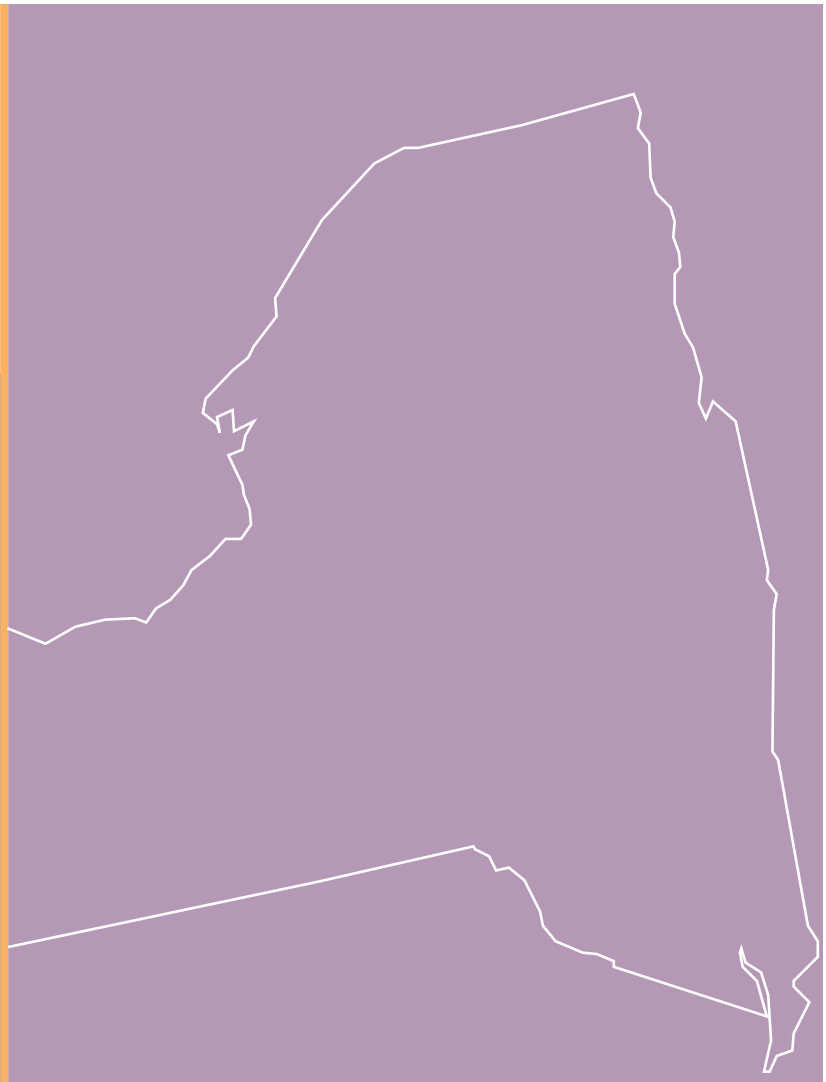
Title
The New York Profile: A review of New York's tobacco prevention and control program

Authors
Krauss, Melissa, MPH
Herbers, Stephanie, BA
Hepp, Lisa, BS
et al.

Publication Date
2003-12-01



The New York PROFILE

A review of New York's tobacco prevention and control program
December 2002

Prepared by The Center for Tobacco Policy Research at Saint Louis University

Acknowledgements

This project to evaluate the current status of 10 - 12 state tobacco control programs is funded by the National Foundation for the Centers for Disease Control and Prevention, Inc. and the American Legacy Foundation.

This profile was developed by:
Melissa Krauss, MPH
Stephanie Herbers, BA
Lisa Hepp, BS
Nancy Mueller, MPH
Douglas Luke, PhD

We would like to acknowledge the contributions of our project team:
Ross Brownson, PhD
Claudia Campbell, PhD
Patricia Lindsey, MA
Janet Wilson, MEd, MPA
Randy Williams, PhD

For more information, please contact:
Nancy Mueller, MPH
Project Manager
Saint Louis University
School of Public Health
3545 Lafayette Avenue, Suite 300
St. Louis, MO 63104
(314) 977-4027
mueller@slu.edu

The investigators would like to extend their sincere appreciation and thanks to the New York tobacco control partners who participated in this evaluation.

Suggested Citation
The Center for Tobacco Policy Research. *The New York Profile: A review of New York's tobacco prevention & control program*. St. Louis, MO: Saint Louis University Prevention Research Center; 2003.

Table of **Contents**

Executive Summary

Project Overview

The Center for Tobacco Policy Research at the Saint Louis University Prevention Research Center is conducting a three-year project examining the current status of 10-12 state tobacco control programs. The project aims to: 1) develop a comprehensive picture of a state's tobacco control program; 2) examine the effects of political, organizational, and financial factors on state tobacco control programs; and 3) learn how the states are using the CDC's *Best Practices for Comprehensive Tobacco Control Programs*. This Profile has been developed as a resource for tobacco control partners and policymakers to use in their planning and advocacy efforts. It presents both quantitative and qualitative results collected in December 2002. All information presented reflects fiscal year 2003 unless otherwise noted.

Summary

Strong policy changes, respectable funding, and new direction at the Department of Health Tobacco Control Program (DOH TCP) have contributed to the next phase of New York's tobacco control efforts. New York has been able to pass strong legislation in the areas of product placement, penalties for sales to minors, an excise tax increase, and a fire safe cigarettes law, despite somewhat unsupportive state policymakers. An improving tobacco control network and the work of local tobacco control champions helped push local clean indoor air policies, which led to a strong statewide clean indoor air law. These positive changes should lead to more progress by tobacco control advocates in New York provided funding can be maintained in the face of a large budget deficit.

Financial Climate

In fiscal year 03, New York dedicated $52.25 million to tobacco control, meeting 55% of the CDC's minimum recommendation for an effective tobacco control program in New York. Counter-marketing and community programs received the most funding, while chronic disease programs received no funding from the tobacco control program. The fact that New York had dedicated a respectable sum of money to tobacco control was viewed as a success. Financial challenges included New York's significant budget deficit and Governor Pataki's securitization proposal. Partners were also disappointed that many counties had securitized their settlement dollars, but were proud of the few that dedicated some of that money to local tobacco control efforts.

Political Climate

New York's political climate was somewhat mixed. Strong policies (*e.g.* clean indoor air) were being implemented despite New York's tough political environment. Partners felt Governor Pataki was not supportive of tobacco control and had strong ties to the tobacco industry, but some gave him credit for passing a number of tobacco control policies. There were pockets of support in the Legislature, but generally the Assembly was viewed as more supportive than the Senate. The tobacco industry had a strong presence through lobbying, campaign contributions, and working through front groups. Although politics in New York were challenging, New York City Mayor Michael Bloomberg, New York City Commissioner of Health Dr. Thomas Frieden, and Assemblyman Pete Granis (D) were recognized as strong tobacco control advocates.

Capacity & Relationships

Organizational characteristics that facilitated partners' tobacco control efforts included their internal communication, training opportunities, and availability of physical resources. The organizational structure and reporting requirements of the agencies both

facilitated and impeded the partners' tobacco control efforts. Staffing levels and experience were adequate, but many partners felt DOH's hiring process impeded recruiting staff with appropriate tobacco control and public health experience. A major strength of the DOH TCP was its new program director, while the bureaucratic and highly political environment of the DOH was an impediment to the program. Partners believed the tobacco control network was improving, with the potential to become very effective. The Coalition for a Tobacco Free New York was identified as an integral component of that network. Some also felt that the network could be counterproductive at times due to competing agency priorities.

Best Practices

New York's tobacco control program relied on a number of sources for guidance, including CDC's *Best Practices for Comprehensive Tobacco Control Programs* (BP). Most partners were familiar with the BP and felt that counter-marketing and cessation programs should be high priorities for the state. They also believed that school programs and enforcement should be lower priorities. New York adjusted the BP to fit a three-pronged programmatic approach, consisting of community mobilization, media and counter-marketing, and cessation, with surveillance and evaluation supporting all programmatic activities. Identified strengths of the BP were that it provides financial guidance, was developed by the CDC, and provides a framework for states with new tobacco control programs. Identified weaknesses of the BP were that it lacks strong supporting evidence, lacks implementation guidance, and needs to be updated.

Program Goals

Eliminating exposure to secondhand smoke and decreasing the social acceptability of tobacco use were seen as appropriate priority goals for New York. However, partners noted that these goals were long-term and could not be accomplished in one year. They recommended additional goals, such as increasing the availability of cessation programs and educating smokers. Partners believed passing clean indoor air legislation in rural counties was a challenge, but that the passage of strong laws in New York City and other counties would have a significant influence on the rest of the state. Enforcement of youth access laws was viewed as a successful activity for addressing the social acceptability of tobacco use. The state had strong penalties for merchants selling to minors, and rates of sales to minors had decreased in the past few years. Partners felt that more staffing, recruiting new partners, and focusing more time and funding on policy issues would help ensure achieving the priority goals.

Disparate Populations

The DOH TCP identified three primary tobacco-related disparate populations in New York: Medicaid beneficiaries, persons with mental illness, and rural, low-income, non-Hispanic whites. Partners agreed that the three populations were high priorities for New York, but suggested that immigrants and Native Americans be added to the list. Strategies were in place to address the disparate populations, specifically targeting Medicaid beneficiaries and persons with mental illness. Finally, partners suggested a need for a clearer definition of disparity and descriptions of effective strategies.

Program Strengths & Challenges

Partners identified the following strengths and challenges of New York's tobacco control program:

- The experience and leadership of the DOH TCP Director was a major strength of the program.
- Clean indoor air efforts throughout the state were also a strength.
- Partners were concerned about the security of funding due to the large state and city budget deficits.
- The highly politicized DOH environment and slow grant process were viewed as barriers to the program.
- Little support from state policymakers and the influence of the tobacco industry made implementing a comprehensive program challenging.

Introduction

Methods

Information about New York's tobacco control program was obtained in the following ways: 1) a survey completed by the New York State Department of Health Tobacco Control Program (DOH TCP) that provided background information about the program; and 2) key informant interviews conducted with 15 tobacco control partners. The DOH TCP was asked to identify partner agencies that played a key role in the state tobacco control program and would provide a unique perspective about the program. Each partner participated in a single interview (in-person or telephone), lasting approximately one hour and 15 minutes. The interview participants also had an opportunity to recommend additional agencies or individuals for the interviews. The following partners participated in the interviews in December 2002:

- New York State Department of Health Tobacco Control Program
- American Cancer Society
- American Heart Association
- American Lung Association
- Coalition for a Tobacco Free New York
- Coalition for a Smoke-Free City
- Tobacco Action Coalition of Long Island
- CDC Office on Smoking and Health
- Roswell Park Cancer Institute
- Desmond Media
- Onondaga Cortland Madison BOCES
- New York Public Interest Research Group
- Bureau of Sanitation and Food Protection, Division of Environmental Health Protection, Center for Environmental Health
- Statewide Center for Healthy Schools
- Tobacco Control Program Advisory Board

Results presented in this Profile are based on an extensive content analysis of qualitative data as well as statisitical analysis of quantitative data. The results represent the major themes or ideas from many partners and do not reflect the thoughts of any one individual or agency.

Profile Organization

The project logic model used to guide the development of this Profile is organized into three areas: 1) facilitating conditions; 2) planning; and 3) activities.

Rationale for Specific Components

Area 1: Facilitating Conditions
Money, politics, and capacity are three important influences on the efficiency and efficacy of a state's tobacco control program. The unstable financial climates in states have a significant impact on the tobacco control funding. Many state tobacco control programs receive little or no MSA funding for tobacco control and are adversely impacted by the state budget crises and securitization. In conjunction with the financial climate, the political support from the Governor and State Legislature, and the strength of the tobacco control champions and opponents have a significant effect on the program. Finally, the organizational capacity of the tobacco control partners and the inter-agency relationships are also important characteristics to evaluate. While states can have adequate funding and political support, if the partners' capacity and the cohesiveness of tobacco control network are not evident then the success of the program could be impaired.

Area 2: Planning
Tobacco control professionals have a variety of resources available to them. Partners may find it helpful to learn what resources their colleagues are utilizing. The *CDC Best Practices for Comprehensive Tobacco Control Programs* (BP) is evaluated extensively due to its prominent role as *the* planning guide for states. Learning how the BP guidelines are being implemented and identifying the strengths and weaknesses will aid in future resource development.

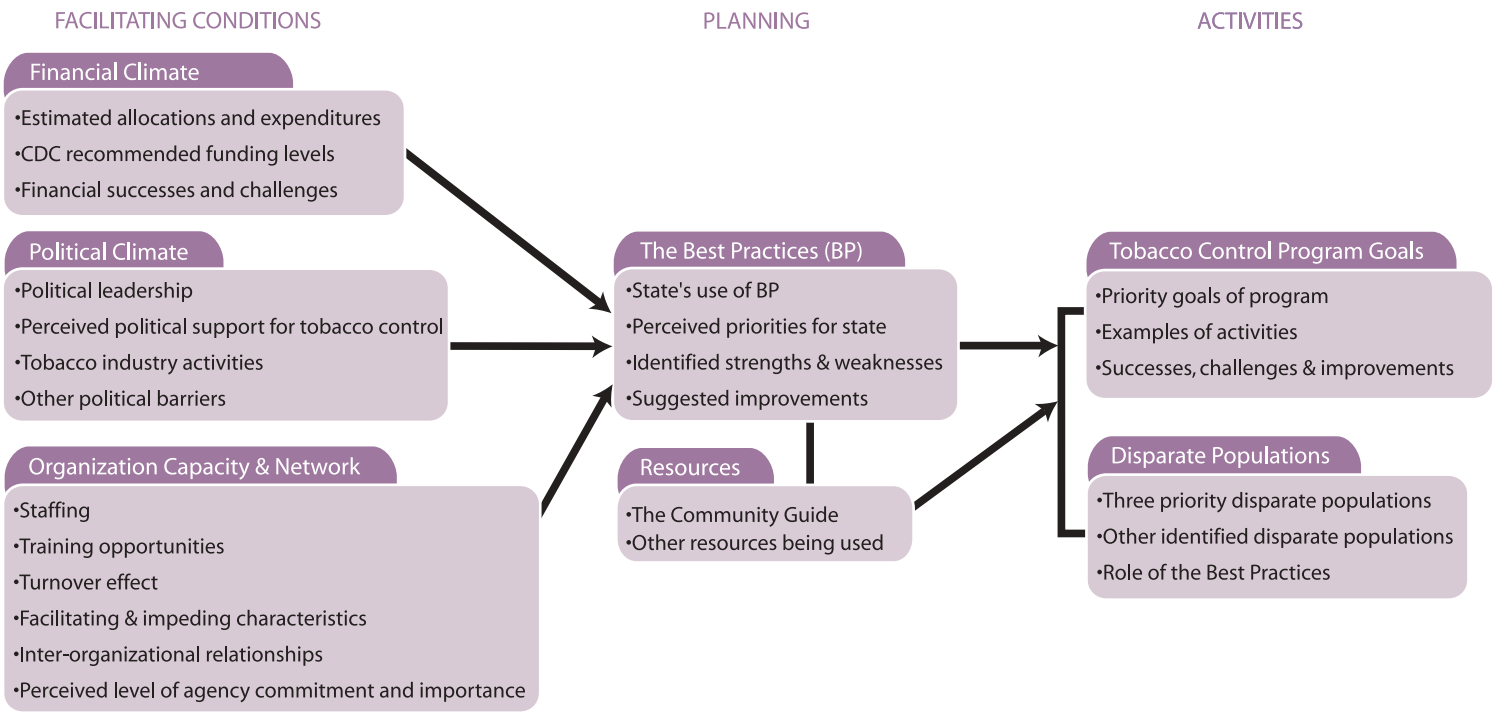
Area 3: Activities
Finally, the outcome of the areas 1 and 2 is the actual activities implemented by the states. The breadth and depth of state program activities and the constraints of the project precluded an extensive analysis of the actual program activities. Instead, two specific areas were chosen to provide an introduction to the types of activities being implemented. These two areas were: the state's top two priority programmatic or policy goals for the current fiscal year (*e.g.* passing secondhand smoke legislation, implementing cessation programs) and the emphasis on disparate populations (*e.g.* identification and addressing disparate populations).

Additional Information

Quotes from participants (offset in green) were chosen to be representative examples of broader findings and provide the reader with additional detail. To protect participants' confidentiality, all identifying phrases or remarks have been removed. At the end of each section, the project team has included a set of suggested approaches. These suggestions are meant to provide the partners with ideas for continuing and/or strengthening their current tobacco control efforts.

Inquiries and requests should be directed to the project director, Dr. Douglas Luke, at (314) 977-8108 or at dluke@slu.edu or the project manager, Nancy Mueller, at (314) 977-4027 or at mueller@slu.edu.

The Best Practices Project Conceptual Framework

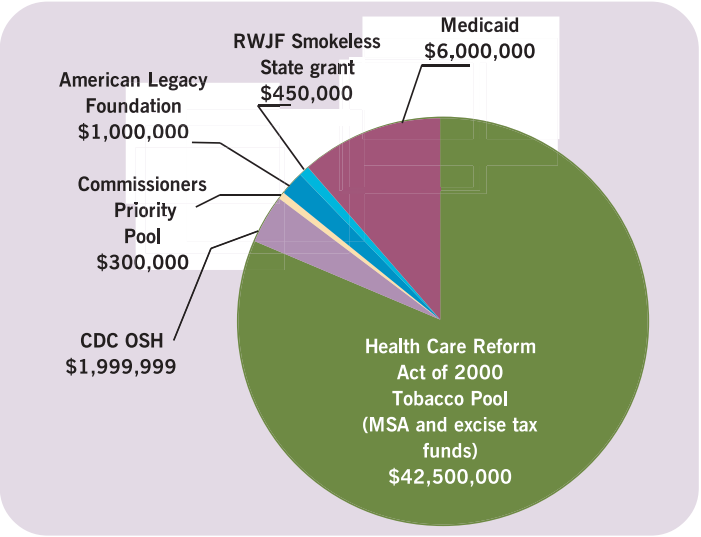


Financial Climate

Section Highlights

- New York dedicated approximately $52.25 million to tobacco control in FY 03, meeting 55% of the CDC's minimum recommendation for an effective tobacco control program.
- Counter-marketing and community programs received the most funding, while chronic disease programs did not receive any tobacco control funding in FY 03.
- The dedication of a respectable level of funding to tobacco control was viewed as a success.
- The potential impact of New York's significant budget deficit and the Governor's securitization proposal on tobacco control caused great concern for partners.
- Although a few counties dedicated their settlement dollars to local tobacco control, partners were disappointed that most counties used the funds for other issues.

Tobacco control funding sources, FY 2003



CDC funding recommendations & estimated expenditures, FY 2003

Best Practices Category	CDC Lower Recommendation	Estimated Expenditures	Status (+/-)[a]
Chronic Disease Programs	$30,099,000	$0	-
Cessation Programs	$19,850,000	$6,427,000	-
Counter-Marketing	$18,138,000	$18,183,000	+
Community Programs	$13,547,000	$13,899,000	+
School Programs	$13,486,000	$1,045,000	-
Surveillance & Evaluation	$8,333,000	$2,456,000	-
Enforcement	$7,955,000	$7,054,000	-
Statewide Programs	$7,255,000	$1,045,000	-
Administration & Management	$4,167,000	$2,090,000	-
Total	$95,830,000	$52,250,000	-

[a](-) = below CDC recommendation
(+) = meets CDC recommendation

Master Settlement Agreement (MSA) Funding

Currently, New York State receives approximately 51% of the tobacco settlement payments, while New York City receives 27%, and the remaining 57 counties receive 22%. For the State, the settlement funds become part of the state's General Fund and are allocated yearly. However the Health Care Reform Act of 2000 (HCRA 2000) set aside a portion of the settlement dollars for several programs. In this Act, a portion of the settlement dollars and a portion of cigarette excise tax revenue, totaling $130 million, was dedicated to tobacco control for January 2000 through June 2003.

FY 2003 Funding

In FY 03, New York dedicated a total of approximately $52.25 million ($2.90 per-capita) to tobacco control, meeting 55% of the CDC's minimum recommendation for an effective tobacco control program in New York. Approximately 81% ($42.5 million) of the total funding was allocated from the HCRA 2000 Tobacco Pool, which includes both MSA funds and excise tax revenue. The remaining tobacco control funds came from a number of other sources, including the Commissioners Priority Pool, the CDC, the American Legacy Foundation, Medicaid funding for cessation medications, and the Robert Wood Johnson Foundation Smokeless States grant which was received by the American Cancer Society.

According to the Department of Health Tobacco Control Program's (DOH TCP) estimated FY 03 expenditures, counter-marketing and community programs received the most tobacco control funding at 35% and 27%, respectively. Chronic disease programs did not receive any tobacco control funding. When comparing these estimated expenditures to the CDC's funding allocation recommendations, New York met the recommendations for both counter-marketing and community programs.

Successes & Challenges

The following influences on the financial climate of tobacco control were identified:

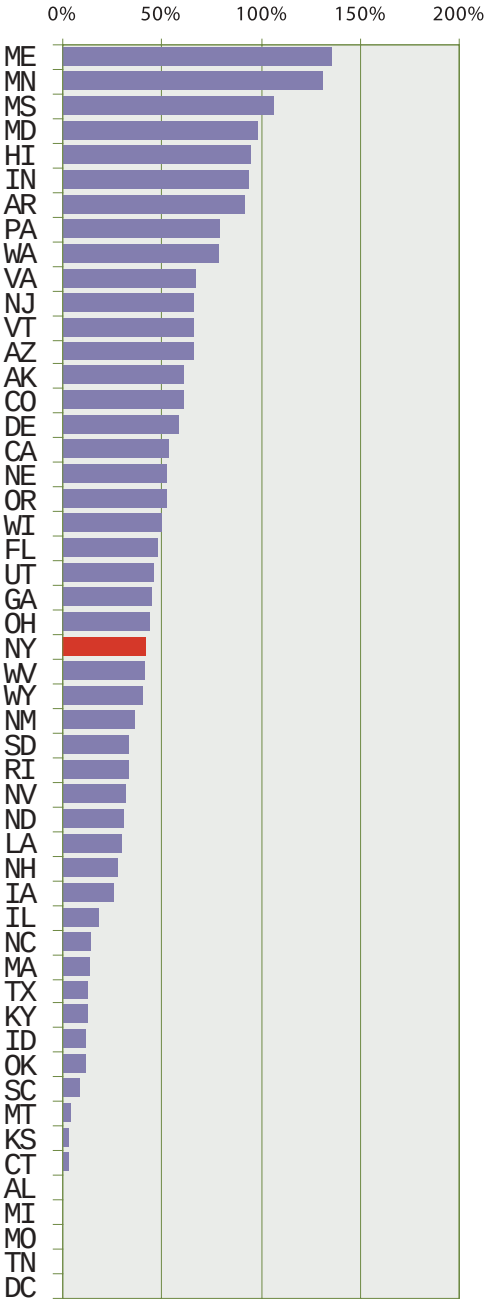
State tobacco control funding
Partners felt that the State of New York dedicated a respectable amount of settlement funding to tobacco control. Furthermore, the three-year appropriation of HCRA 2000 allowed time for the program to begin efforts without having to return to the Legislature for yearly appropriations.

> One of the wonderful things about the funding for this program is that the HCRA law appropriated $130 million for the program for three and a half years…So having that three and half year window to actually establish a program and try to demonstrate some results is really quite a luxury. We're hoping to have that same sort of long-term commitment when our funding is renewed in 2003.

While the funding level for DOH TCP had been greatly increased by HCRA 2000, partners still felt that the funding level was inadequate because it did not meet CDC's minimum recommendation.

> The reality is the State is funding far below the CDC Best Practice guidelines, so it's hard to have a comprehensive program up and running effectively when the dollars are not invested to make it happen.

Where does New York rank?
The percentage of CDC lower estimate funding allocated for tobacco control in FY 2003



Cigarette excise tax rates (as of 01/03)

State	Excise Tax
MA	$1.510
NJ	$1.500
NY	$1.500
WA	$1.425
RI	$1.320
OR	$1.280
MI	$1.250
HI	$1.200
AZ	$1.180
CN	$1.110
AK	$1.000
DC	$1.000
ME	$1.000
MD	$1.000
PA	$1.000
IL	$0.980
VT	$0.930
CA	$0.870
KS	$0.790
WI	$0.770
UT	$0.695
NE	$0.640
IN	$0.555
OH	$0.550
NH	$0.520
MN	$0.480
ND	$0.440
TX	$0.410
IA	$0.360
LA	$0.360
NV	$0.350
AR	$0.340
FL	$0.339
SD	$0.330
ID	$0.280
DE	$0.240
OK	$0.230
NM	$0.210
CO	$0.200
TN	$0.200
MS	$0.180
MT	$0.180
MO	$0.170
WV	$0.170
AL	$0.165
GA	$0.120
WY	$0.120
SC	$0.070
NC	$0.050
KY	$0.030
VA	$0.025

County tobacco control funding

Partners were proud of some counties in New York that showed their commitment by allocating a portion of their MSA funding to tobacco control. Examples of localities that were using significant amounts of settlement funds for tobacco control efforts were Suffolk County and New York City. Although a few counties dedicated their MSA funds to tobacco control, most did not. Partners were disappointed that many of the counties securitized their settlement dollars or used the funds for other issues.

> Many counties, like 90% of them, do not believe that they need to put funding toward tobacco control at the local level. They think that this is the state's job. And they've utilized these funds for roads, golf courses...Most of them are not even addressing the fact that this funding was awarded due to Medicaid and healthcare costs.

Budget deficit

The largest financial barrier facing the tobacco control program was New York's budget deficit. The state's shortfall was estimated at $2 billion for FY 03, while New York City's shortfall was estimated at $5 billion. The deficits were expected to be larger in FY 04, with a shortfall of $10 billion for the state and $6.4 billion for New York City. Partners noted that New York's economy was negatively impacted by the terrorist attack on September 11, 2001.

> New York's been impacted by 9-11 in a very profound way. And no one ever could have anticipated what it's done to our economy. And these are problems that no one anticipated having to solve.

The significant budget deficit caused partners to worry about future funding for tobacco control. The DOH TCP's funding was up for reauthorization in June 2003. Some partners believed the program would not be able to maintain the FY 03 funding levels. Many felt that tobacco control would decrease in priority, and that funding would be dedicated to issues like bioterrorism or bridging the budget gap.

> The State is facing a very large deficit in the current fiscal year, and projected to be much larger in the upcoming fiscal year. The concern, particularly at a time when everyone's concerned about bioterrorism and the public health agenda has shifted, is the risk that tobacco control is going to be moved right to the back of the priority list.

In December 2002, Governor Pataki proposed securitizing approximately half of the state's MSA funds to help address budget concerns. Although the Legislature had not approved the Governor's proposal at the time of the evaluation, many partners feared that securitization would happen. (*Note:* As of May 2003, the Legislature approved the securitization of $4.2 billion of future MSA payments and appropriated $36.95 million for the tobacco control program.)

> We're in a horrible deficit situation. There's all this tobacco money that they could securitize to help deal with the deficit. Obviously there is fear that money is just going to be sucked away and the connection between tobacco control program funding and the Settlement is going to be lost…

Contracts

Finally, the slow contractual process with the DOH TCP was a barrier for some tobacco control program partners. Contractors were without contracts for months, resulting in little tobacco control activity during that time. Although DOH TCP was unable to alter the process, they were making efforts to facilitate the process by starting the process earlier and hiring additional fiscal staff.

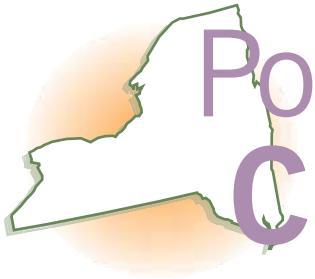
> We can't change the process because it's a departmental process and it involves multiple state agencies controlled by different political parties…We've initiated the contract process very early this year in an effort to allow for that seven- or eight-month delay in getting the contract executed. We're also hiring a fiscal manager who can be devoted to overseeing the contract process.

Partners also offered suggestions to improve the contract process, including:

- Improve infrastructure within DOH to provide better technical assistance to contractors.
- Provide more prescriptive objectives for contractors.
- Extend the length of contracts so contractors have enough time to get programs in place once funding is received.
- Shorten the time between contract approval and disbursement of funds.
- Provide more guidance to contractors to increase coordination.

Suggested Approaches

1. Continue to improve the contract process by trying to incorporate some of the suggestions given by partners.
2. Work to effectively advocate for maintaining current funding levels by:
   a. Strengthening the statewide coalition, Coalition for a Tobacco Free New York; and
   b. Identifying and encouraging tobacco control political champions to publicly support the program and its funding levels.



Political Climate

Section Highlights

- Strong tobacco control policies were being passed despite New York's tough politics.
- Most partners felt Governor Pataki was not supportive of tobacco control due to his ties with the tobacco industry, but some gave him credit for passing a number of tobacco control policies.
- Partners felt there were pockets of support for tobacco control in the Legislature, but that generally the Assembly was more supportive than the Senate.
- New York City Mayor Michael Bloomberg, New York City Commissioner of Health Dr. Thomas Frieden, and Assemblyman Pete Granis were recognized as strong tobacco control leaders.
- Partners believed the tobacco industry had a strong presence in New York through campaign contributions and lobbying efforts. They also felt current efforts were more subtle by working through front groups.
- The New York City smoking ban, the Master Settlement Agreement, and September 11th were political events with significant impact on New York's tobacco control landscape.

Political Climate

New York's political climate was described as "ambiguous", "a mixed bag", and "two ends of the spectrum" since some positive achievements occurred in the midst of poor political support from the state. Despite New York's highly political environment, tobacco control experienced some statewide policy successes, such as the passage of strong product placement and penalties for sales to minors laws, a high excise tax, and a fire safe cigarettes law, which is the only law in the U.S. that requires cigarettes to self-extinguish after a certain amount of time. (*Note*: Public comments on the proposed fire safe cigarettes standard remain under review. The law is not expected to take effect until 2004.) Furthermore, successful local clean indoor air ordinance efforts swept through counties in downstate New York.

> The political climate is a mixed bag. There's some very positive things happening in tobacco control in New York State just because the economy is in the dumper. Often times you'll see an interest in enhancing efforts to raise the tax to fill the budget gap.

> In terms of the leadership in New York State, it's been bad…

Political Support for Tobacco Control and Public Health

In 2002, George Pataki (R) was elected to his third term as Governor. Republicans controlled the Senate, while Democrats controlled the Assembly during the 2002 legislative session. Partners noted that political decisions in New York are primarily made by three key policymakers (*i.e.,* the Governor, the Senate Leader and the Assembly Speaker) behind closed doors.

Approximately 75% of partners felt that Governor Pataki provided little or no support for tobacco control in New York. Examples of his lack of support were his unwillingness to fund the tobacco control program at the CDC's minimum recommendation, his efforts to kill a statewide clean indoor air bill in the 2002 legislative session, and his proposal for securitizing settlement funds. (See the Financial Climate section for more information about securitization.)

> Publicly they'll [the Pataki administration] say they're very supportive…but in reality, behind the scenes we see Pataki for the last two years killing our efforts to pass stronger clean indoor air legislation…the Pataki administration is not very supportive of tobacco control.

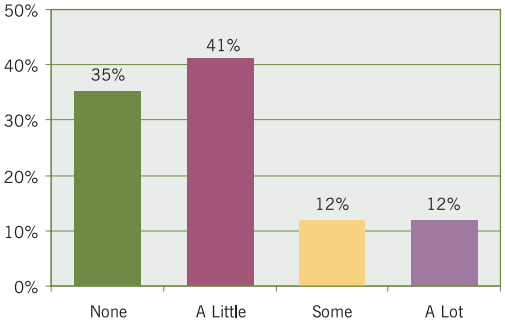
Partners believed other issues were more important to Governor Pataki than tobacco control, with education and crime topping his priority list. They also felt other public health issues took precedence over tobacco control for the Governor.

Governor Pataki was also known for his strong connections with the tobacco industry. He accepted campaign contributions from the industry, especially early in his Administration. A scandal involving Philip Morris hiding expenses on trips for the Governor and expenses on some state legislators was uncovered in the

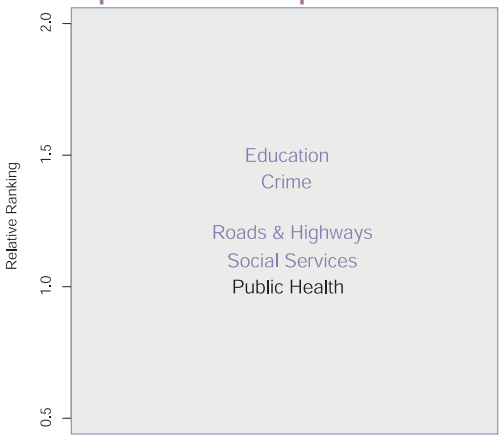
New York's political composition, 2002 legislative session

Governor George E. Pataki	Republican
Attorney General Eliot Spitzer	Democrat
Senate	
President Mary Donohue	Republican
Party Breakdown	36 Republicans 25 Democrats
House of Representatives	
Speaker Sheldon Silver	Democrat
Party Breakdown	97 Democrats 52 Republicans

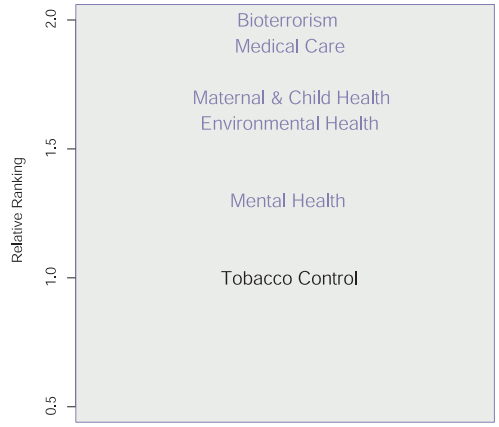
How much support for tobacco control do you receive from Governor Pataki?



Perceptions of Governor Pataki's prioritization of public health



Perceptions of Governor Pataki's prioritization of tobacco control



late 1990s. Partners noted that the scandal embarrassed and pressured the Governor and other legislators into passing tobacco control legislation to dissociate themselves from the tobacco industry.

> We did have a major scandal here in 1999 in which tobacco documents somehow found their way to the New York Times, which showed that Philip Morris' lobbyists had been taking everybody in Albany out to dinner…It caused quite a scandal and led to two or three years where we were enacting legislation because politicians were busy distancing themselves from tobacco. Everybody wanted to be the anti-tobacco champion.

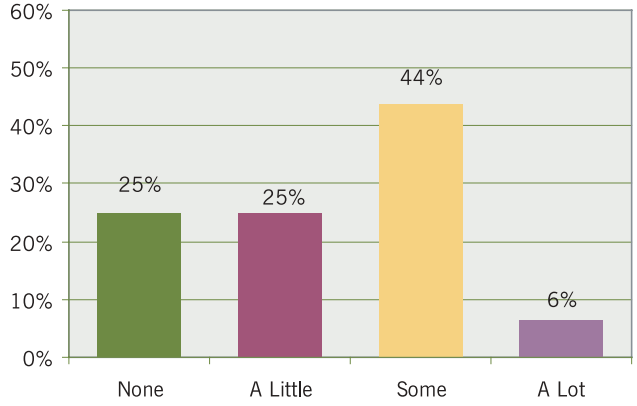
Some partners believed that Governor Pataki deserved some credit for progress made in tobacco control policy, including his financial investment in the tobacco control program, and the passage of a number of other tobacco-related bills. (*Note:* The Governor suported the passage of a statewide clean indoor air bill in March 2003).

> I will give the State Legislature and Governor Pataki a fair bit of credit for what I see as a very aggressive policy stance with regard to tobacco. We have very strong laws regulating how tobacco is sold in terms of product placement, in terms of penalties for sales to minors, in terms of these unusual tobacco products. That's very good and that's not necessarily the norm.

Many partners felt the Legislature was split in its support for tobacco control. Tobacco control was important to some legislators, but not to others. In fact, the Democratic Assembly was viewed as relatively supportive of tobacco control efforts, while the Republican Senate was generally viewed as unsupportive. Partners also noted the tobacco industry's influence on legislators and a lack of support for clean indoor air laws due to their concern for business.

> I would say there's pockets of those legislators that find it [tobacco control] very, very important and those that totally disregard it…And I think then there are a few that are on the fence.

How much support for tobacco control do you receive from the Legislature?



A few partners felt the Legislature was relatively supportive, or had increased its support for tobacco control. They were pleased with the passage of a number of tobacco control bills, and that proposed preemption had not passed recently.

Tobacco Control Champions

New York City Mayor Michael Bloomberg and Commissioner of Health Dr. Thomas Frieden were identified as strong tobacco control champions due to their clean indoor air efforts in the City.

> Certainly Mayor Bloomberg in New York City and Commissioner Frieden, the Commissioner of Health in New York City have taken this issue on. Mayor Bloomberg has made it a public health issue. He has made clean indoor air a worker protection issue. So he's put the issue kind of front and center and appears to be doing so successfully.

Assemblyman Peter Granis (D) was frequently mentioned as an important tobacco control advocate at the state level. He has supported state clean indoor air efforts as well as many other tobacco control bills.

> He's [Pete Granis] been the sponsor of just about every major piece of legislation that we have enacted and has expended political capital in support of our agenda. So he is definitely our strongest champion.

Other individuals and agencies deemed tobacco control champions included:

- Assemblyman Richard Gottfried (D)
- Senator Charles Fuschillo, Jr. (R)
- Russ Sciandra and the Center for a Tobacco Free New York
- Blair Horner and New York Public Interest Research Group
- American Cancer Society
- American Lung Association

Political Barriers

The tobacco industry had a very large presence and influence in New York, thus partners felt the industry had been effective in inhibiting the success of the tobacco control program. Partners noted that Philip Morris' headquarters were located in New York City. (*Note*: Philip Morris' headquarters have been relocated to Richmond, Virginia.) The tobacco industry also had a strong influence on politics, since ties were found with Governor Pataki and state legislators who accepted campaign contributions from the industry.

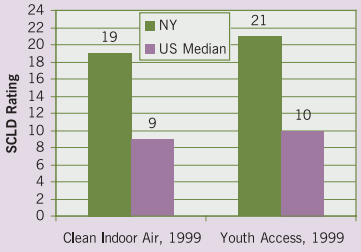
Policy Watch: SCLD Ratings

Rating systems have been developed to measure the extensiveness of youth access and clean indoor air (CIA) legislation, collected by The NCI's State Cancer Legislative Database (SCLD). States with higher scores have more extensive tobacco control legislation. Scores are reduced when state preemption is present.

For youth access, nine areas were measured: six addressed specific tobacco control provisions, and three related to enforcement provisions. Nine areas were also measured for CIA: seven related to controlling smoke in indoor locations, and two addressed enforcement. The maximum scores for youth access and CIA are 36 and 42, respectively.

New York's SCLD ratings were well above the national medians. In 1999, New York's clean indoor air score was 19 and the state law had no preemption. This score should increase for 2003 due to the recent passage of a strict state workplace clean indoor air law. In 1999, the youth access score was 21 and the state law included preemption. Since then, the State has passed stricter youth access legislation as well.

New York's ratings
Clean Indoor Air: **19**
Youth Access: **21**



> The tobacco industry has pervasive influence in terms of statewide policy and represents a real barrier to making dramatic progress. I would say almost to the extent where we are comparable to some tobacco growing states on certain issues.

However, partners felt current tobacco industry efforts were more subtle. They worked through front groups like the Tavern Association and the Association of Convenience Stores. The industry was successful in convincing these associations that clean indoor air laws would hurt business, thereby causing these groups to oppose such regulations.

> They [tobacco industry] get the vendors to come whenever there's an issue about selling tobacco, and they get the restaurants and the bars to come. They fire them up that 'Oh, we're all going to lose business and we're all going to go out of business.' So that elected officials aren't hearing from the tobacco industry, but from the mom and pop shops or the restaurants who are saying 'You pass this law, you're going to put me out of business.'

Significant Event

Partners mentioned some political events that had significant impact on the tobacco control landscape in New York.

1. New York City Mayor Michael Bloomberg's smoke free workplace legislation in New York inspired other counties to pass and consider similar smoking bans. Partners hoped that these strong local clean indoor air ordinances would influence state level policy. In fact, on March 26, 2003 the Legislature passed a state law banning smoking in nearly every restaurant, bar and workplace.
2. The Master Settlement Agreement increased funding resources for the tobacco control program and heightened the visibility of tobacco control.
3. The terrorist attack on September 11th, 2001 resulted in an economic downturn in the state. It also shifted priorities from tobacco control to terrorism defense.

Suggested Approaches

1. Work to identify additional champions in the Legislature to garner more support for tobacco control and future legislative efforts.
2. Continue to strengthen the relationship with Governor Pataki to increase his support for tobacco control and heighten its priority on his political agenda.

Capacity & Relationships

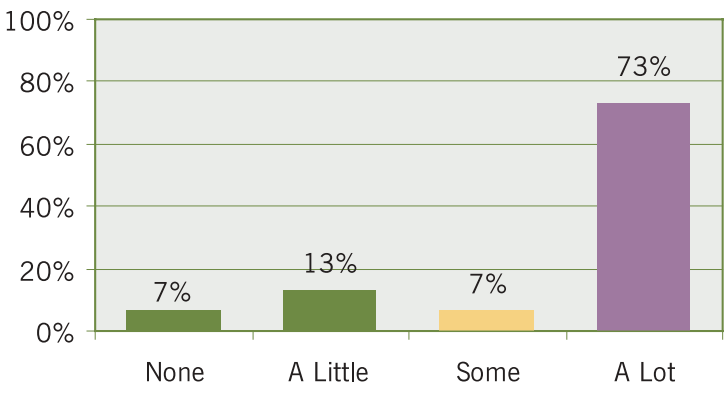
Section Highlights

- Partners' supervisors were highly supportive of their tobacco control efforts.
- Internal communication, training opportunities, and availability of physical resources were viewed as helpful organizational characteristics.
- Organizational structure and reporting requirements were considered both facilitating and impeding to partners' tobacco control efforts.
- Staffing levels and experience were adequate for most partners. However, many thought the DOH hiring process impeded hiring staff that had the appropriate tobacco control and public health experience.
- Partners identified Director Dr. Ursula Bauer as a major strength of the DOH TCP, while the bureaucratic and highly political environment of the DOH was seen as an impediment.
- Several partners felt that the network was improving and had the potential to be very effective. Other partners felt that the network could be counterproductive at times due to competing agency priorities.
- Partners felt that the statewide coalition, Coalition for a Tobacco Free New York, was an integral part of the network.

Organizational Capacity

A number of organizational characteristics were identified that either facilitated or impeded the partners' tobacco control efforts. Partners felt that their supervisors were highly supportive of their efforts. Internal communication within the agencies, opportunities for training, and the physical resources (*e.g.* computers, office space) available were viewed as facilitating to their

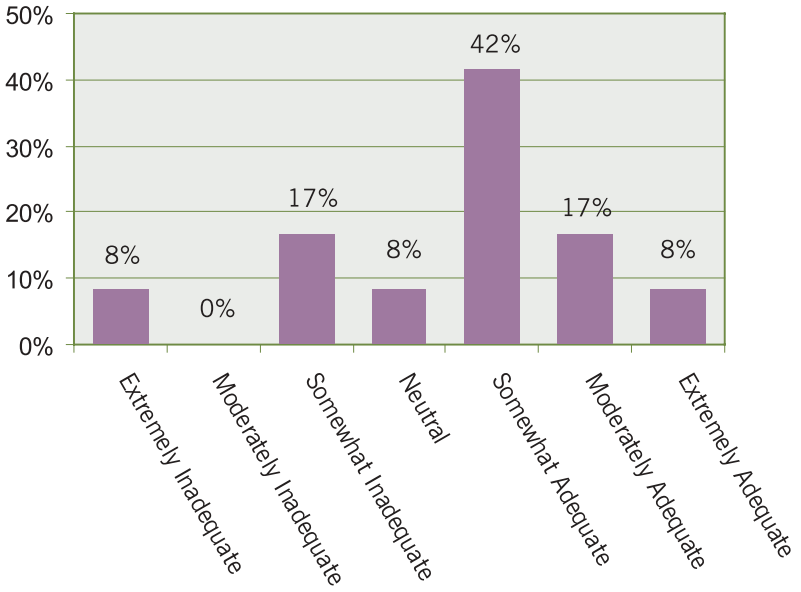
How much support for tobacco control do you receive from your agency leadership?



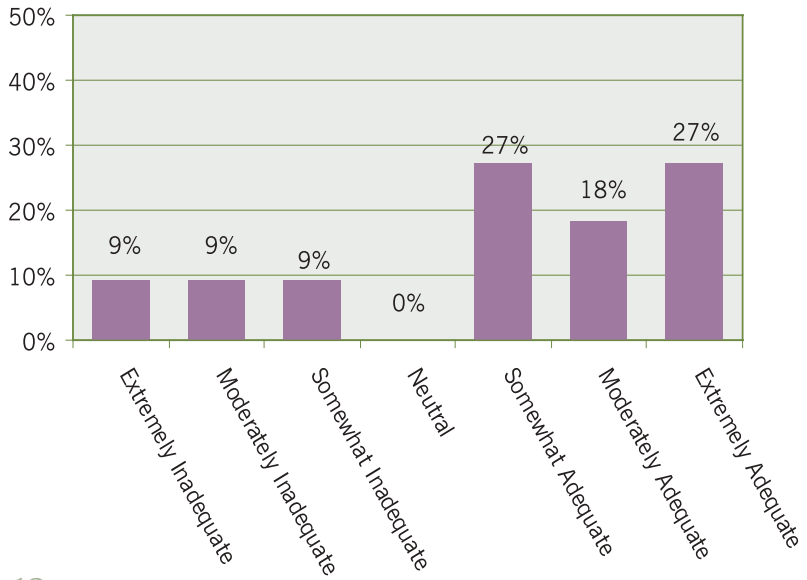
How does each of the following characteristics affect your agency's tobacco control program?

Organizational Characteristic	Helps	Hurts	Both	Neither
Internal communication	65%	12%	18%	6%
Training opportunities	65%	6%	6%	24%
Internal decision-making process	53%	12%	29%	6%
Physical resources	53%	6%	18%	24%
Number of tobacco control staff	44%	38%	13%	6%
Size of agency	41%	18%	18%	24%
Organizational structure of agency	35%	12%	41%	12%
Reporting requirements	19%	6%	25%	50%
Staff turnover	18%	24%	6%	53%

How adequate is your tobacco control staffing level?



How adequate is your staff's tobacco control experience?



tobacco control efforts. However, the organizational structure within the agencies and reporting requirements were seen as both facilitating and impeding their efforts.

Overall, staffing levels and the level of tobacco control experience of staff were reported as being adequate. However, partners felt that the DOH hiring process impeded the DOH TCP because of the slow pace of the process and the inability to hire external individuals, which limited the number of candidates with specific training in tobacco control and public health. Many partners thought that the DOH TCP needed staff with more tobacco control training and experience.

> Like many large bureaucracies hiring is a long drawn out process and when you are in a budget deficit situation hiring is even harder. Rather than lay off people, they'll give you somebody from another department rather than let you hire somebody from outside.

In the past year, partners attended a variety of tobacco control trainings, including trainings held at the national, state or regional, and local levels. Trainings held at the state or regional level were the most common trainings attended, and most felt the trainings were adequate.

While staff turnover did not impede the partners' tobacco control efforts, some felt the retention of staff at the DOH was more of an issue.

> No [staff turnover at DOH has not been a problem]. I think there's been more of a retention of people that should not have been kept on.

Perceptions of the DOH TCP

The DOH TCP's program director was identified as a major strength of the program because of her experience and

strong leadership. Many partners felt that the hiring of the new director led to positive changes in the program.

> Ursula is the biggest strength…She brought all the skills. She brought with her the expertise, the public health training, and the knowledge from doing surveillance and evaluation in Florida…She updated New York's approach.
>
> The beacon of hope we have is Ursula Bauer…She comes to the job with a tremendous reputation and lots of knowledge.

Tobacco Control Network

Fifteen tobacco control partners were identified as core members of New York's tobacco control program and were invited to participate in the interviews. The list of partners included a variety of agency types, including the Tobacco Control Program Advisory Board, a media firm, and a research institution.

Contact Frequency

In the adjacent figure, a line connects two partners who had contact (*i.e.,* meetings, phone calls, emails) with each other at *least* once a month. New York had a relatively centralized communication structure where members of the network frequently had contact with a few central agencies. The DOH TCP had the most control over communication flow, followed by the ACS. The peripheral agencies (indicated by the yellow dots) had infrequent contact with other agencies and the least control over information flow.

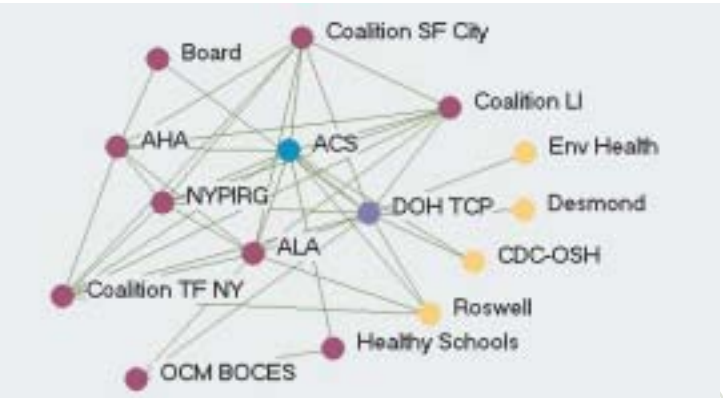
Money Flow

In the adjacent graph, an arrow indicates the direction of money flow between two partners. The graphic illustrates a moderately complex network. The DOH TCP is the primary funding agency where money flows from the DOH TCP to other partners. Therefore, the DOH TCP had the largest financial influence over the network. The CDC-OSH and the Coalition LI followed

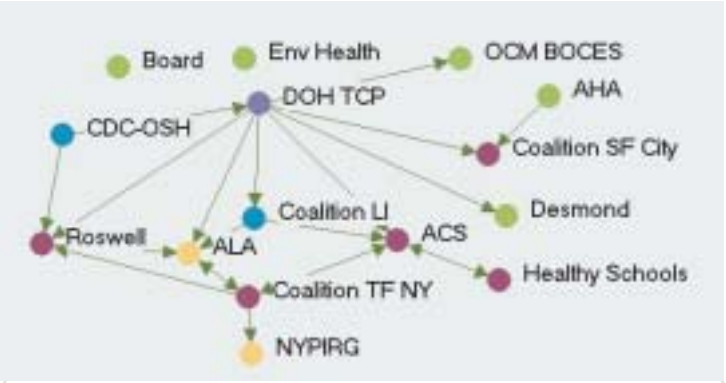
Partners of New York's tobacco control network

Agency	Abbreviation	Agency Type
New York State Department of Health Tobacco Control Program	• DOH TCP	• Lead agency
American Cancer Society	• ACS	• Voluntary
American Heart Association	• AHA	• Voluntary
American Lung Assocaition	• ALA	• Voluntary
Coalition for a Tobacco-Free New York	• Coalition TF NY	• Statewide Coalition
Coalition for a Smoke-Free City	• Coalition SF City	• Regional Coalition
Tobacco Action Coalition of Long Island	• Coalition LI	• Regional Coalition
CDC, Office on Smoking and Health	• CDC-OSH	• Funding Agency
Roswell Park Cancer Institute	• Roswell	• Contractor
Desmond Media	• Desmond	• Contractor
Onondaga Cortland Madison BOCES	• OCM BOCES	• Contractor
New York Public Interest Research Group	• NYPIRG	• Advocacy Group
Bureau of Sanitation and Food Protection, Division of Environmental Health Protection, Center for Environmental Health	• Env Health	• Enforcement Agency
Statewide Center for Healthy Schools	• Healthy Schools	• School-based Agency
Tobacco Control Program Advisory Board	• Board	• Advisory Board

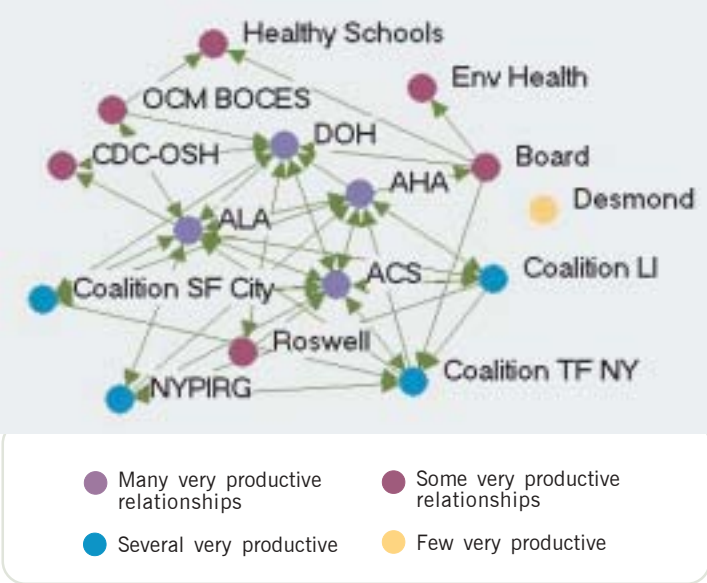
Monthly contact among network partners



Money flow among network partners



Productive relationships among network partners



with some influence over others since they disbursed money to other partners. Little or no money flow was observed among more peripheral partners such as Desmond, AHA, and OCM BOCES.

Productive Relationships

A directional arrow (A→B) indicates that Partner A felt it had a *very* productive relationship with Partner B. A bidirectional arrow (A↔B) indicates that both partners agreed that their relationship was very productive. DOH TCP, ACS, AHA, and ALA had the highest number of very productive relationships, followed by the coalitions and NYPIRG. The agencies with few very productive relationships tended to be contractors who have a narrow role in the tobacco control program.

Perceived Effectiveness of Network

Several partners felt that the network was improving and had potential to be very effective. Partners in the network shared ideas and informed one another of their activities. Furthermore, meaningful relationships among partners were being formed.

> I think that it's a young network, but I think the relationships that are being forged are going to be pretty meaningful and that it will result in some pretty effective stuff happening.

Other partners felt the network was at times counterproductive. Reasons given for this were that tobacco control was not a priority for some groups and at times there were power struggles that led to missed potential.

> The problem is that we have a lot of chiefs and not enough Indians, and so we have a lot of people that think they know everything and how everything should be, but they do not necessarily want to play well with the others to be effective and they want to do it all themselves or they want to get all the glory…

Agency Importance & Commitment

Partners were asked to rate each agency's level of importance for an effective tobacco control program and its level of commitment to tobacco control. The Coalition for a Tobacco-Free New York, American Cancer Society, and DOH TCP were viewed as having a high level of importance and commitment. Desmond Media and Onondaga Courtland Madison BOCES were rated as having less importance and commitment compared to other partners, reflecting their focused roles of media and school-related tobacco control activities, respectively.

Coalitions

Partners felt that the statewide coalition, Coalition for a Tobacco-Free New York, was a very effective and integral component of the network.

> If it weren't for the Coalition [for a Tobacco Free New York], the network would be completely ineffective…that coalition has been very effective.

A few partners felt that the Coalition lacked effective collaboration and suffered from competing partners' agendas. They were concerned that the Coalition would lose its effectiveness.

> I think that we have the potential of being an incredible coalition that's very effective. The problem is that we have partners who are all too willing to put tobacco control on the back burner…So key members basically mute the coalition because they're worried about their other agenda items.

The local community coalitions were considered somewhat effective. Some of the coalitions were very strong in their grassroots efforts and others still needed improvement. Partners thought that this may be due to some state-funded coalitions'

Agency rating of importance to the program & commitment to tobacco control

Importance to the program[a]		Commitment to tobacco control[b]	
Agency	Avg. rating[c]	Agency	Avg. rating[c]
NY DOH,Tobacco Control Program	9.0	Coalition for A Smoke-free City	9.7
Coalition for a Tobacco-Free NY	9.2	Tobacco Action Coalition of Long Island	9.7
Amercian Cancer Society	8.6	Coalition for a Tobacco-Free NY	9.6
Coalition for a Smoke Free City	8.2	American Cancer Society	9.4
American Lung Association	7.8	American Lung Assocation	9.3
CDC, Office on Smoking & Health	7.8	NY DOH, Tobacco Control Program	9.3
Tobacco Control Adviory Board	7.8	Roswell Park Cancer Institute	9.3
NYPIRG	7.7	CDC, Office on Smoking & Health	9.1
Tobacco Action Coalition of Long Island	7.6	Tobacco Control Advisory Board	9.0
Roswell Park Cancer Institute	7.0	NYPIRG	8.4
Bureau of Sanitation & Food Protection	6.6	American Heart Association	7.9
Onondaga Cortland Madison BOCES	6.0	Statewide Center for Healthy Schools	6.9
Desmond Media	5.8	Bureau of Sanitation & Food Protection	6.6
Statewide Center for Healthy Schools	5.2	Desmond Media	6.4
American Heart Association	3.9	Onondaga Cortland Madison BOCES	6.1

a How would you rate the importance of each agency for an effective tobacco control program in your state?
b How would you rate the level of commitment to tobacco control for each of the following agencies in your state?
c 10 = high; 1 = low

uncertainty of the difference between advocacy and education. However, the DOH TCP was working to lessen the confusion.

> My understanding is there are some coalitions around the state, that I'm sure you find in all big states with a lot of coalitions, some are really strong, others are so-so. From what I've heard, I think the Long Island coalition has gotten increasingly active. The [New York] City coalition has become effective in the last two years.

Suggestions for Improvement

Partners suggested several ways to increase the effectiveness of the entire tobacco control network, including:

- Improve coordination and communication throughout the network through bi-annual statewide meetings, more regional meetings, and disseminating tobacco control activities via the Internet.
- Define partners' roles and how they correspond with New York's tobacco control program.
- Continue to educate partners in tobacco control and prevention.
- Include new and diverse partners.
- Increase cooperation and collaboration among the American Cancer Society, American Heart Association, and American Lung Association in order to speak as one voice.

Suggested Approaches

1. Continue to educate local coalitions about their role in policy efforts (*i.e.,* education vs. advocacy).
2. Investigate new ways to recruit and hire trained tobacco control professionals.
3. Develop a formal document describing the roles and responsibilities of the tobacco control partners.
4. Implement the suggestions identified in the previous section to increase the effectiveness of the network.

The Best Practices

Section Highlights

- New York reorganized the Best Practices into three categories: community mobilization (which includes community coalitions, youth partnerships and enforcement), media and counter marketing, and cessation.
- Partners felt that counter-marketing programs should be the highest priority in New York, closely followed by cessation programs. School programs and enforcement were ranked as lower priorities.
- Strengths of the BP were that it provides financial guidance, is developed by the CDC, and provides a framework for states with new tobacco control programs.
- Weaknesses of the BP were that it lacks strong supporting evidence, lacks implementation guidance, and needs to be updated.
- Suggested improvements were to emphasize promoting policy change, prioritize the categories, provide more detailed funding recommendations, and include more examples.

Best Practices category definitions

Community programs – local educational and policy activities, often carried out by community coalitions

Chronic disease programs – collaboration with programs that address tobacco-related diseases, including activities that focus on prevention and early detection

School programs – policy, educational, and cessation activities implemented in an academic setting to reduce youth tobacco use, with links to community tobacco control efforts

Enforcement – activities that enforce or support tobacco control policies, especially in areas of youth access and clean indoor air policies

Statewide programs – activities accessible across the state and supported by the state, including statewide projects that provide technical assistance to local programs and partnerships with statewide agencies that work with diverse populations

Counter-marketing programs – activities that counter pro-tobacco influences and increase pro-health messages

Cessation programs – activities that help individuals quit using tobacco

Surveillance & evaluation – the monitoring of tobacco-related outcomes and the success of tobacco control activities

Administration & management – the coordination of the program, including its relationship with partners and fiscal oversight

The Best Practices

New York tobacco control advocates used the *CDC's Best Practices for Comprehensive Tobacco Control Programs* (BP) in the following ways: 1) to determine appropriate funding levels; 2) to obtain funding; 3) to educate the media, public, and lawmakers on the importance of a comprehensive tobacco control program; and 4) to guide the development of their strategic plan. The BP language was also incorporated into the tobacco use prevention and control

legislation, which established the comprehensive statewide tobacco control program.

New York adjusted the BP to fit a three-pronged programmatic approach to accomplish the four goals recommended by the CDC's National Tobacco Control Program. New York's three main strategies are: 1) community mobilization, which includes community coalitions, youth partnerships and enforcement; 2) media and counter marketing; and 3) cessation. All of these strategies are supported by surveillance and evaluation activities.

Prior to the guidance of the new DOH TCP director the BP was not a significant resource for the program. Partners were very confident in the director's ability and expertise in utilizing the BP guidelines for New York's program.

> Ursula Bauer knows the Best Practices backwards and forwards. She comes at it the right way. Prior to her I don't think that was being done.

Another resource, *The Guide to Community Preventive Services: Tobacco Use Prevention and Control* was more instrumental in the development of New York's program than the BP.

> We follow more closely the Community Guide. And there's not a nice match between the two documents. They're not inconsistent with each other, but when we looked at the strategies that are listed in the Community Guide, that's kind of how we gravitate toward organizing our program and kind of fit it into the Best Practice structure.

In addition to the BP and The Community Guide, New York also relied on the following sources to help guide their tobacco efforts: the National Cancer Institute's S*trategies to Control Tobacco Use in the United States: A blueprint for Public Health Action in the 1990s*, the Commission for a Healthy New York's *Proposal for a Comprehensive Tobacco Prevention and Control Plan*, and *Reducing Tobacco Use: A Report of the Surgeon General*.

Although New York's program relied on a number of resources for guidance many partners were quite familiar with the BP. They felt that counter-marketing programs should be a high priority in New York, while school programs should be a lower priority. However, some partners found it difficult to prioritize the BP because they felt that all the categories must work in tandem to produce an effective tobacco control program.

High BP Priorities

Counter-marketing was ranked as a high priority for the following reasons:

- Reaches the largest audience.

> I think it's the best way to get a message out to the most people. And I think that that's what we really need to do is inform as many people as possible about the problem of smoking, the problem of tobacco use.

- Draws attention to tobacco industry tactics.

> My view is that effective media campaigns provide what I call air cover for the ground war. If you are not setting a general tone in the public dialogue about tobacco use that reveals industry tactics and refutes their promotional themes, then that just makes it harder to get traction for broadly supported community programs, investments in tobacco control, and policy changes.

- Creates change in pro-tobacco norms.

> I think counter-marketing is the best way to get the attention of the public and begin the shift in social norms; it is critical to everything else.

Another major reason counter-marketing was ranked as a high priority was that partners felt New York lacked an effective media campaign. They suggested that counter-marketing efforts were weak due to the lack of resources and commitment. It was also noted there had been some recent improvement compared to previous years.

> So I think we've seen significant improvements in that area. It would be better if the media program were totally under her [Ursula Bauer] control. It's not, so I think that would be something that would be better. But it's improved from how it was a couple of years ago.

Best Practices ranking & DOH TCP estimated budget allocations, FY 2003

BP Category	Mean Rank[a]	Budget %
Counter-Marketing	2.8	35
Cessation Programs	3.2	12
Community Programs	3.4	27
Statewide Programs	4.0	2
Surveillance & Evaluation	4.8	5
Chronic Disease Programs	5.8	0
Enforcement	5.9	13
School Programs	6.1	2
Administration & Management	Not included[b]	4

[a] Ranking: 1 = highest priority; 8 = lowest priority
[b] Not included because not mutually exclusive with the other categories

Suggestions for the improvement of this category included developing a systematic media plan, being more aggressive and creative, and acquiring assistance from a professional agency to help determine the proper content and structure. The addition of Dr. Ursula Bauer as the tobacco control director made many hopeful that counter-marketing would soon reach its potential.

Although *cessation programs* were ranked high, partners had few comments as to why cessation should be a high priority. Partners suggested improvements to the state quit line that was already in place. These suggestions included the inclusion of proactive calling, a more structured program, more useful mailings, and a phone number that is easier to recall. (*Note:* The quit line number has been changed to 1-866-NY-QUITS.) New York is attempting to update and modify the quit line with the addition of a referral system to assist in proactive calling.

Low BP Priorities

School programs were ranked as a low priority for the following reasons:

- Shown to be an ineffective approach.

> School programs [are ranked lowest] because the literature is very shaky that school programs work. And some people feel it's not money well spent particularly if they're not very carefully designed and evaluated.

- Changing community norms is more effective.

> I think clean indoor air laws and just people changing their habits so that they're not partaking in tobacco use in front of children or youth and just setting examples for the youth is a better way of going versus counteracting in school what they see at home.

Partners also ranked *enforcement* as a lower priority. They felt there was limited data supporting its effectiveness and believed the other BP categories needed to be in place before enforcement could be useful.

Some partners also expressed a lack of understanding about the definition of *chronic disease* and *statewide programs*. Chronic disease programs were seen as an economic loss since it did not directly affect prevalence rates. Placing emphasis elsewhere, like community programs, would show a more intense and immediate result. They also found it difficult to clearly distinguish statewide programs from other BP categories.

> When we talk about statewide programs it is very hard to separate those from everything else here. I mean even if you look at Best Practices, it's not all black and white, the segregations between the different components. There is a lot of gray and there's a lot of intermingling.

BP Funding

For FY 03, the DOH TCP allocated the largest portion (35%) of tobacco control funding to counter-marketing programs, which partners also ranked as the highest priority. This was followed by 27% to community programs, 13% to enforcement and 12% to cessation programs (see table on page 20). The rest of tobacco control funds were relatively evenly distributed among the rest of the categories, with the exception of chronic disease programs, which received no tobacco control funding for FY 03.

BP Strengths and Weaknesses

A number of strengths of the BP were identified:

- Provides useful financial guidelines
- Provides a framework for states with new tobacco control programs
- Developed by the CDC
- Sets a national standard

Partners also identified weakness of the BP:

- Lacks strong supporting evidence
- Was created as an outline and lacks implementation guidance
- Lacks details
- Is outdated
- Was not effectively disseminated

Partners had the following recommendations regarding improvements for the BP:

- Promote policy change
- Provide prioritization of the categories
- Document more specific funding recommendations
- Update and add more examples

Suggested Approaches

1. Develop a strategic plan for the counter-marketing campaign by including input from partners and media professionals.
2. Seek avenues of collaboration and coordination with chronic disease programs, emphasizing tobacco control as a component.
3. Refer to other tobacco control resources to supplement the Best Practices. For example,
   - *The Guide to Community Preventive Services for Tobacco Use Prevention and Control* (www.thecommunityguide.org)
   - *The 2000 Surgeon General's Report on Reducing Tobacco Use* (www.cdc.gov/tobacco/sgr_tobacco_use.htm)
   - *The 2000 Public Health Services Clinical Cessation Guidelines* (www.surgeongeneral.gov/tobacco/smokesum.htm)
   - Resources from national tobacco control organizations (see the Resources section on page 33).
4. Take into account the strengths, weaknesses, and areas of potential improvement to the *Best Practices* guidelines identified in this Profile when developing your own tobacco control resources.

Tobacco Control Program Goals

Section Highlights

- Eliminating exposure to second-hand smoke and decreasing the social acceptability of tobacco use were seen as appropriate priority goals.
- Partners recommended adding efforts to increase program funding, increase availability of cessation programs, and educate smokers to the list of goals.
- Passing clean indoor air legislation in rural counties was viewed as a challenge, but partners felt that the passage of strong laws in New York City and other counties would have a significant influence.
- Enforcement of the youth access law was viewed as a successful activity in decreasing the social acceptability of tobacco use.
- Partners felt that more staffing, recruiting new partners, and focusing more time and funding on policy issues would help their agencies meet the priority goals.

Top Two Goals

For this evaluation, the DOH TCP was asked to identify the top two policy or programmatic goals for FY 03. The two goals identified were:

- Eliminate exposure to secondhand smoke.
- Decrease the social acceptability of tobacco use.

These goals were two of the six goals developed during a strategic planning process in May of 2002 and are documented in a draft of the strategic plan, *Tobacco Use Prevention and Control Program Draft Strategic Plan, 2002*. The program goals were chosen because they address other goal areas and include community mobilization, the foundation of New York's program. Specifically, efforts to decrease exposure to secondhand smoke require community involvement, promote cessation, and reduce the social acceptability of tobacco use. Furthermore, changing the acceptability of tobacco use creates an environment that prevents initiation. Program goals and objectives were determined through a strategic planning process at the DOH TCP, which also included input from contractors and stakeholders.

The majority of partners agreed that eliminating exposure to secondhand smoke and decreasing the social acceptability of tobacco use were appropriate priorities. Partners felt that these were goals that everyone could work towards, but some felt that they were more long-term and not something that would be accomplished this year.

> I think they're very reasonable goals. I think those are goals that all the organizations working on tobacco control in New York embrace and have high on their priorities as well prior to their determination.
>
> You know when you say decrease, then it's an achievable goal. When you say eliminate, I mean, it's great as a long-term goal. Is it a goal we're going to achieve this year? No. So I mean, maybe somewhat more specificity, but they're certainly on the right track.

Several partners viewed the secondhand smoke goal as a high priority because the public was supportive and accomplishing this goal would impact other goals, such as preventing initiation and promoting quitting. Others felt that the goal should reflect the need for a statewide policy.

> I think that is exactly what they should be doing. They've gotten a strong movement of citizens that want to eliminate second-hand smoke, they have some leaders that are on their side, so the time is right for that and I think that they have captured the historical moment. It will lead to a lot of health protection for the citizens of New York.

A few partners felt that the social acceptability goal captured a lot of the activities that the community programs were emphasizing. Additionally, they felt this goal was important in order to counter the glamorization of smoking by the tobacco industry.

> They [tobacco industry] spend a million dollars an hour advertising tobacco. We've got to work to de-glamorize it and saying it is not acceptable.

Changes and Additions

Partners suggested the following additions to the priority goals:

- Increase the funding for the tobacco control program.
- Conduct more research on cessation and increase the availability of those programs.
- Educate smokers about the cigarettes they consume.

Successes, Challenges, & Improvements

Eliminating exposure to secondhand smoke
Several partners mentioned that passing clean indoor air laws in

rural counties was a challenge. Partners believed these counties were more concerned about hurting business than counties with larger populations. In addition, rural counties often did not have a full service health department to enforce the laws.

> The easier ones [counties passing stronger laws] are centered around a city, so around Buffalo and Rochester. I think having a larger population helps facilitate it. The rural counties really struggle with clean indoor air laws. They think they're different and that they are going to negatively affect business for a lot of small business owners. So that 's a hurdle that we need to overcome.

Some partners were disappointed that a statewide clean indoor air law did not pass in 2002, but this was also viewed as a blessing because stronger laws were being passed in New York City and other communities. Because New York City, Suffolk, Nassau and other counties had passed strict laws, partners felt they had a better chance of passing a strong statewide law the next legislative session. (*Note*: A statewide clean indoor air law was enacted in March 2003.)

> …in a sense it [failure of statewide legislation] was a blessing because the Bloomberg proposal and what's going on in Long Island and Westchester has really shifted the whole spectrum of debate on this. So we'll probably come back with a much stronger bill in the next session.
>
> It [NYC legislation] has completely changed the dynamic and the discussion in New York as to what we mean by clean indoor air ordinance…it just completely reinvigorated the entire debate in New York and changed the focus of all the local ordinances…

A sampling of New York's activities

Eliminating exposure to second-hand smoke	• Working to implement clean indoor air laws in agencies and communities • Implementing media campaigns to increase smoke-free homes and vehicles • Offering nicotine replacement therapy • Developing research that enhances the likelihood that clean indoor air laws will be adopted across the state
Decreasing social acceptability of tobacco use	• Reality Check, a statewide youth initiative that addresses social acceptability • Enforcing youth access law, making tobacco less available to youth • Working with school districts to make smoking policies more inclusive • Working to implement clean indoor air laws in communities and the state

Decreasing social acceptability of tobacco use

Partners felt enforcement of the youth access laws was a success in decreasing social acceptability of tobacco use. Penalties remained high for those who sold to minors, and sales to minors had decreased over the past few years.

> We have very strict penalties in New York State for vendors that sell to minors and there's been a commitment on the state health department's side…if you look at the compliance rates for vendors not selling to minors, I think they have gone up significantly over the last several years. It's been fairly successful.

Partners identified some improvements in their own agencies that could help ensure meeting the priority goals:

- Reaching out to groups that had not been previously involved (*e.g.,* the clergy, community groups, business organizations interested in public service);
- Focusing more of their time and funds on policy issues and less on programs; and
- Increasing staffing levels.

Suggested Approaches

1. Continue to educate the public, particularly local businesses, about the benefits of smoke-free policies to help ease the transition to a smoke-free state.
2. Expand the tobacco control partnership to include more non-traditional community groups or organizations.

Disparate Populations

Section Highlights

- The DOH TCP identified Medicaid beneficiaries, persons with mental illness, and rural, low income, non-Hispanic whites as experiencing significant tobacco-related disparities.
- Partners agreed that these populations were high priorities for New York. They also suggested other populations to address, including immigrants and Native Americans.
- Strategies were in place to address the disparate populations, specifically targeting Medicaid beneficiaries and persons with mental illness.
- Partners believed the BP was not very useful for addressing disparate populations. They felt the need for a clearer definition of disparity and descriptions of effective strategies.

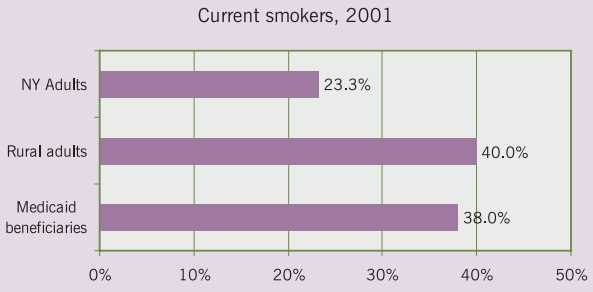
Priority Disparate Populations

The DOH TCP identified the following populations as having tobacco-related disparities:

- Medicaid beneficiaries
- Persons with mental illness
- Rural, low income, non-Hispanic whites

Resources used to help identify the above populations included epidemiologic data, evidence-based literature on tobacco use prevalence, and anecdotal information from tobacco control professionals in New York. In FY 03, the DOH TCP allocated $9.5 million for tobacco control activities for disparate populations. At the time of this evaluation, the DOH TCP had not yet solicited input from these populations in planning tobacco control activities.

NY Disparate Populations



- For the mentally ill, NY relies on literature reports, confirmed anecdotally, that suggest that 70% to 80% of mentally ill adults smoke.

Partners' Comments

Partners agreed that the above populations were a high priority for New York, and that prevalence data supported the need to address them. While the partners believed that Medicaid beneficiaries and persons with mental illness were important, more comments were made regarding rural, low income, non-Hispanic whites.

- Some partners emphasized that New York is extremely rural. They felt that the lack of transportation and, consequently, access to health programs contributed to this tobacco-related disparity.

> The rural population is always going to be tough. There is no public transportation, so it's difficult to get to a cessation program or a doctor.

Additional Populations

While partners agreed with the identified disparate populations, many believed that the immigrant populations should be addressed as well. They felt this group should be a high priority due to New York City's large immigrant population and its high smoking rates.

> The only one I would add [is the immigrant population], because New York City is part of the geography of New York State, and New York City has the largest immigrant population. And immigrants, third world countries, have huge smoking issues.

Many also felt that Native Americans needed to be a priority due to their high tobacco use rates. They had not been a focus in the past because of the complexities of working with the sovereign nations.

> On the Indian reservations within New York State you can sell and purchase tobacco products without the state tax and Native Americans have one of the highest rates of tobacco dependence. And I know that they're sovereign nations and the state really doesn't have control over them.

Other populations of interest among partners were:

- Ethnic minorities in urban areas (African Americans, Hispanics/Latinos, and Asians)
- Youth/college students
- Sexual minorities
- People that abuse other substances

Identified Strategies

Partners identified the following strategies being implemented in New York to address disparate populations:

Medicaid beneficiaries

- Funding is set aside for pharmacotherapy (*e.g.* nicotine replacement therapy), but not for cessation services yet.
- The Quitline is marketed to Medicaid clients, which provides telephone counseling.

Persons with mental illness

- In the Western region of the state, mental and substance abuse institutes have tobacco-free policies and offer cessation programs.
- Conducted trainings for mental health staff to understand the mental addiction to tobacco and the interaction of tobacco and prescription medications.
- Four agencies have been funded to provide cessation services to local mentally ill populations.

Rural, low income, non-Hispanic whites

- The DOH TCP funds two agencies to provide cessation services.
- Funded community activities in rural upstate New York are also able to target this population.

General Concerns about Addressing Disparate Populations

Some partners felt the need for more guidance in defining disparate populations because disparity is sometimes confused with minority status or diversity.

> This is something where CDC leadership has really been lacking. The whole disparities initiative under Clinton was well intentioned, but there really was very little guidance in terms of what we mean by disparity. It instantly got mucked up with race, ethnicity and minority status.

Disparate Populations & Best Practices

Most partners felt that the BP was not useful in addressing disparate populations. They would like to see the following improvements made to the guidelines:

- Include operational definitions to provide guidance for defining disparate populations.
- Describe effective culturally specific intervention strategies.
- Emphasize that states need a funding line dedicated to disparate population identification and activities.

Suggested Approaches

1. Solicit direct input from the identified populations for planning and implementing tobacco control activities.
2. Identify strategies that can specifically address rural, low-income whites and increase access to cessation programs for rural areas of the state.

Program Strengths & Challenges

At the end of each interview, partners were asked to identify the biggest strength and weakness of New York's tobacco control program. Below is a list of the strengths of New York's program and the challenges facing it.

- Partners felt that the experience and leadership of the DOH TCP Director was a major strength of the program.

> I think the biggest strength of the program is the current director, Dr. Ursula Bauer. She's very, very highly qualified, has already identified the major deficiencies in the current program structure, and I think given the opportunity, she could create a state-of-the-art program in New York.

- The agencies and organizations working on policy issues around the state, specifically clean indoor air legislation, was also identified as a strength.

> The biggest strength is our effective implementation of the policy change strategy.

- Several partners felt that funding was insufficient since it did not reach the CDC minimum recommendation, resulting in a lack of financial investment in particular programs (*e.g.* cessation). Partners were also concerned about the present and future program funding due to city and state budget deficits.

> The chances of getting more dollars in the city or state for tobacco control is very, very slim. I think the risk is dollars being taken away. I think that is without question the biggest single problem facing the program.

- Partners felt DOH's highly politicized nature, due to the Pataki administration's influence on the department, was challenging. In addition, the DOH's slow approval and grant processes were seen as barriers.

> I think within the Health Department there isn't a lot of support for the [tobacco control] program. It certainly could be improved and I think that the program is situated where it has to go through many steps sometimes to get to the decision makers.

- Little support from policymakers and the influence of the tobacco industry and its allies also made implementing a comprehensive program challenging.

> …political resistance in both the state and city legislatures and organized opposition from vested interests, including the tobacco industry, their front groups, and small business organizations [were barriers].

Partners also identified the following major changes or events that were likely to have a strong influence on the future of tobacco control in New York:

- The passage of clean indoor air legislation in New York City and other localities would be a positive influence on tobacco control.

> I would say the passage of the clean indoor air law in New York City definitely will affect the perception of a local clean indoor air law statewide and in many other counties across the state.

- The state budget crisis and threat of securitization could negatively impact tobacco control funding.

> The state budget is really going to make it or break it. So we've experienced quite a few years of very good spending going after this issue [tobacco control]. That funding may disappear or that resource may disappear. I don't know. So, that's really going to be the biggest.

Resources

The following is a short list of available tobacco control resources identified by the partners and the project team:

National tobacco control organizations

American Cancer Society	www.cancer.org
American Heart Association	www.americanheart.org
American Legacy Foundation	www.americanlegacy.org
American Lung Association	www.lungusa.org
Americans' for Nonsmokers' Rights	www.no-smoke.org
Campaign for Tobacco-Free Kids	www.tobaccofreekids.org
The Centers for Disease Control & Prevention	www.cdc.gov/tobacco/
The National Cancer Institute	www.tobaccocontrol.cancer.gov
The Robert Wood Johnson Foundation	www.rwjf.org

Other suggested resources

- Tobacco Technical Assistance Consortium (TTAC) www.ttac.org
- The CDC Guidelines for School Health Programs to Prevent Tobacco Use and Addiction www.cdc.gov/tobacco/edumat.htm
- The CDC National Tobacco Control Program State Exchange www.cdc.gov/tobacco/ntcp_exchange/index.htm
- The CDC Media Campaign Resource Center www.cdc.gov/tobacco/mcrc/index.htm
- The CDC Guide to Community Preventive Services for Tobacco Use Prevention and Control www.thecommunityguide.org
- Cancer Control PLANET cancercontrolplanet.cancer.gov/index.html

In addition to the evaluation data presented in this Profile, supplemental data were obtained from the following sources:

- CDC Best Practices www.cdc.gov/tobacco/bestprac.htm
- Campaign for Tobacco Free Kids Cigarette Excise Tax Rates www.tobaccofreekids.org/research/factsheets/
- NCI State Cancer Legislative Database www.scld-nci.net
- New York Health Care Reform Act of 2000 www.health.state.ny.us/nysdoh/hcra/hcrahome.htm
- Show Us the Money: A Report on the States' Allocation of the Tobacco Settlement Dollars, Jan. 2003 www.tobaccofreekids.org/reports/settlements/
- New York State Department of Health Tobacco Control Program www.health.state.ny.us/nysdoh/smoking/main.htm

New York regularly shares information with...

The Prevention Research Center (PRC) at Saint Louis University is one of 28 national Prevention Research Centers funded by the Centers for Disease Control and Prevention. The mission of the PRC is to prevent death and disability from chronic diseases, particularly heart disease, cancer, stroke, and diabetes by conducting applied research to promote healthy lifestyles.