

2016 Independent Evaluation Report of the New York Tobacco Control Program

Prepared for

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Executive Summary

Tobacco use remains the leading cause of preventable death in New York State. To address this, the New York Tobacco Control Program (NY TCP) implements evidence-based tobacco control interventions. **The program's approach centers on a structured, integrated framework with three main components: health communication, health systems change, and community and statewide interventions. The program's objectives focus on reducing tobacco use prevalence, with the intent of reducing tobacco-related morbidity and mortality and alleviating the social and economic burdens caused by tobacco use.**

New York's program is based on behavior change theory and evidence and is aligned with the Centers for Disease Control and Prevention's (CDC's) (2014) *Best Practices for Comprehensive Tobacco Control Programs*. New York has already achieved multiple tobacco control successes, and the program has developed objectives to make further progress. New York has a stable tobacco control program, and the state has implemented a comprehensive clean indoor air law and high prices for tobacco products. NY TCP has shifted its emphasis in recent years to CDC-recommended policy education efforts, such as reducing tobacco advertising and promotion at the retail point of sale and implementing smoke-free multi-unit housing and outdoor public area policies.

Youth and adult smoking prevalence have decreased significantly since NY TCP was funded. However, decreases in tobacco use prevalence have slowed, and discrepancies persist. New Yorkers with poor mental health and those with low income smoke at higher rates than those with good mental health or higher income. The program is tailoring efforts to reach and support these groups.

However, NY TCP funding is 19% of the CDC-recommended level. **The country as a whole is catching up with New York's** early success, and improvements in many key measures have stalled. Increased funding would facilitate additional efforts that **would improve the program's chances of continuing to be a** leader in tobacco control and general health outcomes.

Key Evaluation Findings

- In 2015, adult smoking prevalence was 15.2%, down 28% from 2009.
- In 2015, the prevalence of smoking was higher among adults with poor mental health (28.1%) than among adults with good mental health (13.5%). Adult smoking prevalence was also higher for those with less education or less income.
- Cigarette smoking among young adults aged 18 to 24 decreased 39% from 2009 to 2015, with 14.0% of young adults reporting current smoking in 2015.
- Average daily cigarette consumption among New York current smokers has not changed since 2008 and was 10.5 cigarettes per day in 2015.
- The prevalence of smokers making a quit attempt in the past year increased by approximately 43% from 2003 to 2015. In 2015, 66.1% of smokers made a quit attempt in the past year.
- In 2015, 6.5% of adults in New York used electronic cigarettes (e-cigarettes), similar to the rest of the United States; 3.5% of New York adults were current smokers and e-cigarette users.
- From 2000 to 2014, the prevalence of smoking decreased 56% among high school students in New York, compared with a 45% decline nationally.
- In 2014, 19.5% of high school students reported current use of any tobacco product, down from 33.6% in 2000. In 2014, e-cigarettes were the most commonly used tobacco product among high schoolers.

Measures of NY TCP Reach and Impact

- Local housing authorities have surpassed the New York State Department of Health (NYSDOH) Prevention Agenda objective (increasing smoke-free policies from 3 multi-unit housing facilities to 35, nearly triple the target of 12 by 2018).
- In 2015, 53.0% of New York adult smokers were aware of NY TCP television advertisements, an increase of 36% over the previous year.
- Awareness of the Quitline among smokers in New York remains close to 80%, significantly higher than in the rest of the United States.

- Quitline and Quitsite registrations have been stable in recent years, and New York Quitline reach was 3.8% in 2015, higher than the national average.
- From 2003 to 2015, the percentage of smokers reporting that their health care provider assisted them with a quit attempt increased. In 2015, 50.8% of smokers in New York reported that their provider assisted them compared with 42.2% of smokers in the rest of the United States.

Overall Programmatic Recommendations

- Increase NY TCP funding to a minimum of one-half of **CDC's recommended funding level for the state** (\$203 million) to \$101.5 million.
 - This significant increase would require careful shifts in staffing, contractor allotments, and media, and would help the program implement CDC best practice recommendations. NY TCP could increase funds for statewide and community intervention contractor efforts, health systems contractor activities, and professional development. Health communication interventions could be expanded to reach more specific and hard-to-reach target populations. The program could increase its staffing and communications capacity and expand its surveillance and evaluation activities to assess **the program's impact more comprehensively**.
- Continue to develop and target interventions to reach smokers with disproportionately high rates of smoking, especially adults with low income and poor mental health.
- Update the NYSDOH Prevention Agenda objectives to reflect program successes, and add an objective regarding adult e-cigarette use prevalence.

Introduction

The New York Tobacco Control Program's (NY TCP's) goal is to reduce tobacco-related morbidity and mortality and alleviate the social and economic burdens caused by tobacco use. NY TCP's multifaceted approach is consistent with the Centers for Disease Control and Prevention's (CDC's) *Best Practices for Comprehensive Tobacco Control Programs* (CDC, 2014). The three key components of the program's approach are health communication; health systems interventions; and statewide and community action targeting policy, systems, and environmental changes.

In this report, we highlight contextual influences relevant to NY TCP's progress, describe NY TCP's approach to tobacco control, and assess trends in key outcome indicators. We focus primarily on activities and outcomes for 2015. We address the following evaluation questions for NY TCP in this report, focusing on core tobacco control measures:

- How have key outcome indicators changed over time?
- How do these indicators compare between New York and the United States?

We also address questions specific to unique tobacco control issues and studies:

- What trends are there in tobacco advertising and promotions in New York retail stores?
- To what extent are community contractor activities associated with policy-maker support for tobacco control policies?
- To what extent are quit attempts associated with awareness of media campaigns?
- Are dentists in New York providing guideline-concordant clinical intervention and are they aware of the Medicaid benefit for smoking cessation counseling?

Addressing these evaluation questions will illustrate progress made in key outcome indicators, highlight gaps that need to be addressed moving forward, and explore tobacco control issues in greater detail.

The New York Tobacco Control Program – Context and Programmatic Approach

In this section, we describe the tobacco control context in New York State and present an overview of NY TCP’s current approach to tobacco control.

Tobacco Control Policy Environment

New York has the highest state-level cigarette excise tax in the country. At \$4.35, the New York cigarette excise tax is significantly more than twice the national average for state tax per pack (\$1.61). All New Yorkers are covered by a comprehensive smoke-free air law (workplaces, restaurants, and bars), compared with 48% of the population nationally. In fiscal year (FY) 2015, per capita funding for tobacco control was higher in New York (\$2.11) than the average of all other states (\$1.68) (Table 1), but the difference between these estimates is shrinking. At its peak in 2007, **the state’s per capita funding** was \$5.21, compared with \$2.40 in all other states.

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

Indicator	New York	U.S. Average
State cigarette excise tax (January 1, 2016)	\$4.35	\$1.61
Percentage of the state population covered by comprehensive ^a smoke-free air laws (December 31, 2014)	100%	48%
Annual per capita funding for tobacco control (FY 2015)	\$2.11	\$1.68 (excluding New York)

^a “Comprehensive” refers to laws that create smoke-free workplaces, restaurants, and bars.

Program Budget

The 2016–2017 NY TCP budget is \$39.3 million, similar to recent years. This tobacco control budget represents 19% of **CDC’s recommended funding level for New York (\$203 million) and 27.5% of CDC’s recommended minimum level (\$142.8 million)**. The **state’s** current funding represents less than 2% of annual cigarette tax and Master Settlement Agreement (MSA) payments. In FY 2016, New York State received approximately \$2.68 billion in cigarette tax revenue and MSA payments (Table 2). **New York’s** FY 2016 MSA payment is nearly double **the previous year’s payment**. In late 2015, New York’s attorney

general negotiated a settlement with tobacco companies that requires a one-time payment of \$550 million in funds withheld from prior years to be released. This legal victory settles past issues and provides safeguards for future payments. Half of the released funds will go to the state and will be used to pay debt services; the other half will be split between New York City and counties around the city.

Table 2. Annual New York State Tobacco Tax Revenue, Master Settlement Agreement Payments, and Spending on Tobacco Promotions and Tobacco Control

Revenue/Expenditure Category	Annual Revenue/Expenditure
Revenue from state cigarette excise taxes (FY 2016)	\$1,302,100,000
Revenue from MSA payments (FY 2016)	\$1,380,700,000
Estimated cigarette advertising and promotions in New York State (FY 2014) by five major cigarette manufacturers	\$209,259,578
National advertising for e-cigarettes (CY 2015)	\$37,800,000
New York Tobacco Control Program budget (FY 2016–2017)	\$39,330,600

Note: CY = calendar year; FY = fiscal year; MSA = Master Settlement Agreement.

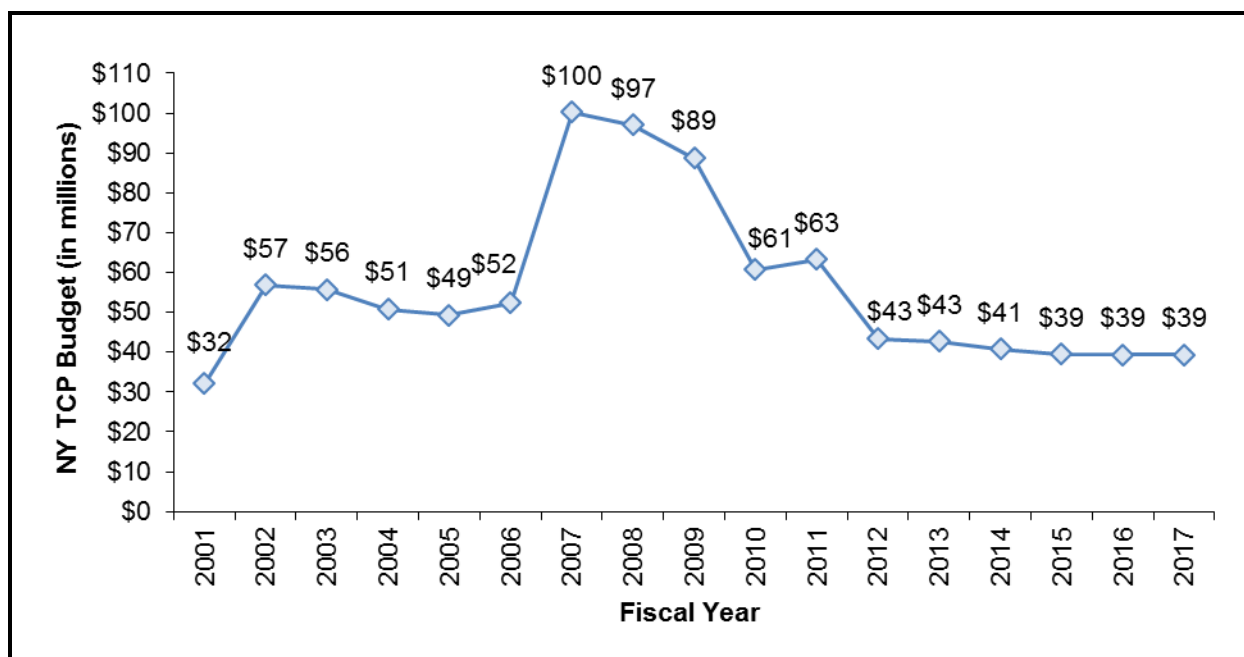
The state’s budget for tobacco control is significantly less than the amount spent on tobacco advertising and promotion. Tobacco companies spent \$8.95 billion nationally on cigarette advertising and promotions in 2013 (Federal Trade Commission, 2016). If these expenditures are spent in proportion to cigarette sales, this translates to \$209 million spent on advertising and promotions overall in New York State. Of this, an estimated \$179 million (85%) was spent on price reductions and retail-value-added bonus cigarettes (e.g., buy two packs, get one free).

Advertising and promotion of e-cigarettes may also pose challenges for NY TCP, given the potential for youth to initiate e-cigarette use and become addicted to nicotine. A recent experimental study shows that exposure to e-cigarette advertising is associated with increased intentions to use e-cigarettes in the future among youth (Farrelly et al., 2015). Although the 2016 release of the Food and Drug **Administration’s (FDA’s)** deeming regulation brings e-cigarettes and other products under FDA regulation, e-cigarettes are not subject to the same advertising restrictions as cigarettes. In 2015, nearly \$38 million was spent on advertising for e-cigarettes in the United States. This estimate includes

e-cigarette advertising via magazines, television, Internet (display and online videos), radio, newspapers, and outdoor media. Nationally, e-cigarette advertising decreased from \$115.9 million in 2014 to \$37.8 million in 2015, largely driven by the decrease in magazine advertising for e-cigarettes (which decreased from \$84.8 million in 2014 to \$15.7 million in 2015).

NY TCP’s approved budget of \$39.3 million for FY 2016–2017 is similar to the previous five FY budgets (Figure 1). The longer-term pattern of NY TCP funding provides context for interpreting the trends in key outcome indicators presented below.

Figure 1. NY TCP Funding FY 2000–2001 to FY 2016–2017



Note: NY TCP = New York Tobacco Control Program; FY 2001–FY 2016 NY TCP budget estimates were adjusted for inflation (base year = FY 2016 dollars).

Table 3 shows the budget for FY 2015–2016 and FY 2016–2017 by program component. Funding for state and community interventions, enforcement, and administration remained largely unchanged in FY 2016–2017 from the previous year. NY TCP increased the budget for nicotine replacement therapy (NRT) provided through the Quitline, health communications, and surveillance and evaluation. These increases were offset by reductions in funding for the Quitline.

Table 3. NY TCP Budget for FY 2015–2016 and FY 2016–2017

Program Component	2015–2016 Expenditure Plan	2016–2017 Expenditure Plan
State and Community Interventions	\$10,394,750	\$10,395,959
Advancing Tobacco-Free Communities	\$9,394,000	\$9,394,000
Center for Public Health and Tobacco Policy	\$500,750	\$501,959
Training/Professional development	\$500,000	\$500,000
Enforcement		
Clean Indoor Air Act and Adolescent Tobacco Use Prevention Act Enforcement	\$4,724,950	\$4,724,950
Health Systems Interventions	\$8,524,770	\$7,604,493
Health Systems for a Tobacco-Free New York	\$3,274,770	\$3,274,770
Quitline	\$4,500,000	\$3,329,723
Nicotine replacement therapy	\$750,000	\$1,000,000
Health Communication Interventions		
Media placement	\$8,760,203	\$9,653,420
Surveillance and Evaluation		
Independent evaluation	\$2,988,927	\$3,014,778
Administration		
Tobacco control and cancer services	\$3,937,000	\$3,937,000
Total	\$39,330,600	\$39,330,600

Although overall NY TCP funding is much lower than the CDC recommended level of \$203 million (CDC, 2014), allocations by program component are relatively similar to CDC recommendations. NY TCP allocates 38% of its funding to state and community interventions, and CDC recommends 30%. **NY TCP’s health communication budget is 25%, very close to the CDC recommended 23%.** Health systems interventions in New York receive 19% of the program budget, compared with 34% by CDC recommendations. The allocation for surveillance and evaluation is 8%, and CDC recommends 9%. Although **New York’s** allocation for administration is higher (10%) than CDC recommendations (4%), this apparent discrepancy is supported by CDC Best Practice budget recommendations; CDC encourages programs to fund their administration, management, and infrastructure activities at the recommended **dollar amount, even if the program’s actual funding is below the CDC-recommended level** (CDC, 2014).

Programmatic Approach

NY TCP's **programmatic approach is built on behavior change** theory and evidence of what works in tobacco control. The **program's** approach is based on the social norm change model, aiming to reduce tobacco use by creating a social environment and legal climate in which tobacco use becomes less desirable, less acceptable, and less accessible (CDC, 2014; Frieden, 2010; NCI, 1991; USDHHS, 2000). To create these contextual **changes, NY TCP's core goals** focus on preventing the initiation of tobacco use by youth and young adults, promoting tobacco cessation by focusing on changes at the health care organization level, and eliminating exposure to secondhand smoke. Specific objectives in the New York State Department of Health's (NYSDOH's) Prevention Agenda include decreasing smoking prevalence among adults to 12.3% by the end of 2018 and reducing the rate of any tobacco use (i.e., cigarettes, cigars, and smokeless tobacco) to 15.0% among high school students.

NY TCP uses a multicomponent approach to reducing tobacco use and thereby decreasing the health, social, and economic burden of tobacco use in the state. The program manages an infrastructure with significant capacity, implements mass-reach health communication interventions, effects health systems change to support cessation, and conducts state and community interventions that engage a range of contractors and partners. In the following sections, we describe NY TCP's central programmatic activities in more detail.

Administration and Support

Consistent with CDC Best Practices, NY TCP maintains a well-connected infrastructure to support its programmatic activities. NY TCP's **multilevel** leadership approach emphasizes strategic **implementation of the program's initiatives**. The program provides professional development for staff and contractors and coordinates surveillance and evaluation activities. NY TCP administration guides the overall programmatic strategy and coordinates effective communication across program staff, **contractors, and partners**. New York's tobacco control infrastructure integrates technical assistance and guidance to manage the effective and efficient investment of state tobacco control funding. To ensure that policy goals are met, NY TCP

revisits its strategic approach, stays aware of proximal and distal influences on tobacco control policy, and maintains strong accountability and reporting procedures. State and community-level activities and program initiatives are supported by development and dissemination of key messages that are communicated by community contractors and via earned and paid media.

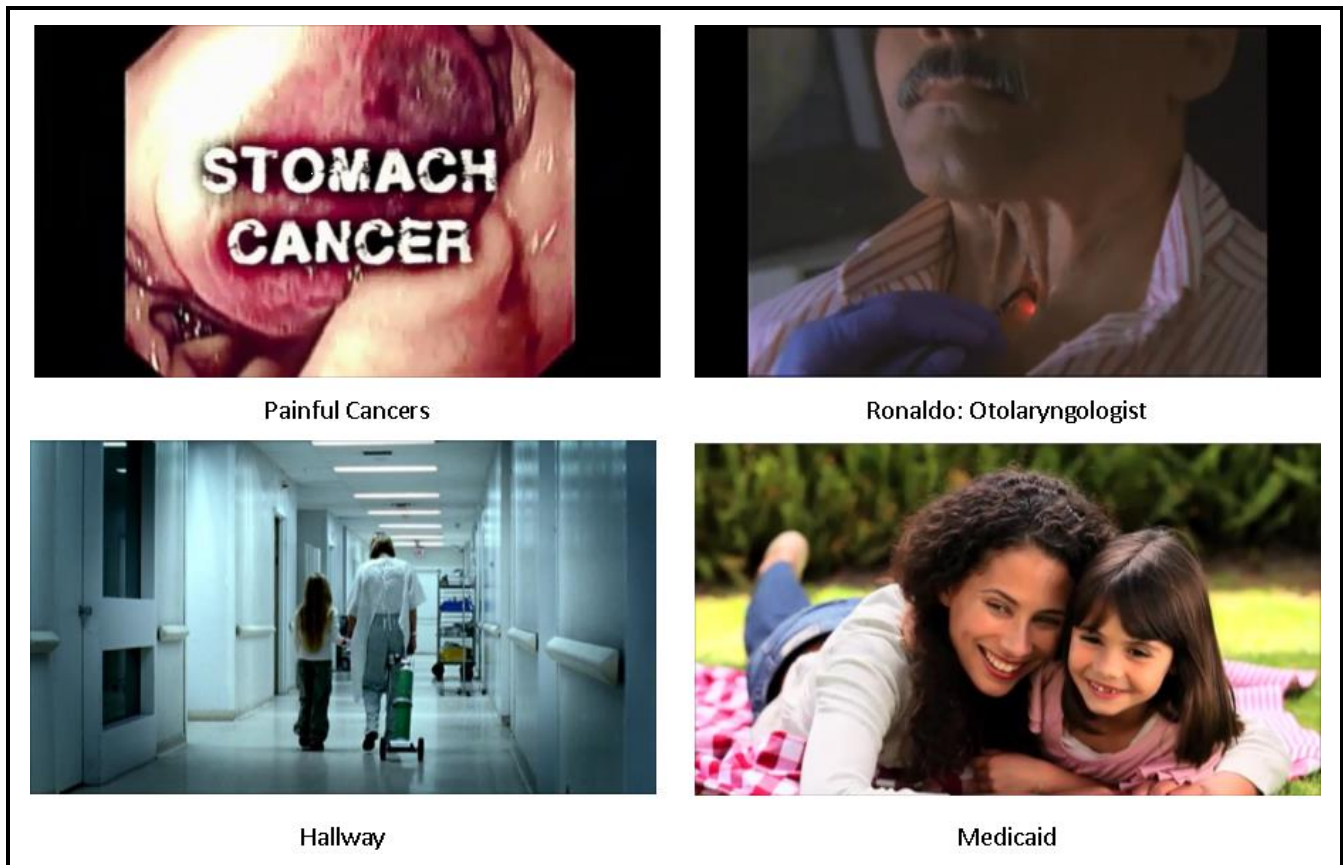
Health Communication

NY TCP uses health communication strategies to motivate tobacco users to stop using tobacco, deglamorize tobacco use, and educate community members and decision makers about tobacco control issues. Antismoking campaigns are effective in reducing cigarette smoking among youth (USDHHS, 2012) and adults (Davis et al., 2015; Farrelly et al., 2012; Bookmark not defined.; NCI, 2008; Wakefield et al., 2010, 2011). NY TCP focuses paid media efforts on promoting smoking cessation, with an emphasis on television advertisements that graphically depict the health consequences of smoking and/or elicit strong negative emotions, as these types of ads have been found to be effective in promoting smoking cessation (Farrelly et al., 2012; McAfee et al., 2013). Nearly all messages include the New York State Smokers' Quitline telephone number and Web site address. Early in 2015, NY TCP changed the text at the end of its **ads from "Call the Quitline" to "You can quit smoking. Call your doctor today. For more help, call the Quitline."** This slight shift offers encouragement and an additional call to action. In addition, NY TCP was awarded CDC funding in 2015 for a health care provider-targeted media campaign. This campaign encourages providers to help patients quit with evidence-based methods and complements health systems efforts and existing health communication campaigns encouraging smokers to quit.

During 2015, NY TCP used message strategies that have been successful in the past several years, with campaigns that primarily focus on promoting cessation (Figure 2 shows sample ad images). Early in the year, ads depicted the effects of smoking-related illness to motivate smokers to quit. In **particular, the "Painful Cancer" ad series focuses** on graphic images associated with stomach cancer, pancreatic cancer, and esophageal cancer, and on the painful and invasive treatments

for these diseases. These ads were followed by NY TCP ads featuring the testimonial of Ronaldo, who highlights the challenges he faces living life with a tracheostoma and electrolarynx due to throat cancer caused by smoking.

Figure 2. Sample Ad Images



Spring 2015 also included ads featuring an emotional appeal that emphasizes the effects of tobacco use and related illnesses on tobacco **users and their families**. **"Hallway"** shows a woman walking through a hospital hallway with her oxygen tank as her young daughter walks beside her. A narrator explains that **Emily, who is 7, knows the real cost of tobacco because, "last year, smoking cost Emily her mom."** Another ad, **"Last Dance,"** depicts a wife dancing with her dying husband in their living room while their child looks on.

In 2015, NY TCP aired an ad targeting Medicaid recipients. This ad focuses on the benefits of cessation and reminds Medicaid-enrolled New Yorkers that their Medicaid benefits cover

medications to help them quit. The ad shows a mother and daughter and uses an encouraging tone to motivate smokers to quit.

NY TCP continued to air ads from CDC's *Tips From Former Smokers (Tips)* tobacco education campaign. "**Amanda**" discusses her experience having a baby that was premature because of her smoking. "**Suzy**" features a 62-year-old former smoker who suffered a stroke and now relies on her son for even the most basic tasks. Ads from the "**Terrie**" series feature a woman who has a tracheostoma as a result of treatment for oral and throat cancer. In "**Terrie's Voice**," she offers a tip to smokers to "**read a children's storybook or sing a lullaby**" before they lose their voice.

In 2016, NY TCP plans to continue airing ads that graphically depict the effects of smoking-related illness. "**16 Cancers**" discusses many of the types of cancers that can be attributed to smoking, and "**Symptoms**" focuses on the impact of smoking-related emphysema. "**Breathless**" encourages smokers by acknowledging that quitting can be difficult, but is worthwhile: "A little suffering now can save a lot of suffering later." These messages will again be complemented by ads from CDC's *Tips* campaign.

Health Systems Interventions

NY TCP's health systems interventions involve an evidence-based multistrategy approach to promote cessation by institutionalizing changes in health systems, offering telephone-based smoking cessation counseling, and reducing the cost of tobacco dependence treatments for patients. Health systems change approaches include updating health care organizations' policies and systems to ensure that patients are asked about tobacco use and provided assistance with quitting, facilitating changes in the health care setting that promote treatment of tobacco dependence, and promoting Medicaid benefits for smoking cessation. The New York State Smokers' Quitline offers tobacco cessation counseling, provides access to NRT for eligible individuals, and serves as an information clearinghouse regarding cessation. The following sections describe NY TCP health systems interventions in more detail, summarizing health systems contractor interventions, the New York State Smokers' Quitline, and reduced patient costs for treatment.

Health Systems Contractor Interventions

For more than a decade, NY TCP's health systems change intervention activities have focused on funding contractors to increase the number of medical and mental health care 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. Brief advice to quit smoking by a health care provider significantly increases the odds that a smoker will quit, and NY TCP's approach is aligned with CDC Best Practices and other evidence-based recommendations. NY TCP funds 1 statewide Center of Excellence and 10 regional health systems contracts. The statewide Center of Excellence works at the state level to foster a climate that encourages health care organizations to institutionalize guideline-concordant policies and systems, and the Center of Excellence has a role in supporting the regional contractors. The regional contractors assist health care organizations throughout New York State in making changes to improve provider tobacco cessation intervention, establish regular provider training, facilitate system improvement, and provide technical assistance.

When they began their efforts in 2004, contractors targeted hospitals and then later shifted their emphasis to medical practices, where the majority of smokers report getting regular care. Consistent with RTI recommendations, NY TCP instructed the contractors to focus on organizations that serve higher proportions of tobacco users. Specifically, NY TCP redirected the focus of this initiative from medical practices to organizations that serve groups with higher rates of smoking. This primarily involves targeting community health centers (CHCs), which serve underserved populations, including those with low income, and programs that serve individuals with severe mental illness. Because populations with low income and populations with mental illness use tobacco at higher rates than the general population, working with CHCs and mental health facilities provides a significant opportunity for health systems contractors to target their efforts to organizations where smokers receive care. Regional health systems contractors provide these organizations with guidance and strategic assistance on systems-level changes that support the assessment and treatment of tobacco dependence.

In addition to supporting the regional contractors, the Center of Excellence contractor convenes the Statewide Stakeholder Workgroup, which brings together representatives from key organizations in the state to influence policy and respond to emerging opportunities, such as promoting tobacco cessation Medicaid benefit coverage and utilization and creating and disseminating standard tobacco-related templates for electronic health records (EHRs) for health care organizations to use. This approach facilitates changes in health care systems and the state-level context in which they operate.

In 2015, RTI conducted a study to assess the presence of systems-level policies and practices that support the institutionalization of provider intervention and document the extent to which regional contractors were reaching CHCs. Statewide, regional contractors are actively working with 45% of the 61 CHCs in New York State to implement health systems changes, and they are building relationships with additional CHCs.

Many CHCs have existing tobacco-related systems in place and a strong infrastructure on which to expand these systems. As a funding requirement, CHCs must report to the federal Health Resources and Services Administration a number of quality measures, including the percentage of their patients who are asked about tobacco use and advised to quit. There is still room for improvement in tobacco-related policies, fields in EHRs to document tobacco use status and counseling, and required training for providers about cessation methods. CHC staff reports regarding cessation intervention training and feedback processes for cessation intervention and documentation are more often accurate in CHCs that are partnering with an NY TCP-funded contractor.

The Center of Excellence contractor supports the regional contractors and leverages statewide organizations to create an environment supportive of cessation-focused health systems change. One of the Center of Excellence's **key activities at the** state level is to convene the Statewide Stakeholder Workgroup, which brings together representatives from key organizations in the state to influence policy and leverage resources to support implementation of tobacco assessment and treatment in health systems. In collaboration with NY TCP, the Center of Excellence invited representatives from key organizations across the state

to meet quarterly for strategic planning efforts regarding health systems-related policy and activities. These activities include facilitating conversations among key stakeholders regarding tobacco cessation Medicaid benefit coverage and utilization, working to create and disseminate standard tobacco-related templates for EHRs, and actively engaging key stakeholders regarding statewide health care delivery service redesign projects to facilitate inclusion of tobacco cessation measures into those projects.

New York State Smokers' Quitline

The **New York State Smokers' Quitline provides individualized** telephone counseling to adult smokers who want to quit. In addition, the Quitline offers free 2-week NRT starter kits to eligible clients by phone or Internet, prerecorded telephone messages covering a range of topics related to quitting, and an interactive Quitsite Web site. For health care providers, the Quitline offers a program to facilitate automatic patient referrals and provides free cessation continuing medical education programs. 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) facilitating 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 cessation resource. NY TCP has expanded the **Quitline's role to promote health systems change by** referring smokers to health care providers, reporting back to health care providers who refer to the Quitline, and informing callers about cessation-related insurance benefits.

During 2015, the Quitline reported receiving 115,515 incoming calls, and 41,327 unique Quitline callers received counseling and/or free NRT. The Quitline website received 1,367,068 visits in 2015, and 24,322 individuals registered for Quitline services online. Health care providers directly referred 11,960 patients to the Quitline in 2015. Compared with 2014, Quitline incoming calls and registrations by phone decreased in 2015. Visits to the Quitline website increased from 2014 to 2015, although the number of website registrations decreased. Provider referrals increased by 42% from 2014 to 2015. The decreases in Quitline

calls and in registrations by phone and online from 2014 to 2015 were **not unique to New York**. Data from CDC's National Quitline Data Warehouse show consistent declines in these measures across states from 2014 to 2015. The overall reach of **New York's Quitline, or the percentage of** adult smokers who received counseling and/or NRT, decreased from 2014 to 2015. However, **New York Quitline's annual reach** of 2.43% in 2015 was still 2.4 times higher than the average state reach of 1.00%, and New York ranked fourth in quitline reach out of the 45 states reporting quitline data to CDC.

Reduced Patient Costs for Treatment

NY TCP has worked with the New York State Medicaid program to expand coverage for smoking cessation counseling and pharmacotherapy. Since January 1, 2014, the Affordable Care Act requires all Medicaid programs to cover all tobacco cessation medications. However, all states have not yet fully implemented this requirement (Singleterry et al., 2015). New York's fee-for-service (FFS) Medicaid covers all first-line, FDA-approved medications except nicotine lozenges, and all New York Medicaid Managed Care (MMC) plans cover at least the nicotine patch and gum, bupropion (Zyban®), and varenicline (Chantix®); some plans also cover the nasal spray, inhaler, and lozenge. Two 3-month courses of medication are covered per year, including combination therapy (e.g., patch and gum). Medicaid also reimburses for up to eight counseling sessions annually for all Medicaid beneficiaries, expanded from previously covering counseling for adolescents and pregnant and postpartum smokers only. In October 2015, NYC Medicaid benefits expanded to offer unlimited trials of all several FDA-approved medications and smoking cessation counseling to those with behavioral health diagnoses, who have higher rates of tobacco use. NY TCP and the statewide Center of Excellence contractor encourage health plans to expand coverage and promote cessation services to their members.

New York State continues to expand enrollment in MMC; in FY 2013–2014, 75.9% of Medicaid recipients were enrolled in MMC plans, whereas 24.2% were enrolled in Medicaid FFS. New York State plans to expand the percentage of recipients enrolled in MMC plans to 95% within the next few years (DiNapoli, 2015). NY TCP and its health systems Center of Excellence contractor are supporting MMC plans and groups of providers in their

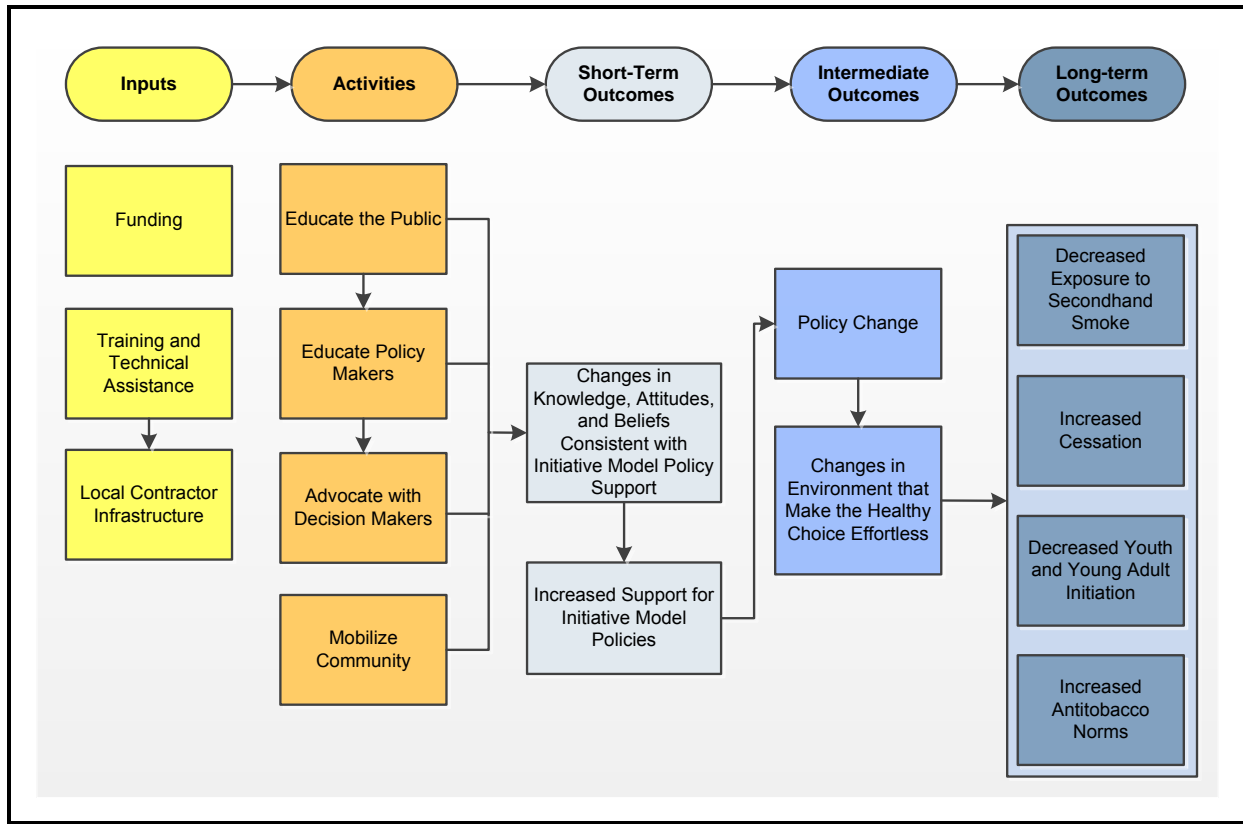
systems change efforts focused on increased smoking cessation treatment, including use of the Medicaid benefits for cessation medication and counseling. In 2014, New York expanded counseling to include dentists and dental hygienists. New York **State's Delivery System Reform Incentive Payment (DSRIP)** program charges provider groups with carrying out performance improvement projects with the goal of reducing unnecessary hospital visits. NY TCP has conducted presentations to MMC plans and has partnered with DSRIP stakeholders to establish NY TCP health systems contractors as resources to help with cessation projects.

Statewide and Community Action

With tobacco control policies in place at the state level, including smoke-free public places and the highest cigarette excise tax in the nation, NY TCP's community interventions focus on policies at the local level with the potential to prevent youth tobacco use initiation and promote cessation. The policy areas targeted and strategies implemented are recommended by CDC (2014) and considered essential to the continued declines in tobacco use (Institute of Medicine, 2007). NY TCP currently funds 25 Advancing Tobacco-Free Communities (ATFC) contractors to conduct these tobacco control activities at the local level. ATFC contractors educate the public and local leaders about the burden of tobacco use and possible policy solutions. ATFC contractors prioritize policy change that affects a significant proportion of the state's population, such as municipalities (i.e., villages, towns, cities, and counties) and large businesses (e.g., large housing complexes, real estate management companies) (Figure 3).

ATFC contractors focus their efforts on four initiatives: point of sale, tobacco-free outdoors, smoke-free multi-unit housing, and smoke-free media. Contractors promote these initiatives by conducting four types of strategies: community education, community mobilization, government policy-maker education, and advocacy with organizational decision makers. These strategies are supported by state and community paid media efforts.

Figure 3. Theory of Change for NY TCP Community Program



Each contractor organization is responsible for a geographically defined catchment area, ranging from a single borough in New York City (e.g., Queens) to three counties. The community program was restructured in 2014 to facilitate integration of adult-led and youth-led activities. Each organization funded as an ATFC contractor is required to have a Community Engagement coordinator and a Reality Check Youth Action (Reality Check) coordinator.

In fall 2015, RTI administered a web-based survey of ATFC contractors to examine the status of Community Engagement and Reality Check coordinator collaboration, youth engagement, and community mobilization subsequent to the community program reorganization. Findings suggest that co-locating Community Engagement and Reality Check coordinators facilitates collaboration between them and integration of youth into community tobacco control activities. In addition, the survey documented that the majority of contractors had implemented community mobilization efforts by

actively involving partner organizations in their tobacco control activities.

Across the four initiatives, collaboration between coordinators and involvement of youth in community activities were highest for the point of sale initiative. More than 90% of coordinators reported working with their youth or adult counterparts on the point of sale initiative, and nearly 80% of coordinators reported that youth were actively involved in point of sale initiative activities. In contrast, fewer coordinators collaborated on the smoke-free multi-unit housing initiative (66%). Challenges to youth involvement in this initiative included finding a meaningful role for youth **and potential exposure to “heated and passionate discussions” with landlords** or tenants. Contractors report that they integrate youth into community activities, beginning in the planning stage, when coordinators explicitly identify youth roles.

Coordinators reported that they have successfully mobilized partner organizations in their tobacco control activities. Almost all Community Engagement and Reality Check coordinators had identified at least one organization as a potential ally, and nearly 75% of coordinators named five organizations they had identified as allies. More than 80% of coordinators had already conducted activities with a partner organization, and half of them reported an ongoing relationship of several years.

In the remainder of this section, we briefly summarize the policy goals for each initiative and the level of contractor activity for each initiative from July 2015 through March 2016.

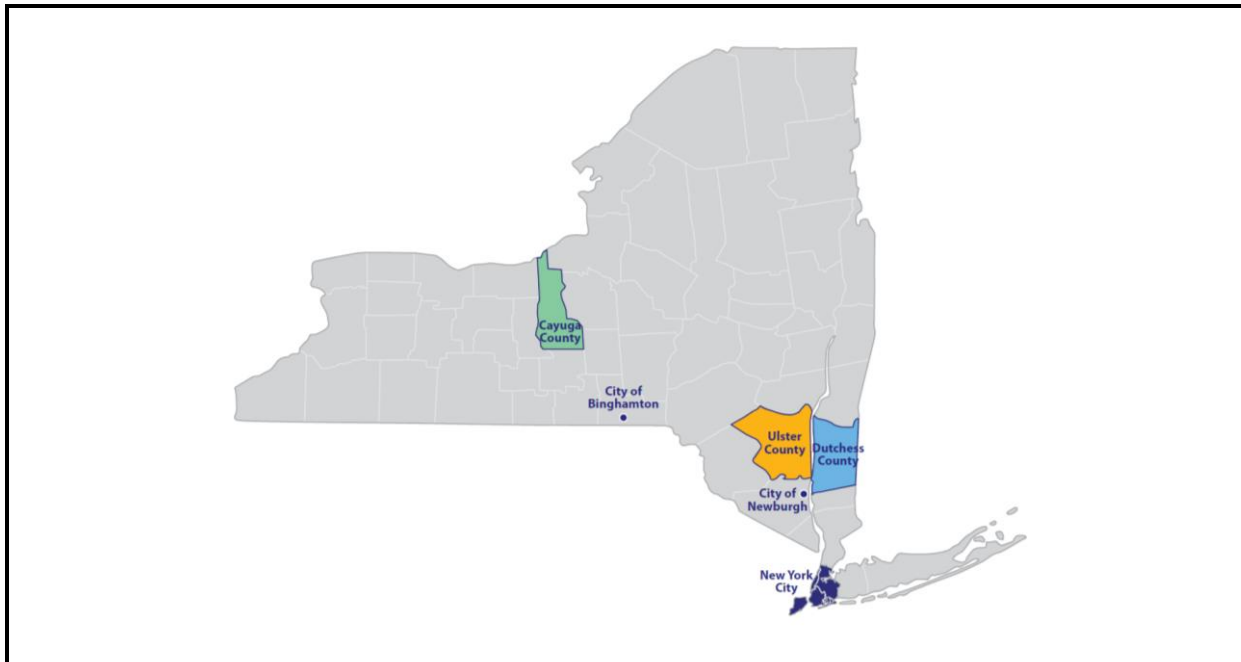
Point of Sale Initiative: The goal of the point of sale initiative is to reduce the impact of retail tobacco product marketing on youth. The point of sale initiative includes education about policies that prohibit the display of tobacco products in stores, limit the number of retailers that can sell tobacco products in a community, prohibit the sale of tobacco products in stores near schools, prohibit the sale of tobacco products in pharmacies, and prohibit retailers from redeeming coupons or offering special promotions, such as buy one, get one free offers. Contractors may also work with jurisdictions on efforts to raise the age for legal purchase of tobacco products from 18 to 21.

From July 2015 through March 2016, ATFC contractors reported more than 360 meetings to educate local policy makers about

the point of sale initiative. These policy makers included elected leaders of villages, townships, and New York City boroughs, as well as county officials, local boards of health, and state legislators. ATFC contractors also conducted 504 community education events related to point of sale.

The NYSDOH Prevention Agenda established a target of 10 point of sale policies by the end of 2018. In 2012, the Village of Haverstraw adopted a policy banning tobacco product displays; however, the policy was quickly rescinded in response to a lawsuit (Curry et al., 2014). New York City has a law that addresses a range of point of sale policy areas, including setting a minimum price for cigarettes and little cigars and prohibiting price promotions. Other jurisdictions have established local licensing or registration requirements for tobacco retailers, with some also prohibiting new retailers from locating near schools. A total of six jurisdictions in the state have implemented point of sale policies (Figure 4).

Figure 4. Map Highlighting Six New York Jurisdictions with Point of Sale Policies



Tobacco-Free Outdoors Initiative: The goal of the tobacco-free outdoors initiative is to reduce the social acceptability of tobacco use by decreasing the number of public places where it is allowed. The policy goals for this initiative include restrictions on smoking in outdoor public places, such as beaches, parks, and playgrounds, and policies prohibiting smoking on grounds or near entrances of community colleges, museums, and other businesses. From July 2015 through March 2016, ATFC contractors advocated with organizational decision makers and reported over 250 instances of educating about the issue and educating about policy solutions; they reported 70 instances of obtaining commitment for a tobacco-free outdoors policy. The targeted organizations included municipalities, small and large businesses, libraries, and 24 colleges and universities. During this period, contractors also reported 300 meetings with local policy makers about the tobacco-free outdoors initiative.

From July 2015 through March 2016, 10 municipalities adopted policies that prohibit smoking near building entryways, protecting more than 133,000 New Yorkers. A total of 19 municipalities adopted a policy that prohibits smoking at beaches, parks, and/or playgrounds, affecting nearly 150,000 residents. During this same time, 84 additional tobacco-free outdoors policies were adopted by 8 colleges and 72 other organizations, including small businesses, major employers, libraries, medical centers, churches, gyms, and malls (57 of these policies prohibited smoking on organization grounds, 5 at parks or other venues, and 45 in building entryways).

Smoke-Free Multi-Unit Housing Initiative: The goal of the smoke-free multi-unit housing initiative is to eliminate exposure to secondhand smoke by increasing the number of housing units where smoking is prohibited. Contractors advocate with building owners and managers for smoke-free policies in large housing complexes and are directed to prioritize those with at least 50 units. Smoke-free homes not only protect nonsmokers and children from secondhand smoke, they also have the potential to increase quit attempts among smokers (Pizacani et al., 2004). From July 2015 through March 2016, ATFC contractors reported over 250 instances of educating about the issue and policy solutions; they reported 101 instances of obtaining commitment for a smoke-free multi-unit housing policy. ATFC contractors met with 185 unique targets, including

individual landlords, management companies, and public housing authorities.

During this period, ATFC contractors reported that 54 apartment complexes or management companies adopted smoke-free multi-unit housing policies. As a result, 12,222 units are now smoke-free. The NYSDOH Prevention Agenda objective of increasing the number of local housing authorities with tobacco-free policy for all housing units from 3 (in 2012) to 12 by the end of 2018 has already been met. ATFC contractors have reported a total of 35 local housing authorities that require all units to be smoke-free, including housing authorities in Albany, Buffalo, Syracuse, Troy, and Yonkers.

Smoke-Free Media Initiative. The goal of the smoke-free media initiative is to reduce youth exposure to tobacco use imagery in movies and on the Internet. Youth members engage the support of influential community members, including media stakeholders, to advocate with the Motion Picture Association of America (MPAA) and Internet companies (e.g., YouTube) to remove tobacco imagery from media targeted at youth. Youth also reach out to individual media outlets (e.g., radio stations) and movie theaters, regional and national media providers (e.g., Comcast, Viacom, Disney Sony), and the MPAA. Between July 2015 and March 2016, ATFC contractors reported 137 instances of educating specific targets about the issue, and contractors conducted 284 community education events.

Key Evaluation Questions

This section addresses NY TCP progress from 2003 to 2015 for key outcome indicators for New York State and the remaining United States, when available. The key evaluation questions for this year include core tobacco control measures and special studies:

- How has NY TCP influenced trends in tobacco use from 2003 to 2015? Specifically, we examine trends in the following indicators:
 - Percentage of adults in New York and the United States who currently
 - smoke cigarettes,
 - smoke cigars,

- use smokeless tobacco, and
- use e-cigarettes
- Prevalence of smoking among New York adults who report annual income less than \$25,000 or poor mental health
- Average daily cigarette consumption among current adult smokers in New York and the rest of the United States
- Percentage of adult smokers who made a quit attempt in the past 12 months in New York and the rest of the United States
- Percentage of youth in New York and nationally who currently
 - smoke cigarettes,
 - smoke cigars,
 - use smokeless tobacco, and
 - use e-cigarettes
- Percentage of New York adult smokers who report provider cessation interventions
- We also address questions specific to unique tobacco control issues and studies:
 - What are trends in tobacco advertising and promotions in New York retail stores?
 - To what extent are community contractor activities associated with policy-maker support for tobacco control policies?
 - To what extent are quit attempts associated with awareness of media campaigns?
 - Are dentists in New York providing guideline-concordant clinical intervention and are they aware of the Medicaid benefit for smoking cessation counseling?

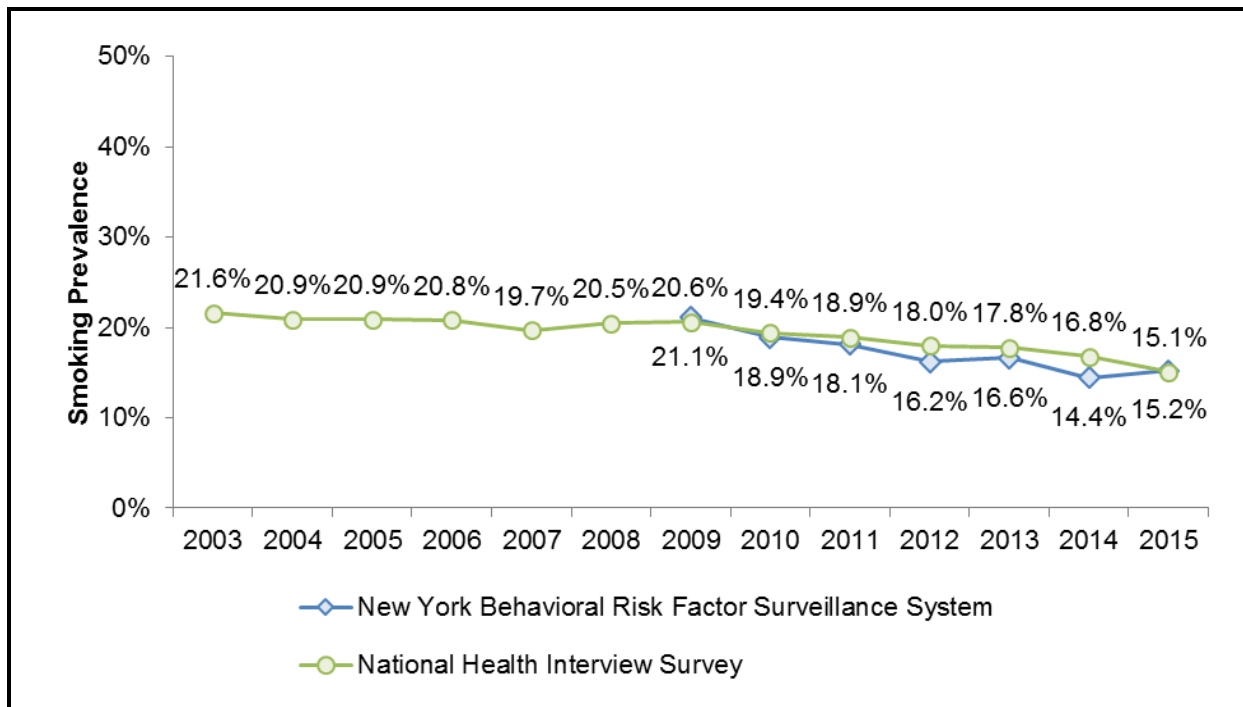
Adult Tobacco Use Measures

In this section, we present trends in the prevalence of adult smoking in New York from 2009 to 2014 using the Behavioral Risk Factor Surveillance System (BRFSS). **Prior years' BRFSS** estimates of smoking prevalence are not directly comparable due to changes in the data collection and weighting methodologies. We report national smoking prevalence

estimates for comparison from the National Health Interview Survey (NHIS) from 2003 to 2014. We also discuss progress toward relevant tobacco control objectives in the NYSDOH Prevention Agenda.

From 2009 to 2015, the prevalence of smoking declined by 28.0% in New York and by 26.7% nationally (Figure 5). NY TCP reached the original NYSDOH Prevention Agenda objective of decreasing adult smoking prevalence to 15.0% in 2014 and set a new target of decreasing prevalence to 12.3% by 2018.

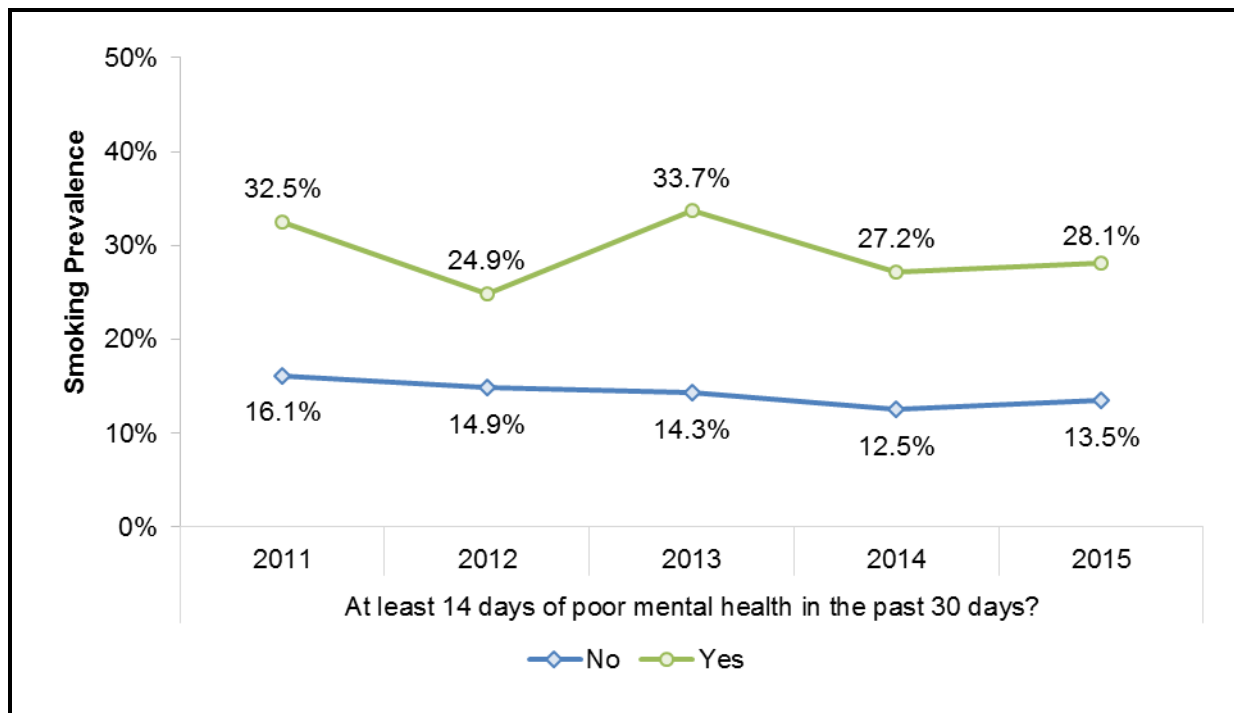
Figure 5. Percentage of Adults Who Currently Smoke in New York (Behavioral Risk Factor Surveillance System) 2009–2015 and Nationally (National Health Interview Survey) 2003–2015



Note: There is a statistically significant downward trend in smoking prevalence among adults in New York State and in the United States from 2009 to 2015.

Stark differences remain in the prevalence of smoking by mental health status, with higher rates of smoking among populations that report poor mental health than among those that report good mental health. The NYSDOH Prevention Agenda set a target of decreasing smoking among New York adults with poor mental health from 32.5% in 2011 to 26.5% by the end of 2018. The current prevalence estimate among New York adults with poor mental health is 28.1% (Figure 6).

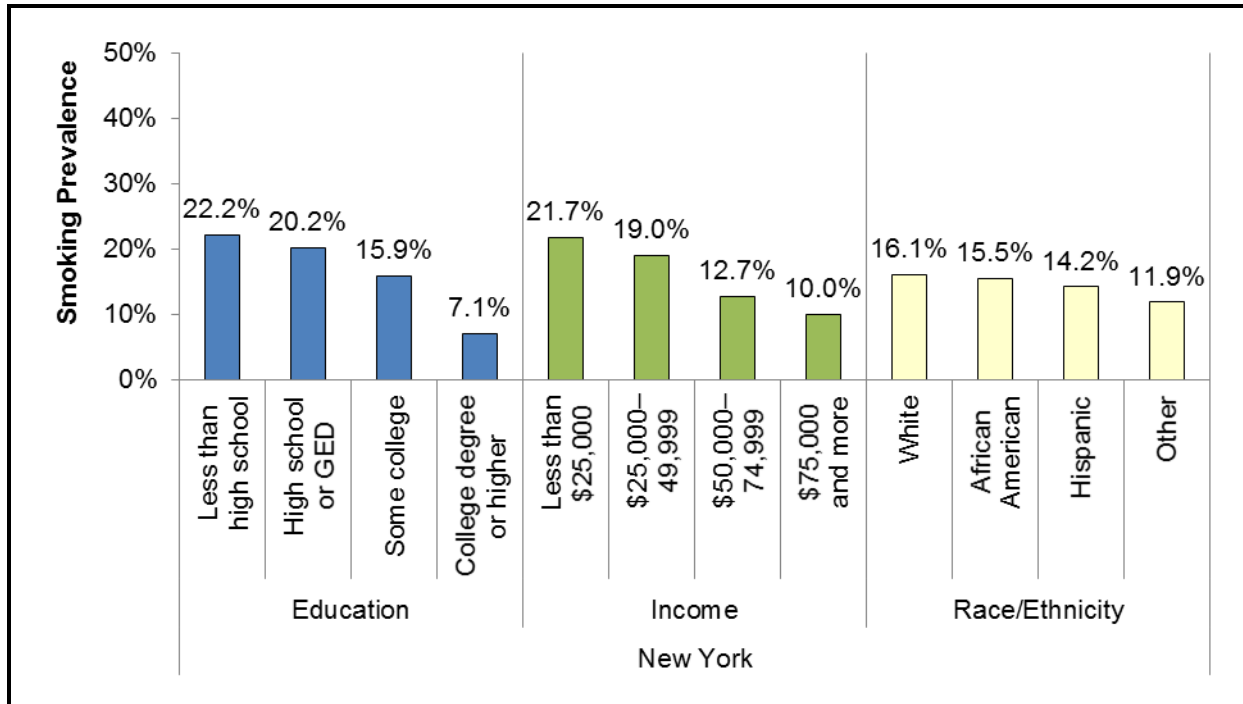
Figure 6. Percentage of New York Adults with Poor Mental Health Who Currently Smoke, New York Behavioral Risk Factor Surveillance System, 2011–2015



Distinct patterns in smoking prevalence are also evident by income level, with smoking rates higher for those with incomes less than \$50,000 than for those with incomes of \$50,000 or more (Figure 7). Smoking prevalence estimates are similar among white, African American, and Hispanic New York adults. **NYSDOH’s Prevention Agenda includes an objective of decreasing smoking prevalence among adults with income of less than \$25,000 to 20% by the end of 2018.** In 2015, 21.7% of New York adults with an income of less than \$25,000 reported current smoking, down from 27.8% in 2011 (a decrease of 22%) (see Figure 7).

Lower levels of education are also associated with higher smoking prevalence in New York (see Figure 7). The prevalence of smoking is higher for those with less than a high school degree or a high school degree or equivalent than for those with some college or a college degree or higher.

Figure 7. Percentage of New York Adults Who Currently Smoke, by Income, Education, and Race/Ethnicity, Behavioral Risk Factor Surveillance System 2015



Note: Prevalence of smoking differs significantly by education; those with a college degree or higher have lower smoking prevalence than those with less than a high school education, those with a high school diploma or GED, and those with some college experience. In addition, smoking prevalence among those with some college experience is lower than among those with less than high school education and those with a high school diploma or GED. The prevalence of smoking also differs significantly between adults with incomes \$49,999 or less and those with incomes of \$50,000 or higher. There are statistically significant differences in the prevalence of smoking between white adults and adults with a race/ethnicity of "other."

The NYSDOH Prevention Agenda also identifies young adults as a population of interest. Smoking prevalence among New York young adults has achieved the Prevention Agenda objective of 18% by 2018. In 2015, 14.0% of New York young adults aged 18 to 24 reported current smoking (Figure 8).

Among all New York adult smokers, daily cigarette consumption decreased from 14.7 cigarettes per day in 2003 to 10.5 cigarettes per day in 2015 (Figure 9). Among adults nationally, daily cigarette consumption was 11.7 cigarettes per day in 2015. Estimates of daily cigarette consumption have plateaued in recent years, both in New York and in the rest of the United States.

Figure 8. Percentage of New York Adults Aged 18 to 24 Who Currently Smoke, Behavioral Risk Factor Surveillance System 2009-2015

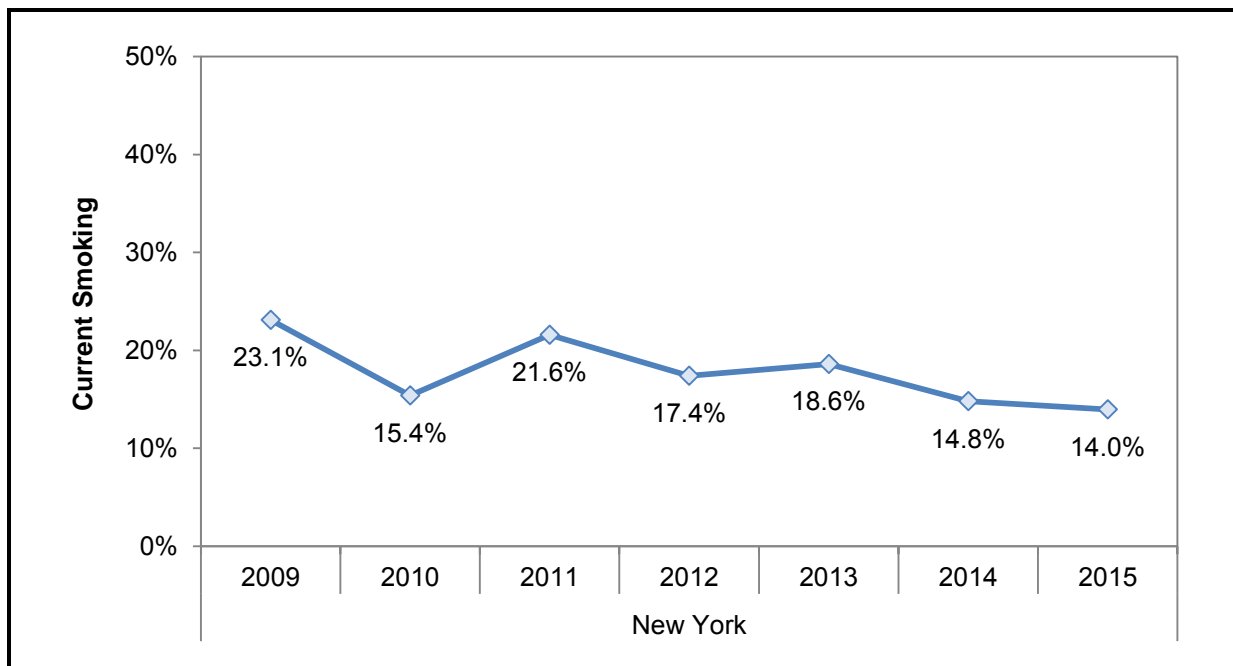
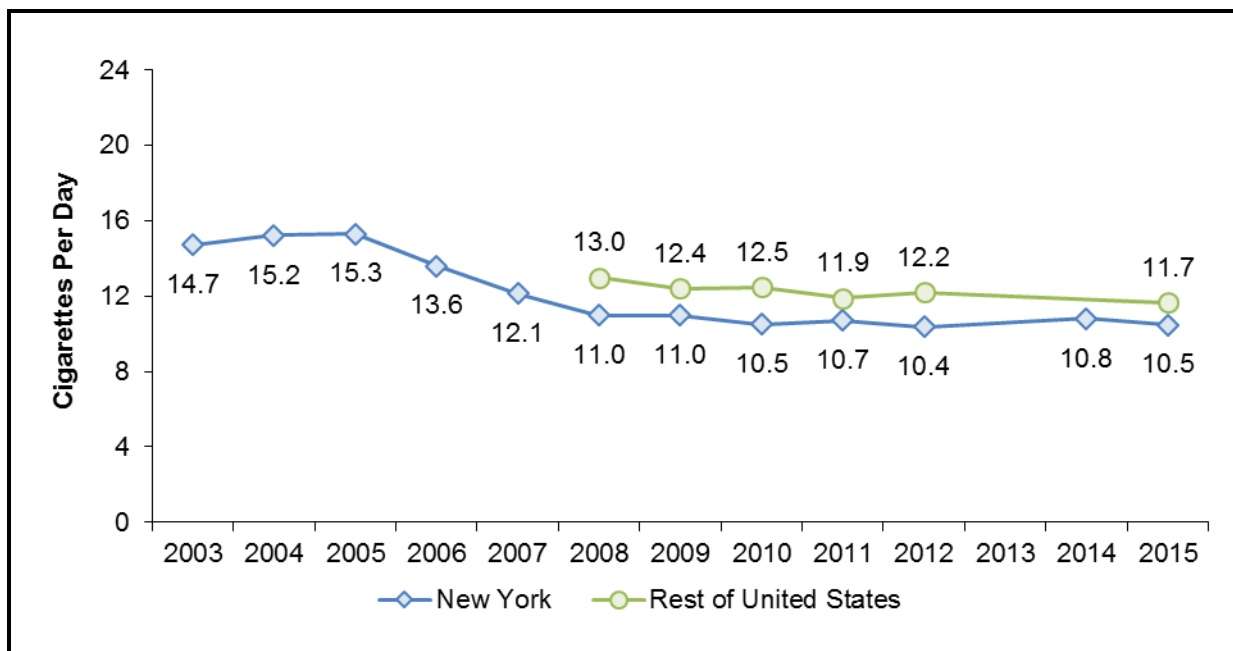


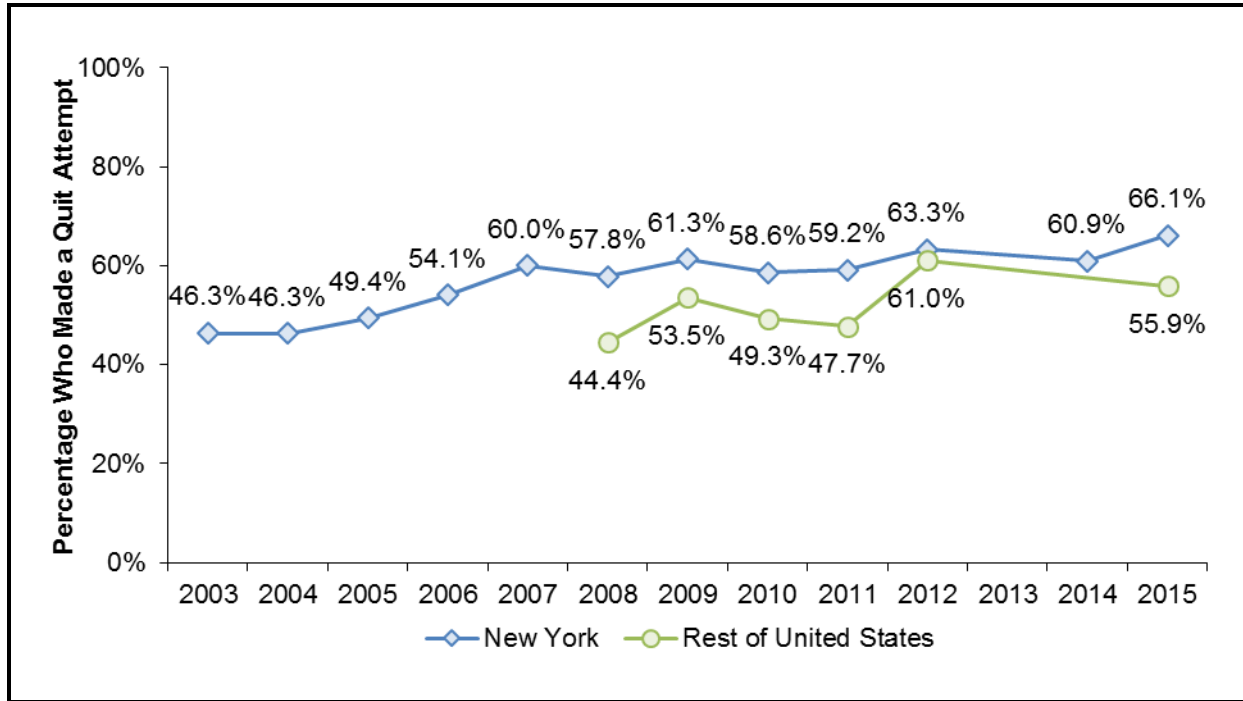
Figure 9. Average Daily Cigarette Consumption by Current Smokers, New York Adult Tobacco Survey 2003-2015 and National Adult Tobacco Survey 2008-2015



Note: There is a statistically significant downward trend among smokers in New York.

The proportion of New York adult smokers who made a quit attempt in the past 12 months was 66.1% in 2015, compared with 55.9% of adult smokers in the rest of the United States (Figure 10). This represents the highest level in the 12 years that this measure has been assessed in the New York Adult Tobacco Survey.

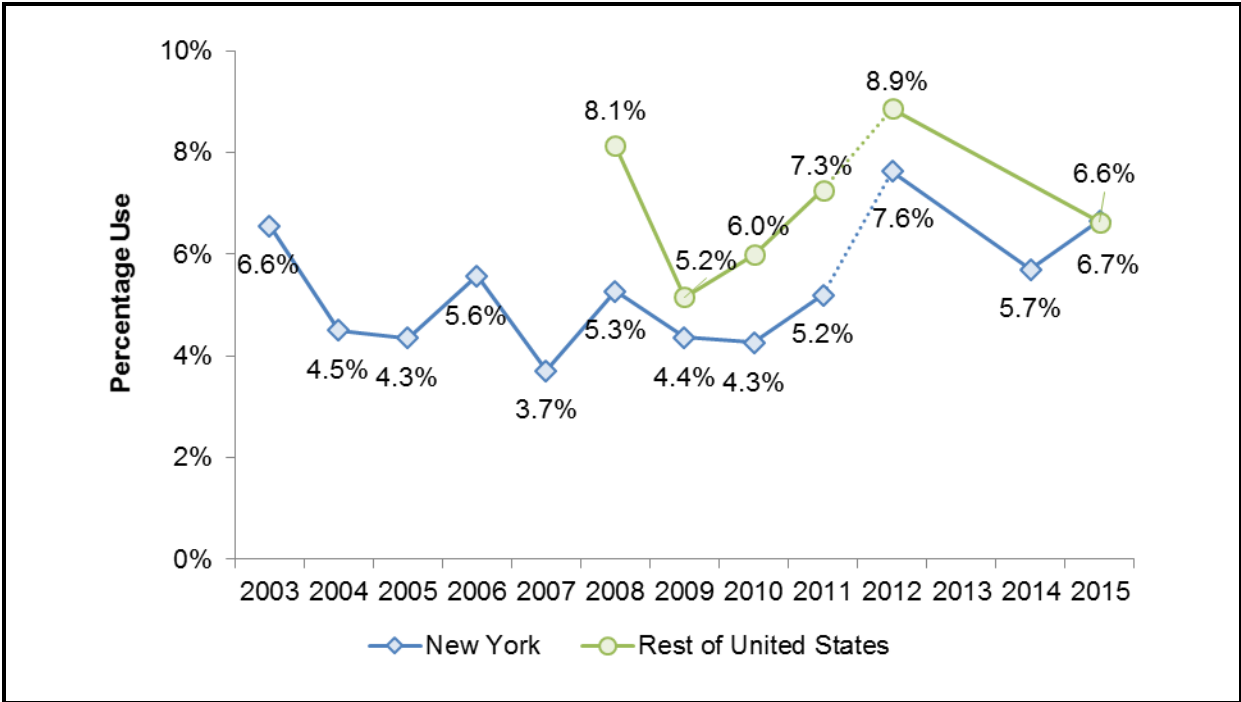
Figure 10. Percentage of Adult Smokers Who Made a Quit Attempt in the Past 12 Months, New York Adult Tobacco Survey 2003–2015 and National Adult Tobacco Survey 2008–2015



Note: There is a statistically significant upward trend among smokers in New York and the rest of the United States.

In 2015, 6.7% of New York adults reported current use of cigars, nearly the same as the national rate (6.6%) (Figure 11). New York adult cigar use appears to trend upward, although a change in question wording may explain this increase. Beginning in 2012, current use began including those who report using cigars “rarely” (in addition to “every day” and “some days”).

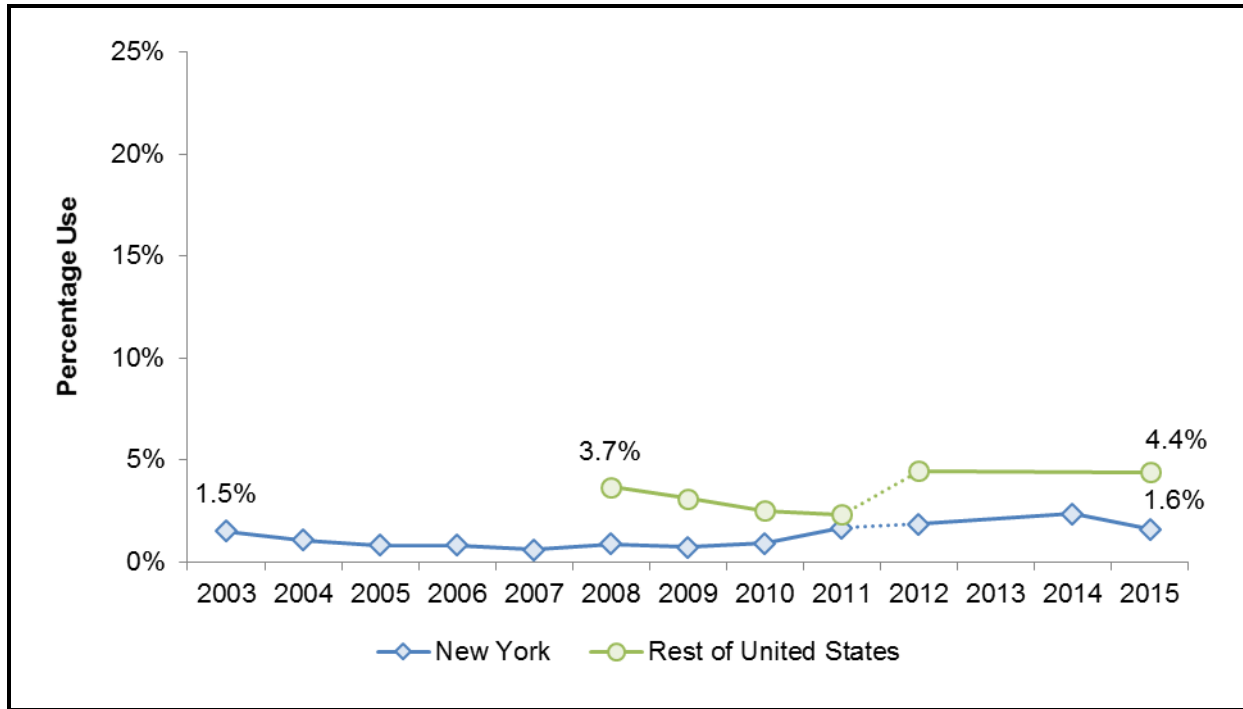
Figure 11. Percentage of Adults Who Currently Smoke Cigars, New York Adult Tobacco Survey 2003–2015 and National Adult Tobacco Survey 2008–2015



Note: In 2012, the data include “rarely” as an additional response option for current cigar use in addition to “Every day,” “Some days,” and “Never.” There is a statistically significant upward trend in current cigar use among adults in New York State.

Smokeless tobacco use is lower in New York than in the rest of the United States (Figure 12). In 2015, smokeless tobacco use prevalence was 1.6% in New York compared with 4.4% in the rest of the country.

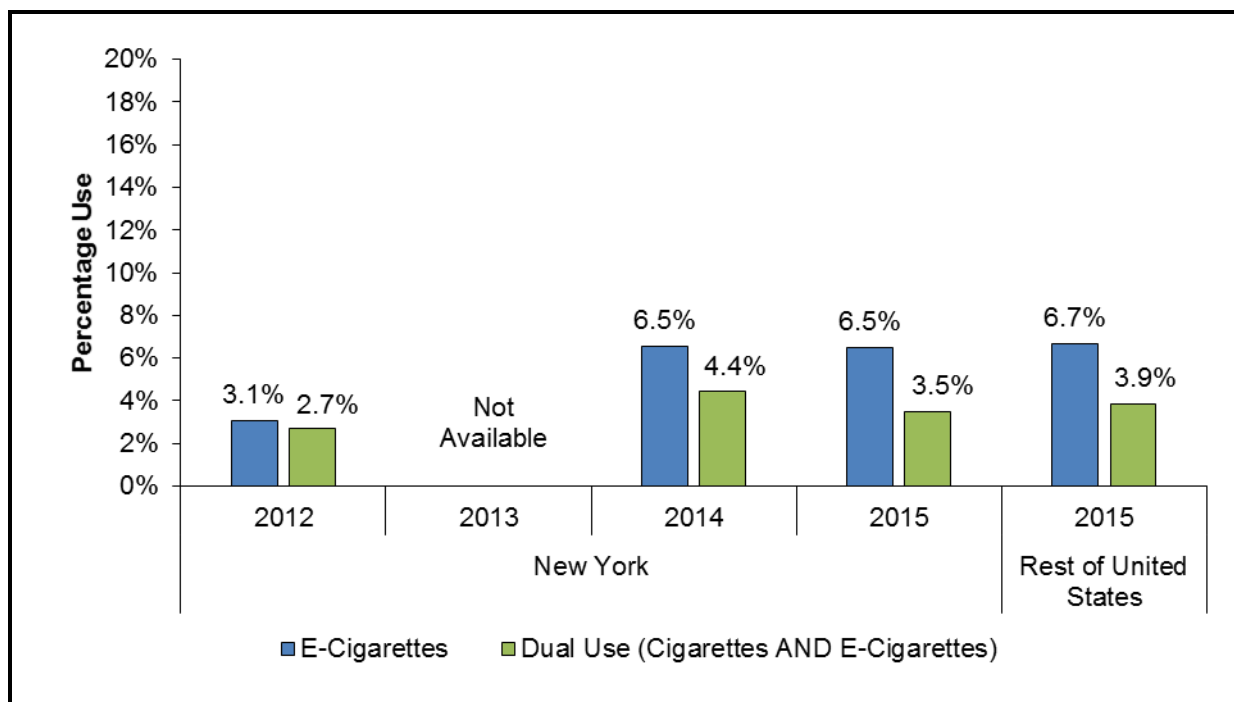
Figure 12. Percentage of Adults Who Currently Use Smokeless Tobacco, New York Adult Tobacco Survey 2003–2015 and National Adult Tobacco Survey 2008–2015



Note: In 2015, current smokeless tobacco use was significantly different in New York State and the rest of the United States. There is a statistically significant upward trend in current smokeless use among New York adults. From 2003 to Quarter 3, 2011, smokeless tobacco included chewing tobacco, snuff, and dip. Since Quarter 4, 2011, smokeless tobacco includes chewing tobacco, snuff, dip, and snus. Since 2012, data include “rarely” as an additional response option for current smokeless tobacco use in addition to “Every day,” “Some days,” and “Never.”

NY TCP began tracking rates of electronic cigarette (e-cigarette) use via the New York Adult Tobacco Survey in 2012. In 2015, 6.5% of New York adults reported current e-cigarette use, and 3.5% of New York adults used both cigarettes and e-cigarettes. Adult use of e-cigarettes increased from 2012 to 2015 in New York and was stable from 2014 to 2015. E-cigarette use in the rest of the United States was similar to New York in 2015 (Figure 13). Dual use of e-cigarettes and cigarettes has not changed significantly over time in New York and is similar to the rate of dual use in the rest of the United States.

Figure 13. Percentage of Adults Who Currently Use E-Cigarettes and Percentage of Adults Who Report Both Cigarette and E-Cigarette Use, New York Adult Tobacco Survey 2012–2015 and National Adult Tobacco Survey 2015

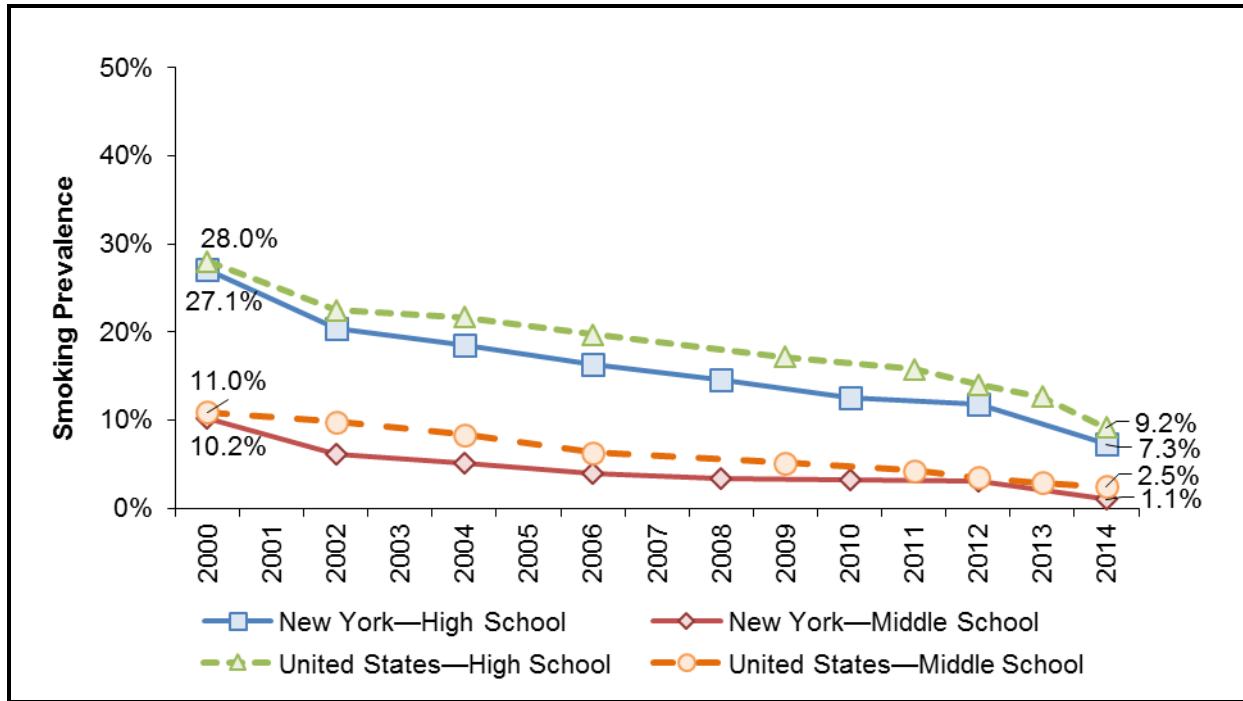


Note: There is a statistically significant upward trend in current e-cigarette use among New York State adults.

Youth Tobacco Use Measures

The following figures present trends in the use of cigarettes, cigars, smokeless tobacco, and e-cigarettes among middle and high school students in New York and nationally. The prevalence of cigarette smoking has declined substantially since 2000 for middle and high school students, leading to historically low rates of smoking in 2014. Specifically, the prevalence of current smoking in New York declined by 73% among high school students and by 89% among middle school students (Figure 14). In 2014, the prevalence of smoking was lower in New York than in the United States for middle and high school students.

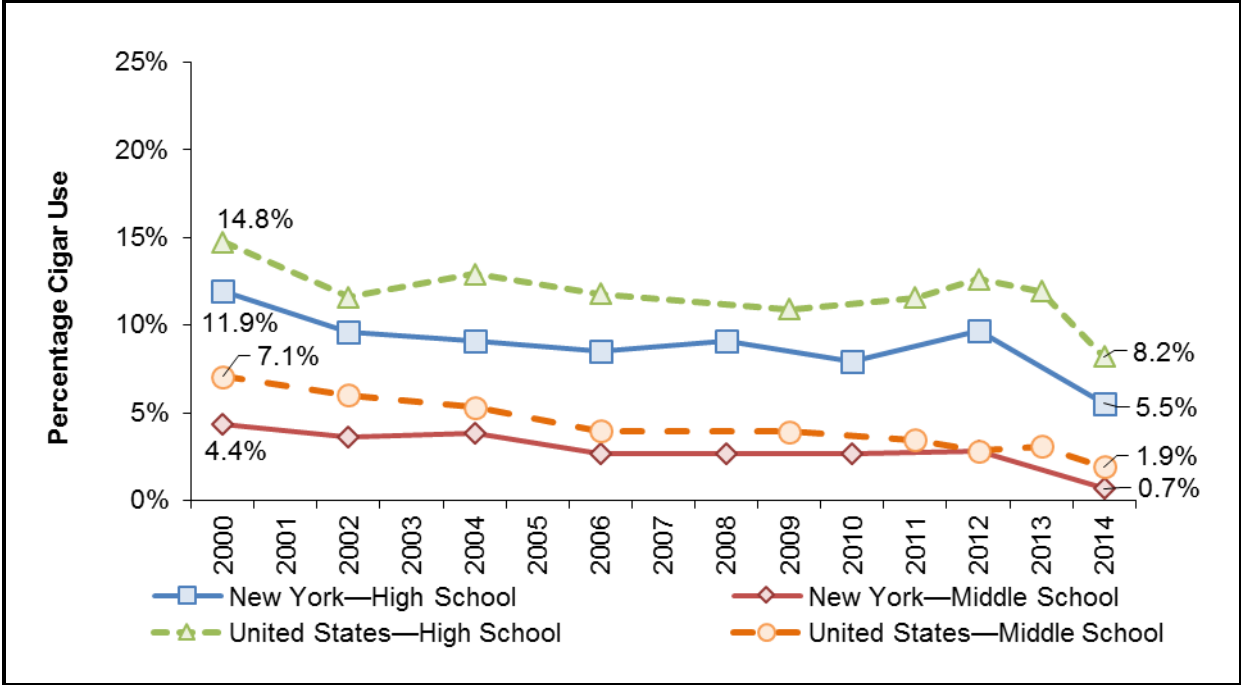
Figure 14. Percentage of Middle and High School Students Who Currently Smoke Cigarettes in New York and Nationally, New York Youth Tobacco Survey 2000–2014 and National Youth Tobacco Survey 2000–2014



Note: There is a statistically significant downward trend among middle and high school students in New York and in the United States. There is a statistically significant difference in smoking between New York and the United States among middle and high school students in 2014.

Rates of cigar use have declined dramatically in New York and nationally among middle and high school students. Less than 1% of middle school students in New York reported current cigar use, an 84% decrease since 2000. In 2014, 5.5% of New York high school students reported current cigar use, a 54% decrease since 2000 (Figure 15). National trends in youth cigar use have paralleled New York’s decline over time, although youth cigar use is lower in New York than nationally.

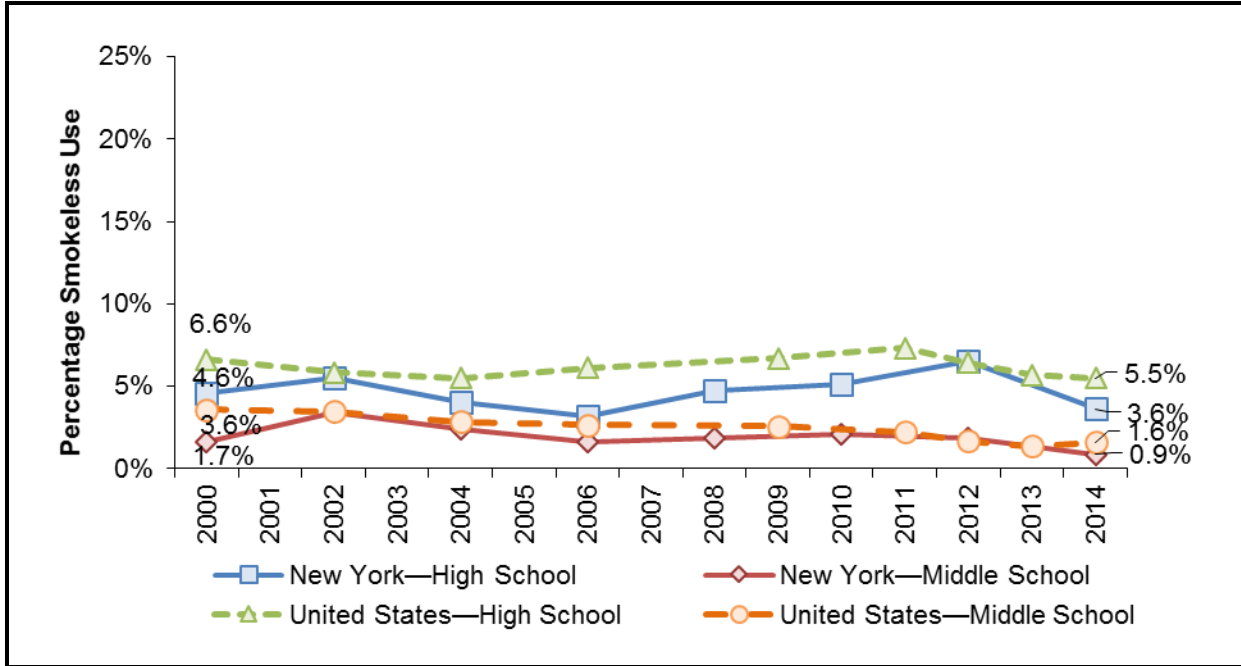
Figure 15. Percentage of Middle and High School Students Who Currently Smoke Cigars in New York and Nationally, New York Youth Tobacco Survey 2000–2014 and National Youth Tobacco Survey 2000–2014



Note: There is a statistically significant downward trend among middle and high school students in New York and among middle school students in the United States. There is a statistically significant difference in cigar use between New York and the United States among middle and high school students in 2014. Starting in 2014 in New York, questions about other tobacco product use were combined into one question with separate response options for each product type. There was no similar change nationally.

Youth use of smokeless tobacco is low in New York and the United States as a whole. In 2014, 0.9% of New York middle school students and 3.6% of New York high school students reported current use of smokeless tobacco (Figure 16).

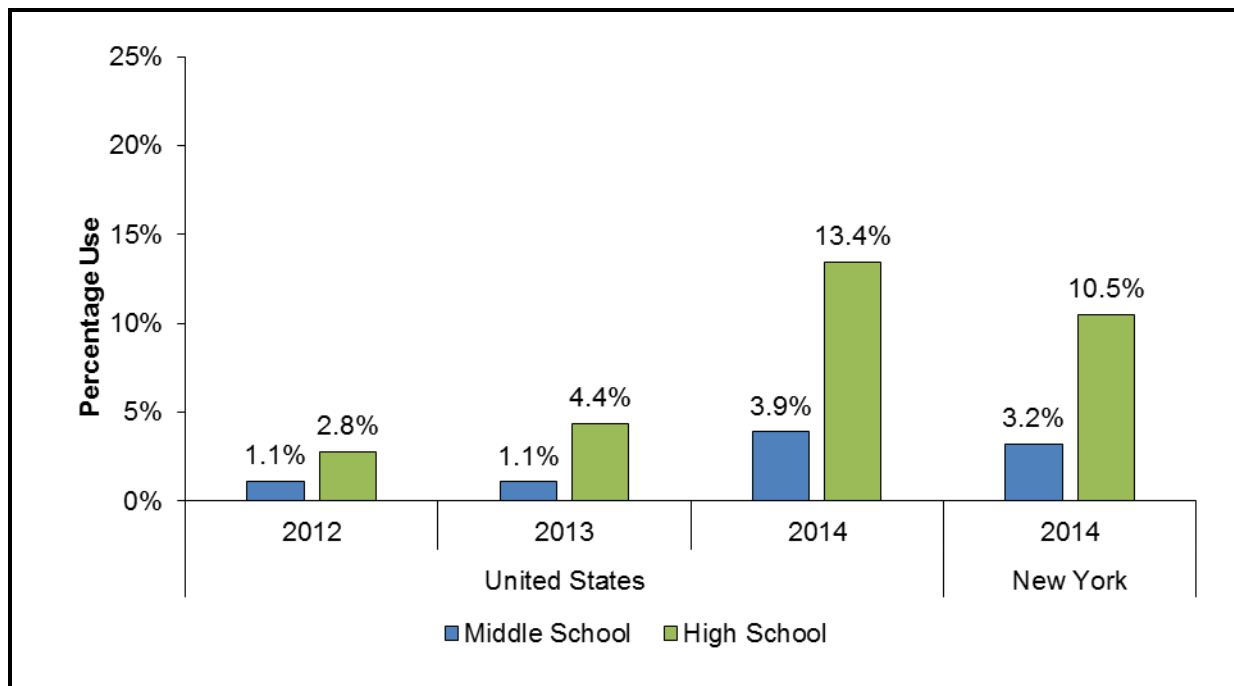
Figure 16. Percentage of Middle and High School Students Who Currently Use Smokeless Tobacco in New York and Nationally, New York Youth Tobacco Survey 2000–2014 and National Youth Tobacco Survey 2000–2014



Note: There is a statistically significant downward trend among middle school students in New York State and the United States. There is a statistically significant upward trend among high school students in the United States. There is a statistically significant difference in smokeless tobacco use between New York and the United States among middle and high school students in 2014. Starting in 2014 in New York, questions about other tobacco product use were combined into one question with separate response options for each product type. There was no similar change nationally.

National rates of cigarette, cigar, and smokeless tobacco use among youth are decreasing, whereas e-cigarette use among youth has increased substantially. Between 2013 and 2014, e-cigarette use among high school students more than tripled in the United States, increasing from 4.4% to 13.4% (Figure 17). Current e-cigarette use among New York high school students is lower than the national average but is still higher than the prevalence rate for cigarettes, cigars, and smokeless tobacco products. A higher percentage of New York middle school students report current e-cigarette use (3.9%) than report cigarette, cigar, or smokeless tobacco product use.

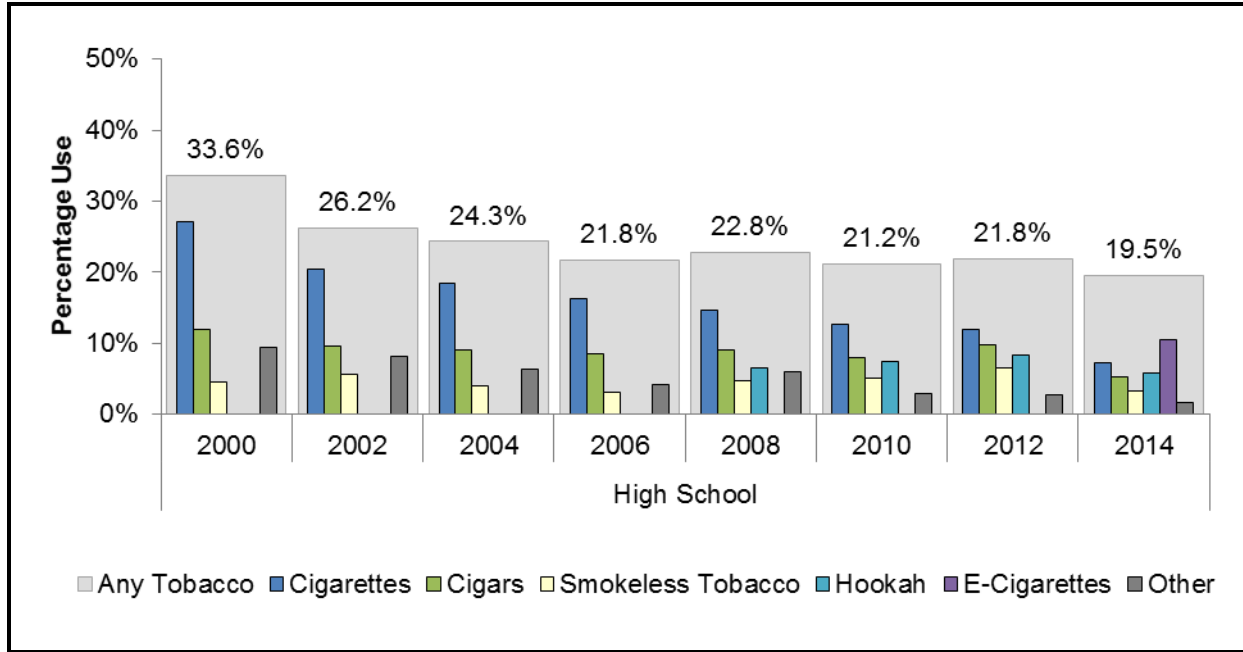
Figure 17. Percentage of Middle School Students and High School Students Who Currently Use E-Cigarettes in New York and Nationally, New York Youth Tobacco Survey 2014, National Youth Tobacco Survey 2012–2014



Note: There is a statistically significant upward trend among middle school students and high school students across the United States. There is a statistically significant difference in e-cigarette use between New York and the United States among high school students in 2014.

The NYSDOH Prevention Agenda set an objective of decreasing the prevalence of any tobacco product use among high school students to 15.0% by the end of 2018. Youth use of tobacco products in 2010 (cigarettes, cigars, smokeless, hookah, bidi, or kreteks) was 21.2%. Youth use of tobacco products (including e-cigarettes) in 2014 was 19.5% (Figure 18).

Figure 18. Percentage of New York High School Students Reporting Current Use of Any Tobacco Product, New York Youth Tobacco Survey 2000–2014

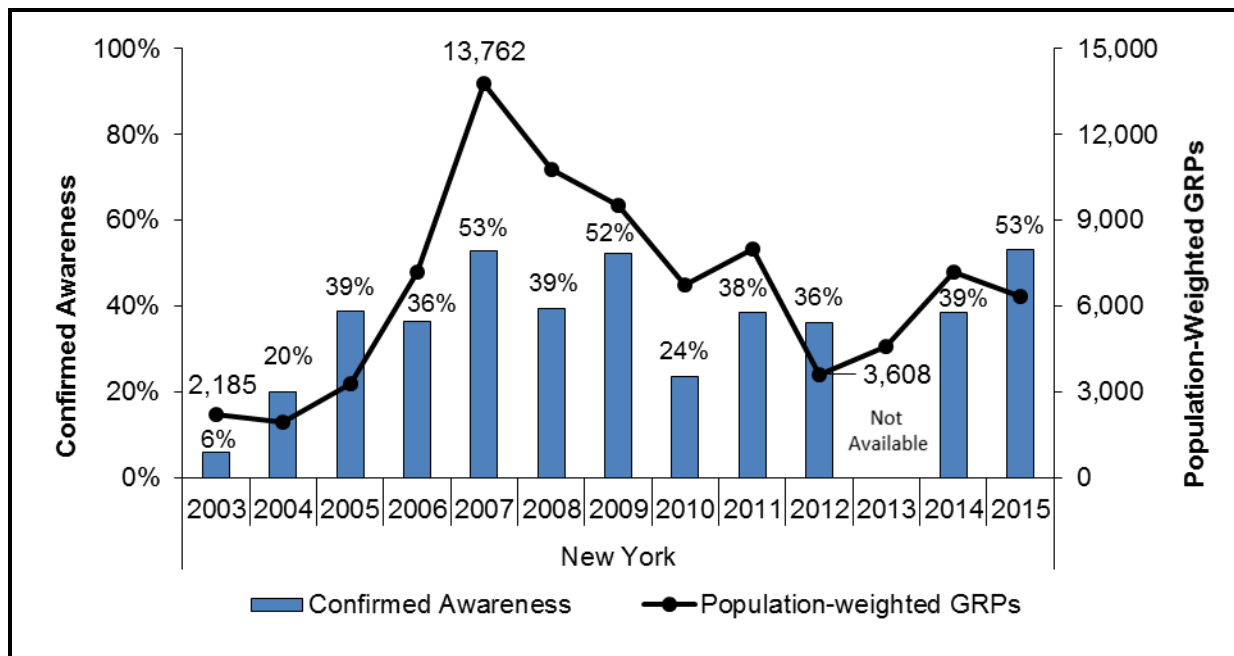


Note: There is a statistically significant downward trend in current use of any tobacco product. Current tobacco use is defined by indicating use of cigarettes, cigars (large cigars, cigarillos, or little cigars), smokeless tobacco (chew, snuff, or dip), hookah (or waterpipe), e-cigarettes, or other tobacco products (snus, pipe, bidi, kretek, or dissolvable) on 1 or more days in the past 30 days. Survey questions addressing various tobacco products have varied over time; specifically, data regarding e-cigarette use were first available in 2014, hookah use data were available from 2008 to 2014, bidi and kretek use data were available from 2000 to 2010, pipe use data were available from 2000 to 2008 and in 2014, snus use data were available in 2012 and 2014, and dissolvable use data were available in 2014.

Trends in Other Key Outcome Indicators

In 2015, 53% of New York adult smokers recalled seeing at least one NY TCP-sponsored television advertisement, as high as awareness in 2007, when NY TCP antitobacco countermarketing was funded at more than twice the current budget (Figure 19). Quarterly gross rating points (GRPs) ranged from 1,036 to 3,081, and estimates of **smokers'** awareness of NY TCP antitobacco ads ranged from 39% to 67% in 2015 (data not shown).

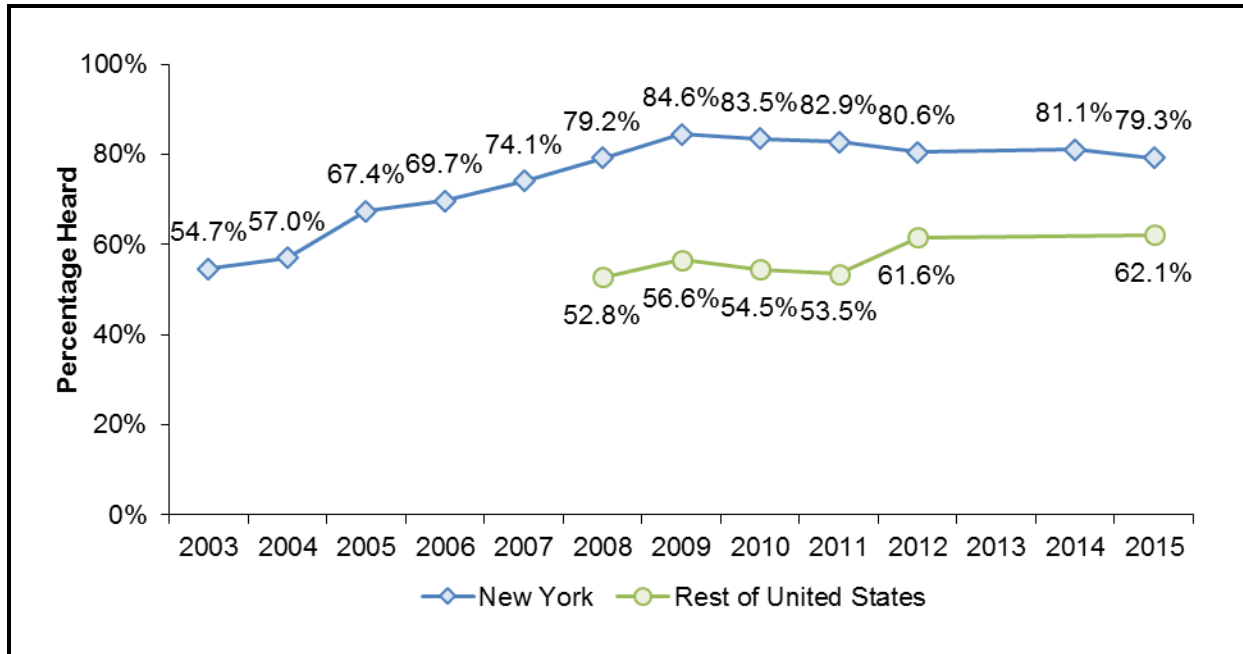
Figure 19. Confirmed Awareness of Paid Advertisements among Smokers and Population-Weighted Statewide Average Gross Rating Points (GRPs) 2003–2015, New York Adult Tobacco Survey 2003–2015



Note: There is a statistically significant upward trend in confirmed awareness of NY TCP antitobacco advertisements among smokers in New York State.

Awareness of the New York State Smokers’ Quitline among New York smokers was 79.3% in 2015, higher than awareness of quitlines among adult smokers in the rest of the country (Figure 20). **Nationally, smokers’ awareness of quitlines was 62.1%, an increase from 52.8% in 2008.**

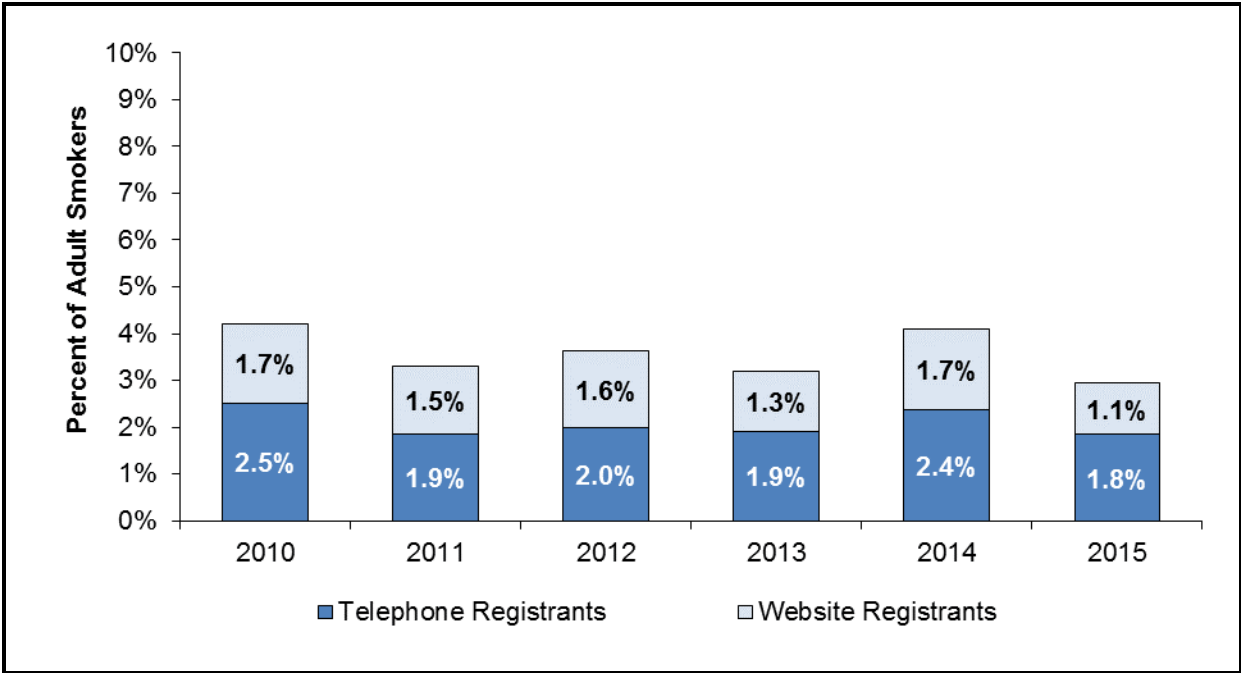
Figure 20. Percentage of Adult Smokers Who Have Heard of Quitline, New York Adult Tobacco Survey 2003–2015 and National Adult Tobacco Survey 2008–2015



Note: New York smokers were asked if they had heard of the New York State Smokers’ Quitline. Smokers in the rest of the United States were asked if they had heard of any telephone quitlines, such as 1-800-QUIT-NOW. There is a statistically significant upward trend among smokers in New York State and the rest of the United States. There is a statistically significant difference between smokers in New York State and the rest of the United States in 2015.

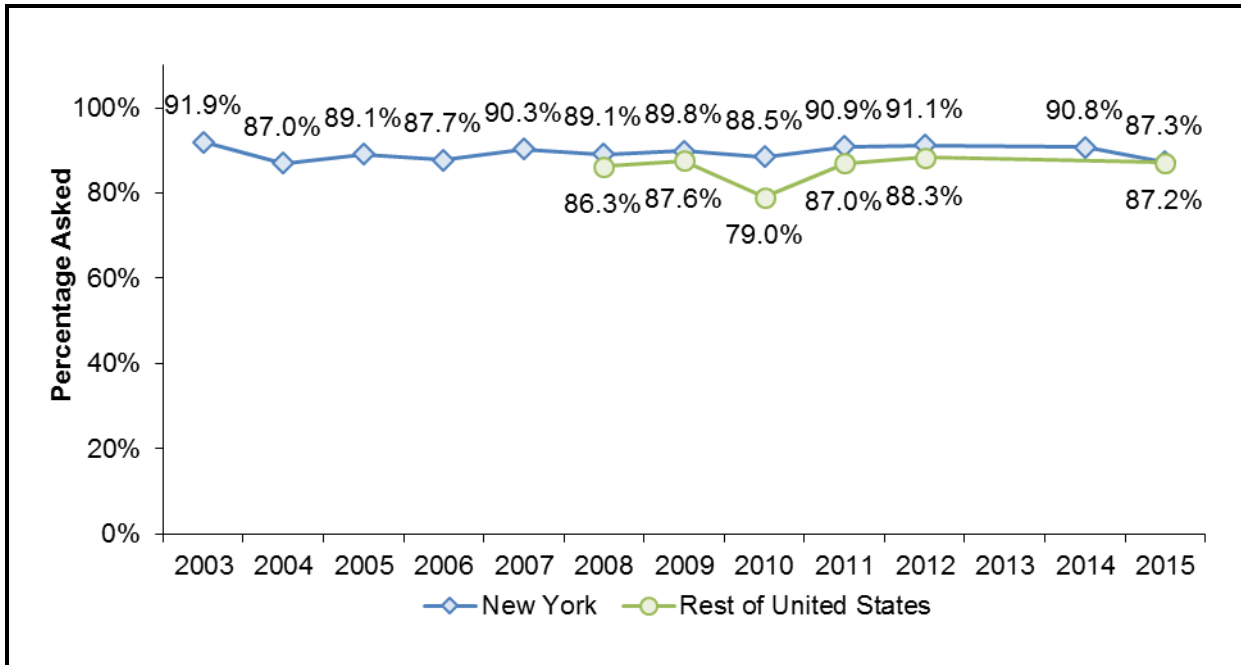
On average in the United States, state quitlines reach about 1% of smokers annually (CDC, 2014). The reach of the **New York State Smokers’ Quitline is significantly higher than the national average**. Between 3% and 4% of New York adult smokers registered for Quitline services in recent years (Figure 21).

Figure 21. Percentage of Adult Cigarette Smokers in New York Who Registered for Services from the New York Quitline, 2010–2015



Health care providers have the opportunity to conduct evidence-based interventions with patients who smoke. Health systems interventions in New York focus on implementing sustainable organizational changes that routinize the delivery of cessation interventions with each patient who smokes. In 2015, 87.3% of smokers in New York who visited a health care provider in the past 12 months reported that they were asked about their smoking status, approximately the same percentage of smokers who were asked nationally (Figure 22).

Figure 22. Percentage of Adult Smokers Who Were Asked About Their Tobacco Use by Their Health Care Provider in the Past 12 Months, New York Adult Tobacco Survey 2003–2015 and National Adult Tobacco Survey 2008–2015



Smokers’ reports of their health care provider advising them to quit smoking have not changed significantly over time in New York or the rest of the United States (Figure 23). In 2015, rates of provider advice were 72.6% among New York smokers and 74.0% nationally.

Although nearly three-quarters of smokers in New York report provider advice to quit, closer to half of smokers reported that a provider assisted them with quitting, measured by provider suggestions of setting a quit date; provision of quit-smoking materials; and discussion of cessation medications, quitlines, or classes. Assistance with a quit attempt has increased over time in New York. In 2015, 50.8% of New York adult smokers reported provider assistance (Figure 24).

Figure 23. Percentage of Adult Smokers Who Were Advised by Their Health Care Provider to Quit Smoking in the Past 12 Months, New York Adult Tobacco Survey 2003–2015 and National Adult Tobacco Survey 2008–2015

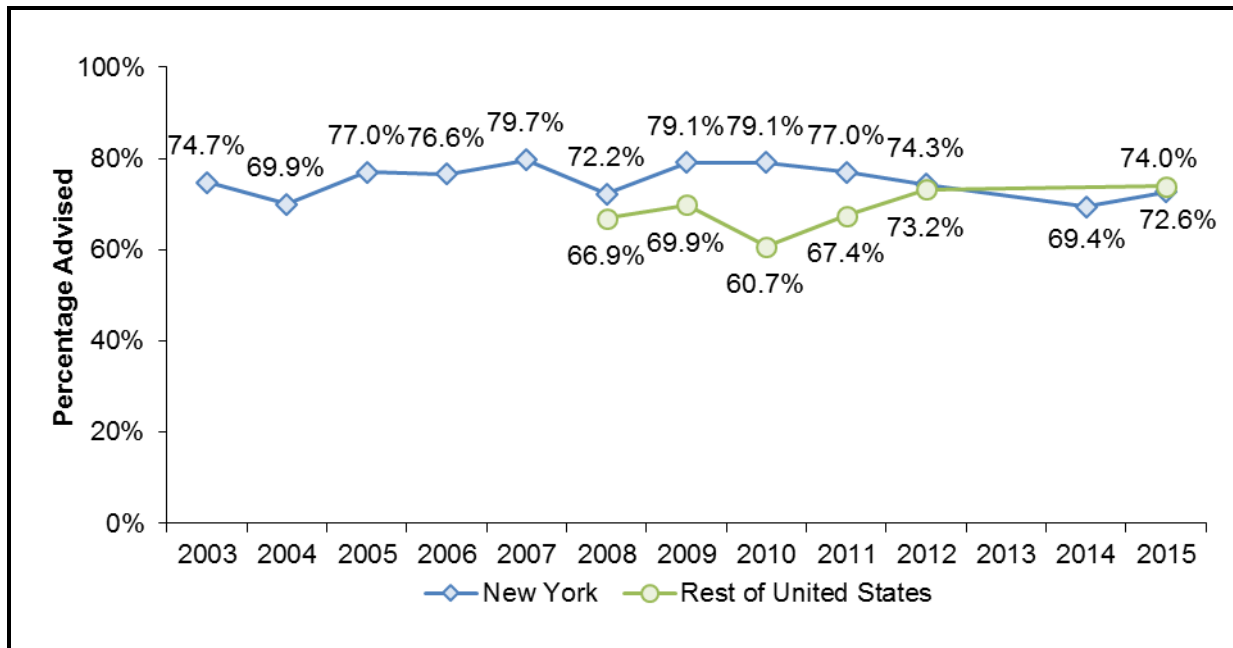
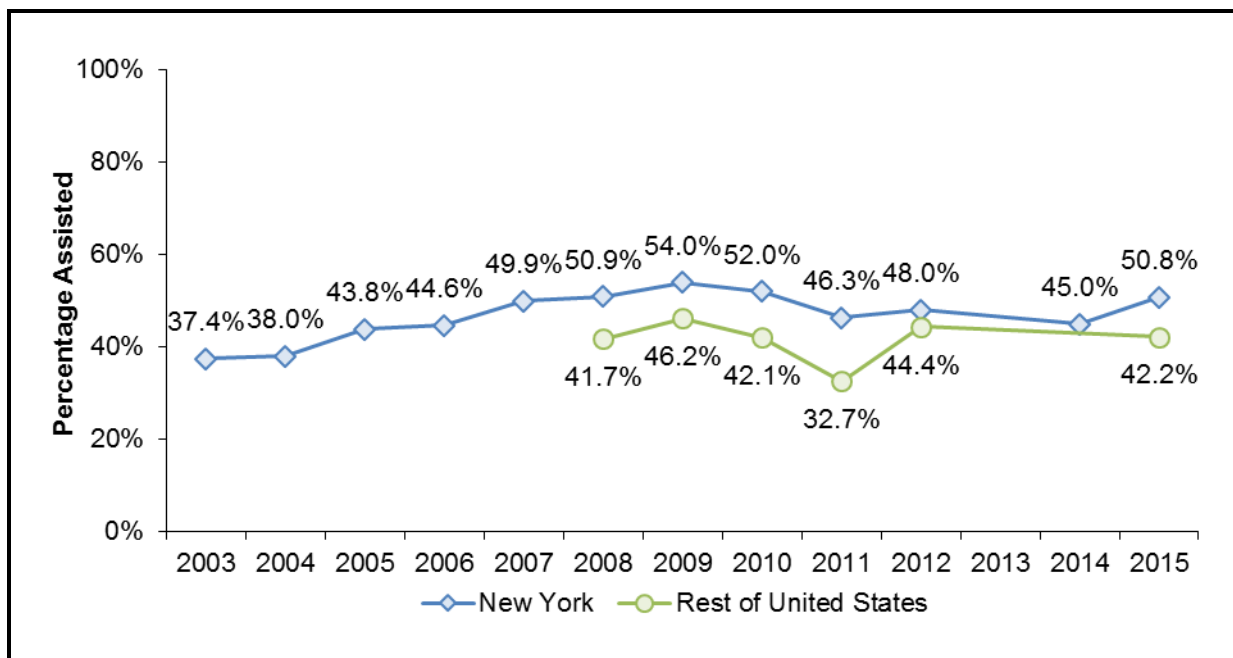


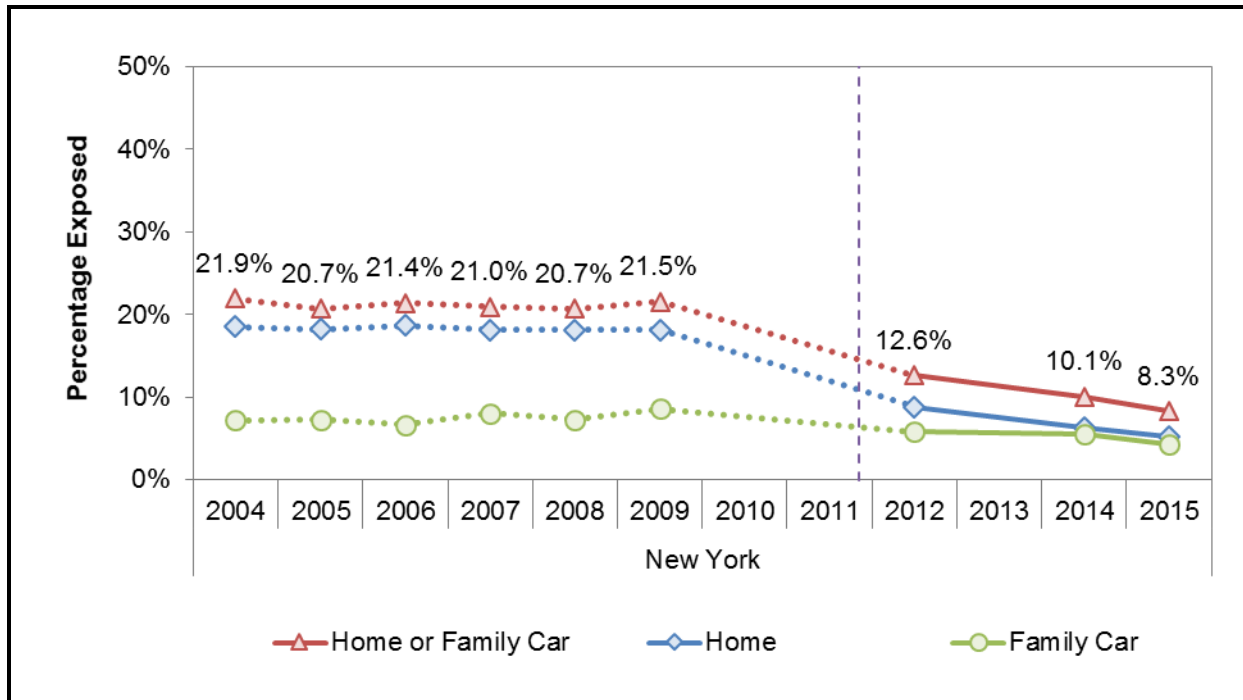
Figure 24. Percentage of Adult Smokers Who Report That Their Health Care Provider Assisted Them with Smoking Cessation in the Past 12 Months, New York Adult Tobacco Survey 2003–2015 and National Adult Tobacco Survey 2008–2015



Note: There is a statistically significant upward trend among New York smokers.

Exposure to secondhand smoke among New York adults has decreased. The NYSDOH Prevention Agenda defined a goal of decreasing secondhand smoke exposure from 27.8% in 2009 to 20% by 2018, a level already reached by 2015. Estimates of nonsmoker exposure to secondhand smoke are even lower. In 2015, only 8.3% of nonsmoking adults reported secondhand smoke exposure in homes or cars (Figure 25).

Figure 25. Percentage of New York Nonsmokers Who Report Being Exposed to Secondhand Smoke, New York Adult Tobacco Survey 2004–2015



Note: Due to question wording changes, estimates for secondhand smoke exposure are not directly comparable before and after 2009. There is a statistically significant downward trend in secondhand smoke exposure from 2012 to 2015 among New York nonsmokers. The percentage of nonsmokers exposed to secondhand smoke is defined by responding 1 or more hours to “During the past 7 days, approximately how many hours (total in a week) did you spend in a room (either work or home) where someone has been smoking?” or “During the past 7 days, approximately how many hours (total in a week) did you spend in a vehicle where someone else has been smoking?” from 2004 to 2009; or responding 1 or more days to “During the past 7 days, on how many days did anyone smoke cigarettes, cigars, or pipes anywhere inside your home?” or “During the past 7 days, on how many days did anyone smoke cigarettes, cigars, pipes, or hookah anywhere inside your family car?” from 2012 onward.

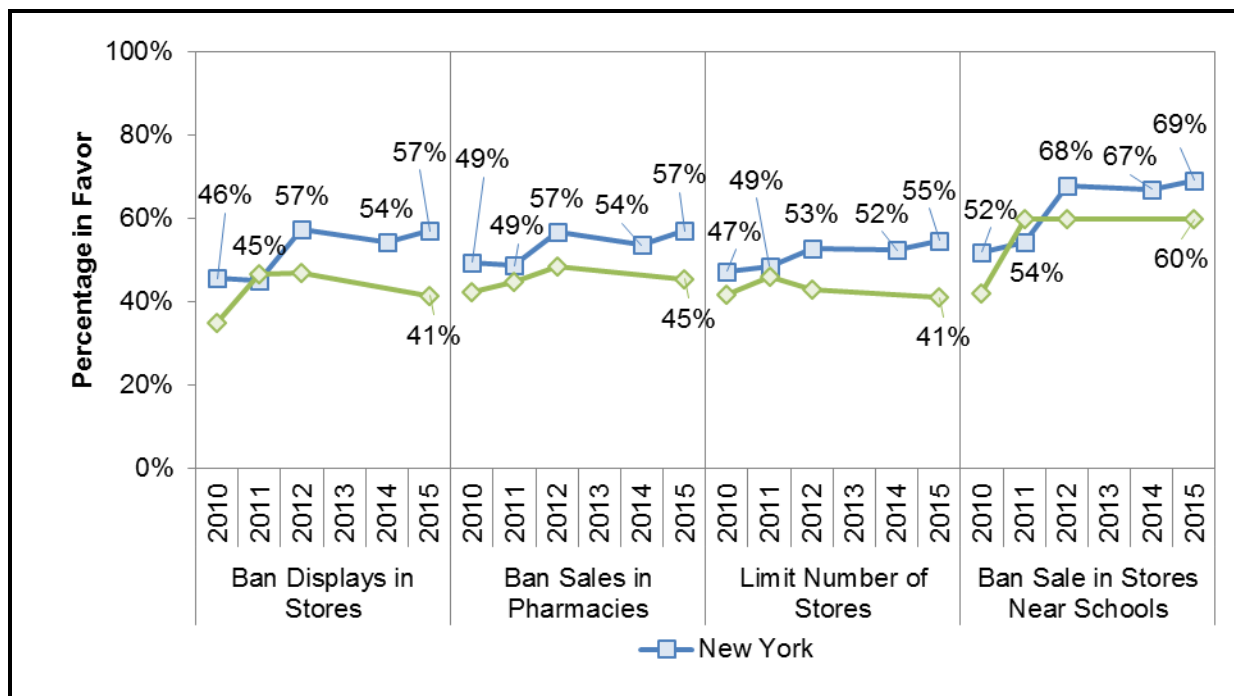
Public Support for Point of Sale Policy

NY TCP’s ATFC contractors educate the public, policy makers, and decision makers about tobacco control issues. For example, contractors focused on point of sale policy change educate policy makers about the research literature documenting the relationship between tobacco product marketing at the point of

sale and tobacco use initiation (e.g., Henriksen et al., 2004, 2008, 2010; Wakefield et al., 2006). Past analyses of New York data consistently demonstrate that policy makers who believe that point of sale marketing influences youth tobacco initiation are more likely to support point of sale policies (Schmitt et al., 2012, 2015). Policy change in this area has been slow, which increases the importance of monitoring more proximal outcomes of contractor activities, such as changes in knowledge and beliefs consistent with the program’s messaging.

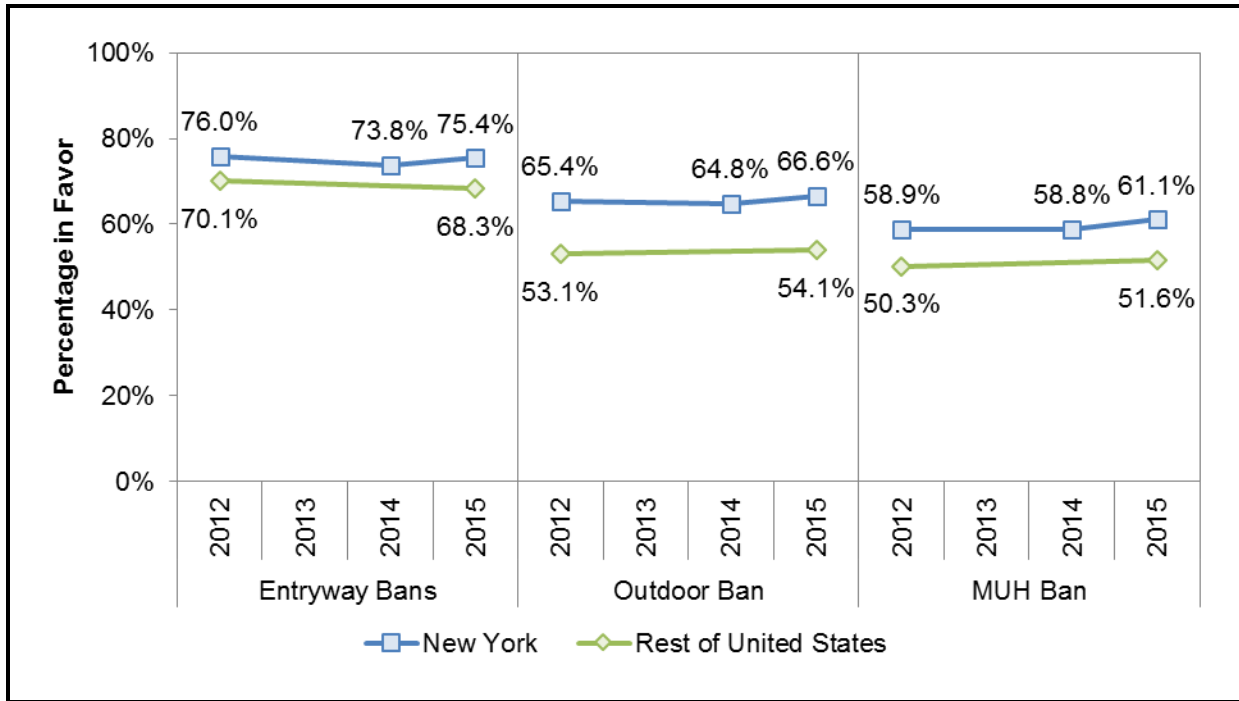
Support for prohibiting the display of tobacco products, prohibiting pharmacy sales, limiting the number of stores that can sell tobacco, and prohibiting tobacco sales in stores near schools all increased significantly between 2014 and 2015 (Figure 26). Support for these policies was significantly higher among New Yorkers than among adults in the rest of the United States. New York adults also expressed support for policies to ban smoking in building entryways, in outdoor areas like parks and playgrounds, and in multi-unit housing (Figure 27).

Figure 26. Support for Point of Sale Tobacco Policies among Adults, New York Adult Tobacco Survey 2010–2015 and National Adult Tobacco Survey 2010–2015



Note: Support for all of these policies increased significantly between 2014 and 2015 and was significantly higher in New York than in the rest of the United States.

Figure 27. Support for Policies to Ban Smoking in Entryways, in Outdoor Areas like Parks, and in Multi-Unit Housing Among Adults, New York Adult Tobacco Survey 2010–2015 and National Adult Tobacco Survey 2010–2015



Trends in Tobacco Retail Advertising and Promotions

The 1998 Master Settlement Agreement (MSA) changed the landscape of tobacco advertising. The MSA eliminated transit advertisements and billboards, prohibited the use of cartoon characters and brand name merchandise, restricted sponsorships for sporting events and concerts, and reaffirmed existing prohibitions on tobacco advertising in movies and on television (Campaign for Tobacco Free Kids, 2003). However, the MSA did not address tobacco advertising and promotion in the retail setting. Since then, tobacco industry spending in the retail environment increased from \$5.3 billion in 1998 to \$8.95 billion in 2013, the latest year for which data are available (Federal Trade Commission, 2016). In 2013, tobacco industry spending on the retail environment included \$7.6 billion for price discounts to reduce the price of cigarettes, \$689.1 million for promotional allowances, \$248.8 million for coupons, and \$55.7 million for point of sale advertising (Federal Trade Commission, 2016).

Tobacco marketing is widespread (Barnoya et al., 2014; Feighery et al., 2008; Frick et al., 2012; Roeseler et al., 2010). Tobacco advertising and promotion at the point of sale (such as in Figure 29) are associated with adolescent smoking initiation (Henriksen et al., 2010; Slater et al., 2007), current youth smoking (Kim et al., 2013), relapse among former smokers (Kirchner et al., 2013), and unplanned cigarette purchases (Carter et al., 2009). Point of sale advertising is more common in low-income and minority neighborhoods (Burton et al., 2014; Feighery, 2008), in stores near schools (Barnoya et al., 2014), and in stores frequented more often by adolescents (Henriksen et al., 2004).

Figure 29. Example of Tobacco Product Display and Advertising at the Retail Point of Sale



NY TCP has conducted a store audit of tobacco retailers since 2004. This New York Retail Advertising of Tobacco Survey (NY-RATS) provides data on the retail environment in New York to provide partners, policy makers, and other stakeholders with information to facilitate change in the retail tobacco environment. We present highlights from NY-RATS regarding the presence and number of cigarette advertisements, presence of price promotions, presence of required age-of-sale signage, and presence of banned self-service tobacco displays from 2004 to 2015.

Data and Methods

We obtained a list of registered tobacco retailers from the New York State Department of Tax and Finance. The sample design

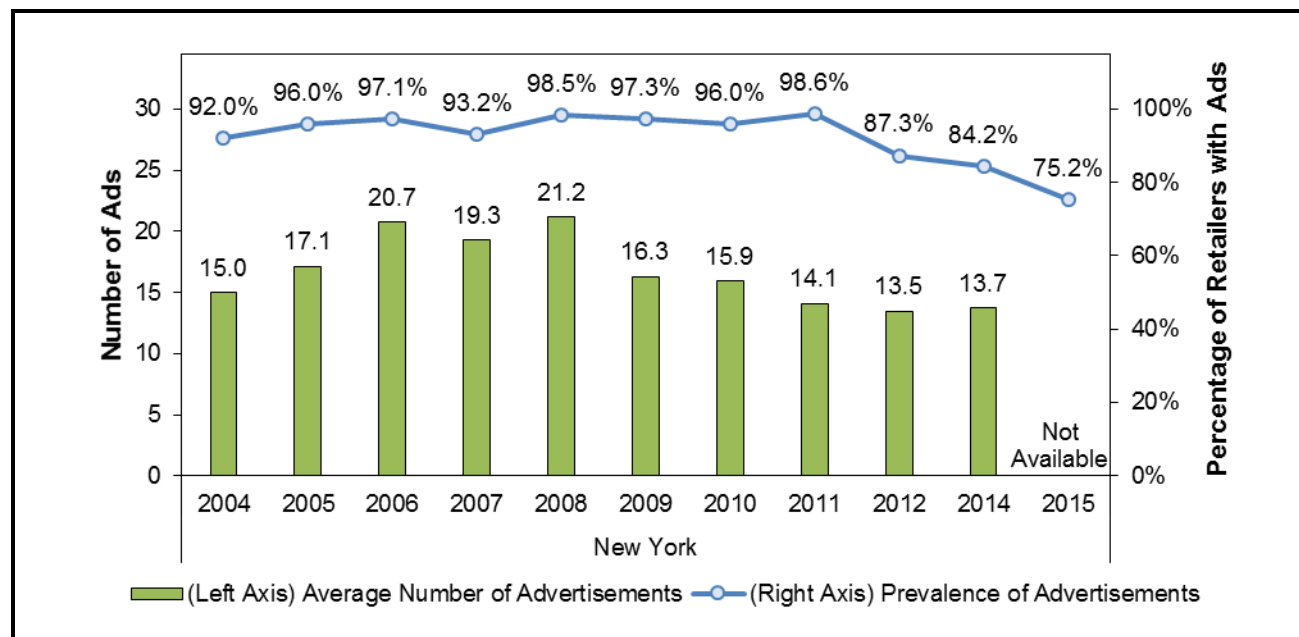
of the NY-RATS was a stratified random sample of retailers based on outlet type and geographic areas of New York State. Trained data collectors visited each sampled retailer and completed a survey instrument. Data collectors assessed the presence and number of cigarette advertisements, presence of cigarette price promotions, presence of age-of-sale sign, and presence of self-service tobacco. We tested for statistically significant differences in these key variables over time.

Results

In all years, small grocers were the most common type of tobacco retailer, accounting for approximately 40% of retailers in the state. Convenience and convenience/gas accounted for 20% to 25%, followed by pharmacies (8%), large grocers (3%), tobacco specialty (2%), and mass merchandisers (1%). Although **“other” retailers** accounted for 20% to 30% of tobacco retailers, this group is so diverse that we focus our results and discussion on the remaining categories. Data from the 2015 NY-RATS showed that 95.7% of retailers sold cigarettes, and a majority also sold cigars (82.7%) and e-cigarettes (67.6%).

The prevalence of retailers with at least one cigarette advertisement decreased significantly from 2014 (84.2%) to 2015 (75.2%) ($p < 0.001$) and trended downward significantly from 2004 to 2015 (OR = 0.81, $p < 0.001$) (Figure 30). The average number of cigarette advertisements increased from 15.0 advertisements in 2004 to a peak of 21.2 advertisements in 2008 and then decreased to 13.7 advertisements in 2014. The presence of at least one price promotion decreased from 45.2% in 2014 to 24.3% in 2015 ($p < 0.001$) (data not shown). Compliance with the age-of-sale sign requirement increased from 39.2% in 2004 to 92.3% in 2015, a statistically significant upward trend (OR = 1.20, $p < 0.001$) (data not shown).

Figure 30. Prevalence and Number of Cigarette Advertisements by Year, NY-RATS, 2004–2015



In general, compliance with state and federal restrictions on self-service access to tobacco products was very high. Across all years, less than 3% of non-tobacco specialty retailers had self-service tobacco products (data not shown). However, given that self-service products were banned in retailers open to minors in 2009, non-tobacco specialty retailers should not have self-service areas.

Summary

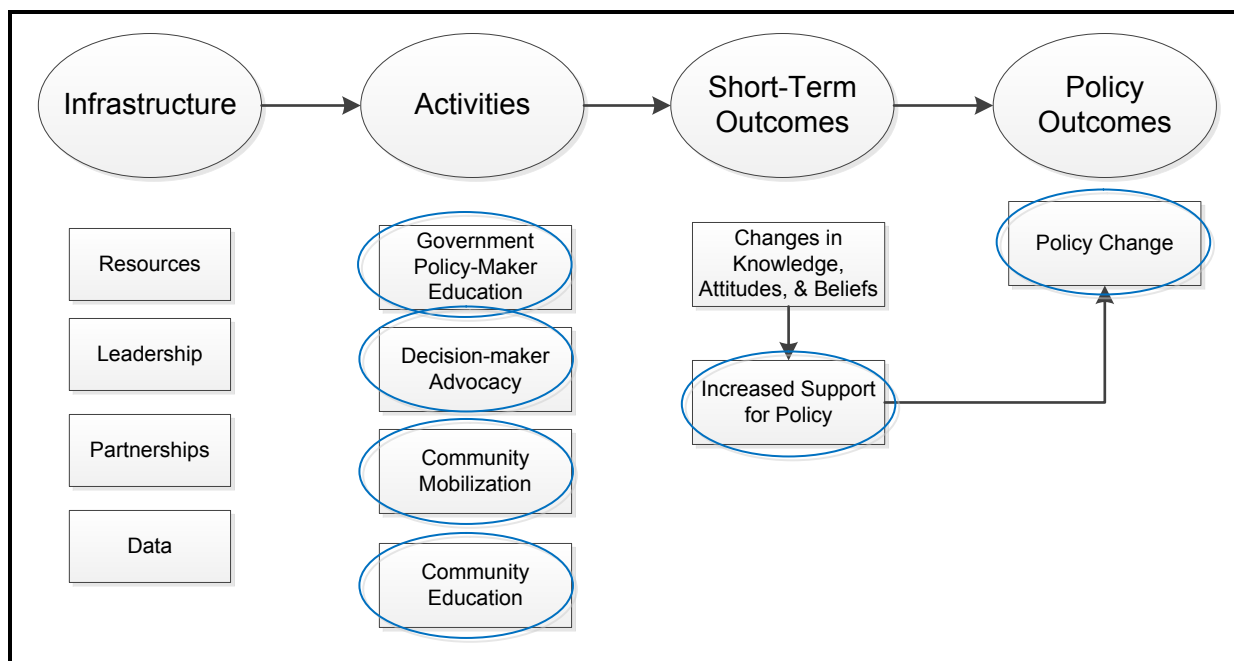
Overall, the results presented here show that substantial reductions have occurred in the extent of point of sale tobacco advertising and promotion in New York State. Between 2004 and 2015, the number of stores that sell tobacco, the prevalence of cigarette advertisements, and the number of cigarette advertisements decreased significantly. We also found that the prevalence of price-reducing promotions decreased significantly in recent years. We found increased compliance with required age-of-sale signage and high levels of compliance with the ban on self-service tobacco displays. Although it is encouraging that cigarette advertising has decreased, a high level of advertising remains.

Community Contractor Activities and Policy-Maker Support for Policy Change

The overarching purpose of the community program evaluation is to document contractor efforts, progress toward policy change, and ultimately progress toward program goals. Documenting progress requires that incremental outcomes—the sequential expected effects of program efforts that occur before policy and longer-term goals are achieved—be well-defined by the program and systematically measured (Hendricks et al., 2008). Traditionally, however, it has been challenging to document the relationships between program efforts and outcomes in community-level evaluations (Sparks, 2007). In this section, we summarize three analyses focused on examining the relationships between program efforts and outcomes. We focused on contractor efforts between 2011 and 2014 and outcomes that were documented in 2014.

Figure 31 presents a subset of the Community Program conceptual model, including infrastructure, ATFC contractor activities, short-term outcomes, and policy outcomes. In the analyses that follow, we examine the relationships between the circled components of this model, including relationships between the quantity of contractor activities and the number of **policies adopted in that contractor’s catchment area and policy-maker support for policy change**.

Figure 31. Conceptual Model Guiding Evaluation of NY TCP Community Program



Data and Methods

We used data recorded in NY TCP’s Community Activity Tracking (CAT) system between 2011 and 2014 to summarize the number of activities contractors recorded for each of the following activity types: government policy-maker education, decision-maker advocacy, community education, and community mobilization. We also used data recorded in the CAT reporting system to summarize the number of policies adopted regarding tobacco-free outdoor areas and smoke-free multi-unit housing. We used data from the 2014 Local Opinion Leaders Survey (LOLS) to measure opinion leader support for tobacco-free outdoors and point of sale policies. Opinion leaders were defined as county-level elected officials and health department officials.

We used correlational analyses to examine the relationships between the number of activities conducted and the number of tobacco-free outdoors and point of sale policies adopted and to examine the relationship between the number of activities conducted and policy-maker support for tobacco-free outdoors, point of sale, and smoke-free multi-unit housing policies. We used regression analyses to examine the relationship between

the number of contractor activities and opinion leader support for tobacco-free outdoors and point of sale policies. For the opinion leader analyses, we first examined the relationship between contractor activities and the average of opinion leader support for all point of sale policies and subsequently examined support for each individual policy type. It should be noted that these analyses are encouraging but preliminary; because there was no significant relationship between an activity and one of the outcomes, does not mean those activities were not effective or that they should be abandoned.

Results

Overall, we found that the more activities a contractor conducted, the more tobacco-free outdoors and smoke-free multi-unit housing policies they reported having changed. We also found a similar relationship between the number of contractor activities focused on changing point of sale policies and the level of policy-maker support for these policies.

Contractor Activities and Policies Adopted

Having more meetings with government policy-makers about the tobacco-free outdoor issue was associated with more tobacco-free policies being adopted (Table 5). We did not find a similar association between the number of community mobilization activities a contractor reported and policy change.

Table 5. Analysis of Associations between NY TCP Community Contractor Activities and Tobacco-Free Outdoors Policies Adopted, CAT System, 2011–2014

Community Contractor Activities (Independent Variable)	Association with Tobacco-free Outdoors Policy	
	Correlation Coefficient (r)	p-Value
Number of Meetings with Government Policy Makers	0.53	<0.01
Number of Community Mobilization Activities	0.16	0.44

Similarly, contractors who met most frequently with organizational decision makers to discuss smoke-free multi-unit housing policies reported that a greater number of smoke-free multi-unit housing policies were adopted in their catchment area (Table 6). We did not find a similar association between

the number of community mobilization activities a contractor reported and policy change.

Table 6. Analysis of Associations between NY TCP Community Contractor Activities and Smoke-Free Multi-Unit Housing Policies Adopted, CAT System, 2011–2014

Community Contractor Activities (Independent Variable)	Association with Smoke-Free Multi-Unit Housing Policy	
	Correlation Coefficient (r)	p-Value
Number of Meetings with Organizational Decision Makers	0.48	0.05
Number of Community Mobilization Activities	0.36	0.43

Contractor Activities and Local Opinion Leader Support for Policy Change

We examined whether the number and type of contractor activities were associated with greater policy-maker support for tobacco control policies. Using data collected between 2011 and 2014, we found higher support for a policy prohibiting tobacco product displays among opinion leaders in catchment areas where contractors reported more meetings to educate policy makers about point of sale issues ($B = 0.01$, $p < 0.01$).

Summary

Overall, we found preliminary evidence that contractor activities were associated with increased support for selected policies among opinion leaders and with an increased number of policies being adopted. We found greater support for a policy that would prohibit retailers from displaying tobacco products in catchment areas where contractors conducted more point of sale initiative activities, although this policy area is no longer a primary focus for NY TCP contractors. In addition, we found that more tobacco-free outdoors and smoke-free multi-unit housing policies were adopted in catchment areas where contractors reported more activities focused on these initiatives. These findings are particularly intriguing, given the inherent challenges of linking program efforts to policy-related outcomes in community evaluations. At the same time, these analyses highlight the timing-related challenges of measuring how a strong leader can influence policy support and policy adoption.

Linking community-level efforts to outcomes is challenging, in part because the measures of contractor efforts are simply the quantity of efforts expended in a defined geographic area. These measures do not capture the skill with which a contractor implements those activities and in the case of community mobilization, do not currently capture the level of partner activity that occurred as a result of contractor efforts. In addition, these analyses assume that all opinion leaders are equally influential and that policy adoption becomes more likely as some critical proportion of leaders support that policy. Policy change usually requires a majority vote by a governing body. However, if a strong leader champions a tobacco control policy, that leader could rapidly build support for it before we would ever have an opportunity to measure that support. Capturing quality of efforts (such as the skill with which a contractor communicates the need for policy change) in a measure is possible, and documenting the influence of a strong leader on policy adoption is also possible. However, both of these measures require a significant investment in more qualitative approaches to measurement. Moving forward, we anticipate working with NY TCP staff on better incorporating quality-of-effort measures into the community evaluation. We also anticipate conducting focused case studies to document the processes through which policies are adopted in New York communities. These case studies are likely to yield important information that the program can use to help contractors better tailor their efforts to local context and leverage their relationships with the most influential local leaders.

In addition to the challenges of validly incorporating effort quality into the community evaluation, policy change does not occur in a vacuum; multiple contextual factors affect whether a policy sees the light of day. For example, competing priorities, such as high unemployment rates, can consume the attention and efforts of local legislative bodies and leave little time and interest for tobacco control issues. In the coming years, we anticipate using NY TCP staff knowledge and secondary data (including the **U.S. Census Bureau's** American Community Survey) to better understand how community context serves as a facilitator or barrier to contractor efforts.

All proposed measure development and analyses conducted for the community program evaluation are designed to identify factors that can be modified by program efforts or context that

contractors need to understand to tailor their efforts to their communities. This two-pronged approach is designed to ensure that the NY TCP community intervention is maximally effective and can serve as a model for other states.

Associations between Health Communication Campaigns and Key Outcomes

NY TCP's health communication campaigns promote smoking cessation through television advertisements depicting the consequences of smoking. As noted earlier in this report, antismoking campaigns are effective in reducing smoking among youth and adults. The majority of NY TCP's antismoking advertisements encourage smokers to talk to their doctor. These ads include the New York State Smokers' Quitline telephone number and web site address. To create meaningful changes in smoking behavior, NY TCP's advertising must reach a large portion of the state's smokers.

We conducted an analysis to assess how the reach of NY TCP's health communication campaigns influences the degree to which the campaigns promote smoking cessation. We assessed the relationship between potential campaign reach as measured by GRPs and smokers making quit attempts. To do this, we compared the actual number of smokers making a quit attempt to the number who would have made a quit attempt if potential campaign reach achieved the CDC-recommended 75% confirmed awareness among smokers.

Data and Methods

We used the quit attempt measure from the NY ATS telephone survey of New York adults for 2003 through 2015, except for 2013. To estimate reach, we used quarterly data on GRPs for each of the 10 media markets in New York State. GRPs are a measure of potential campaign reach that is a function of the **frequency of an advertisement's airing and the percentage of the target audience reached during those airings.**

To implement the analyses, we first predicted the level of GRPs needed to reach 75% confirmed awareness among smokers. We found that reaching this level of awareness would require 8,235 GRPs per quarter. We then predicted quit attempts as a function of past-year cumulative GRPs while controlling for

sociodemographic measures (i.e., age, education, race/ethnicity, and income) cigarettes smoked per day, self-reported price paid per pack of cigarettes, and an annual measure of national quit attempt prevalence determined by using NHIS data. Past-year cumulative GRPs were transformed by taking their square root to account for the diminishing returns of GRPs as campaign reach increases to high levels.

In addition, we predicted the effect of changes in levels of media exposure to the prevalence of quit attempts using two counterfactuals: (1) eliminating media campaigns (or 0 GRPs) and (2) increasing the potential reach of media campaigns such that confirmed awareness would approach 75% on average or 8,235 GRPs per quarter.

We then estimated the number of adult smokers who make a quit attempt under different countermarketing scenarios. To do this, we estimated the number of adult smokers by taking U.S. Census estimates for the adult population in New York State and multiplying by the prevalence of current smoking using data from BRFSS. We then multiplied the population of adult smokers by our set of predicted levels of quit prevalence. Estimates of the number of smokers making a quit attempt are for the years 2003 through 2015.

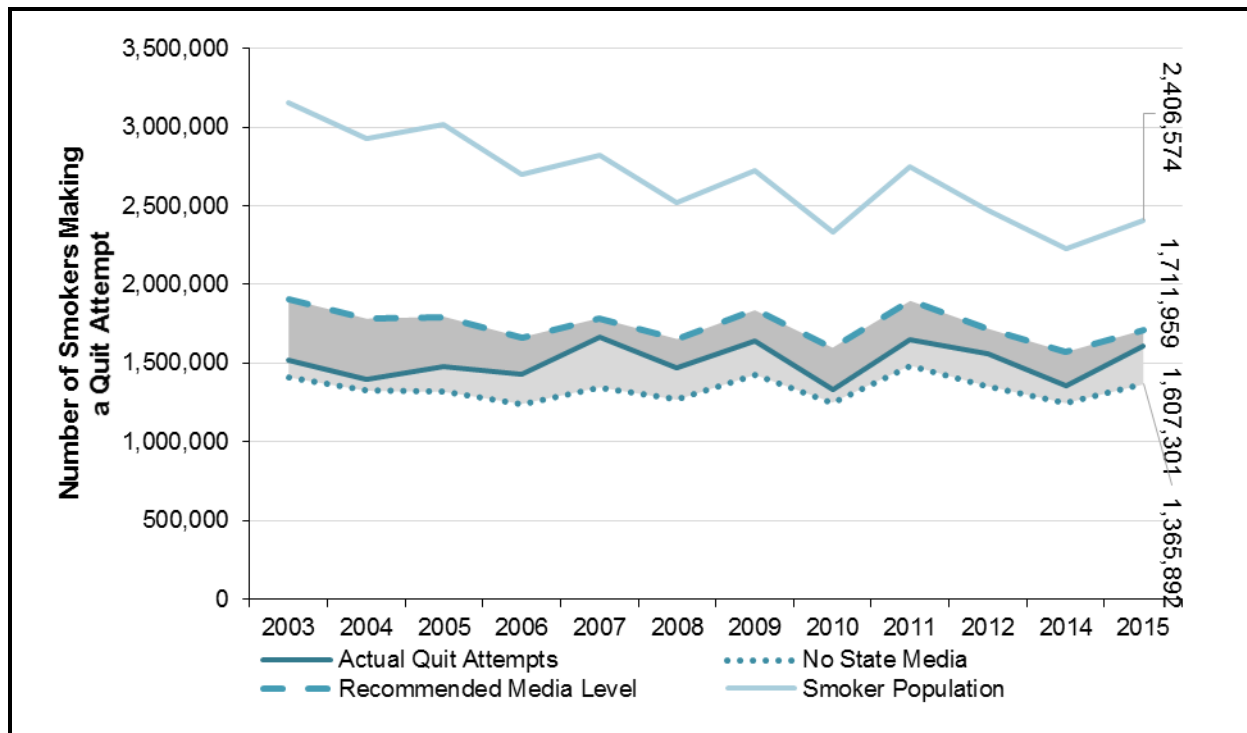
Results

We found evidence of the impact of **NY TCP's antismoking** campaigns on smoking cessation. Figure 32 illustrates the impact of different levels of GRPs on the prevalence of smokers making a quit attempt. **Our analyses found that if NY TCP's** antismoking campaigns had not been aired from 2003 to 2015, 174,000 fewer smokers would have made a quit attempt per year on average. This represents a cumulative impact of over 2 million additional smokers making a quit attempt.

The predicted number of smokers making a quit attempt increases when campaign GRPs are increased to reach 75% confirmed awareness. We estimate that with 8,235 GRPs per quarter (32,940 per year), approximately 233,000 more smokers would make a quit attempt each year compared with current levels—16% more smokers making a quit attempt each year. For comparison, NY TCP antismoking campaigns average 6,548 GRPs per year. The estimated cumulative impact of

increasing campaign GRPs amounts to an increase of 2.8 million smokers making quit attempts from 2003 through 2015.

Figure 32. Estimated Number of Adult Smokers Who Report Making a Quit Attempt in the Past 12 Months by Levels of Campaign GRPs, 2003–2015



Summary

NY TCP’s health communication campaigns are making a positive impact on New York adult smokers’ cessation outcomes. There is potential to increase the number of smokers who are aware of NY TCP’s antismoking campaigns, which has the benefit of promoting smoking cessation. This analysis suggests that larger NY TCP media buys will lead to significant increases in quit attempts, a conclusion that is supported by previous research (Farrelly et al., 2012).

Smoking Cessation Counseling among New York Dentists

In May 2014, New York State announced the expansion of Medicaid smoking cessation benefits to cover cessation counseling provided by dentists and dental hygienists

(NYSDOH, 2014). These dental practitioners can be reimbursed for providing smoking cessation counseling sessions that are conducted individually, in person, for more than 3 minutes, and for which 4 of the 5 A's intervention components are documented in the dental record. Up to two smoking cessation counseling sessions are reimbursable within any 12 continuous months (effective April 1, 2014, for FFS and July 1, 2014, for MMC). The expansion of this benefit was communicated to dentists and hygienists via the NYSDOH Medicaid update newsletter (NYSDOH, 2014).

One of NY TCP's objectives is to increase use of evidence-based cessation treatments among Medicaid beneficiaries. In this section, we describe a special study that RTI conducted in 2015 to **assess dentists' and hygienists' awareness of Medicaid** benefits and guideline-concordant clinical intervention.

Data and Methods

In 2015, RTI obtained a list of general dentists in New York State who serve Medicaid beneficiaries. We identified dentists who had submitted at least one claim (for Medicaid FFS) or had encounter data (for MMC) between October 2013 and September 2014. We excluded pediatric dentists, dentists with addresses outside of New York State, and dentists who could not be matched to the licensure database. The sampling frame included 3,874 eligible dentists.

RTI selected a random sample of 750 dentists. We mailed a survey to all sampled dentists and included a survey for one **hygienist from each dentist's office**. The survey measured **dental practitioners' tobacco**-related clinical interventions (the 5 A's: Ask, Advise, Assess, Assist, Arrange) and awareness of the Medicaid benefit and other available cessation services in New York State. To measure the Assist component, we used a composite measure created from five items regarding providers prescribing or recommending pharmacotherapy, suggesting the smoker set a quit date, suggesting a smoking cessation class or telephone quitline, or providing self-help materials.

The response rate was 22.3%. We received 274 completed surveys from eligible dentists (n=182) and dental hygienists (n=92) who serve Medicaid enrollees in New York State.

Results

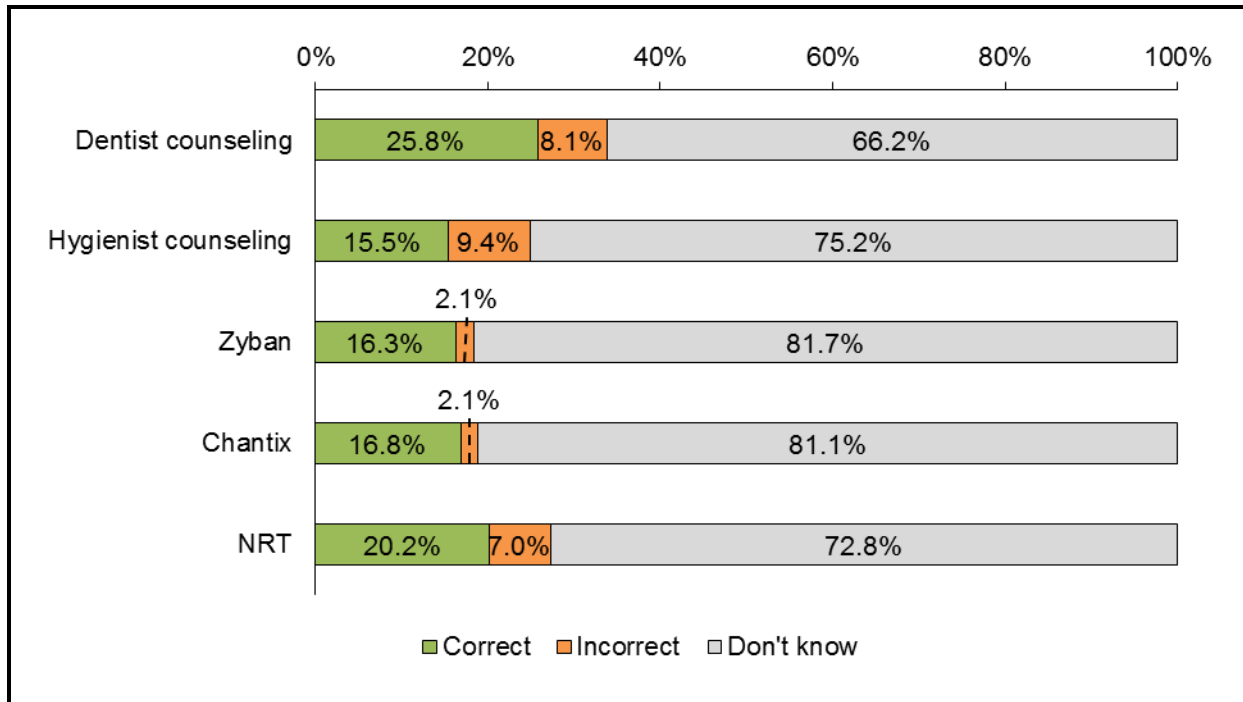
Most (73.4%) respondents reported asking patients about their smoking status **“always” or “often”** (Table 4); 58.3% document **patients’ smoking status in patients’ charts**. Most respondents (83.7%) reported advising patients who smoke to quit; 48.9% **assessed tobacco users’ readiness to quit**, **49.1% assisted with quitting**, and 10.4% arranged a smoking-specific follow-up with tobacco users.

Table 4. Smoking Cessation Intervention Behaviors among New York Dentists and Hygienists Who Serve Medicaid Patients, 2016

5 A Component	Percent
Ask	73.4%
Advise	83.7%
Assess	48.9%
Assist (composite measure)	49.1%
Assist (individual items)	
Set quit date	23.0%
Discuss withdrawal	17.6%
Suggest cessation class/counseling	24.7%
Suggest a quitline	20.4%
Provide self-help materials	14.6%
Prescribe/recommend NRT/medications	19.5%
Arrange	10.4%

Fewer than 30% of dentists and hygienists in New York reported being aware that smoking cessation counseling is a Medicaid-reimbursable service when conducted by dentists (25.8%) or hygienists (15.5%) (Figure 28). About two-thirds of dentists (66.8%) reported that their office does not currently bill for Medicaid reimbursement for smoking cessation counseling (data not shown). Most dentists and hygienists were not aware of Medicaid coverage of stop-smoking medications (e.g., stop-smoking medications such as Zyban or Chantix, over-the-counter NRT) (see Figure 28).

Figure 28. Dentist and Hygienist Reports of Medicaid Smoking Cessation Coverage, 2016



Note: "Correct" indicates that the respondent, when asked if each type of smoking cessation service or medication was covered by New York State Medicaid, answered "Yes." "Incorrect" indicates that the respondent answered "No," and "Don't know" indicates that the respondent answered "Don't know" to the question.

Summary

Dentists and hygienists who serve Medicaid patients talk with patients about smoking, but they are inconsistently assisting patients with quitting smoking and are largely unaware of available Medicaid benefits to help their patients with smoking cessation. There is an opportunity to increase dental health professionals' **awareness** of the relatively new smoking cessation counseling benefit available for their use and increase awareness of cessation resources for their patients through Medicaid. **Increasing dental health professionals' awareness of the Medicaid benefit and cessation services can help to achieve NY TCP's goal of increasing use of evidence-based treatments among Medicaid beneficiaries.**

Discussion

Progress in Changing Tobacco Use

Adult smoking prevalence has decreased over time in New York and in the rest of the United States. The adult smoking

prevalence goal set for the end of 2018 (15% prevalence) in the NYSDOH Prevention Agenda was adjusted downward (to 12.3%) because of progress already achieved. Cigarette smoking prevalence among young adults aged 18 to 24 decreased to a level much lower than the NYSDOH Prevention Agenda objective years before the target date. However, discrepancies in adult smoking prevalence remain by education, income, and mental health status. The rate of cigarette smoking among New York adults with poor mental health is more than twice that of those with good mental health. This disparity continues to be a focus of NY TCP efforts across program components, including health systems change targeting mental health organizations and communication about the expansion of Medicaid benefits for individuals with a mental health diagnosis.

Overall, daily cigarette consumption has remained unchanged over the past 7 years. Quit attempts have increased over time, and NY TCP is focusing on promoting the use of evidence-based treatment to increase the likelihood that quit attempts will be successful.

Although cigarette smoking is declining, the use of other tobacco products remains largely unchanged in recent years. The rate of cigar use in New York is consistent with national rates. Although smokeless tobacco use in New York has not decreased, it is currently less than 2% and is lower than the national rate. E-cigarette use has increased since these products were first introduced, but the rate was unchanged from 2014 to 2015 and is similar to rates in the rest of the country. Approximately half of e-cigarette users also smoke cigarettes.

Cigarette smoking among youth has decreased dramatically since 2000, and estimates of smoking among New York middle and high school students dropped from 2012 to 2014. The NYSDOH Prevention Agenda target decrease in youth tobacco use prevalence (15.0%) has not yet been met. Declines in cigarette smoking rates among New York youth follow the same pattern as national rates, and New York youth report lower use of tobacco products than youth in the United States overall. However, New York high school students now use e-cigarettes more than any other tobacco product. To meet the NYSDOH

Prevention Agenda youth tobacco use objective, the program will need to rein in youth e-cigarette use.

New York's strong tobacco control environment will likely maintain current antitobacco norms and tobacco use prevalence rates. However, NY TCP recognizes that continued reductions in tobacco use, including among adults with low income and poor mental health, require strengthening traditional tobacco control interventions and implementing new interventions that increase cessation and decrease youth initiation (Institute of Medicine, 2007). Currently, NY TCP funding is 19% of the CDC-recommended level. A recent influx of revenue creates a potential opportunity to allocate more funds to tobacco control; the Attorney General settlement with the tobacco industry released \$550 million in funds, half of which will go to New York State. The country as a **whole is catching up with New York's** early success, and improvements in many key measures have stalled. Increased NY TCP funding would facilitate additional **efforts that would improve the program's chances of continuing** to be a leader in tobacco control and general health outcomes.

Health Communications

New York's health communication efforts achieve efficient reach. More than half of smokers in the state are aware of NY **TCP advertisements even though the state's allocated funding is** approximately 20% of the CDC recommended level for the state. The program uses graphic and emotional ads to encourage smokers to quit and to seek support for quitting, including talking with their doctor and calling the Quitline. This integration of programmatic initiatives offers a broader call to action.

Health Systems Change

The program conducts evidence-based interventions focused on health systems change to support tobacco use cessation, including funding health systems contractors to facilitate systems changes in health care organizations across the state and funding the Quitline. The health systems Center of Excellence works at the state level to foster an environment supportive of cessation-focused health systems change that encourages health care organizations to institutionalize guideline-concordant policies and systems.

Health systems contractors are focusing on systems change in organizations where populations with the highest rates of smoking are concentrated, in CHCs and mental health facilities. New York adult smokers report that health care providers ask about tobacco use and advise them to quit at high rates, but less than half of smokers report that their provider assisted them with quitting. Even as Quitline calls and reach trend downward nationwide, the New York **State Smokers' Quitline** is efficiently providing services to smokers in the state. In addition, New York has made additional changes to expand Medicaid benefits for smoking cessation.

Statewide and Community Action

Community Engagement and Reality Check collaborate under the existing contract structure, supported with professional development, strategic planning, and policy initiatives. Contractors have made ongoing progress with point of sale, tobacco-free outdoors, smoke-free multi-unit housing, and smoke-free media initiatives. Public support for some key policy areas has increased over time, and many targeted policy initiatives have significant support among New York adults. The number of retailers with cigarette ads and promotions has decreased, and assessments have documented good compliance with regulations on self-service and age-of-sale signage.

Programmatic Recommendations

Overall Recommendations

- Increase NY TCP funding to a minimum of one-half of **CDC's recommended funding level for the state** (\$203 million) to \$101.5 million.
 - This significant increase would require careful shifts in staffing, contractor allotments, and media, and would help the program implement CDC best practice recommendations. NY TCP could increase funds for statewide and community intervention contractor efforts, health systems contractor activities, and professional development. Health communication interventions could be expanded to reach more specific and hard-to-reach target populations. The program could increase its staffing and

communications capacity and expand its surveillance and evaluation activities to assess **the program's impact more comprehensively.**

- Continue to develop and target interventions to reach smokers with disproportionately high rates of smoking, especially adults with low income and poor mental health.
- Update the NYSDOH Prevention Agenda objectives to reflect program successes, and add an objective regarding adult e-cigarette use prevalence.

Health Communication Recommendations

- Review placement strategy to maximize media reach to smokers, particularly those with low income and/or poor mental health.
- **Review data regarding smokers' media use habits to assess whether media campaigns could be more specifically targeted by type of media, including social media.**

Health Systems Change Recommendations

- Continue directing Health Systems for a Tobacco-Free New York contractors to focus their efforts on organizations that serve high proportions of low-income tobacco users, such as CHCs.
- Continue to promote health systems change in mental health organizations through work with agency administrators and statewide organizations.
- Collaborate with New York State Medicaid to conduct additional educational efforts targeting enrollees and providers to promote awareness and use of the Medicaid benefit for smoking cessation.
- Encourage the health systems Center of Excellence to implement meaningful initiatives to help create changes in the state-level context for health systems change that support the institutionalization of tobacco dependence treatment.

Statewide and Community Action Recommendations

- Continue educating the public and policy makers about the influence of tobacco marketing at the point of sale on youth and the continued emphasis on the

evidence-based policies that would reduce exposure to tobacco marketing at the point of sale.

- Increase the reach of the point of sale initiative messaging by sustaining and expanding paid media that reinforce the messages contractors communicate through policy-maker advocacy, public education, and community mobilization.

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