertising in Retail Environments Reported by Community Partnerships and Youth Action Contractors, Community Activity Tracking System, Q1 2006–Q2 2010



- Increase the number of local laws, regulations, and voluntary policies that prohibit tobacco use in outdoor areas.

During the first two quarters of FY 2009–2010, Community Partnerships reported that 86 policies were adopted that prohibit tobacco use in outdoor areas (Figure 14). Eighteen of these policies were adopted by municipalities—1 city, 7 towns, 9 villages, and 1 state park—and an additional 7 were adopted by libraries. Smoke-free outdoor policies at individual businesses and organizations account for the remainder of the policies recorded. Because the proportion of the population protected from outdoor secondhand smoke is dependent upon the number of venues the policy covers (e.g., beaches, entranceways), contractor efforts focused on policy change in municipalities, including public libraries and parks, have a greater overall reach than efforts focused on policy change at individual establishments or buildings.

Figure 14. Policies Prohibiting Tobacco Use in Outdoor Areas Reported by Community Partnerships and Youth Action Contractors, Community Activity Tracking System, Q1 2006–Q2 2010

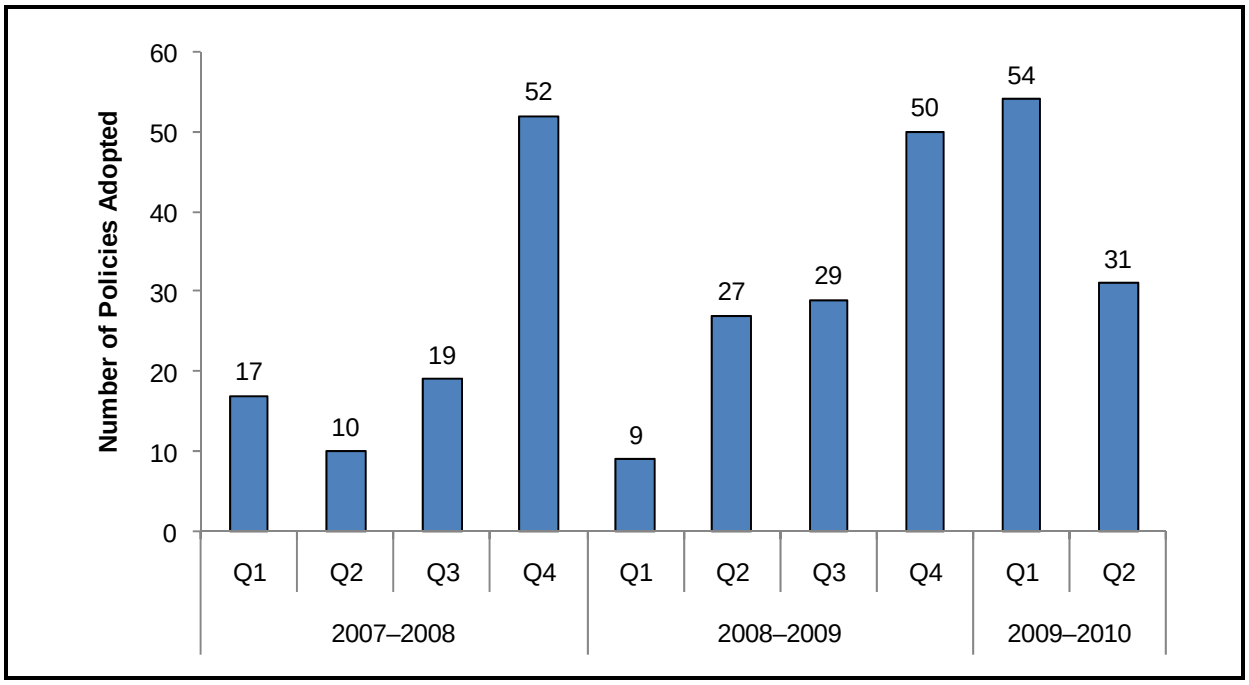


Beginning in FY 2007–2008, 11 Community Partnerships were required to implement strategies promoting smoke-free policies in multi-unit dwellings. In FY 2009–2010, these Community Partnerships educated apartment complex managers, landlords, and other stakeholders about the impact of secondhand smoke exposure and the benefits of smoke-free housing, and they advocated for smoke-free policies in multi-unit dwellings in support of the following objective:

- Increase the percentage of adult smokers and youth who live in households where smoking is prohibited by promoting smoke-free multi-unit housing policies.

During the first two quarters of FY 2009–2010, Community Partnerships reported that 85 smoke-free multi-unit housing policies were adopted (Figure 15). To maximize the number of multi-unit dwellings subject to smoke-free policies, many contractors advocated with landlords who are responsible for multiple properties rather than with individual property owners responsible for a small number of rental units. As a result, more than half of the policies reported by contractors were adopted by landlords or realty management companies that have responsibility for 2 to 25 properties.

Figure 15. Policies Prohibiting Tobacco Use in Multi-Unit Dwellings by Community Partnerships, Community Activity Tracking System, Q1 2007–Q2 2010



Community Partnerships reported 239 instances of earned media during the first two quarters of the fiscal year, primarily consisting of new stories and "other." The initiative most frequently covered by earned media was the point-of-sale initiative (58%) followed by news coverage of the smoke-free outdoors initiative (38%).

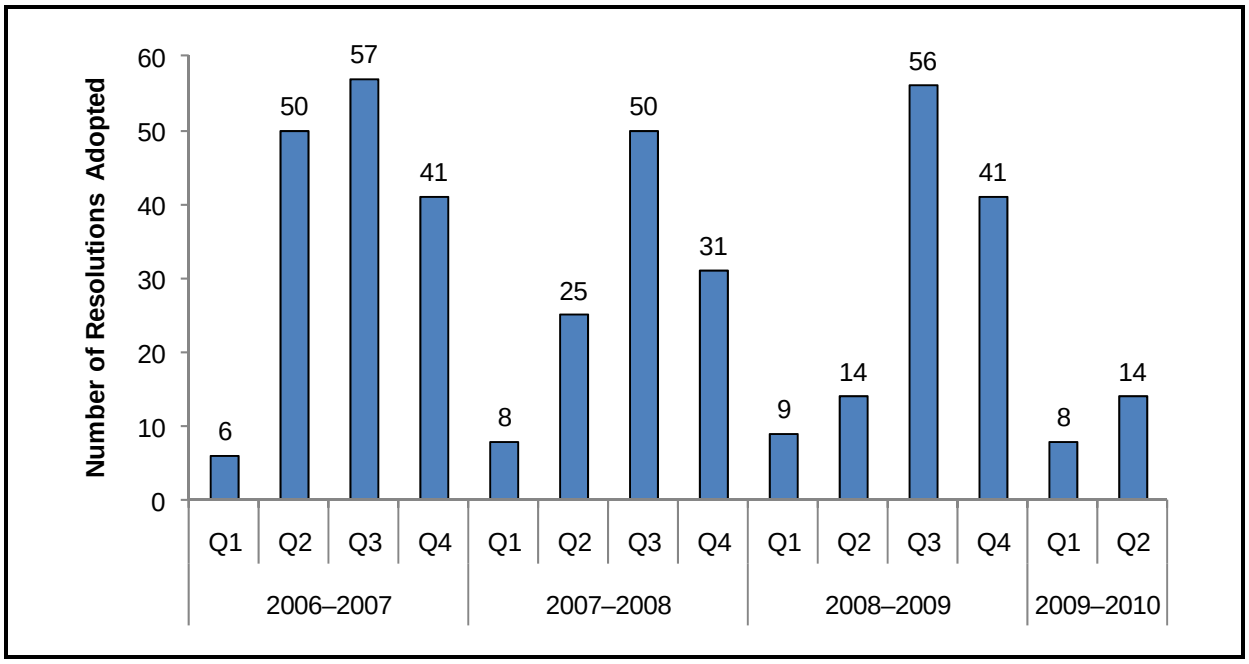
Youth Action Contractors

In FY 2009–2010, 16 Youth Action contractors engaged youth leaders to challenge and change community norms regarding tobacco use through policy advocacy and community education efforts. During this time, Youth Action contractors were the only modality to work on the following objective:

Eliminate smoking and tobacco imagery from movies rated G, PG, and PG-13.

- They obtained smoke-free movie resolutions from organizations throughout the state and collected petition signatures in support of smoke-free movies. In the first two quarters of FY 2009–2010, Youth Action contractors reported obtaining smoke-free movie resolutions from 22 organizations (Figure 16), which were sent to the

Figure 16. Resolutions Focused on Smoke-Free Movies Reported by Youth Action Contractors, Community Activity Tracking System, Q1 2006–Q2 2010



Motion Picture Association of America and the parent companies of major movie studios. Youth Action contractors 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 June 2009, more than 200 Reality Check members joined State Health Commissioner Dr. Richard Daines, Christine Morrison (Senior Tobacco Counsel in the New York Attorney General's Office), and prominent tobacco control advocates Barbara Zolty (World Health Organization Policy Officer) and Dr. Stanton Glantz (University of California San Francisco) in New York City to demand that the parent companies who own the six major motion picture studios eliminate smoking and other tobacco imagery from youth-rated movies.

In FY 2009–2010, 10 Youth Action contractors conducted activities to obtain letters in support of tobacco-free advertising in magazines to send to publishers with copies sent to the Attorney General, the National Association of Attorney Generals, and the tobacco companies. They also advocated with local organizations and businesses to display information about

tobacco advertising and its effect on youth. These activities are in support of the following objective:

- Increase the number of publishers of magazines and newspapers that have a written policy prohibiting acceptance of tobacco company, retailer, or product advertising.

Five Youth Action contractors also worked independently or with Community Partnerships on the following objective:

- 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).

Youth Action contractors reported that four policies were adopted that prohibit tobacco use in outdoor areas. One of those policies was adopted by a village park, and the other three were adopted by organizations or businesses.

Youth Action Programs reported 31 instances of earned media with approximately equal coverage of the periodical and smoke-free movies initiatives.

School Policy Contractors

In FY 2009–2010, 33 School Policy contractors worked with schools and school districts to implement and enforce tobacco-free school policies that meet standards developed by NY TCP. These standards include the following:

- 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.

Since April 2006, School Policy contractors have built relationships with 1,364 schools in 600 school districts—representing 85% of the school districts in New York State. During the first two quarters of FY 2009–2010, 25 individual schools and school districts passed policies promoting tobacco-free schools, of which 6 policies included all elements necessary to meet NYSDOH's core standards for comprehensive tobacco-free school policies.

For FY 2010–2011, School Policy contractors will be integrated with the Division of Chronic Disease and Injury Prevention's Obesity Prevention and Healthy Heart programs to develop comprehensive school health policies that will reduce tobacco use, increase physical activity, and increase access to and consumption of healthy foods. While tobacco-free school policies can reduce students' opportunities to use tobacco, decrease exposure to adult modeling of tobacco use, change norms regarding the acceptability of tobacco use, and reduce access to tobacco products, school policies can also impact obesity by increasing opportunities for physical activity, increasing access to healthy foods, and decreasing access to unhealthy foods such as sugared soft drinks.

"We're Watching" Media Campaign

Following a strategy similar to the Cessation Centers' effort to expand the reach of their message with the "Don't Be Silent" media campaign, the School Policy contractors developed the "We're Watching" campaign. Phase 1 of the "We're Watching" campaign, which ran during the fall of 2009, emphasized the importance of enforcing tobacco-free school policies to target audiences, including administrators and key decision makers. The target audience of the campaign included all public and private middle and high school principals and superintendents in New York State. The campaign consisted of a series of print ads featuring a student at school facing the camera with text encouraging the enforcement of tobacco-free policies.

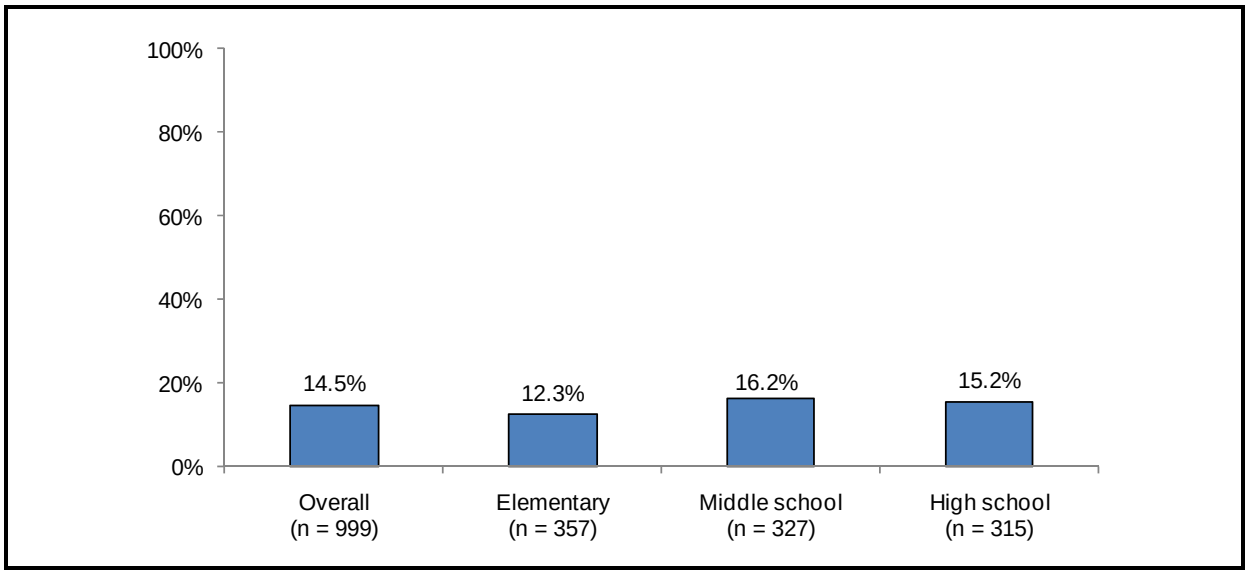
Campaign advertisements were featured in journals and magazines commonly read by school administrators. In addition, Web banner and leaderboard advertisements were featured on Web sites such as District Administration, Edutopia, and Edweek. Finally, e-mail advertisements were sent in

communication from the New York City Council of School Supervisors and Administrators, School Association of Administrators in New York State, New York State Education Department Secondary Education School Executives Bulletin, and Phi Delta Kappa to administrators. The campaign's Web site, tobaccofreepolicy.org, also featured the ads.

To assess the "We're Watching" campaign, RTI conducted a baseline survey of principals of elementary, middle, and high schools using an online survey. All school principals in New York State who met eligibility criteria were invited via e-mail to participate (N = 4,500). The baseline survey was conducted in November and December 2009 and resulted in 1,078 completed surveys. The survey measures awareness of and receptivity to the campaign (among all respondents), use of Web and print media channels, reported implementation and importance of school policy components, and attitudes about and perceived importance of enforcing tobacco-free school policies.

Overall awareness of the "We're Watching" campaign was 14.5% (Figure 17). These results were expected given the brief duration of the campaign, the small media buy, and limited media placement. Most principals (78.0%) reported that the ads grabbed their attention. However, just over half (51.6%) of school principals strongly agreed or agreed that the campaign made them think about doing more to enforce their school policy.

Figure 17. Confirmed Awareness of the "We're Watching" Campaign, by School Type, 2009 New York School Media Survey



Colleges for Change

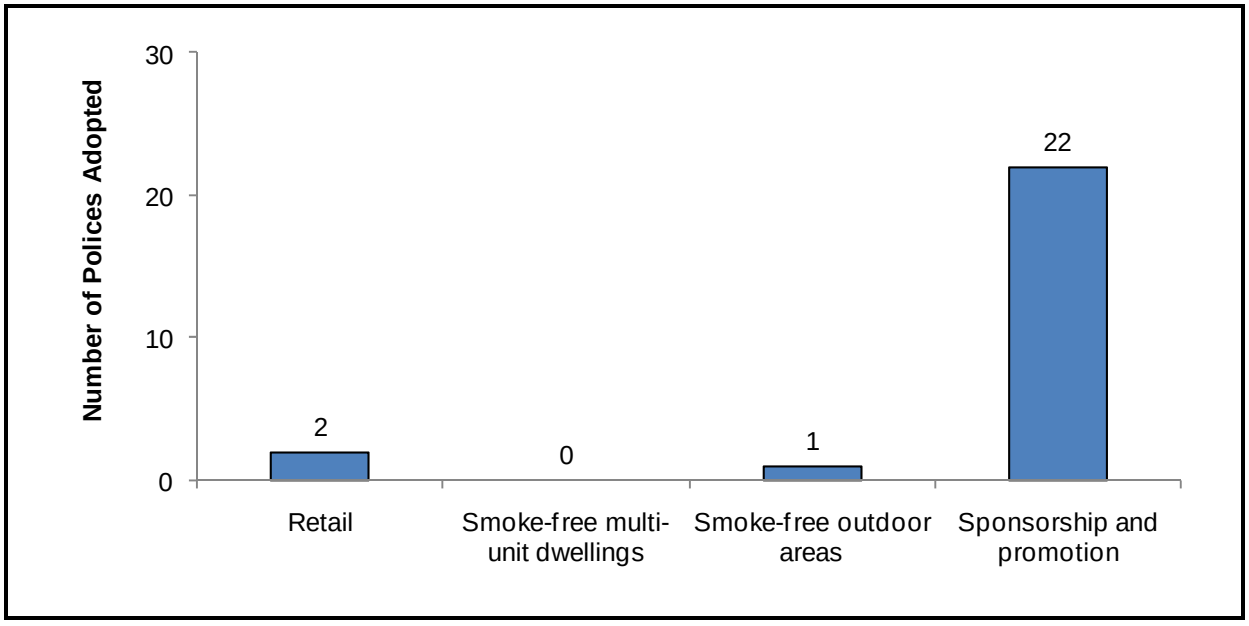
Launched in July 2009, the seven Colleges for Change contractors have focused on engaging young adult leaders to work on and off college campuses to promote policy change that limits where and how tobacco products are promoted, advertised, and sold. This initiative is intended to combat the significant amount of tobacco industry marketing aimed at young adults (Sepe, Ling, and Glantz, 2002; Gilpin, White, and Pierce, 2005), reduce industry sponsorships, and promote smoke-free multi-unit housing policies. To denormalize and reduce tobacco use, Colleges for Change contractors focus on the following objectives:

- 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, college campuses).
- Increase the percentage of adult smokers and youth who live in households where smoking is prohibited by promoting smoke-free multi-unit housing policies.
- Reduce the amount of tobacco company corporate giving, sponsorship, and product promotion at events and organizations in New York communities by promoting policies that prohibit college organizations and local businesses from accepting tobacco industry funding.

- Decrease the number of retail stores that sell tobacco products by promoting policies that ban tobacco product sales on college campuses.

During the first two quarters of FY 2009–2010, Colleges for Change reported that 25 policies were adopted that address tobacco use among four initiatives (Figure 18). Most of the policies adopted supported the sponsorship and promotion initiative, with 10 policies being adopted by campus clubs/sports and 11 policies being adopted by fraternities and sororities. During the first two quarters of FY 2009–2010, no policies were passed in bars or clubs.

Figure 18. Policies Addressing Tobacco Use by Initiative, Colleges for Change, Community Activity Tracking System, Q1–Q2 2010



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 (NCI, 1991; USDHHS, 2000). This section addresses NY TCP progress in achieving its statutorily mandated outcomes of reducing tobacco use and strengthening antitobacco attitudes from 2003 to 2009. Where available, data are presented for the remaining United States 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

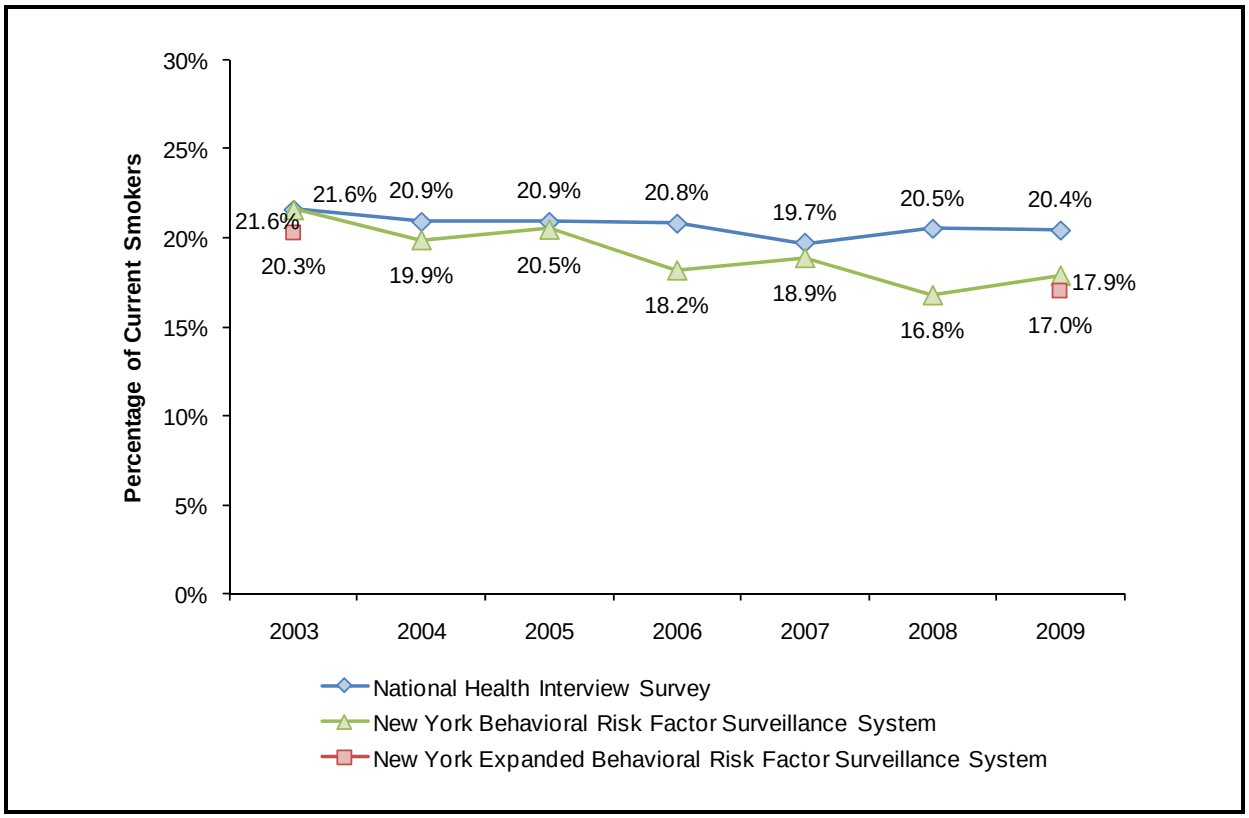
The key outcome indicators for this section include the

- percentage of adults who currently smoke in New York and the United States,
- number of cigarettes smoked per day by current adult smokers in New York and the rest of the United States,
- 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 2009, New York Behavioral Risk Factor Surveillance System and National Health Interview Survey data show a statistically significant downward trend in the percentage of adults who smoke (Figure 19). However, the percentage decline over this period was much greater in New York (17%) than in the United States (6%). Although it appears that the prevalence of smoking increased from 2008 to 2009 in New York, this change is not statistically significant.

We also examined the change in the prevalence of smoking in the New York Behavioral Risk Factor Surveillance System from 2003 to 2009 by gender, race/ethnicity, education, and mental health status to assess whether the decline in smoking was comparable across these groups over this time period (Table 3). We found that none of these groups experienced the same rate of change.

Figure 19. Percentage of Adults Who Currently Smoke in New York (Behavioral Risk Factor Surveillance System [BRFSS] and Expanded BRFSS) and Nationally (National Health Interview Survey), 2003–2009



Statistically significant declines were observed for men; whites; those with a high school degree or at least a college degree; those with incomes between $25,000 and $49,999 and $75,000 or higher; and those who reported good mental health. Mental health is measured by the question, “Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?” Good mental health is defined as those reporting fewer than 15 days of “not good” mental health (90% of New Yorkers).

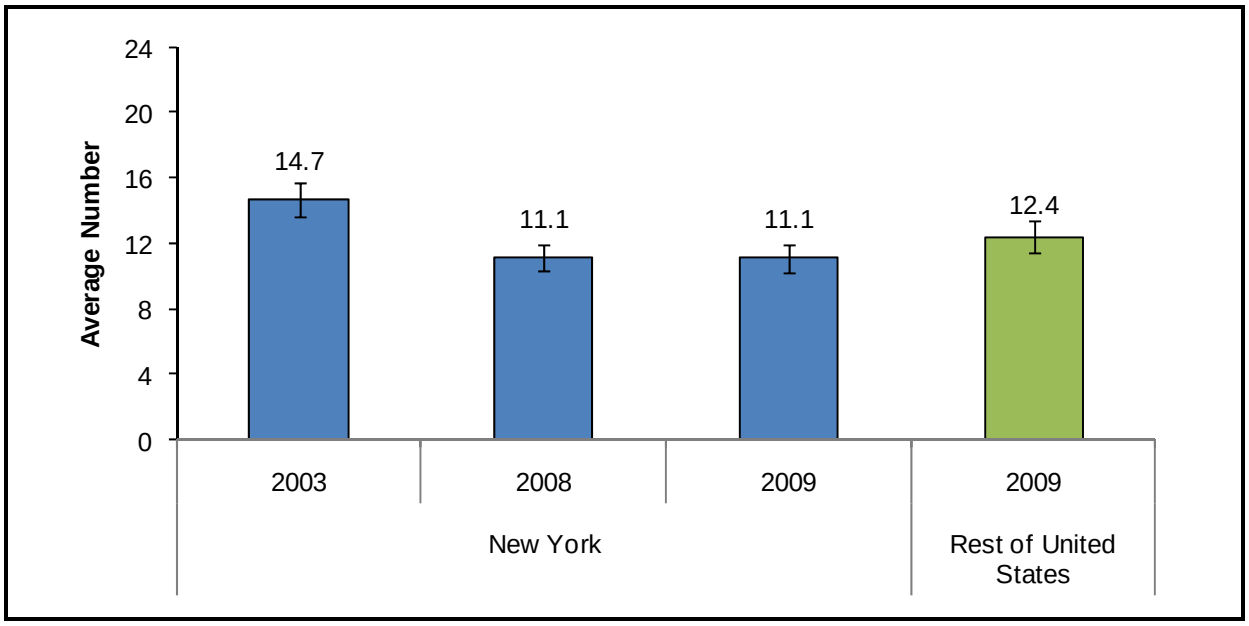
Over this same period, self-reported daily cigarette consumption declined by 24% (from 14.7 to 11.1 cigarettes). In 2009, average cigarette consumption was lower in New York (11.1) than in the rest of the United States (12.4) (Figure 20).

Table 3. Percentage of Adults Who Currently Smoke in New York by Demographic Groups, Behavioral Risk Factor Surveillance System 2003 and 2009

Group	2003	2009	Relative % Change
Gender			
Female	18.8%	16.8%	−11%
Male	**24.6%**	**19.3%**	**−22%**
Race/Ethnicity			
White	**23.1%**	**18.5%**	**−20%**
African American	22.2%	20.1%	−9%
Hispanic	18.6%	16.5%	−11%
Education			
< High school	27.3%	26.6%	−3%
High school	**28.0%**	**21.8%**	**−22%**
Some college	22.1%	21.9%	−1%
College graduate	**13.3%**	**10.7%**	**−20%**
Income			
Less than $25,000	27.7%	26.4%	−5%
$25,000–$49,999	**24.2%**	**19.9%**	**−18%**
$50,000–$74,999	19.4%	18.2%	−6%
$75,000 and more	**15.9%**	**11.8%**	**−26%**
Mental Health in Past Month			
Good	**20.4%**	**16.2%**	**−20%**
Not good	35.8%	34.0%	−5%

Note: Statistically significant changes between 2003 and 2009 are presented in bold text.

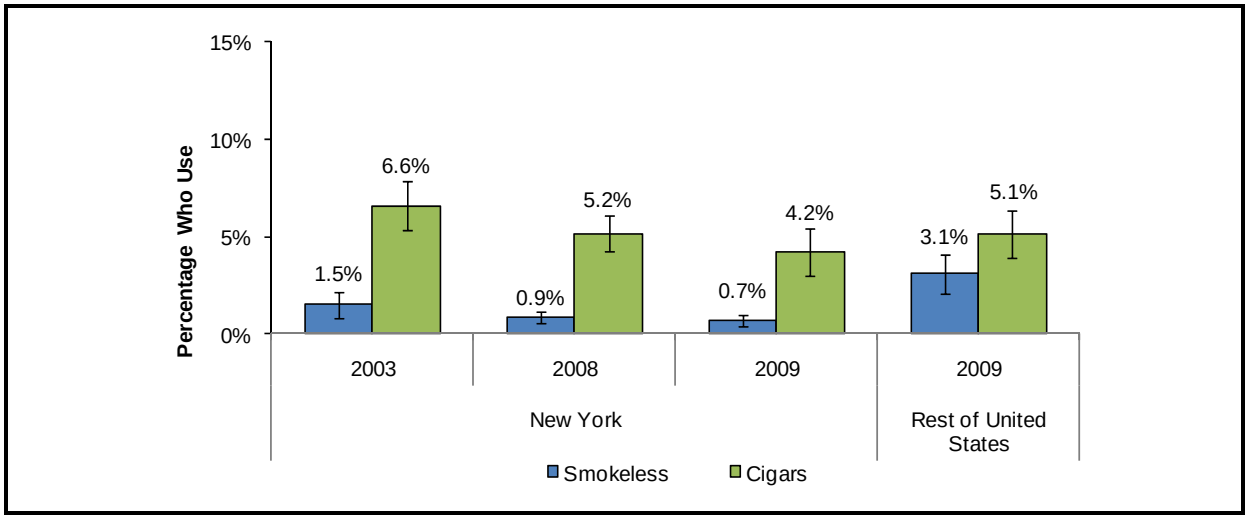
Figure 20. Average Daily Cigarette Consumption by Current Smokers, Adult Tobacco Survey 2003–2009 and National Adult Tobacco Survey 2009



Note: Statistically significant decrease between 2003 and 2009 among New York adult smokers.

Between 2003 and 2009, smokeless tobacco and cigar use decreased significantly. In 2009, the prevalence of smokeless use was lower in New York (0.7%) than in the remaining United States (3.1%) (Figure 21).

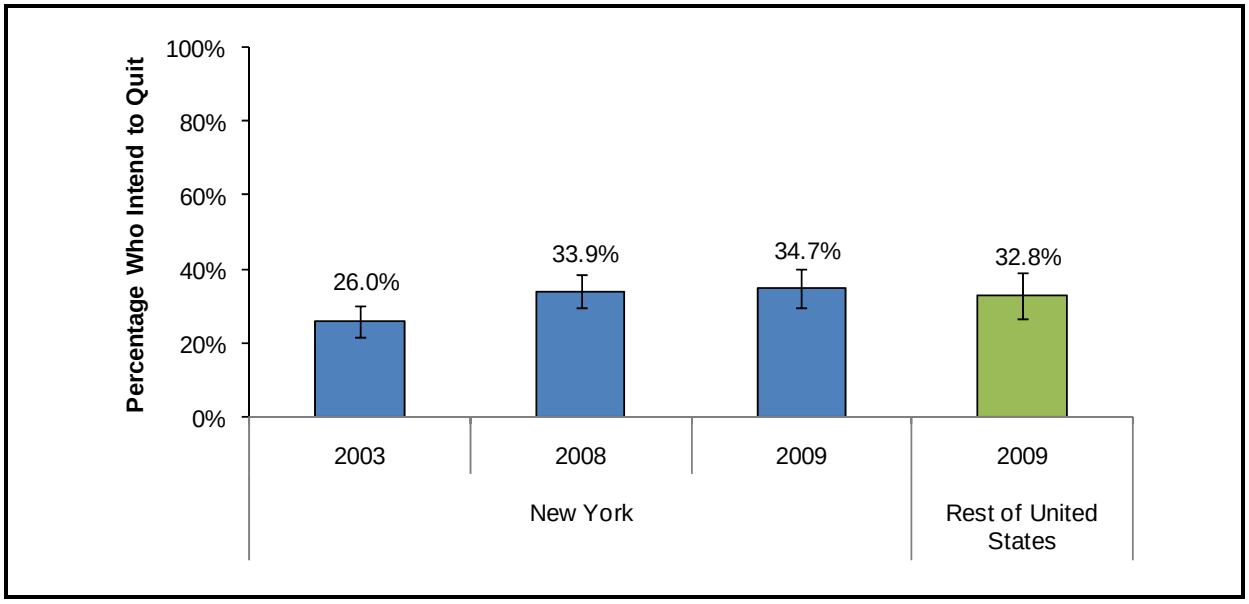
Figure 21. Percentage of Adults Who Currently Use Smokeless Tobacco and Smoke Cigars, Adult Tobacco Survey 2003–2009 and National Adult Tobacco Survey 2009



Note: Statistically significant decrease in smokeless tobacco and cigar use between 2003 and 2009. Difference between New York and the remaining United States is statistically significant for smokeless tobacco use.

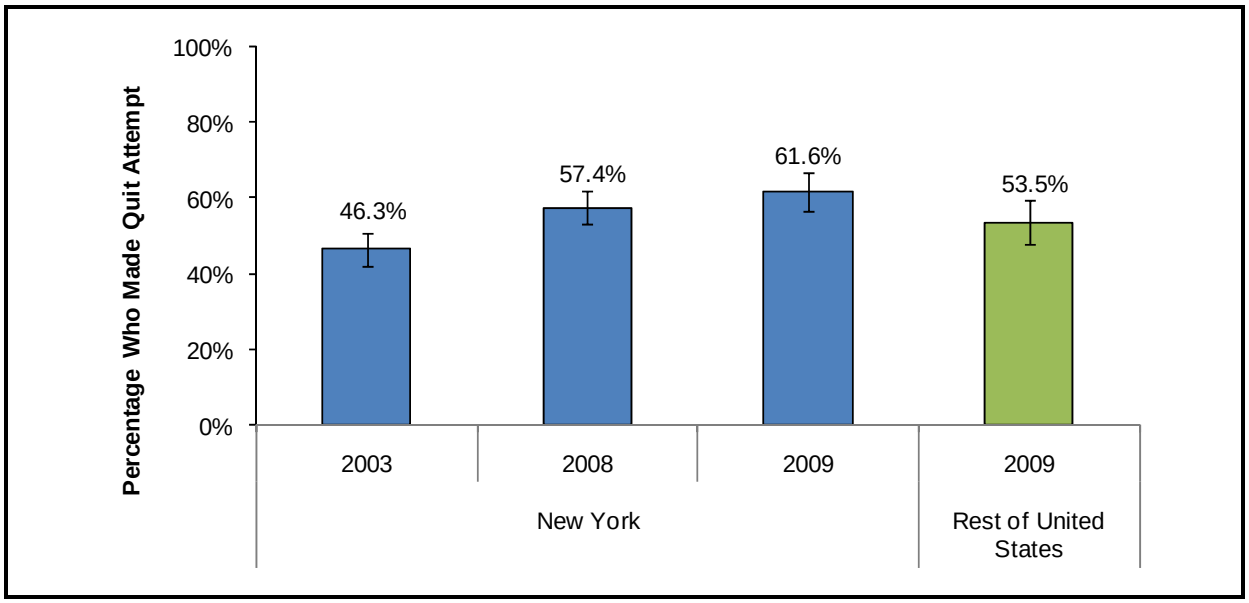
Consistent with the declines in smoking prevalence and cigarette consumption, there was a significant increase from 2003 to 2009 in the percentage of current smokers who intend to make a quit attempt in the next 30 days (Figure 22) and who made a quit attempt in the past year (Figure 23). The percentage of current smokers who made a quit attempt in the past year is significantly higher in New York than in the remaining United States.

Figure 22. Percentage of Adult Smokers Who Intend to Make a Quit Attempt in the Next 30 Days, Adult Tobacco Survey 2003–2009 and National Adult Tobacco Survey 2009



Note: Statistically significant increase from 2003 to 2009 among New York adult smokers.

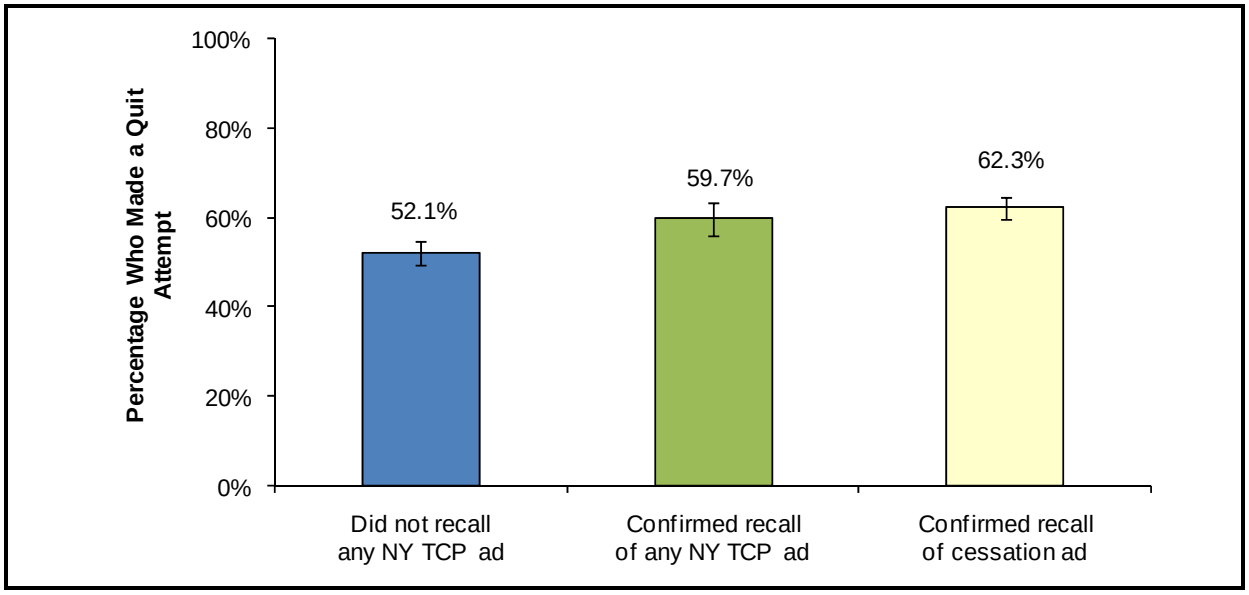
Figure 23. Percentage of Adult Smokers Who Made a Quit Attempt in the Past 12 Months, Adult Tobacco Survey 2003–2009 and National Adult Tobacco Survey 2009



Note: Statistically significant increase from 2003 to 2009 among New York adult smokers. Difference between New York and the remaining United States is statistically significant.

In addition, to highlight the importance of public health marketing, we show that smokers who are aware of NY TCP television advertisements were more likely to make a quit attempt than those who were not aware (Figure 24).

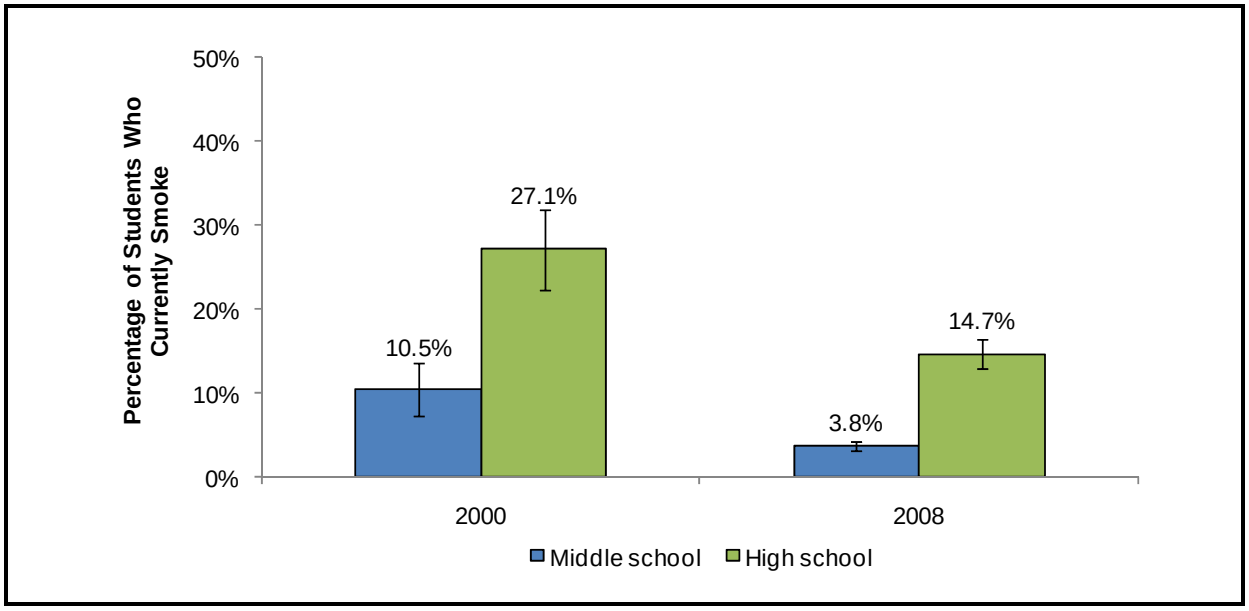
Figure 24. Percentage of Adult Smokers Who Made a Quit Attempt in the Past 12 Months by Awareness of NY TCP Television Advertisements, Adult Tobacco Survey 2003–2009



Note: Statistically significant difference between smokers who recalled at least one NY TCP ad and smokers who recalled any ad and any cessation ad.

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 25). As previously noted, from 2000 to 2006, the decline in smoking in New York outpaced the national trend. More recent comparable national data are not currently available. However, data from the Monitoring the Future surveys of 8th-, 10th-, and 12th-grade students suggest that declines in smoking prevalence among youth nationally have slowed (University of Michigan News Service, 2009).

Figure 25. Percentage of Middle and High School Students Who Currently Smoke in New York, Youth Tobacco Survey 2000–2008



Note: Statistically significant decrease from 2000 to 2008 among middle and high school students.

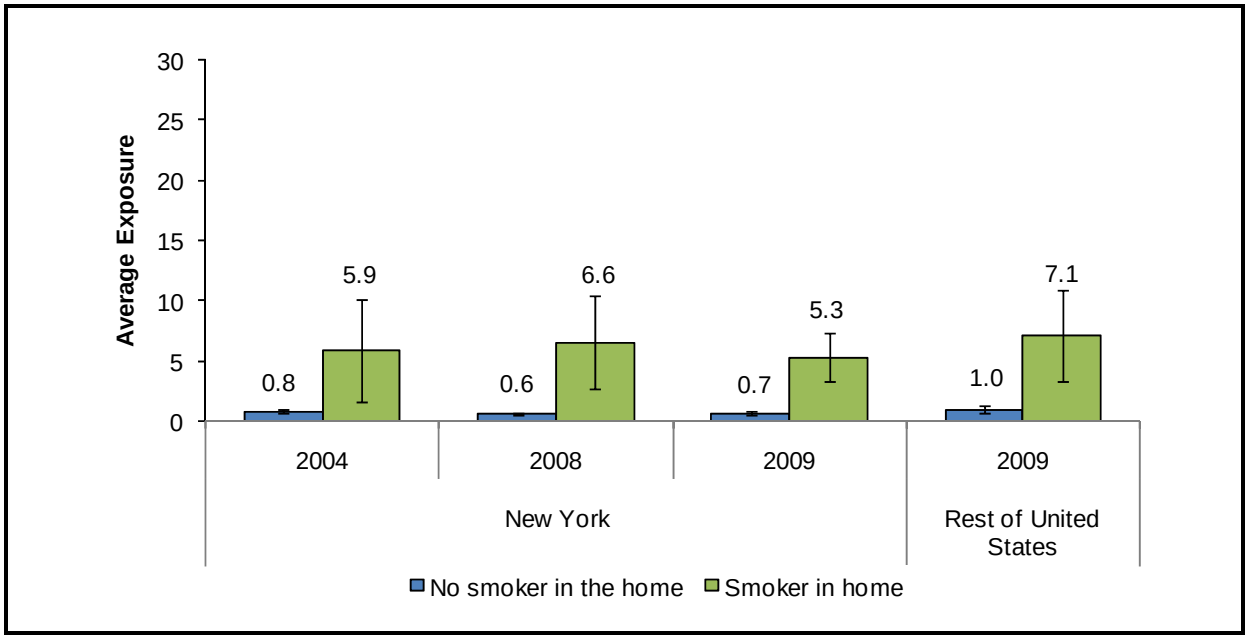
Exposure to Secondhand Smoke

Since the 2003 amendment to the New York Clean Indoor Air Act, 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 two related key outcome indicators below:

- hours of exposure to secondhand smoke among adult nonsmokers who do and do not live with a smoker, and
- percentage of smokers who report that their home is 100% smoke-free.

In 2009, nonsmokers in New York who do not live with a smoker were exposed to less secondhand smoke than their counterparts nationally (0.7 versus 1.0 hours per week) (Figure 26). Exposure to secondhand smoke among nonsmokers who live with a smoker was comparable in New York and the United States in 2009.

Figure 26. Number of Hours Nonsmokers Spent in a Room Where Someone Was Smoking by Presence of a Smoker in the Home, Adult Tobacco Survey 2004–2009 and National Adult Tobacco Survey 2009



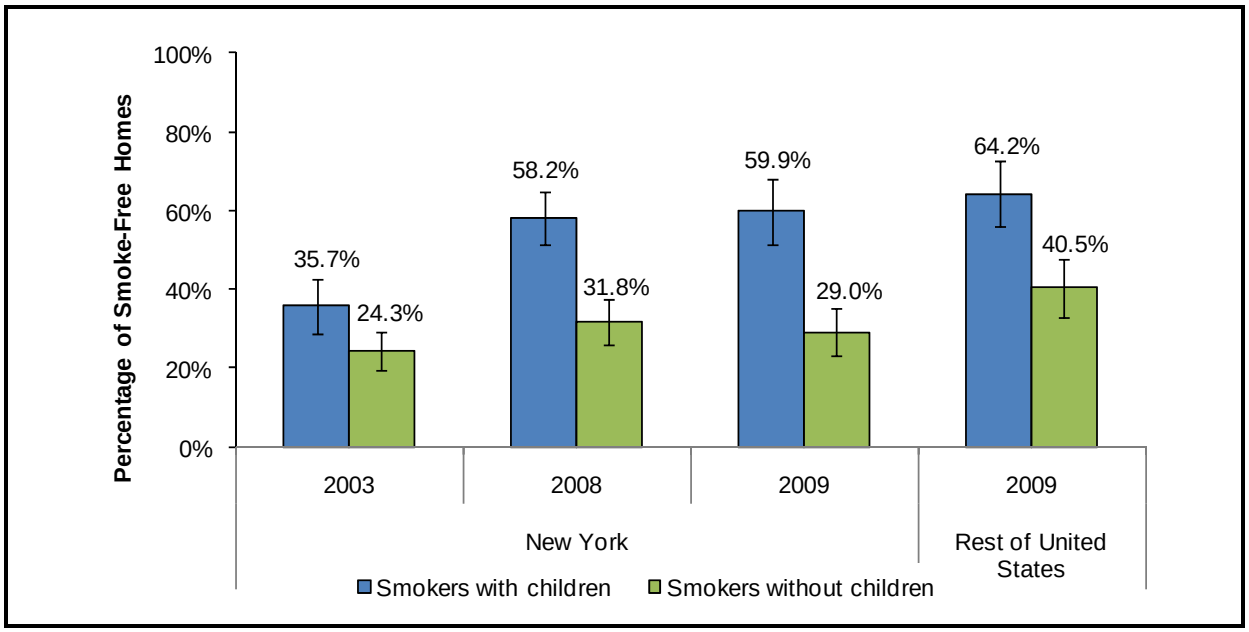
Note: Difference between New York and the remaining United States is statistically significant for homes with no smokers.

From 2003 to 2009, there was a statistically significant increase in the percentage of adult smokers with children who reported that their homes were smoke-free (Figure 27). This percentage increased from 36% to 60%. A lower percentage of New York smokers without children have 100% smoke-free homes than in the remaining United States.

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

Figure 27. Percentage of Adult Smokers Who Report That Their Homes Are 100% Smoke-Free by Presence of Children Under Age 18, Adult Tobacco Survey 2003–2009 and National Adult Tobacco Survey 2009



Note: Statistically significant increase between 2003 and 2009 among smokers with children. Difference between New York and the remaining United States is statistically significant among smokers without children.

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 28). This percentage has been steady from 2003 to 2009 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. However, significantly more New York adult smokers were advised to quit smoking than in the remaining United States (Figure 29). In contrast, between 2003 and 2009, an increasing percentage of smokers in New York reported that their health care provider assisted them with smoking cessation (Figure 30).

Figure 28. Percentage of Adult Smokers Who Were Asked by Their Health Care Provider if They Smoked in the Past 12 Months, Adult Tobacco Survey 2003–2009 and National Adult Tobacco Survey 2009

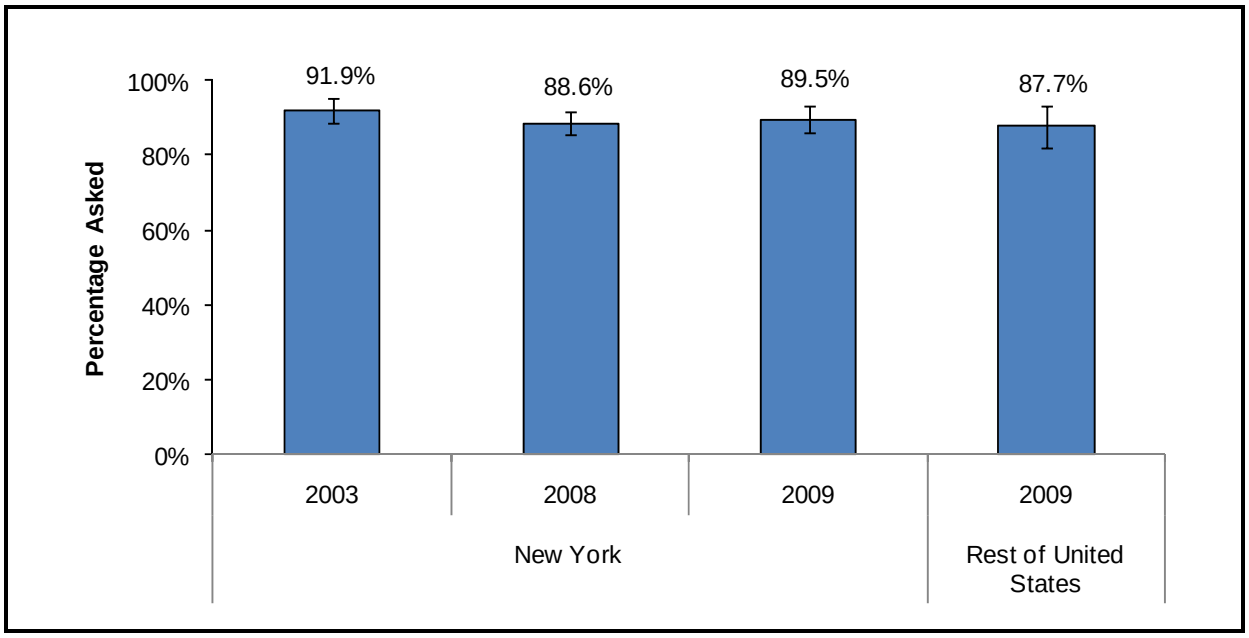
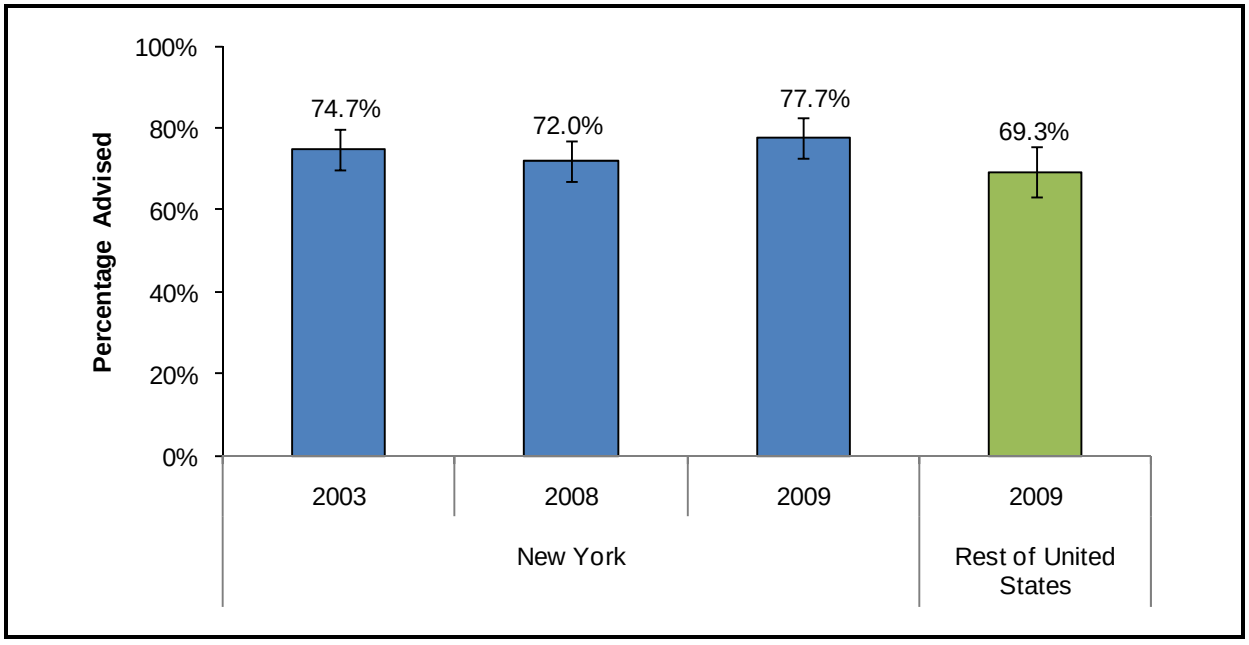
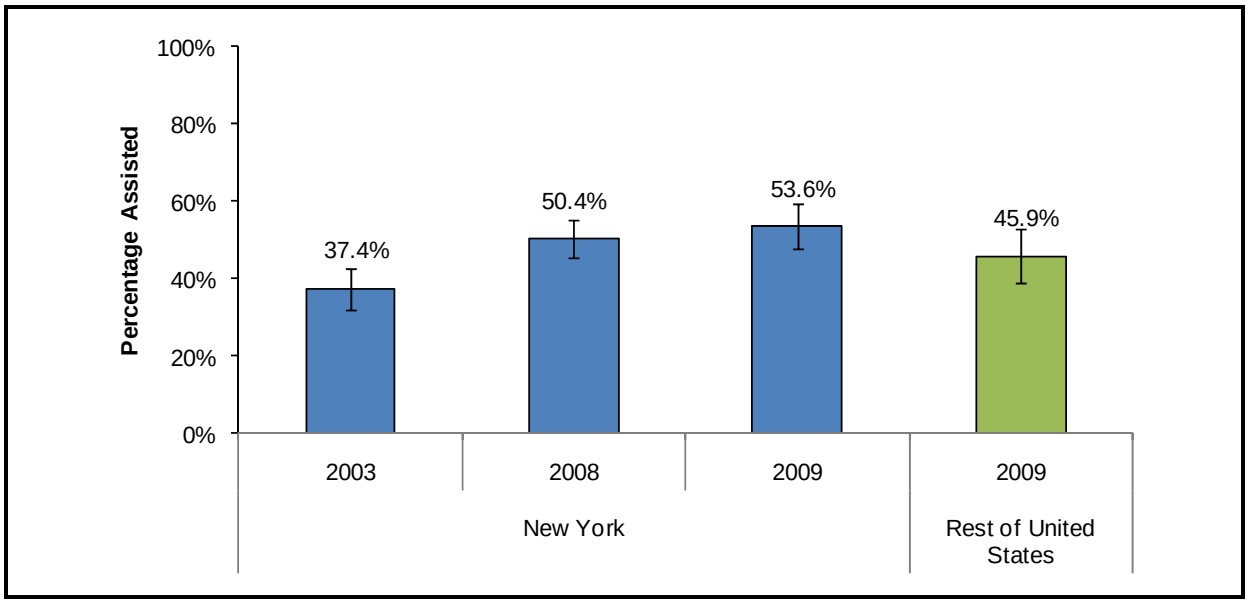


Figure 29. Percentage of Adult Smokers Who Were Advised by Their Health Care Provider to Quit Smoking in the Past 12 Months, Adult Tobacco Survey 2003–2009 and National Adult Tobacco Survey 2009



Note: Difference between New York and the remaining United States is statistically significant among adult smokers.

Figure 30. Percentage of Adult Smokers Who Report That Their Health Care Provider Assisted Them with Smoking Cessation in the Past 12 Months, Adult Tobacco Survey 2003–2009 and National Adult Tobacco Survey 2009



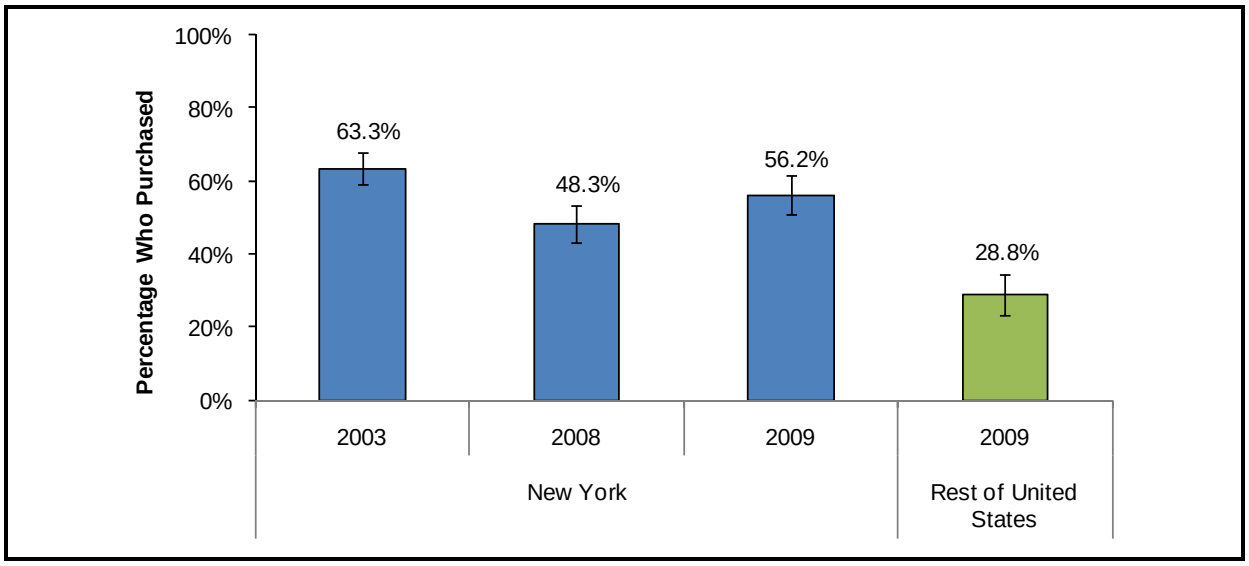
Note: Statistically significant increase between 2003 and 2009 among New York adult smokers.

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. In addition, the federal tax increased from $0.39 to $1.01 in April 2009. Figures 31 through 33 present data on smokers' efforts to avoid the tax and the prices they paid per pack for their last pack or carton purchased.

From 2008 to 2009, there was an increase in the percentage of smokers who purchased cigarettes from any low or untaxed sources (i.e., Indian reservations, Internet, neighboring states, duty-free shops, and toll-free numbers) (Figure 31). The two primary sources of tax evasion are purchases from the Internet and Indian reservations. Since 2003, purchases made over the Internet declined, but purchases from Indian reservations remained constant. Purchasing from both sources is more

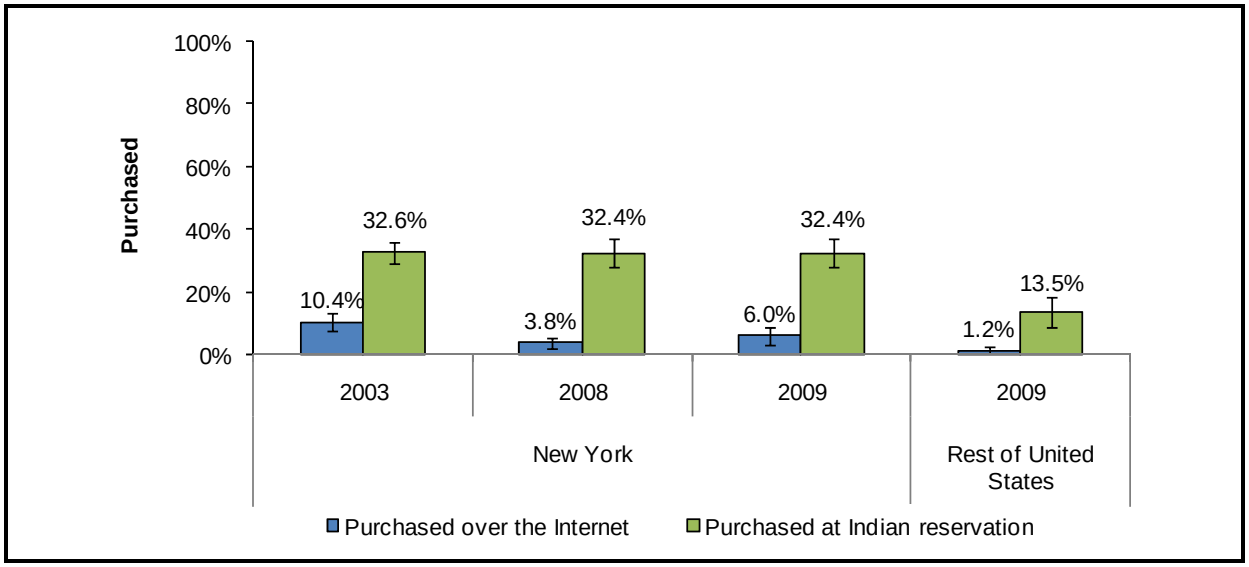
Figure 31. Percentage of Adult Smokers Who Purchased from Low or Untaxed Sources in the Past 12 Months, Adult Tobacco Survey 2003–2009 and National Adult Tobacco Survey 2009



Note: Statistically significant decrease from 2003 to 2009 among New York adult smokers. Difference between New York and the remaining United States is statistically significant.

common in New York than in the remaining United States. Of note, approximately one-third of smokers reported that they made purchases from an Indian reservation in the past 12 months (see Figure 32).

Figure 32. Percentage of Adult Smokers Who Purchased Cigarettes at an Indian Reservation or on the Internet in the Past 12 Months, Adult Tobacco Survey 2003–2009 and National Adult Tobacco Survey 2009

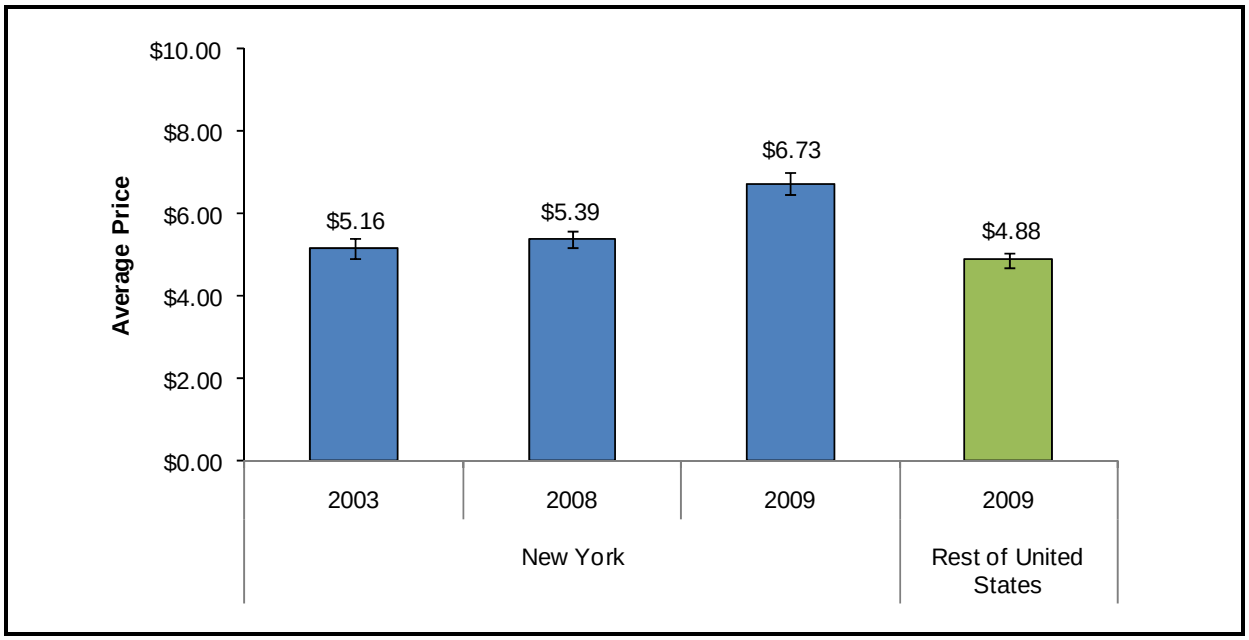


Note: Statistically significant decrease from 2003 to 2009 for cigarette purchases over the Internet. Difference between New York and the remaining United States is statistically significant for cigarette purchases over the Internet and from Indian reservations.

Cigarette tax evasion amounts to revenue losses to New York State between $468 and $612.8 million per year. These estimates are based on smokers' self-reported frequency of purchasing from the various sources noted above (i.e., "all the time," "sometimes," "rarely," and "never") and the current value of cigarette excise taxes and sales taxes. Given the qualitative responses, we assume that between 10% (lower bound) and 50% of all purchases by smokers who report avoiding taxes come from untaxed sources.

Following the state and federal tax increases, New York smokers reported paying $6.73 per pack (Figure 33)—higher prices per pack than smokers in the remaining United States. The average price paid per pack increased by almost 25% from 2003 to 2009 in New York. In 2009, the price of a pack of cigarettes was 38% higher in New York than in the rest of the country.

Figure 33. Real Price Per Pack of Cigarettes for Most Recent Purchase, Adult Tobacco Survey 2003–2009 and National Adult Tobacco Survey 2009



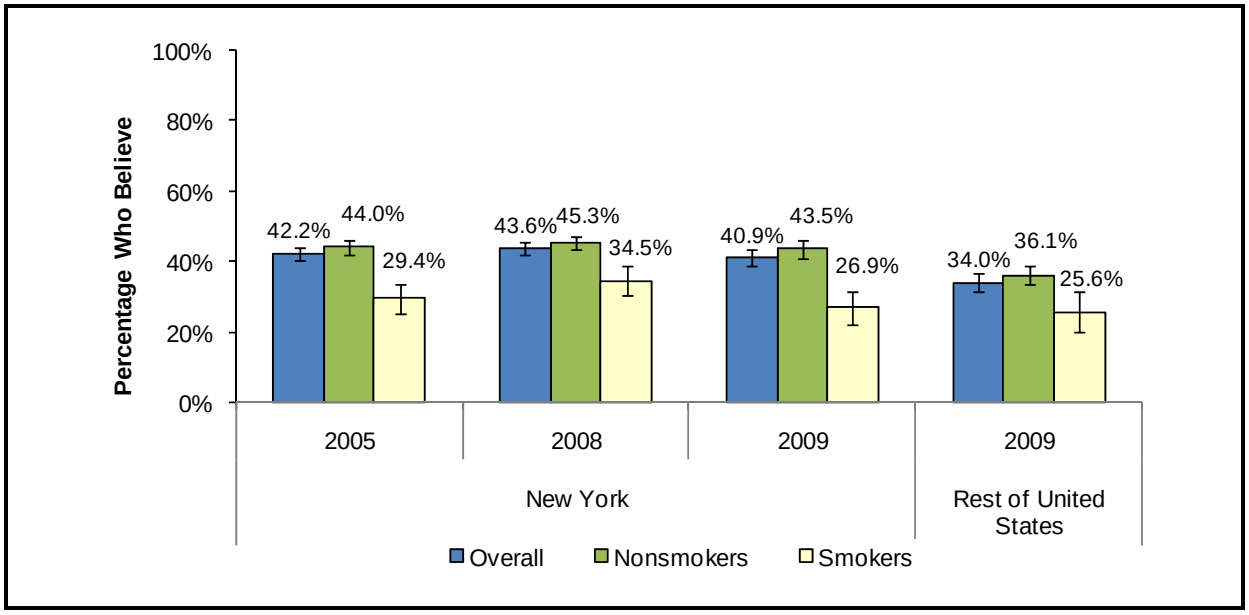
Note: Statistically significant increase between 2003 and 2009 among New York adults. Difference between New York and the remaining United States is statistically significant.

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 2009, 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 34). However, support has not changed over time in New York.

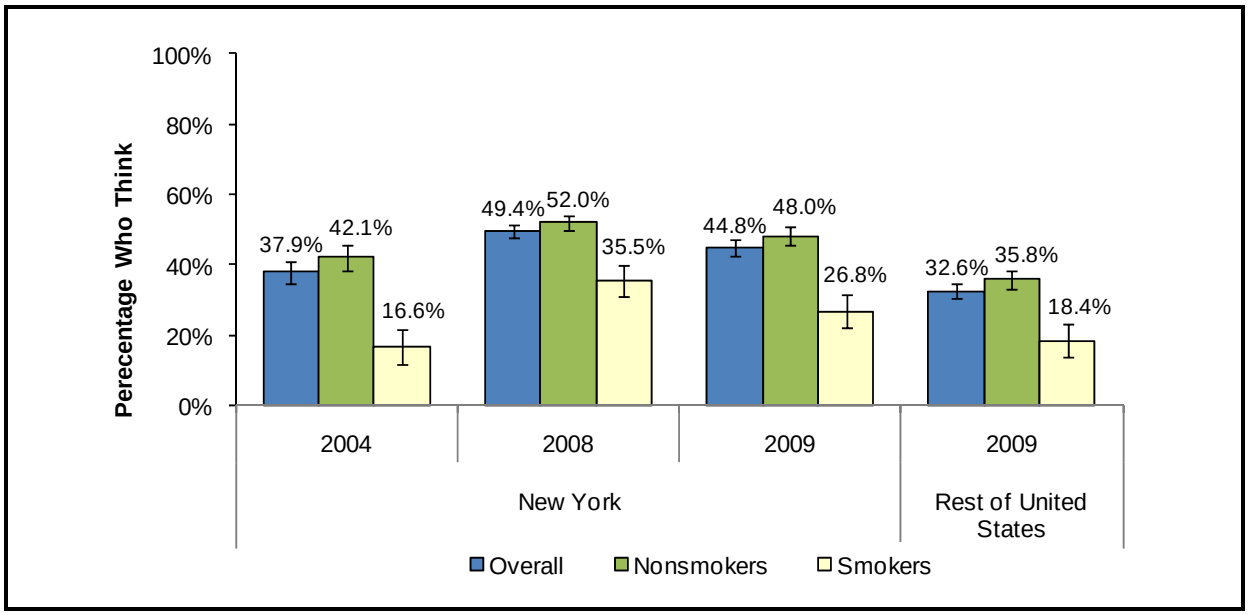
Figure 34. Percentage of Adults Who Believe That Tobacco Use Is Among the Most Important Health Problems in Their Community, Adult Tobacco Survey 2005–2009 and National Adult Tobacco Survey 2009



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

One issue that is particularly salient now that the Food and Drug Administration has the authority to regulate tobacco, deals with restricting tobacco advertising at the point of sale. The passage of the Tobacco Control Act allows the possibility of regulating the place, timing, and manner (but not the content) of cigarette advertising. Figure 35 illustrates that in 2009 a greater percentage of adults overall, smokers, and nonsmokers believe that tobacco advertising should not be allowed in stores compared to 2004. Moreover, Figure 35 suggests that there is more support for banning cigarette advertising in stores in New York than in the rest of the United States among all adults, smokers, and nonsmokers.

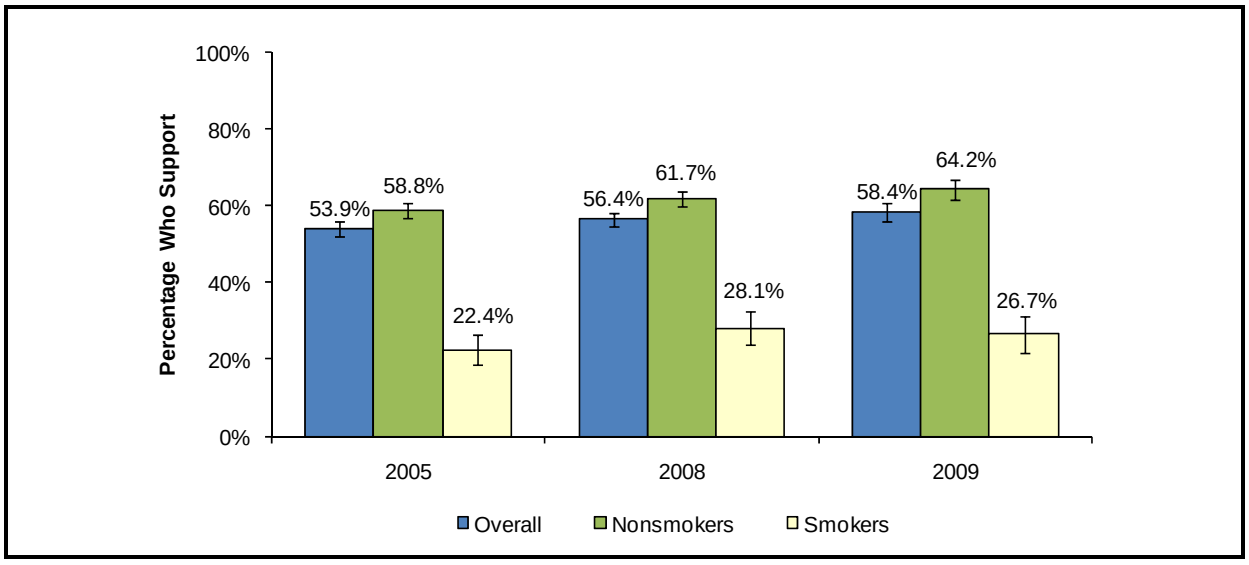
Figure 35. Percentage of Adults Who Think Tobacco Advertising in Stores Should Not Be Allowed, Adult Tobacco Survey 2004–2009 and National Adult Tobacco Survey 2009



Note: Statistically significant increase between 2004 and 2009 among smokers, nonsmokers, and adults overall. Differences between New York and the remaining United States are statistically significant.

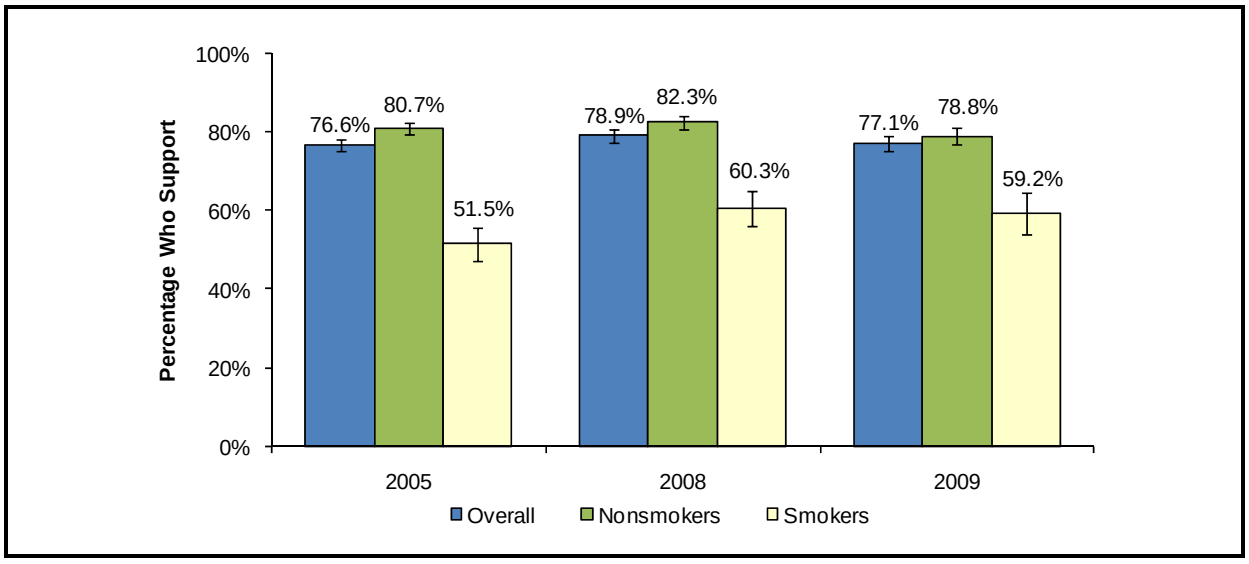
Three additional measures gauge support for other community contractor policy initiatives: banning smoking in outdoor places; banning smoking in building entranceways; and eliminating smoking in movies rated G, PG, and PG-13. The majority of New Yorkers support a ban on smoking in outdoor public places (e.g., beaches and parks) (Figure 36). 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 2009, nearly 8 in 10 New Yorkers favor a ban on smoking in building entranceways, and support among smokers has increased over time (Figure 37).

Figure 36. Percentage of Adults Who Support a Ban on Smoking in Outdoor Public Places, Adult Tobacco Survey 2005–2009



Note: Statistically significant increase between 2005 and 2009 among smokers, nonsmokers, and adults overall.

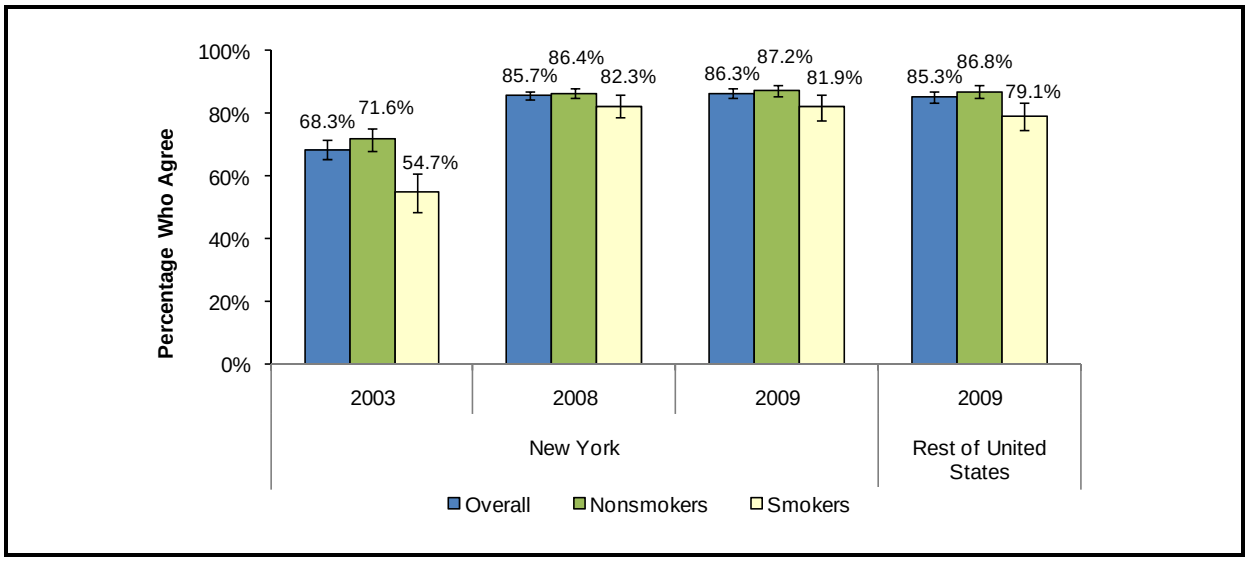
Figure 37. Percentage of Adults Who Support a Ban on Smoking in Building Entranceways, Adult Tobacco Survey 2005–2009



Note: Statistically significant increase between 2005 and 2009 among smokers.

From 2003 to 2009, 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 2009, a level similar to that of nonsmokers (Figure 38). Attitudes toward smoking in the movies are similar in New York and the remainder of United States.

Figure 38. Percentage of Adults Who Agree That Movies Rated G, PG, and PG-13 Should Not Show Actors Smoking, Adult Tobacco Survey 2003–2009 and National Adult Tobacco Survey 2009



Note: Statistically significant increase from 2003 to 2009 among smokers, nonsmokers, and adults overall.

Discussion

Overview

After observing significant progress on all of the key outcome indicators for tobacco use and smoking cessation in New York from 2003 to 2008, it appears that progress may be slowing as nearly all of these indicators are similar between 2008 and 2009. Although the prevalence of smoking, smokeless tobacco use, and making a quit attempt in the past year in New York compare favorably to the remaining United States, the differences have narrowed in the past year.

The differences in key tobacco use outcome indicators between New York and the remaining United States are likely explained by higher than average per capita funding for tobacco control during previous fiscal years, strong tobacco control policies that have been shown to reduce tobacco use, the fifth highest state cigarette tax and commensurately higher cigarette prices, and a comprehensive smoke-free air law that covers virtually all workplaces. 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 and increased over the past year with more than 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, although decreasing following Altria's exit from Manhattan.

A likely contributing factor in the slowing progress in key outcome indicators is the decrease in public health marketing as a result of budget reductions and administrative delays. Awareness of NY TCP public health marketing among smokers has dropped from its peak of 53% in 2007 to 45% in 2009—well below our recommendation of 60% and CDC's recommendation of 75% to 85% reach (CDC, 2007b). As we have shown in this report and previous reports, exposure to public health marketing influences quit intentions, quit attempts, and calls to the Quitline.

Although the overall decline in smoking statewide from 2003 to 2009 compared favorably to the decline nationally over this period, we found that not all sociodemographic groups experienced the same declines. Most notably, there was no statistically significant change in smoking for several groups that had average or above average smoking rates in 2003, including African Americans, those with less than a high school degree, those with annual incomes less than $25,000, and those with poor mental health. This is despite the fact that these populations are thought to be more responsive to increases in cigarette prices and that these groups had higher awareness of NY TCP media over this time period. In addition, the Program offered more NRT and Quitline counseling to Medicaid beneficiaries and the uninsured for several years. To continue to make progress in reducing smoking statewide, the Program will need to better understand what factors explain these differential trends in smoking prevalence.

Fortunately, NY TCP has shown in the past that it is able to adapt its strategies and activities to emerging needs. As we noted above, the Program is already leveraging the opportunities presented by the Tobacco Control Act of 2009 that gives the Food and Drug Administration the authority over tobacco and states the ability to curb ubiquitous point-of-sale marketing with state and local laws.

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

Health Communication

In the past year, NY TCP shifted its media strategy to focus increasingly on cessation messages and messages that feature strong negative emotions and/or graphic images—choices consistent with previous evaluation findings and recommendations. We found that early in 2009, awareness of NY TCP television advertisements reached an historic high of 70% (Q2 2009), but as a result of severe budget reductions to the media placement budget and contract approval delays, awareness plummeted by year end to 14% (Q4 2009).

Such budget cuts have consequences for NY TCP key indicators—intentions to quit, quit attempts, and calls to the Quitline are all correlated with media exposure; as the media placement budget declines, so do quit attempts and calls to the Quitline. Because quit attempts are a marker of more sustained quitting, such disruptions in the media plan jeopardize NY TCP's ability to reach its goal of 1 million fewer smokers by 2010.

After significantly reducing television advertising focused on highlighting the dangers of secondhand smoke from 21% in 2007 to 5% in 2008, this percentage increased to 14% in 2009. This increase occurred despite the lack of clear evidence that these advertisements are positively influencing any key outcome indicators with the exception of Quitline call volume. Once again, we urge the Program to consider including 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.

Finally, consistent with the 2009 Independent Evaluation Report recommendation, NY TCP developed a plan to more explicitly support statewide and local community action with statewide media. This recommendation is consistent with CDC's *Best Practices for Comprehensive Tobacco Control Programs*, which recommends that community interventions should be combined with mass media campaigns as "an effective strategy to decrease the likelihood of tobacco initiation and promote smoking cessation" (p. 33). The Program did ensure that contractor budgets included adequate allocations to support

coordinated statewide media campaigns that directly support their local efforts. The plan is being implemented but without an NY TCP contractor for media development. In the absence of a statewide effort, however, several community contractors collaborated to develop a statewide campaign designed to support the newly refocused point-of-sale initiative. The campaign, called "It Starts in Our Stores," was designed to educate the public and decision makers about the impact that retail tobacco marketing has on children. In addition, the School Policy contractors developed the "We're Watching" campaign to educate school principals and administrators about the importance of enforcing comprehensive tobacco-free school policies.

Cessation Interventions

The evidence base indicates that a combination of system change and provider education is effective in promoting cessation in health care settings. However, this evidence comes mostly from studies where interested organizations participate in the interventions. What is not clear from the literature is how to identify and engage organizations to promote system-level change. As a result, Cessation Centers have had to develop strategies to encourage participation and effect system changes. It is challenging to effect change broadly throughout the state in light of the large number of medical practices in New York State and the fact that practices are less likely than hospitals to have written policies in general. Cessation Centers have attempted to reach practices that provide services to populations with higher tobacco use rates. The Cessation Centers' "Don't Be Silent" campaign has been an effective complement to core cessation strategies to raise awareness of the importance of counseling patients to quit smoking.

Since 2005, more hospitals report having written policies or guidelines regarding tobacco dependence screening and treatment as well as increases in systems to document treatment. Greater percentages of hospitals require providers to provide guideline-concordant care, including asking all patients about tobacco use, advising tobacco users to quit, and offering NRT. However, among group practices, there were few changes since 2005.

Health care organizations that have worked with Cessation Centers for a longer period of time appear to have more guideline-concordant systems, according to Cessation Center reports. We used statewide survey data to compare hospital outcomes in 2009 by whether each hospital had a relationship with a Cessation Center. We did not find statistically significant differences regarding whether hospitals had written guidelines on tobacco use identification and treatment or awareness of cessation resources between hospitals that had relationships with Cessation Centers and hospitals that did not. The one exception to this was a greater awareness of the Fax-to-Quit program among hospitals that had a relationship with Cessation Centers. It is possible that the measure we used to identify hospitals with Cessation Center relationships is not the most valid indicator of meaningful interaction or that we need to better account for the length of time the hospital has had a relationship with a Cessation Center. Perhaps there are overarching trends among hospitals to implement tobacco-related guideline-concordant care. Although we did not find differences in whether hospitals had systems to document tobacco status or tobacco intervention by relationship with a Cessation Center, more than 90% of hospitals overall reported having such systems. Such high awareness may be partially attributable to the fact that the individuals responding to the survey were identified as being the most knowledgeable about systems, practices, and policies related to screening and treating patient tobacco dependence.

Although we have seen an increase in the number of hospitals that have written guidelines and require guideline-concordant provider practices, provider self-reported behavior has not changed over time. It is possible that it takes even more time before new policies have an impact on provider behavior, or this disconnect could be due to a breakdown in communication of policies or low levels of provider self-efficacy and training on effective interventions.

Provider reports of implementing all components of the Public Health Service guideline clinical tobacco intervention are fairly low. Time constraints and competing priorities were reported as barriers to fully implementing guideline-concordant care. Within hospitals, responsibility for the different components is distributed somewhat across types of providers. As a result, we might not expect any single provider type to report all five

components. The component least often implemented in both hospitals and group practices is arranging for follow-up with tobacco users; this is the most logistically complicated component, as it does not take place during the clinical encounter like the other intervention components.

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 (4% of smokers annually). Given budget constraints, NY TCP must explore opportunities to provide NRT in the most cost-effective manner possible. A recent NY TCP-funded study conducted by Roswell Park Cancer Institute showed that Quitline 2-week NRT starter kits are as effective in promoting quitting as 4- or 6-week supplies. There is a lack of evidence supporting distribution of free NRT via sources other than the Quitline. Finally, NY TCP has launched Qunity, a new Web site with features that allow users to blog, chat, and use other online tools. The Qunity Web site is intended to reduce costs by actively encouraging online services over telephone counseling for interested smokers; this potentially allows a greater number of smokers to receive services with a lower burden on Quitline staff.

Statewide and Community Action

CDC and other leading public health organizations suggest that activities focused on policy change create a context in which the healthy options—in this case a tobacco-free lifestyle—are the "default choice" (Frieden, 2010, p. 2) and therefore have the potential to improve public health. Consistent with these recommendations, the New York community contractor initiatives are overwhelmingly focused on policy change.

In the 2009 Independent Evaluation Report, we noted that the reach of the community contractor policy efforts was limited

and that contractor-reported policy changes did not necessarily represent any real change in practice. Finally, we observed that contractor policy efforts likely had limited effectiveness because they were not supported by a consistent media message and that their advocacy efforts were not sufficiently magnified by the support of other like-minded organizations and mobilized citizens.

Since that report, the Program has addressed a number of the gaps identified, particularly those activities focused on reducing the influence of tobacco industry marketing. However, some of the same limitations persist for other initiatives. While many contractors focus their policy efforts on organizations or individuals with broad reach, such as municipalities and large employers, some continue to focus policy change efforts on individual small businesses. Likewise, there is some evidence that contractors occasionally advocate for policy changes that will result in no change to that organization's current policies and practices related to tobacco control, such as advocating for smoke-free outdoor policies with organizations that are actively involved in tobacco control, such as local health departments, American Heart Association affiliates, or allied prevention coalitions. Finally, not all initiatives have the benefit of a media campaign to support contractor advocacy efforts.

The most substantive positive changes have occurred as the Program has refocused its efforts to decrease the influence of tobacco industry marketing. The current point-of-sale initiative has changed Community Partnership and Youth Action contractor practices and objectives to those with more potential reach than in previous years. Rather than advocating with individual retailers to reduce or eliminate the tobacco advertising in their stores, in FY 2009–2010, contractors developed a census of grocery chain stores in their catchment areas, prioritized the grocery chains to target for policy change, and coordinated their efforts.

More importantly, however, the Program changed its policy objectives such that contractor efforts will be more efficient and that each policy passed will reach a greater proportion of the population. Community Partnerships and Youth Action contractors will now focus on educating and working with local policymakers to pass ordinances to reduce the display of tobacco products and restrict the number, type or location of

retailers allowed to sell tobacco products in local communities. Each ordinance passed will affect tobacco industry marketing at multiple stores and further, if consistent with the model ordinances developed by the Center for Public Health and Tobacco Policy, will be enforceable by law. Finally, the Program has developed key messages in support of the point-of-sale initiative objectives.

While changes in contractor activities focused on tobacco industry marketing are likely to be more effective and reach a greater proportion of New Yorkers, some contractor activities on the multi-unit dwelling initiative remain inefficient and unlikely to reach a significant proportion of New Yorkers. Contractors are directed to develop a census of rental units in their catchment areas and prioritize those representing the largest number of living units, but some contractors appear to be focusing on individual building owners, who may represent only a small proportion of rental units. The Program could better monitor contractor compliance with its directives by requiring contractors to record the number of rental units affected by each policy adopted.

The outdoor smoking ban initiative focuses on restricting tobacco use in multiple outdoor settings, including beaches, parks, and building entranceways. A review of the policies passed in FY 2009–2010 shows that contractors have had smoke-free outdoor ordinances passed in nine villages and one state park. Educating and working with community leaders and elected officials to change policies at the municipal level (counties through villages) is an effective and efficient way to restrict smoking in multiple areas (such as beaches and parks) with one ordinance. Contractors also report policy changes at many small organizations, which could be more efficiently reached through other means. For example, daycare centers could be included as part of a municipality's smoke-free policy (as they are in the outdoor smoking regulations passed in April 2010 by the City of Ithaca), and local interfaith councils or religious networks could be asked to adopt a smoke-free policy that would apply to all of its member churches. Finally, contractors might consider prioritizing their efforts on municipalities with the largest number of public spaces (e.g., parks) and on realty companies that manage multiple buildings.

The Colleges for Change modality began activities in August 2009. Of the 21 sponsorship and promotion policies reported during FY 2009–2010, 16 were adopted by individual Greek organizations or college clubs, and 4 were adopted college-wide by organizations with campus-wide jurisdiction. Consistent with the American College Health Associations Position Statement on Tobacco on College and University Campuses (2009), we recommend that Colleges for Change contractors advocate with university decision makers for a policy that prohibits receipt of tobacco industry funding and sponsorships by any university-sanctioned organization or sponsored event. This approach would subsume any and all potential recipients of tobacco industry largesse under a single policy.

As part of their work in communities adjacent to colleges, Colleges for Change should continue advocating for smoking bans in multi-unit dwellings and prioritize advocacy with management companies or large buildings that house a high proportion of college students. In the coming years, it will be important for them to focus on policy changes in local bars and clubs, where the tobacco industry targets college students with promotions and product giveaways (Biener et al., 2004; Rigotti, Moran, and Wechsler, 2004).

Ideally, each community contractor initiative should have a supportive media campaign that conveys the same messages that community contractors convey through media advocacy, policy advocacy, and policy-maker education. In the past, community contractors have not had the resources for a media campaign to augment and support contractor activities and earned media, and it has been difficult for them to build the broad base of public and policy maker support that is needed for successful policy change. However, during March 2010, community contractors launched a statewide paid media and concomitant media advocacy and public education activities in support of the point-of-sale initiative. For the other community contractor initiatives, it may be difficult to increase the rate of policy change without a supporting media campaign to build a broad base of support needed for these efforts to succeed.

Collaborations between community organizations have been a core component of comprehensive tobacco control programs since their inception (Anderson et al., 2005; IOM, 2007; Thompson et al., 1995), 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 contractor grants, beginning in 2010, will integrate with nutrition and physical activity efforts. While the community contractors are strongly encouraged by NY TCP to collaborate with each other and to build alliances with other influential organizations, they have not been required to do so. As a result, the potential reach of their activities is limited because they are not leveraging the influence and resources of other organizations in their catchment areas.

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). 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. Although community contractor work plans include activities to educate the public and gain their support for initiatives, contractors are not required to develop and maintain a list of grassroots supporters that can be quickly mobilized for high-profile events and to contact media. However, community mobilization is appropriately included as a key component of the 2009–2010 point-of-sale initiative.

Programmatic Recommendations

NY TCP has established itself as a leader in tobacco control by developing a strategic plan based on evidence-based strategies, acting decisively to leverage national funding and legislative opportunities, and providing appropriate guidance to its funded partners to fulfill its strategic vision. This leadership contributed to the significant progress in the Program's key outcome indicators from 2003 through 2009.

Despite strong program leadership, careful stewardship of public funds, and a demonstrated track record of success, NY TCP's budget was severely and disproportionately cut over the past 2 years compared to the overall NYSDOH budget. Given the strong evidence base for tobacco control, demonstrated

progress in New York, and significant implications for the life expectancy of New Yorkers the rationale for such significant budget cuts is unclear. As a result, it is now highly unlikely that the Program will achieve the NYSDOH goal of 1 million fewer smokers by 2010. In the sections below, RTI offers some overall and specific program component recommendations to help increase NY TCP effectiveness and help New York State resume progress toward its important goal.

Overall Recommendations

- Increase NY TCP funding to a minimum of $77 million per year; this level of funding reflects a restoration of funds so that budget reductions for tobacco control are 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 cessation-focused campaigns.
  - Fully fund the media contract that would support the creation of campaigns that explicitly support state and local community efforts to effect policy change.
  - Restore core support for program administration and surveillance so that the Program can continue to provide adequate resources for strategic planning, oversight, and management of NY TCP-funded contractors.
  - Increase support for training of community contractors to ensure that they conduct Program activities using evidence-based strategies and that the information they convey in support of Program initiatives is consistent with the Program's strategic plan and media campaigns.
- Eliminate NY TCP financial support for the Asthma Coalitions because they are not a core tobacco control intervention and it is not clear how they contribute to NY TCP goals and objectives.
- Further investigate possible explanations for the relatively slow declines in smoking prevalence for specific populations, such as African Americans, Hispanics, and adults with low incomes and/or education.

Health Communication Recommendations

- Invest sufficient funds in health communication to increase annual average confirmed awareness of NY TCP television advertisements from 45% in 2009 to at least 60%.
- Avoid unplanned gaps in health communication activities that result from delays in contract executions and amendments.
  - Ensure that a core/minimum amount of funds ($3 million to $5 million) are available to NY TCP for media placement for the first quarter of every fiscal year to avoid disruptions to the Program's media plan that result from annual delays in expenditure plan approvals and contract renewals.
- Develop new campaigns to support ongoing statewide and community action.

Cessation Intervention Recommendations

- Maintain current funding level of Cessation Centers.
  - Continue to advocate for improvements in tobacco dependence assessment and treatment systems.
  - Focus on ways to ensure sustainable changes become part of health care provider interactions by formalizing documentation requirements and integrating tobacco dependence screening and treatment into patient-provider interactions. Emphasize the importance of meaningful feedback to providers through audits, chart reviews, or continuous quality improvement.
  - Continue to complement systems-level change with efforts to ensure that such changes reach individual providers, including provider training on relevant content and skills.
  - Continue to target group practices and clinics that serve populations with a high proportion of tobacco users. Cessation Centers should continue to work with Medicaid Managed Care plans to raise awareness of Cessation Center services, motivate practices and clinics to consider making changes, and encourage Medicaid Managed Care plans to implement additional incentives or requirements for systems changes.

- The New York State Medicaid Program should take a more active role in promoting tobacco cessation Medicaid benefits to Medicaid recipients and providers.
- Continue to promote the health care provider media campaign to add salience and reach to Cessation Centers' efforts and increase awareness.
- Capitalize on the opportunities presented with current health reform changes. Cessation Centers can help group practices integrate electronic medical records in a way that meets the American Recovery and Reinvestment Act "meaningful use" criteria and includes tobacco questions and functionality to conduct audits or data review.
- Maintain current funding for the New York State Smokers' Quitline.
  - Eliminate support for NRT distribution in Office of Alcoholism and Substance Abuse Services addiction treatment centers, because there is no evidence that this increases quit rates in this setting (RTI, 2009), the policy that NRT was intended to support has been successfully implemented, and the NY TCP budget has been reduced.
- Conduct a cost-effectiveness study to better understand the impact of the Qunity Web site on program costs.
- Encourage the New York State Office of Mental Health to adopt tobacco-free regulation for their facilities. Such a policy change would be consistent with the recent Office of Alcoholism and Substance Abuse Services tobacco-free regulation.

Statewide and Community Action Recommendations

- Continue to maintain community contractors' current emphasis on the point-of-sale initiative.
- Develop a core theme (or message) for all community contractor initiatives, and incorporate the theme into all contractor strategies for those initiatives (as the Program is currently doing with the point-of-sale initiative).
- Provide structured requirements to community contractors to collaborate with other organizations in their communities to increase the reach of their efforts.
- Continue to ensure that contractors prioritize multi-unit dwelling advocacy activities on agencies that are

responsible for managing a large number of rental units (e.g., realty management companies; public housing authorities) and on buildings with large numbers of units, rather than single landlords or small apartment complexes.

- Continue and increase contractor efforts focused on smoke-free outdoor policy changes in villages, towns, cities, and counties, particularly those with a large number of public areas, such as parks and beaches.
  - Include daycare centers as part of a model smoke-free outdoor policy for municipalities.
- Recommend that contractors leverage their successes with local churches to advocate with local or regional interfaith councils or networks for a smoke-free outdoor policy that could be adopted by its full membership.
- Develop guidelines that direct contractors to prioritize smoke-free outdoor policies (particularly policies focused on building entranceways) on organizations with the greatest potential reach, such as building management companies (especially those responsible for multiple buildings) and large employers.
- Direct Colleges for Change contractors to leverage their successes with college clubs (e.g., math club) and fraternities/sororities and advocate for a college-level policy change that bans tobacco industry sponsorship and donations to any college-sponsored or affiliated organization or at any college-affiliated or sponsored event.
- Increase Colleges for Change contractors' focus on advocating for policy change with bars and clubs so that they will no longer sponsor tobacco industry promotions and product giveaways.

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