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# 2015 Independent Evaluation Report of the New York Tobacco Control Program

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## Executive Summary

New York State has invested steadily in evidence-based programs that promote a tobacco-free norm. In addition, New York has been a leader in tobacco policies as one of the first states to have a comprehensive smoke-free air law and the state with the highest cigarette excise tax. After successfully implementing the comprehensive smoke-free air law (2003), the New York Tobacco Control Program (NY TCP) turned its attention to what the Institute of Medicine (IOM) called “next generation” tobacco control policies in 2007 (Bonnie, Stratton, & Wallace, 2007). These include policies that promote smoke-free outdoor spaces and multi-unit housing and reduce the influence of the point-of-sale (POS) tobacco environment (e.g., reducing the number of tobacco retailers near schools and in communities overall). At the same time, NY TCP began promoting systems-level change in health care settings to prompt providers to do more to encourage tobacco cessation.

For several years, funding has remained stable at approximately 20% of the Centers for Disease Control and Prevention’s (CDC’s) recommended funding level, so it is not surprising that many of the key outcome indicators have remained steady in recent years. However, the prevalence of smoking among adults has declined by 31% since 2009 compared with 18% for the United States as a whole. As of 2014, the prevalence of smoking in New York (14.5%) was lower than the national prevalence (16.8%). Despite these declines in the prevalence of smoking, notable disparities exist by education, income, and mental health status. The prevalence of smoking is quite low for those with at least a college degree (6.8%) and annual income of \$75,000 or more (9.4%) compared to those with less than a high school degree (22.4%) or income less than \$25,000 (19.9%).

These disparities persist even though New York has had a comprehensive smoke-free air law for over a decade, the highest state cigarette excise tax in the country for several years, and a media campaign that has been shown to increase quit attempts among smokers across diverse sociodemographic groups (Farrelly et al., 2012). To reduce the disparities in smoking prevalence, an increase in program funding is needed

to increase the reach of tobacco-focused health communications and other evidence-based interventions. It may also be possible to reach the affected populations more effectively with a more efficiently targeted media campaign.

NY TCP has made progress in encouraging communities to adopt “next generation” tobacco policies. Six million New Yorkers now live in communities with smoke-free beaches and/or parks, and 2 million live in communities that no longer permit smoking near building entryways. Although these policies help support a tobacco-free norm, they may not be sufficient to reduce smoking prevalence in the near term. That may require more broadly adopted policies that reduce availability of tobacco products and exposure to tobacco promotions and systems changes in health care settings that support smoking cessation. NY TCP has had some success in promoting these policy and systems changes, but its reach is currently limited. To accelerate the adoption of these policy and systems changes will likely require more resources, including targeted media campaigns aimed at building support among the public and key decision makers.

Currently, NY TCP funding of \$39.3M is a small percentage of state tobacco revenue and Master Settlement Agreement (MSA) payments and less than one-fifth of what CDC recommends. To reduce disparities in cigarette smoking and to make progress on many of the stalled trends, key outcome indicators will require a greater commitment of resources. A gradual increase of funding to \$101.5M (half of CDC’s recommendation) would allow NY TCP time to build capacity and address the health and economic burden associated with the leading cause of premature death in the United States.

## *Key Evaluation Findings*

### **Tobacco Use**

- The prevalence of adult smoking in New York declined by 31% from 2009 (21.1%) to 2014 (14.4%) compared with an 18% decline nationally (from 20.6% to 16.8%).
- In 2014, the prevalence of smoking in New York was considerably higher than the statewide average among adults who have less than a high school degree (22.4%), annual income less than \$25,000 (19.9%), or

have ever been told they have a depressive disorder (23.3%).

- As of 2014, the adult prevalence of electronic cigarette (e-cigarette) use was 6.5%, and 4.4% were both current smokers and current users of e-cigarettes.
- Average cigarette consumption among current smokers in New York has remained steady since 2009 and in 2014 was similar to average consumption in the rest of the United States.
- The prevalence of smokers making a quit attempt in the past year has not changed since 2009. In 2014, 60.9% of smokers made a quit attempt in the past year—statistically similar to the rest of the United States.
- The percentage of smokers using evidence-based methods for quitting increased from 13.7% in 2003 to 20.9% in 2014, a 52.6% increase.
- From 2000 to 2014, the prevalence of smoking declined by 56% among high school students in New York compared with 45% nationally. Among middle school students, smoking prevalence declined by 84% in New York and by 73% nationally.
- In 2014, 3.2% of middle school students in New York used e-cigarettes in the past 30 days, which is similar to the national prevalence of 3.9%. Among high school students, the prevalence of e-cigarette use was lower in New York (10.5%) than nationally (13.4%).

### Measures of NY TCP Program Reach and Impact

- In the past decade, smokers' awareness of NY TCP television advertisements has held steady at nearly 40%.
- Since 2008, approximately four out of five smokers are aware of the New York State Smokers' Quitline.
- Similarly, Quitline call volume and Quitsite registrations have been stable in recent years.
- In 2014, 45% of smokers reported that their health care provider had assisted them with smoking cessation in the past year—unchanged for several years and similar to the rest of the United States.
- Support for POS policies, including limiting the number of tobacco retailers in a community and near schools, banning the sale of tobacco in pharmacies, and banning tobacco displays, has increased over time among adults and local elected officials.

- To date, two municipalities with nearly 300,000 residents have adopted policies that restrict the type or location of tobacco retailers.
- Approximately three-quarters of New Yorkers support banning smoking near building entryways, and two-thirds support banning smoking in outdoor spaces (e.g., parks and beaches).
- From 2012 to 2015, 45 municipalities with 2 million residents adopted policies that ban smoking near building entryways.
- Over that same period, 171 municipalities with approximately 6 million residents banned smoking in beaches, parks, and/or public playgrounds.
- Two-thirds of New Yorkers support banning the sale of tobacco products near school and raising the minimum purchase age for tobacco products to 21.
- As a result of a state law passed in 2010, cigarette wholesalers had to pre-pay cigarette state excise taxes starting in 2011, including those sold on Native American reservations.
- Despite this change in law, the percentage of smokers reporting that they purchased cigarettes from low-tax sources and on reservations did not change significantly. However, more smokers began to purchase native brand cigarettes, sold tax-free on reservations.

### *Overall Programmatic Recommendations*

- Increase NY TCP funding to a minimum of one-half of CDC's recommended funding level for New York (\$203M) per year. This represents a small percentage of New York State's annual revenue from tobacco taxes and MSA payments.
- Continue to develop and implement interventions to reduce disparities in smoking rates.
- Continue to enhance surveillance of e-cigarettes among youth and adults to better understand how they are influencing patterns of tobacco product use and population health.

## Introduction

The New York Tobacco Control Program (NY TCP) has a long history of implementing evidence-based tobacco control programming consistent with the Centers for Disease Control and Prevention's (CDC's) *Best Practices for Comprehensive Tobacco Control Programs* (CDC, 2014). The Program's approach consists of three key components: health communication; cessation interventions; and statewide and community action aimed at policy, systems, and environmental changes.

Patterns of tobacco use today are significantly different from 15 years ago. During this period, the prevalence of smoking in New York has declined markedly among youth and steadily among adults. As of 2014, the prevalence of current smoking was 14.5% among adults, 7.3% among high school students, and 1.1% among middle school students. However, in the past few years, use of electronic cigarettes (also known as e-cigarettes, vape pens, and e-hookahs) has increased substantially, especially among youth, and waterpipe/ hookah use has also increased. Despite the steady declines in smoking among adults, persistent differences remain across demographic groups. The prevalence of smoking remains high among those with relatively low education and/or income, racial/ethnic minorities, and those with poor mental health.

In this report, we describe the contextual influences that can affect NY TCP's progress, outline NY TCP's approach to tobacco control, review trends in key outcome indicators, and address the following critical evaluation questions for NY TCP:

- How have key outcome indicators changed over time?
- How do these indicators compare between New York and the United States?
- How has public and policy-maker support for tobacco control policies changed over time?
- Has the percentage of smokers buying from Native American reservations changed following recent policy changes?

Addressing these central evaluation questions will illustrate progress made in key outcome indicators and highlight gaps that need to be addressed moving forward.

## The New York Tobacco Control Program – Context and Programmatic Approach

In this section of the report, we describe the tobacco control context in New York State. We then provide an overview of the Program’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 nearly \$3 more than the national average tax per pack. All New Yorkers have been covered by a comprehensive smoke-free air law (workplaces, restaurants, and bars) for over a decade, compared with 55% of the population nationally. In fiscal year (FY) 2014, per capita funding for tobacco control was higher in New York (\$2.17) than in the average of all other states (\$1.71) (Table 1). At its peak in 2007, New York’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, 2015)	\$4.35	\$1.54
Percentage of the state population covered by comprehensive <sup>a</sup> smoke-free air laws (December 31, 2014)	100%	54.8%
Annual per capita funding for tobacco control (FY 2014)	\$2.17	\$1.71 (excluding New York)

<sup>a</sup> “Comprehensive” refers to laws that create smoke-free workplaces, restaurants, and bars.

### *Program Budget*

The NY TCP budget of \$39.3 million for FY 2015–2016 is similar to recent years and 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 current funding represents less than 2% of annual cigarette tax and Master Settlement Agreement (MSA) payments. New York State received cigarette tax revenue and MSA payments totaling approximately \$2.33 billion for FY 2015 (Table 2).

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

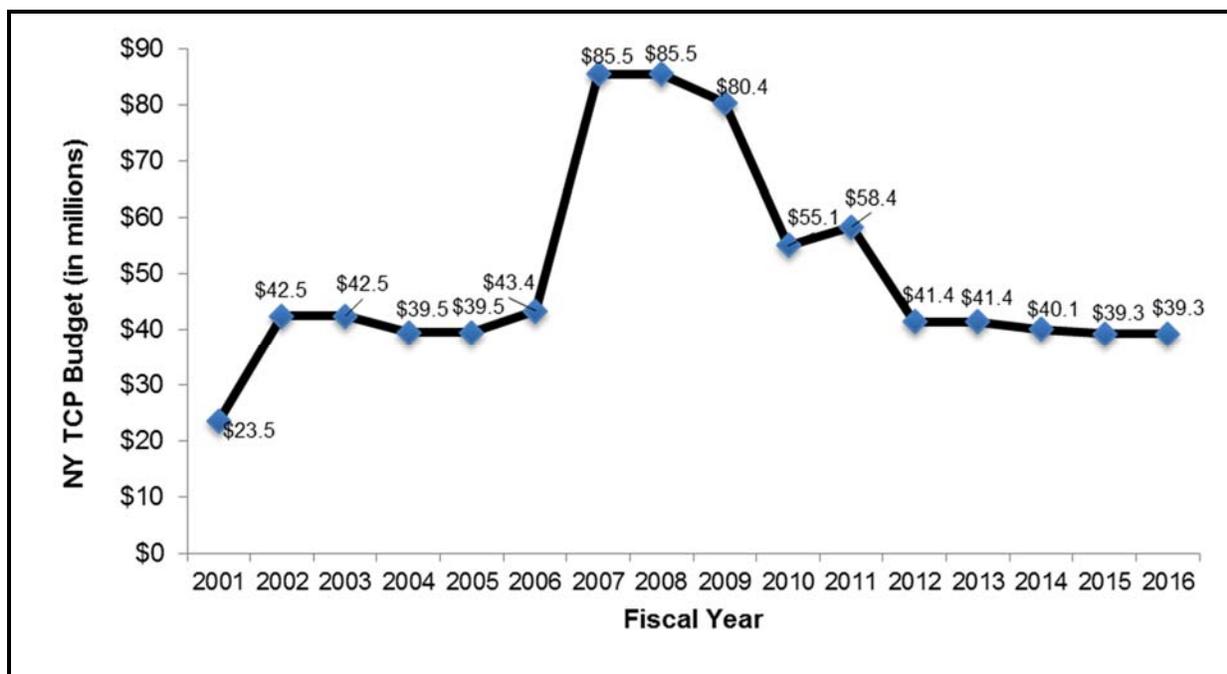
Revenue/Expenditure Category	Annual Revenue/Expenditure
Revenue from state cigarette excise tax (FY 2015)	\$1,390,000,000
Revenue from MSA payments (FY 2015)	\$713,000,000
Estimated cigarette advertising and promotions in New York State (CY 2013) by five major cigarette manufacturers	\$239,463,563
National advertising for e-cigarettes (CY 2014)	\$113,400,000
New York Tobacco Control Program budget (FY 2015–2016)	\$39,330,600

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

Tobacco companies spent \$9.2 billion nationally on advertising and promotions in 2012 (Federal Trade Commission, 2015). If these expenditures are spent in proportion to cigarette sales, then this translates to \$239 million spent on advertising and promotions overall in New York State. Of this, an estimated \$204 million (85%) is for price reductions and retail-value-added bonus cigarettes (e.g., buy two packs, get one free). In addition, advertising for e-cigarettes has grown in recent years. For 2014, \$113.4 million was spent on advertising for e-cigarettes across multiple media channels, including television, magazines, outdoor, Internet, online video, newspapers, and radio. In comparison, major cigarette companies spent \$98 million nationally on advertising alone in 2012. However, unlike tobacco advertising, e-cigarette advertising is spent largely on television. 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).

The approved budget of \$39.3 million for FY 2015–2016 is similar to the previous four FY budgets. The longer-term pattern of NY TCP funding is shown in Figure 1 and provides context for interpreting the longer-term trends in key outcome indicators presented below.

Figure 1. NY TCP Funding FY 2000–2001 to FY 2015–2016



Note. NY TCP = New York Tobacco Control Program

Table 3 shows the budget for FY 2014–2015 and FY 2015–2016 by program component. The overall budget was essentially unchanged across these two years. Resources are similar across the two years for the Quitline and the provision of nicotine replacement therapy (NRT). Cessation Center contracts ended in June 2014, and the new funding opportunity restructured the health systems efforts and renamed the contractors Health Systems Change for a Tobacco-Free New York contractors. Funding for media placement increased by roughly 13%. Effective June 30, 2014, Community Partnerships and Reality Check contracts ended, and new Advancing Tobacco-Free Communities contractors took their place. With these changes in the structure of procurements, the FY 2014–2015 expenditure plan shows funds for Community Partnerships, Reality Check, and Cessation Centers through June 2014. Overall funding for community contractors remained similar across FY 2014–2015 to FY 2015–2016.

**Table 3. NY TCP Budget for FY 2014–2015 and FY 2015–2016**

<b>Program Component</b>	<b>2014–2015 Expenditure Plan</b>	<b>2015–2016 Expenditure Plan</b>
<b>State and Community Interventions</b>	<b>\$10,688,509</b>	<b>\$10,394,750</b>
Community Partnerships	\$2,036,453	—
Reality Check	\$590,006	—
Advancing Tobacco-Free Communities	\$7,050,000	\$9,394,000
Center for Public Health and Tobacco Policy	\$513,766	\$500,750
Training/Professional development	\$498,284	\$500,000
<b>Enforcement</b>		
Clean Indoor Air Act and Adolescent Tobacco Use Prevention Act Enforcement	<b>\$4,724,950</b>	<b>\$4,724,950</b>
<b>Cessation Interventions</b>	<b>\$9,268,011</b>	<b>\$8,524,770</b>
Cessation Centers	\$1,375,719	
Health Systems for a Tobacco-Free New York	\$2,456,078	\$3,274,770
Quitline	\$4,636,214	\$4,500,000
Nicotine replacement therapy	\$800,000	\$750,000
<b>Health Communication Interventions</b>		
Media placement	<b>\$7,723,052</b>	<b>\$8,760,203</b>
<b>Surveillance and Evaluation</b>		
Independent evaluation	<b>\$2,988,926</b>	<b>\$2,988,927</b>
<b>Administration</b>		
Tobacco control and cancer services	<b>\$3,937,000</b>	<b>\$3,937,000</b>
<b>Total</b>	<b>\$39,330,448</b>	<b>\$39,330,600</b>

Although the 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 22% of funds for health communication, compared with CDC’s recommended 23%. Statewide programs constitute 26% of the budget, compared with the CDC recommended 30%. For cessation funding, NY TCP allocates 22%, compared with the recommended 34%. The allocation for surveillance and evaluation (8%) is close to the recommended percentage (9%). The allocation for administration is higher (10%) than CDC recommendations

(4%), but 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 bases its approach on the social norms 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). California was one of the first state tobacco control programs to use a social norms approach and achieved a substantial decline in smoking among adults and youth (CDHS, 1998). Currently, NY TCP is focused on the goals of reducing the prevalence of smoking to 15% among adults and reducing the rate of any tobacco use (i.e., cigarettes, cigars, and smokeless tobacco) to 15% among high school students by 2017. 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 require strengthening traditional tobacco control interventions and implementing new interventions that increase cessation and decrease youth initiation (Bonnie et al., 2007).

NY TCP's statewide and community initiatives focus on promoting evidence-based policies at the local level to decrease exposure to secondhand smoke and reduce the social acceptability of tobacco. Strategic planning and training efforts reinforce the emphasis on implementing policies that can reach a significant proportion of the population. Local policy goals include increasing the number of tobacco-free multi-unit dwellings in the state and increasing the number of tobacco-free outdoor public spaces, such as beaches, parks, and building entryways. Additionally, NY TCP has focused on changing the tobacco retail environment to reduce youth exposure to tobacco product marketing. Local contractors educate the public and local policy makers about the effects of tobacco POS marketing on youth initiation and the need for local policies to reduce that exposure. In the following sections,

we describe NY TCP's major programmatic activities in more detail.

### *Administration and Support*

Consistent with CDC Best Practices, NY TCP supports its programmatic activities with a multilevel management approach that emphasizes strategic implementation of the program's initiatives. NY TCP provides training and technical assistance and coordinates surveillance and evaluation activities. NY TCP administration drives the overall programmatic strategy, building and maintaining an effective tobacco control infrastructure, providing technical assistance and guidance, and managing the effective and efficient investment of state tobacco control funding. To ensure that policy goals are met, NY TCP has implemented an integrated approach and implemented strong accountability procedures. State and community-level activities, as well as program initiatives, are supported by development and dissemination of key messages focused on key programmatic initiatives. The messages 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, promote smoke-free homes, deglamorize tobacco use, and educate community members and decision makers about tobacco control issues. There is growing evidence that antismoking campaigns are effective in reducing cigarette smoking among youth (USDHHS, 2012) and adults (Farrelly et al., 2012a; NCI, 2008; Wakefield et al., 2010, 2011). NY TCP has focused 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., 2012a). Nearly all messages include the New York State Smokers' Quitline telephone number and Web site address.

During 2014, NY TCP continued to use message strategies that have been successful in the past several years, with campaigns that primarily focus on promoting cessation. In the first half of

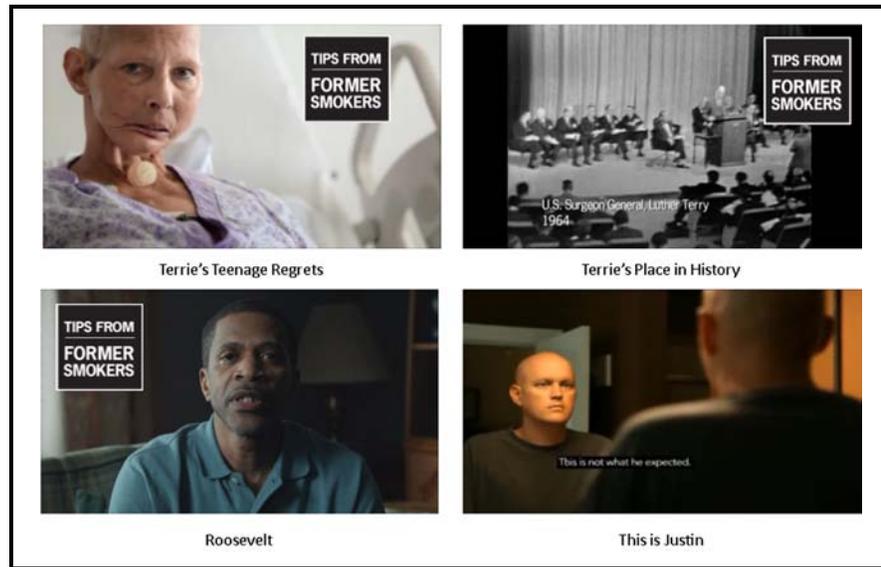
the year, NY TCP's cessation-focused advertising included two ads from the Reverse the Damage campaign. "Reverse Heart Attack" and "Reverse Lung Cancer" promote the immediate and long-term benefits of smoking cessation through a series of graphic images and end with a motivational plea to stop smoking immediately. At the same time, NY TCP also aired "The Wait," a cessation-focused ad set in a doctor's exam room with a patient waiting for the doctor to return with a diagnosis. The ad ends with the narrator asking, "If you're not planning to quit smoking, what are you planning?"

In summer 2014, NY TCP continued to air messages designed to motivate tobacco users to quit with "Suffering—Emphysema"—an ad in the Suffering Every Minute campaign, which was successfully used in 2013. These ads portray the devastating long-term suffering from smoking-related diseases, and emphasize that dying from smoking is rarely quick and never painless. In addition, through graphic images of smokers' organs and descriptions of the immediate harm caused by tobacco, ads from the Every Cigarette Is Doing You Damage campaign also stressed the dangers of smoking even in small amounts.

From October to December 2014, NY TCP aired three ads that feature the story of Justin Andrews, a young father who is suffering from lung cancer. Through interviews and scenes from his life, he describes the physical and emotional toll the disease has taken on him and on his family as he goes through chemotherapy and can no longer participate in all of the things he enjoys. The ads end with a dedication indicating that Justin lost his battle with cancer at age 30. Throughout the year, NY TCP complemented these messages by continuing to air ads from CDC's *Tips From Former Smokers (Tips)* tobacco education campaign (Figure 2).

In 2015, NY TCP plans to continue to use ads that focus on cessation and secondhand smoke. Ads that depict the effects of smoking-related illness are included in the Painful Cancer series, which focus on graphic images associated with stomach cancer, pancreatic cancer, and esophageal cancer, as well as the painful and invasive treatments for these diseases. Emotional appeals will be used in "Hallway" and "Last Dance"—ads that emphasize the effects of tobacco use and related illnesses, not just on the users but their families too. These

Figure 2. Sample Ad Images



messages will again be complemented by ads from CDC's *Tips* campaign ("Ronaldo," "Suzy," "Terrie's Voice"), which use personal experience to highlight the potential health effects of tobacco use.

### *Health Systems Interventions*

NY TCP's health systems interventions involve an evidence-based multistrategy approach to promote cessation by institutionalizing changes in health systems and offering telephone-based smoking cessation counseling. 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 the Medicaid benefits for smoking cessation. The New York State Smokers' Quitline offers tobacco cessation counseling, provides access to NRT, and serves as an information clearinghouse for cessation. Below, we describe NY TCP health systems interventions in more detail, addressing health systems contractor interventions, the New York State Smokers' Quitline, and reduced patient costs for treatment.

## Health Systems Contractor Interventions

NY TCP's health systems change intervention activities have focused on funding contractors to increase the number of health care provider organizations that have systems to screen all patients for tobacco use, provide brief advice to quit at all visits, and provide assistance to help patients quit successfully. This approach is aligned with evidence-based recommendations citing that brief advice to quit smoking by a health care provider significantly increases the odds that a smoker will quit. New York health systems contractors partner with health care organizations across New York State. NY TCP funds 10 regional health systems contractors and 1 statewide Center of Excellence. The regional contractors help with changes to improve tobacco cessation intervention, establish regular provider training, facilitate system improvement, and provide technical assistance. The statewide Center of Excellence provides support to the regional contractors and works at the state level on broad changes to motivate health care organizations to institutionalize guideline-concordant policies and systems.

When they began their efforts more than 10 years ago, contractors targeted hospitals and then branched out to medical practices, where the majority of smokers report getting regular care. Consistent with RTI recommendations, NY TCP instructed the contractors to shift their focus to organizations that serve higher proportions of tobacco users. Specifically, NY TCP redirected the focus of this initiative from medical practices to community health centers and programs that serve individuals with severe mental illness. Because populations with low socioeconomic status and populations with mental illness use tobacco at higher rates than the general population, working with community health centers and mental health facilities provides a significant opportunity for health systems contractors to target their efforts. 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.

RTI conducted a qualitative study that explored how policies, systems, and patient records guide tobacco use screening and treatment in Federally Qualified Health Centers (FQHCs) and their clinical sites. This study found that FQHCs often have

written policies regarding tobacco screening and treatment, but that electronic health records (EHRs) and standard workflows are important tools to reinforce those policies. FQHC administrators and providers indicated that, while there is some interoperability between EHRs and other organizations' systems, the tobacco-related fields are inconsistent within and across organizations. The study identified factors that facilitate systems change, including special projects or initiatives, external requirements from funding agencies, collaborative decision making within the organization, long-term champions, support at multiple levels, and the flexibility to tailor the change process.

### **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) providing a call to action in mass media messages designed to promote cessation; and (4) enhancing the ability of health care providers to refer their patients to a helpful resource. In 2014, the Quitline reported receiving 162,027 calls and having 1,184,182 visits to their online Quitsite, nearly double the previous year's visits (691,085).

### **Reduced Patient Costs for Treatment**

NY TCP has worked with the Medicaid program to expand coverage for smoking cessation counseling and pharmacotherapy. Fee-for-service Medicaid covers all first-line, Food and Drug Administration–approved medications except nicotine lozenges, and most Medicaid Managed Care plans

cover at least the nicotine patch and gum, bupropion (Zyban®), and varenicline (Chantix®); some cover even more. Two 3-month courses are covered per year, including combination therapy (e.g., patch and gum). Medicaid also reimburses for up to six counseling sessions annually for all Medicaid beneficiaries, expanded from previously covering counseling for adolescents and pregnant and postpartum smokers only. NY TCP and the Statewide Center of Excellence Health Systems contractor encourage health plans to expand coverage and promotion of cessation services to their members.

Additionally, NY TCP and the Center of Excellence are supporting Medicaid Managed Care plans and groups of providers in their systems change efforts focused on increased cessation treatment, including use of the Medicaid medication and counseling benefits. New York State's Delivery System Reform Incentive Payment program charges provider groups with carrying out performance improvement projects with the goal of reducing unnecessary hospital use. NY TCP has conducted a presentation to Medicaid Managed Care plans and has partnered with Delivery System Reform Incentive Payment stakeholders to establish NY TCP health systems contractors as resources to help plans and providers with cessation projects.

### *Statewide and Community Action*

New York's statewide tobacco control interventions include a comprehensive statewide clean indoor air law and a cigarette excise tax that is the highest statewide tax in the nation. With these strong, evidence-based policies in place at the state level, NY TCP's community action efforts focus on policies at the local level with the potential to reduce youth tobacco use initiation and promote cessation. The policy goals and the activities to support them are recommended by CDC (2014) and considered essential to the continued reduction of tobacco use (Bonnie et al., 2007). The community program prioritizes 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).

Community activities are conducted by 25 Advancing Tobacco-Free Communities (ATFC) contractors. Each contractor organization is responsible for tobacco control activities within a

geographically defined catchment area, which currently range from a single borough in New York City (e.g., Queens) to three counties. Each organization funded as an ATFC contractor is required to have a Community Engagement Coordinator and a Reality Check Youth Action Coordinator. The Reality Check Coordinator is responsible for recruiting and retaining youth aged 13 to 18 to participate in tobacco control activities. In contrast to the program structure before 2014, where Community Partnerships were *strongly encouraged* to coordinate activities with Reality Check Youth in their catchment area, this coordination is now required.

ATFC contractors conduct 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.

Before and during FY 2014–2015, ATFC contractors focused their efforts on the POS, tobacco-free outdoors (TFO), smoke-free multi-unit housing (SF MUH), and SF media initiatives. In this section, we briefly summarize the policy goals for each initiative and the level of contractor activity for each initiative between 2012 (when we last reported this information in the IER) and May 2015. During this period, ATFC contractors pooled a total of \$2,106,608 for paid media to support community initiatives. In these years, the majority of paid media was spent on the POS initiative (mean = 78.0%), with approximately 13.6% spent on the SF MUH initiative and less than 10% on the TFO and SF media initiatives.

*POS initiative:* The goal of the POS initiative is to reduce the social acceptability of tobacco use by reducing the impact of retail tobacco product marketing on youth. The POS policy goals are intended to reduce the level of tobacco product marketing and include policies that prohibit the display of tobacco products in establishments open to youth; limit the number of retailers that can sell tobacco products in a community; prohibit the sale of tobacco products in stores that are 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. Raising the age for legal purchase of tobacco products from 18 to 21 was also recently added as a policy goal for this initiative.

After the adoption and subsequent rescission of a display ban policy in Haverstraw in 2012 and increasing evidence that the courts would not support such a ban, the Program has reduced its emphasis on the display ban model policy, although contractors continue to educate policy makers and the public about the effects of tobacco advertising and displays on youth. Between 2012 and 2015, ATFC contractors reported 1,574 meetings to educate local policy makers about the POS initiative, representing at least 185 unique municipalities, multiple state legislators, and the Governor of New York. ATFC contractors also participated in 2,600 community education events related to POS, with the greatest number of events occurring in 2012 (n=1,361).

*TFO initiative:* The goal of the TFO 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 are 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. Since the last IER that reported community activities (2012), ATFC contractors reported 704 instances of educating about the issue, 640 instances of educating about policy solutions, and 243 instances of obtaining commitment for a TFO policy. The organizations targeted included small and large businesses, libraries, and 42 colleges and universities.

*SF MUH initiative:* The goal of the SF MUH initiative is to eliminate exposure to secondhand smoke by increasing the number of housing units where smoking is prohibited. Contractors in more densely populated areas of the state advocate with building owners and managers for smoke-free policies in large housing complexes and are directed to prioritize those with a minimum of 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). Since 2012, ATFC contractors reported 742 instances of educating about the issue, 597 instances of educating about policy solutions, and 193 instances of obtaining commitment for an SF MUH policy. ATFC contractors met with 480 unique organizations, including individual landlords, management companies, and public housing authorities.

*SF media initiative.* The goal of the SF media initiative is to promote policies that reduce tobacco use imagery in youth-rated 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 to remove tobacco imagery from media targeted at youth. Since 2012, ATFC contractors reported 267 instances of educating about the issue, 208 instances of educating about policy solutions, and 35 instances of obtaining commitment for a SF media policy.

Since 2012, Reality Check youth have contacted 104 unique individuals and organizations in support of this initiative. The targets of their activities include individual media outlets (e.g., radio stations) and movie theaters, regional and national media providers (e.g., Comcast, Viacom, Disney, YouTube), policy makers, and the MPAA. From 2012 to 2015, contractors conducted 714 community education events related to the SF media initiative.

In addition to continued efforts to pressure the MPAA to assign an “R” rating to movies with tobacco imagery, in the past year, youth members have identified YouTube videos that promote tobacco use and/or market tobacco products to youth. They “flagged” these videos as inappropriate for youth, asked for their removal, and monitored compliance with this request. In some cases, youth made several requests before the video was removed or made available only to adults.

## Key Evaluation Questions

**T**his section addresses NY TCP progress from 2003 to 2014 for key outcome indicators for New York State and the remaining United States, when available. The key evaluation questions for this year include the following:

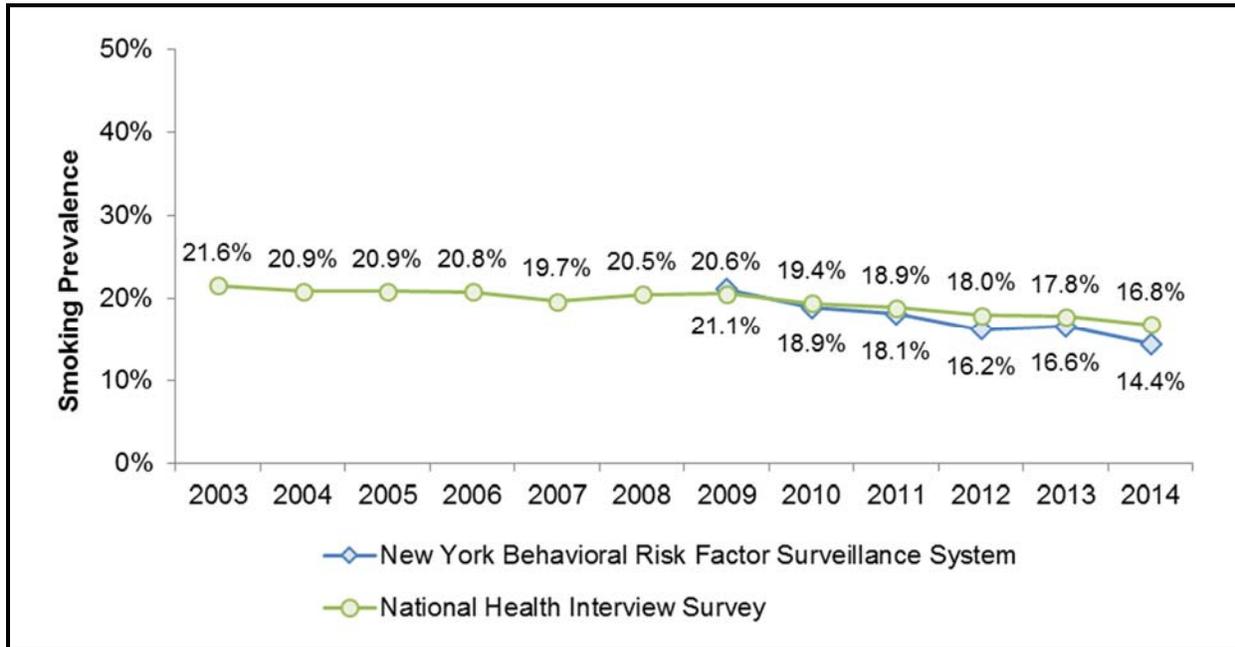
- How has NY TCP influenced trends in tobacco use from 2003 to 2014? Specifically, we examine trends in the following indicators:
  - Percentage of adults in New York and the United States who currently
    - smoke cigarettes,
    - smoke cigars, and
    - use e-cigarettes

- 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 adult smokers who made a quit attempt in the past 12 months in New York by media awareness
- Percentage of adult smokers who made a quit attempt in the past 12 months in New York by use of an evidence-based cessation method
- Percentage of middle and high school students in New York and nationally who currently
  - smoke cigarettes,
  - smoke cigars,
  - use hookah, and
  - use e-cigarettes.
- How has public and policy-maker support for tobacco control policies changed over time?
- How has cigarette tax evasion changed over time?
- How has call volume to the New York State Smokers' Quitline changed over time, and how is it influenced by NY TCP health communication efforts?

### *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). Due to changes in the data collection and weighting methodologies, estimates of smoking prevalence from previous years are not directly comparable. We report national smoking prevalence estimates from the National Health Interview Survey (NHIS) from 2003 to 2014 for comparison. From 2009 to 2013, the prevalence of smoking declined by 23.3% in New York and by 18.4% nationally (Figure 3). In 2014, the prevalence of smoking was lower in New York than in the United States.

**Figure 3. Percentage of Adults Who Currently Smoke in New York (Behavioral Risk Factor Surveillance System) 2009–2014 and Nationally (National Health Interview Survey), 2003–2014**



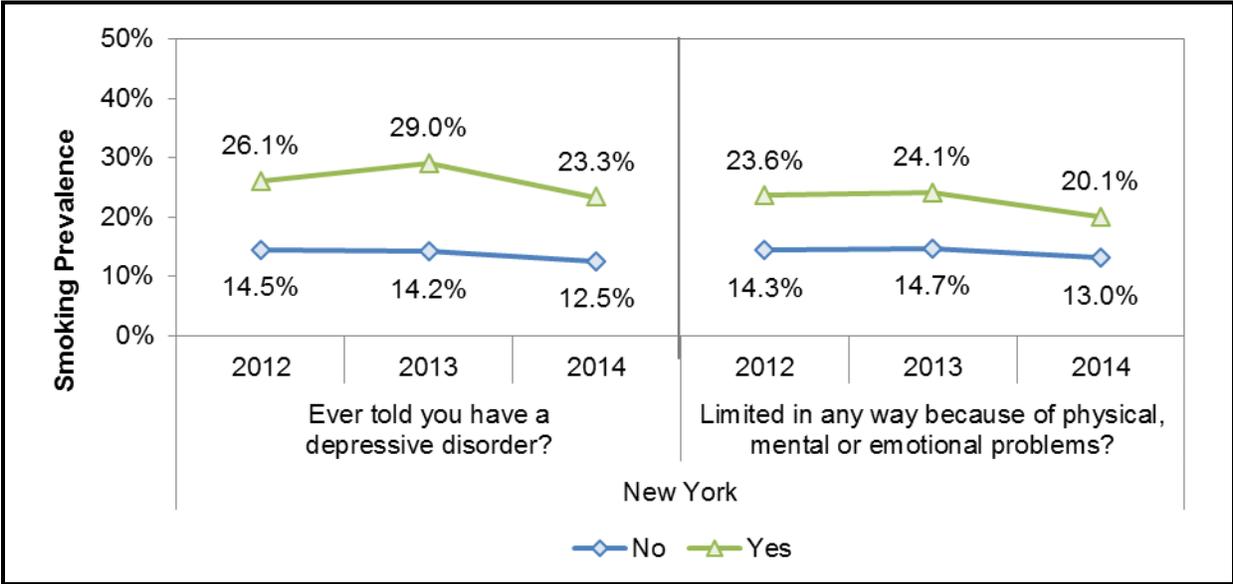
Note: There is a statistically significant difference in smoking prevalence between New York State and the United States in 2014.

There are stark differences in the prevalence of smoking by mental health (Figure 4), education, income, and race/ethnicity (Figure 5). In 2014, those who have ever been told they have a depressive disorder smoke at nearly twice the rate of those who have not (23.3% v. 12.5%). Similarly, those who report having physical, mental, and/or emotional health limitations smoke at a significantly higher rate (20.1%) than those without any limitations (13.0%).

Lower levels of education and income are also associated with higher smoking prevalence (see Figure 5). The prevalence of smoking is highest for those with less than a high school degree (22.4%), followed by those with a high school degree or equivalent (17.0%), some college (16.3%), and a college degree or higher (6.8%).

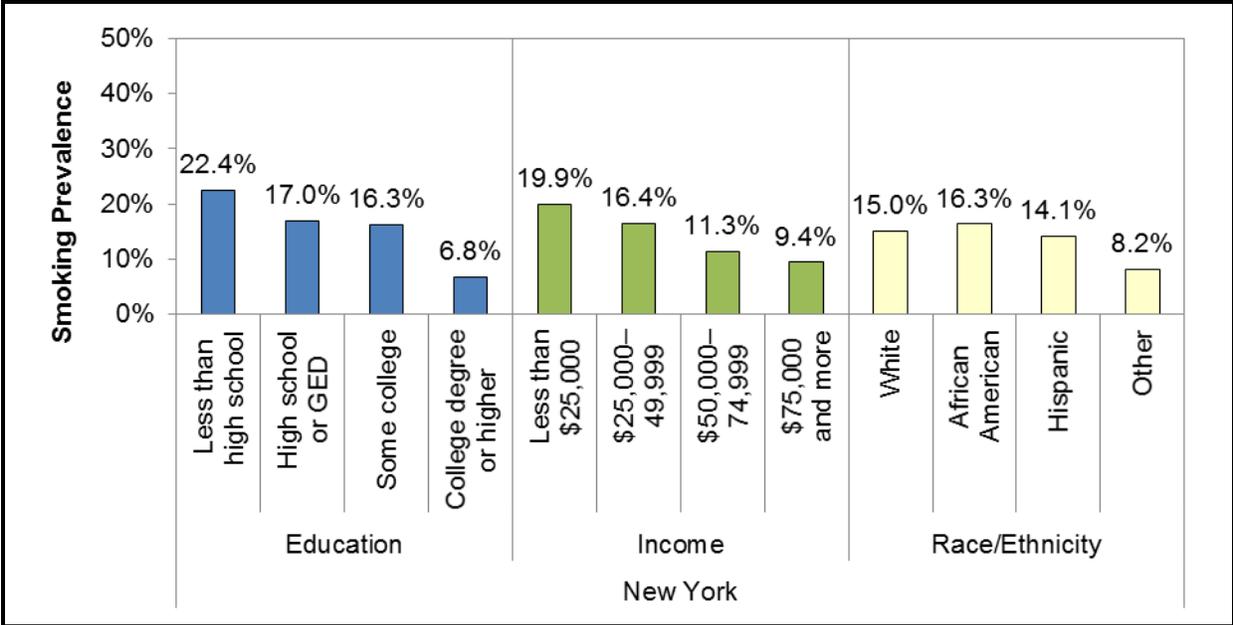
The prevalence of smoking is highest for those with incomes less than \$25,000 (19.9%) and higher than for those with incomes between \$25,000 and \$50,000 (16.4%), which is in

**Figure 4. Percentage of New York Adults Who Currently Smoke, by Mental Health Status, Behavioral Risk Factor Surveillance System 2012–2014**



Note: There is a statistically significant downward trend among those that have never been diagnosed with poor mental health. There is a statistically significant difference between those that have ever been diagnosed with poor mental health and those reporting poor physical or mental health compared with their counterparts in 2014.

**Figure 5. Percentage of New York Adults Who Currently Smoke, by Education, Income, and Race/Ethnicity, Behavioral Risk Factor Surveillance System 2014**

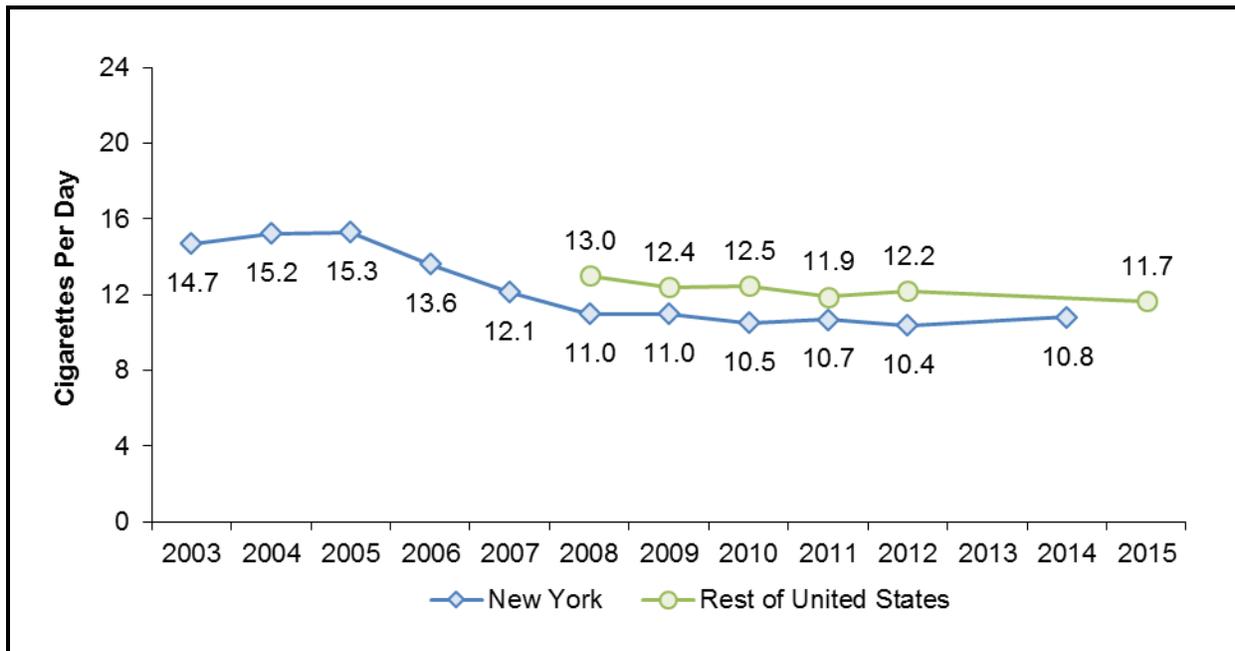


Note: There are statistically significant differences in the prevalence of smoking between those with less than a high school education, those with a high school diploma or GED and some college experience, and those with at least a college degree. There are statistically significant differences in the prevalence of smoking between adults with incomes \$49,999 or less and those with incomes of \$50,000 or more. There are statistically significant differences in the prevalence of smoking between “other” and the remaining race/ethnicity groups.

turn higher for the next two highest income groups (see Figure 5). The prevalence of smoking is statistically similar for the second highest income group (11.3%) and the highest income group (9.4%).

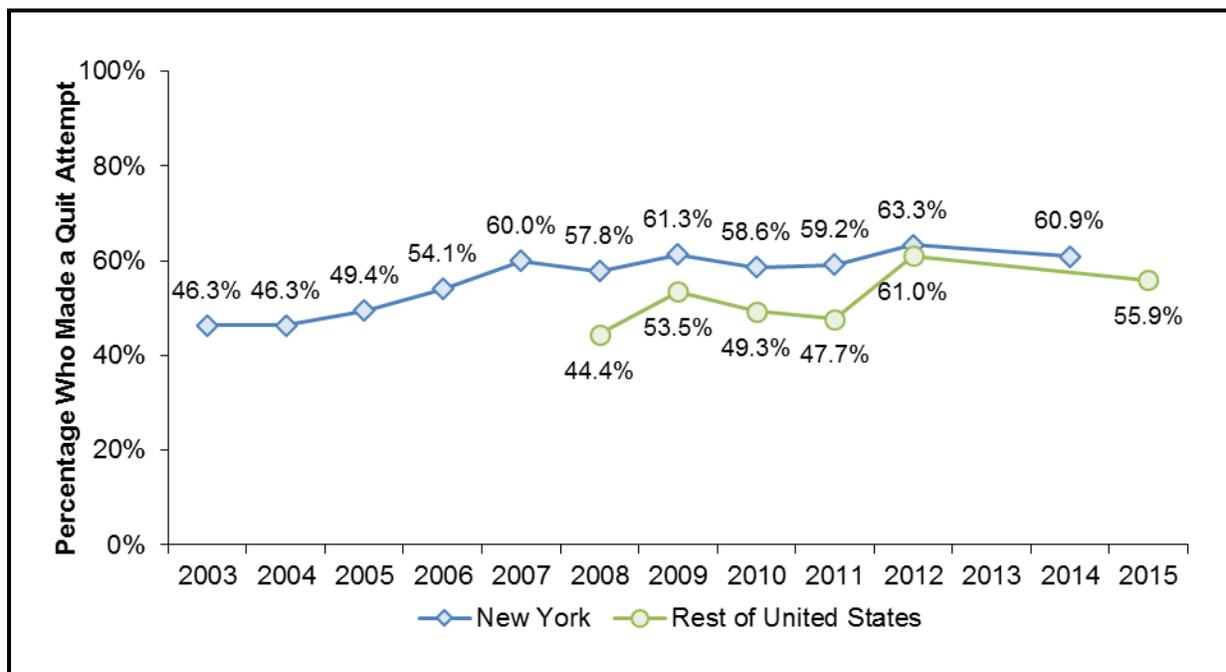
Average daily smoking among current adult smokers in New York has declined by 26.5% since 2003 (Figure 6). However, it has remained unchanged for the last 7 years. It is important to note that there has never been an explicit Bureau of Tobacco Control program aimed at encouraging smokers to reduce the amount of cigarettes they smoke. There have been efforts to encourage smokers to quit (e.g., public education campaigns) and, as shown in Figure 7, the percentage of adult smokers in New York who have made a quit attempt in the past year increased by 31.5% from 2003 to 2014 (from 46.3% to 60.9%). Despite this long-term improvement, this percentage has not changed significantly since 2007.

**Figure 6. Average Daily Cigarette Consumption by Current Smokers, New York Adult Tobacco Survey 2003–2014 and National Adult Tobacco Survey 2008–2015**



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

**Figure 7. Percentage of Adult Smokers Who Made a Quit Attempt in the Past 12 Months, New York Adult Tobacco Survey 2003–2014 and National Adult Tobacco Survey 2008–2015**

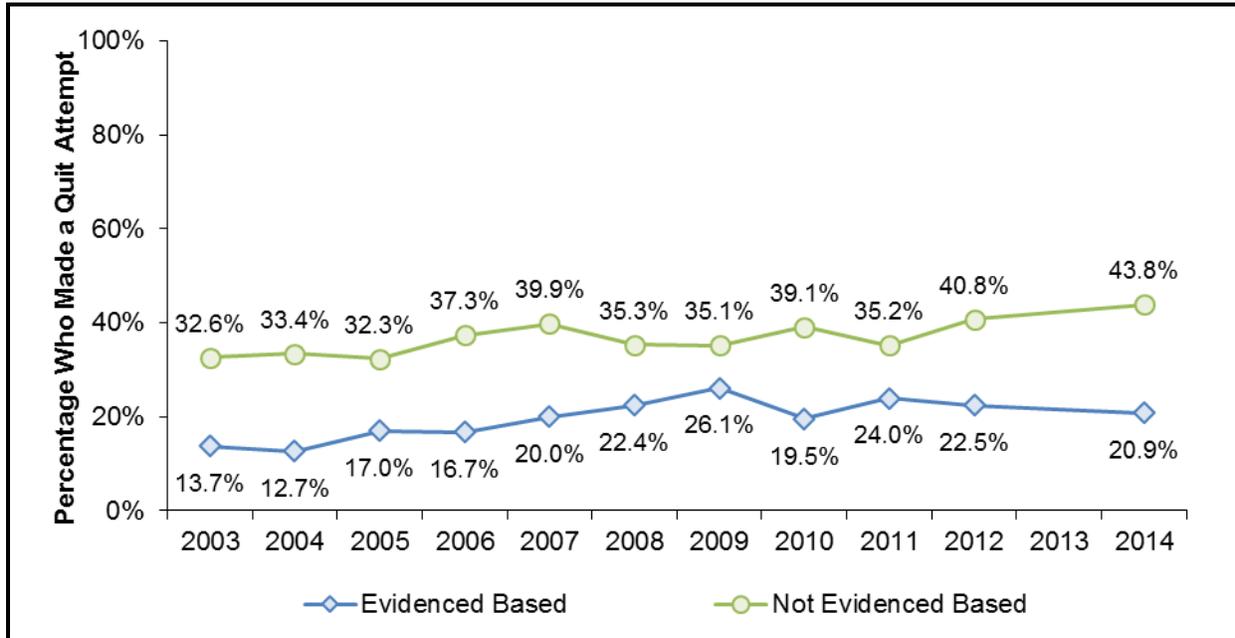


Note: There is a statistically significant upward trend among smokers in New York and the rest of the United States.

In addition to an overall upward trend in the prevalence of quit attempts, the percentage of smokers making quit attempts using evidence-based methods (e.g., counseling, NRT, pharmacotherapy) increased from 2003 to 2014 (Figure 8). From 2003 to 2014, the percentage making an evidence-based quit attempt in the past 12 months increased by 52.5% compared with a 34.4% increase for non-evidence-based methods.

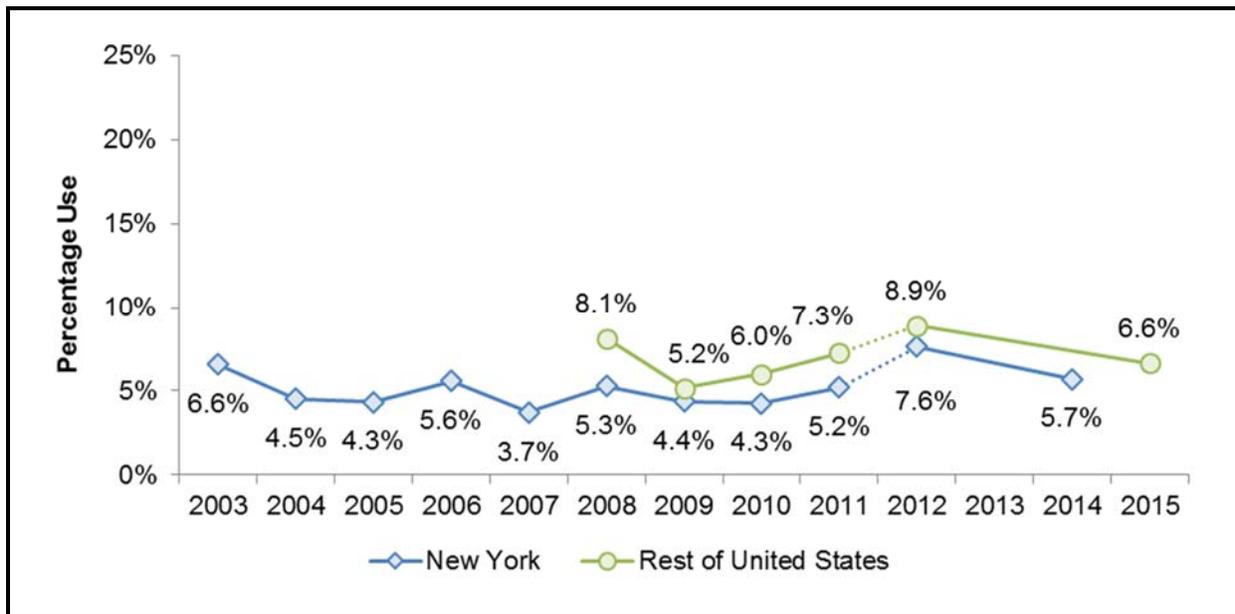
The prevalence of adult cigar use in New York has remained at a relatively low and stable level since 2003 (Figure 9). Including “rarely” as a response category appears to have influenced the prevalence of cigar use in New York and the rest of the United States. The prevalence of cigar use largely follows the same pattern as the national rate and appears lower in New York in 2014 than the national rate in 2015. To date, no programmatic activities have explicitly discouraged adult cigar use. However, cigar taxes increased in 2009 from 37% to 46% of the wholesale price and again in 2010 to 75%.

**Figure 8. Percentage of Adult Smokers Who Made a Quit Attempt in the Past 12 Months by Use of an Evidence-Based Cessation Method, New York Adult Tobacco Survey 2003–2014**



Note: There is a statistically significant upward trend in adult current smokers who made a quit attempt using evidence-based and non-evidence-based methods. Evidence based cessation methods included attending a stop-smoking clinic, cessation class, or support group; getting counseling; getting help from a free telephone quit line; and using medications like the nicotine patch, nicotine gum, Zyban, or Chantix. The 2014 data include data from quarters Q1 and Q4 only.

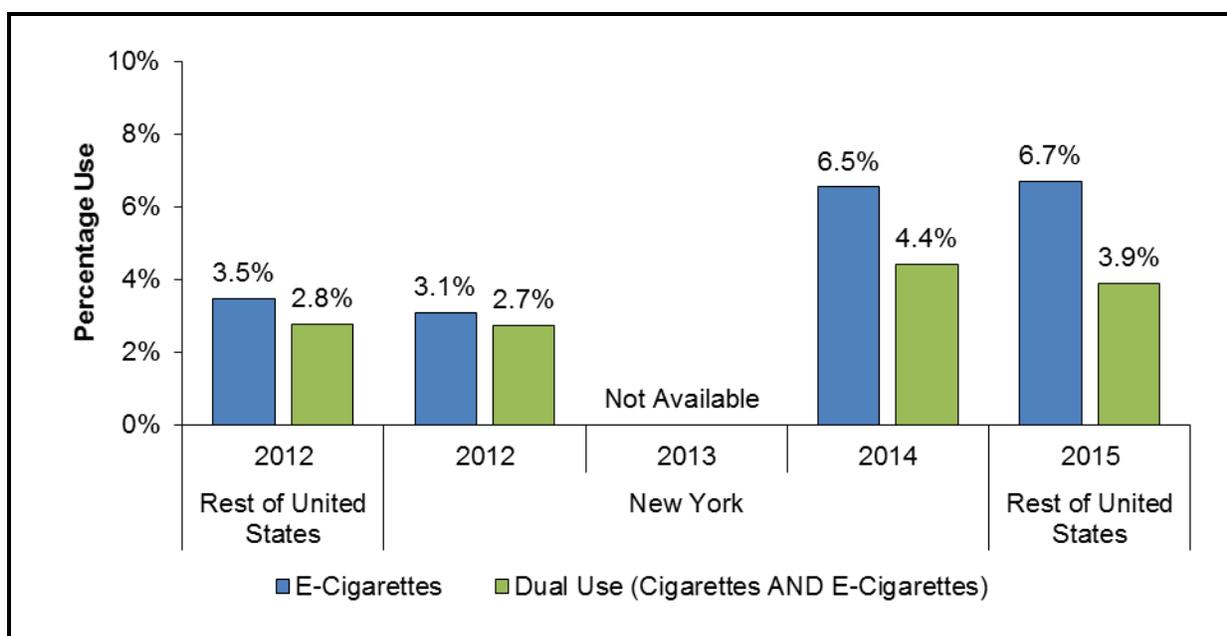
**Figure 9. Percentage of Adults Who Currently Smoke Cigars, New York Adult Tobacco Survey 2003–2014 and National Adult Tobacco Survey 2008–2015**



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 difference in current cigar use between New York State in 2014 and the rest of the United States in 2015.

The use of e-cigarettes, vapor pens, e-hookahs, and other electronic vapor products has more than doubled among adults in New York from 2012 to 2014 (3.1% to 6.5%) (Figure 10). In 2012, nearly all adult users were also current smokers. As of 2014, the proportion of electronic vapor product users who also smoke cigarettes decreased in New York; we see the same pattern in the rest of the United States from 2012 to 2015. Current use and dual use is similar between New York (2014) and the rest of the country (2015).

**Figure 10. Percentage of Adults Who Currently Use Electronic Vapor Products or Cigarettes and Electronic Vapor Products, New York Adult Tobacco Survey 2012–2014 and National Adult Tobacco Survey 2012 and 2015**

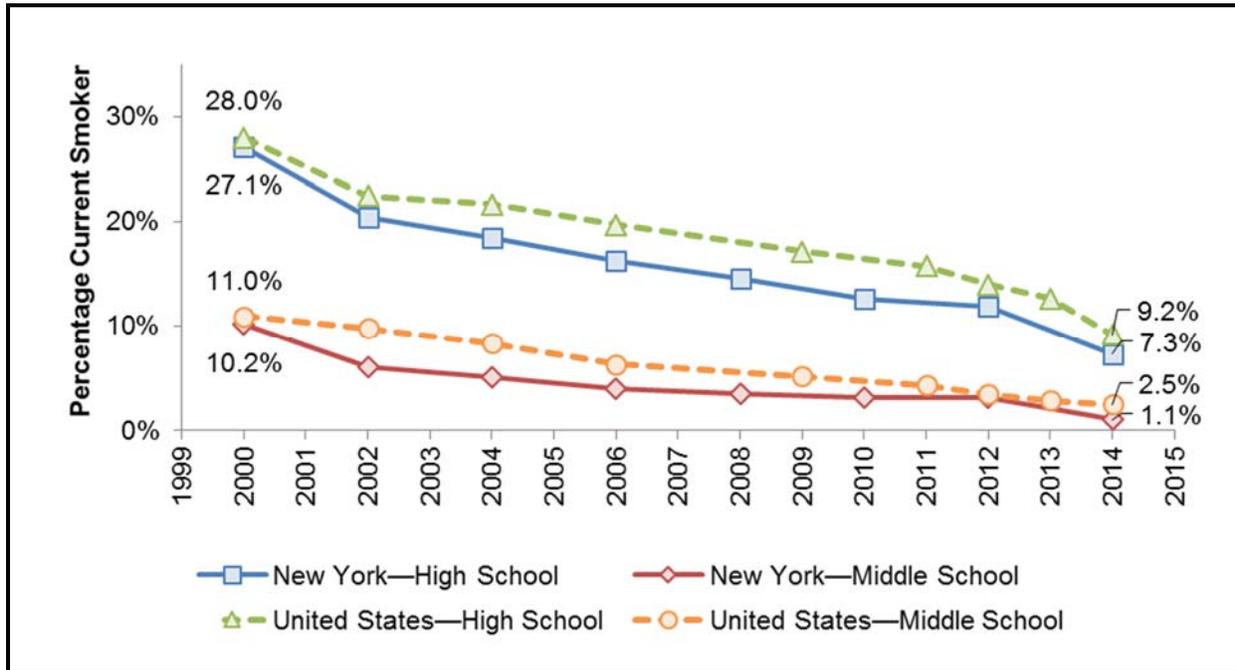


Note: There is a statistically significant difference in current e-cigarette use and current dual use between 2012 and 2014 among New York adults. There is a statistically significant difference in current e-cigarette use and current dual use between 2012 and 2014 among adults in the rest of the United States.

### *Youth Tobacco Use Measures*

The following set of figures present trends in the use of cigarettes, cigars, hookah, and e-cigarettes and other electronic vapor products. 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 declined in New York by 73% among high school students and 89% among middle school students (Figure 11). Nationally, the prevalence

**Figure 11. Percentage of Middle and High School Students Who Currently Smoke in New York and Nationally, New York Youth Tobacco Survey 2000–2014 and National Youth Tobacco Survey 2000–2014**

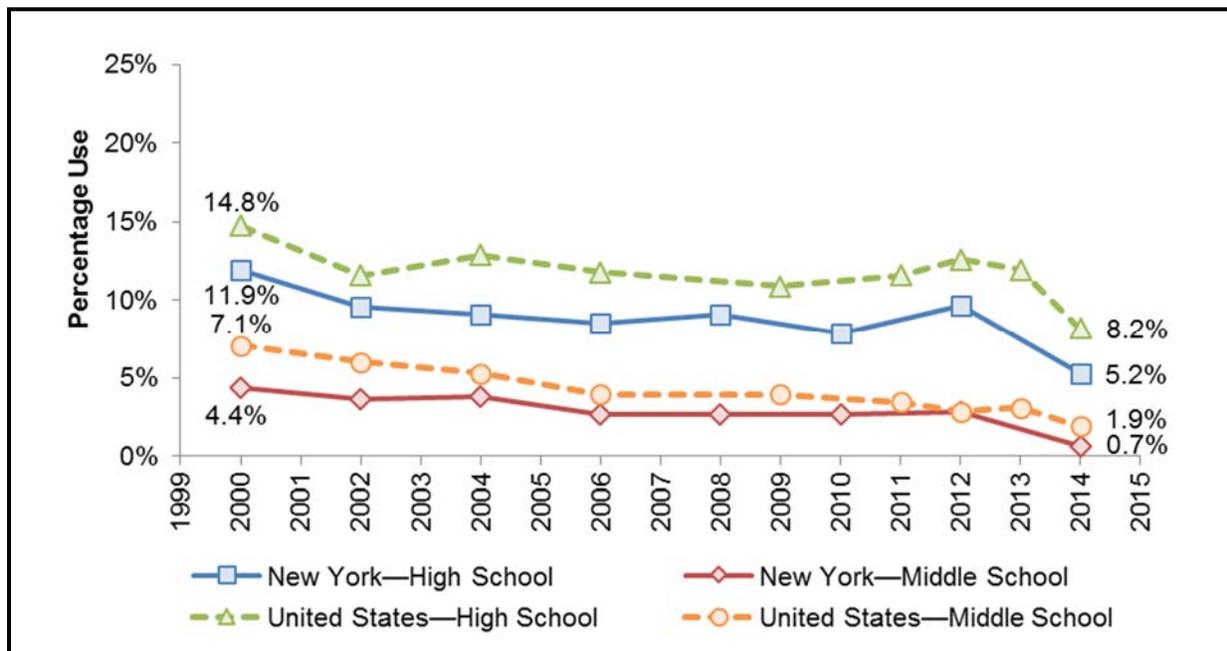


Note: There is a statistically significant downward trend among middle and high school students in New York and in the United States. There is a statistically significant difference between New York and the United States in 2014 for both middle and high school students.

of smoking declined by 67% among high school students and 77% among middle school students. In 2014, the prevalence of smoking was lower in New York than in the United States for both middle and high school students.

The prevalence of cigar use also declined markedly in New York and nationally from 2000 to 2014 (Figure 12). Among high school students, cigar use declined by 56% in New York and 45% nationally. Among middle school students, the relative decline was even greater, at 84% in New York and 73% nationally. In 2014, the prevalence of cigar use was lower in New York than nationally for both middle and high school students.

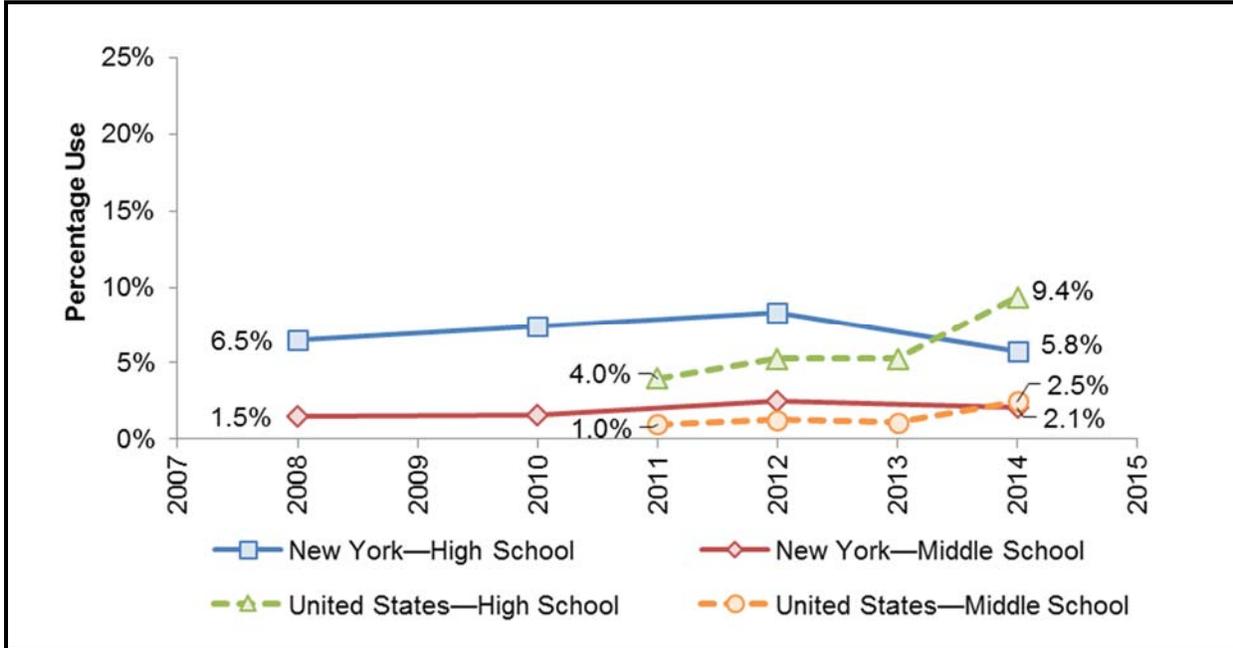
**Figure 12. Percentage of Middle and High School Students Who Currently Smoke Cigars in New York and Nationally, New York Youth Tobacco Survey 2000–2014 and National Youth Tobacco Survey 2000–2014**



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

Smoking tobacco from a waterpipe or hookah (also known as shisha and hubble bubble) began hundreds of years ago in the eastern Mediterranean region and has grown in popularity in the United States more recently. Tobacco used in hookahs often includes fruit or candy flavors. The tobacco is heated indirectly, creating a smoke that passes through water before being inhaled. The New York Youth Tobacco Survey has included a question about current hookah use since 2008, while the National Youth Tobacco Survey included the same question starting in 2011. Hookah use has remained stable among high school students in New York, while increasing nationally. Use is higher nationally than in New York among high school students. The prevalence of use among middle school students increased in New York and nationally over time, but remains relatively low (Figure 13).

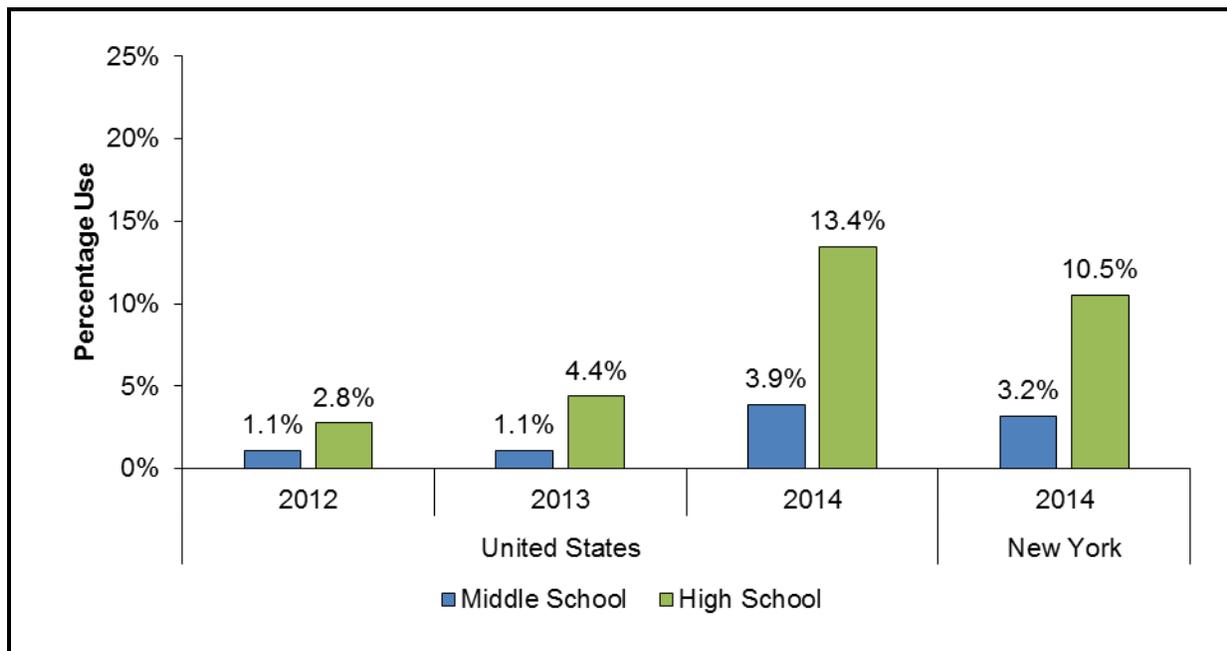
**Figure 13. Percentage of Middle and High School Students Who Currently Use Hookah in New York and Nationally, New York Youth Tobacco Survey 2008–2014 and National Youth Tobacco Survey 2011–2014**



Note: There is a statistically significant upward trend among middle school students in New York from 2008 to 2014. There is a statistically significant upward trend among middle and high school students in the United States from 2011 to 2014. There is a statistically significant difference between New York and the United States in 2014 among high school students.

In recent years, current use of e-cigarettes and other electronic vapor products among youth has increased dramatically. Nationally, use increased 255% (1.1% to 3.9%) among middle school students and 379% (2.8% to 13.4%) among high school students from 2012 to 2014. In 2014, the prevalence of use among high school students was lower in New York than nationally. In that same year, the prevalence of e-cigarette use was higher than the prevalence of current cigarette smoking in New York and nationally (Figure 14).

**Figure 14. Percentage of Middle 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**

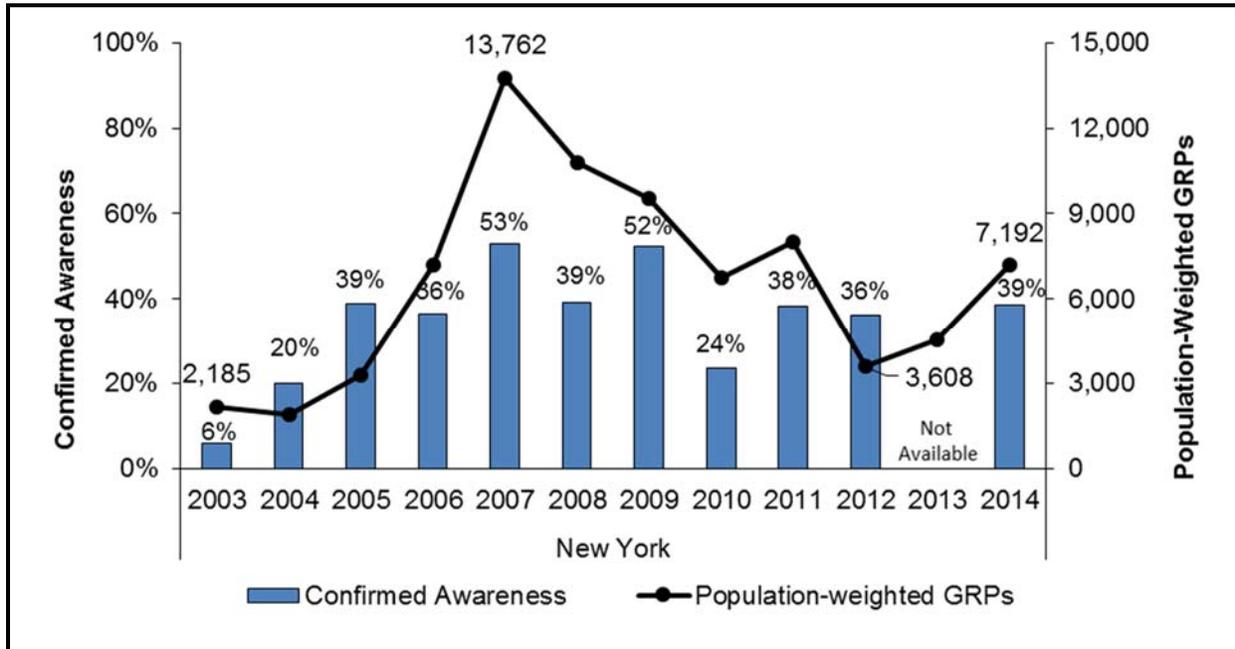


Note: There is a statistically significant difference between High School students in New York and the United States in 2014. There is a statistically significant upward trend among middle school students and high school students across the United States.

### *Trends in Other Key Outcome Indicators*

In recent years, the percentage of smokers who recall seeing at least one NY TCP-sponsored television advertisement has been stable at nearly 40% (Figure 15). That is consistent with the level of program funding dedicated to the placement of television advertisements. Although this is less than the recommended level of 60% awareness among smokers, the quarterly data from 2014 indicate that this goal was exceeded in the third quarter. Confirmed awareness was 0%, 50.2%, 61.4%, and 35.8% in Quarters 1 through 4, respectively, and did not differ significantly by education or income level (data not shown).

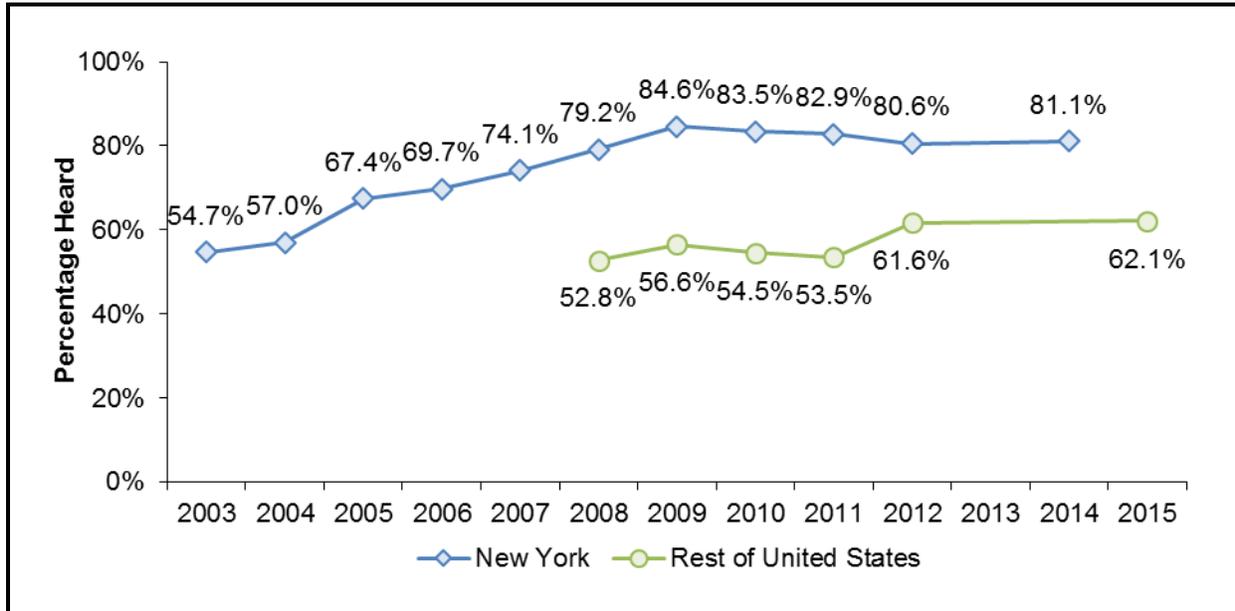
**Figure 15. Confirmed Awareness of Paid Advertisements among Smokers and Population-Weighted Statewide Average Gross Rating Points (GRPs), New York Adult Tobacco Survey 2003–2014**



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

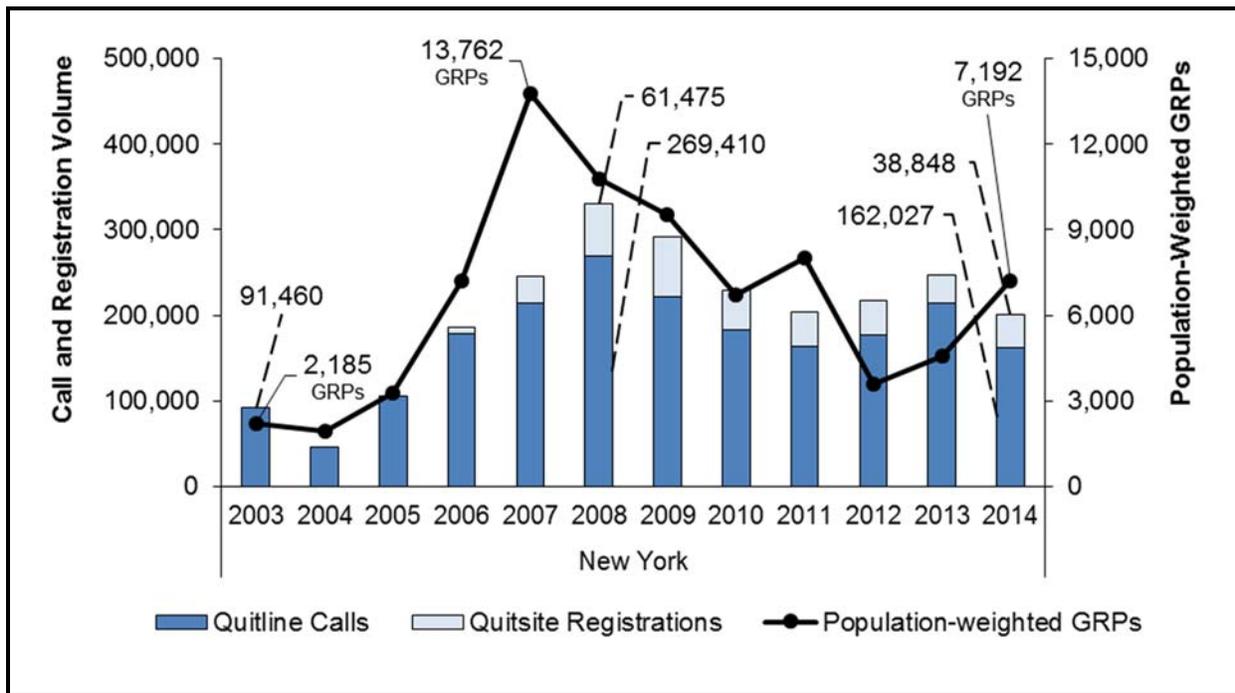
Consistent with the pattern of awareness of NY TCP-sponsored television advertisements, awareness of the New York State Smokers' Quitline has been stable in recent years. Approximately 8 out of 10 smokers had heard of the Quitline—significantly higher than the comparable national awareness level (Figure 16). There has also been very minimal variation in annual Quitline call volume and Quitsite registrations in recent years (Figure 17).

**Figure 16. Percentage of Adult Smokers Who Have Heard of Quitline, New York Adult Tobacco Survey 2003–2014 and National Adult Tobacco Survey 2008–2015**



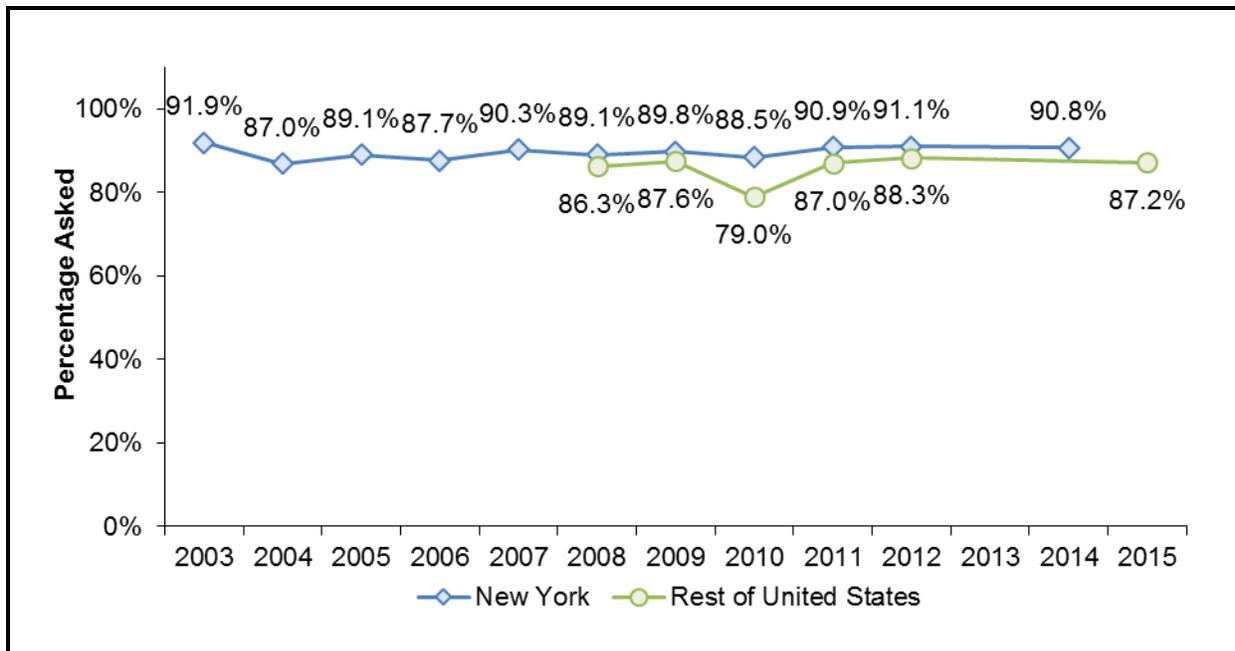
Note: New York smokers were asked if they had heard of the New York State Smokers’ Quitline. Smokers in the rest of the United States were asked if they had heard of any telephone quitlines, such as 1-800-QUIT-NOW. There is a statistically significant upward trend among smokers in New York State and the rest of the United States. There is a statistically significant difference between smokers in New York State in 2014 and the rest of the United States in 2015.

**Figure 17. Annual New York State Smokers’ Quitline Call Volume, Quitsite Registrations and Population-Weighted Statewide Average Gross Rating Points (GRPs), 2003–2014**

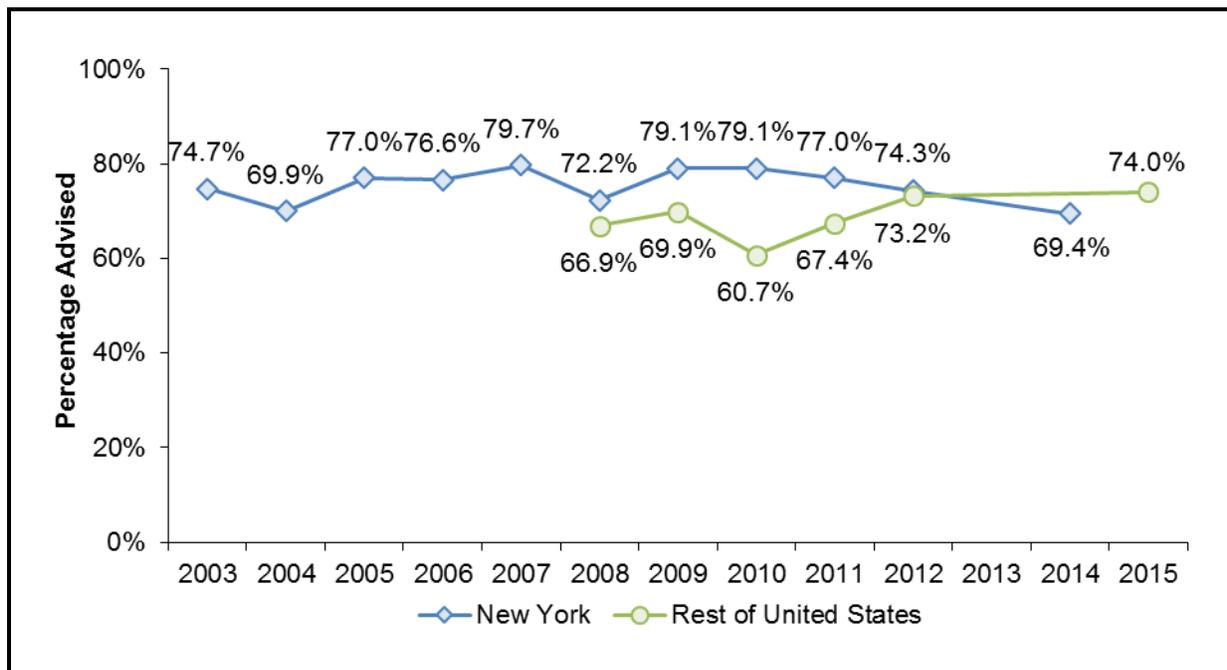


Turning to health care providers' support for smoking cessation, Figures 18 through 20 assess smokers' self-reported interactions with health care providers in the past 12 months. Approximately 9 in 10 smokers report that their health care provider has asked about their tobacco use (see Figure 18). However, as of 2014, only about 7 in 10 (69.4%) smokers reported that their health care provider advised them to quit (see Figure 19). There is a marginally significant upward trend ( $p = 0.07$ ) in this measure in the rest of the United States.

**Figure 18. 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 2003–2014 and National Adult Tobacco Survey 2008–2015**



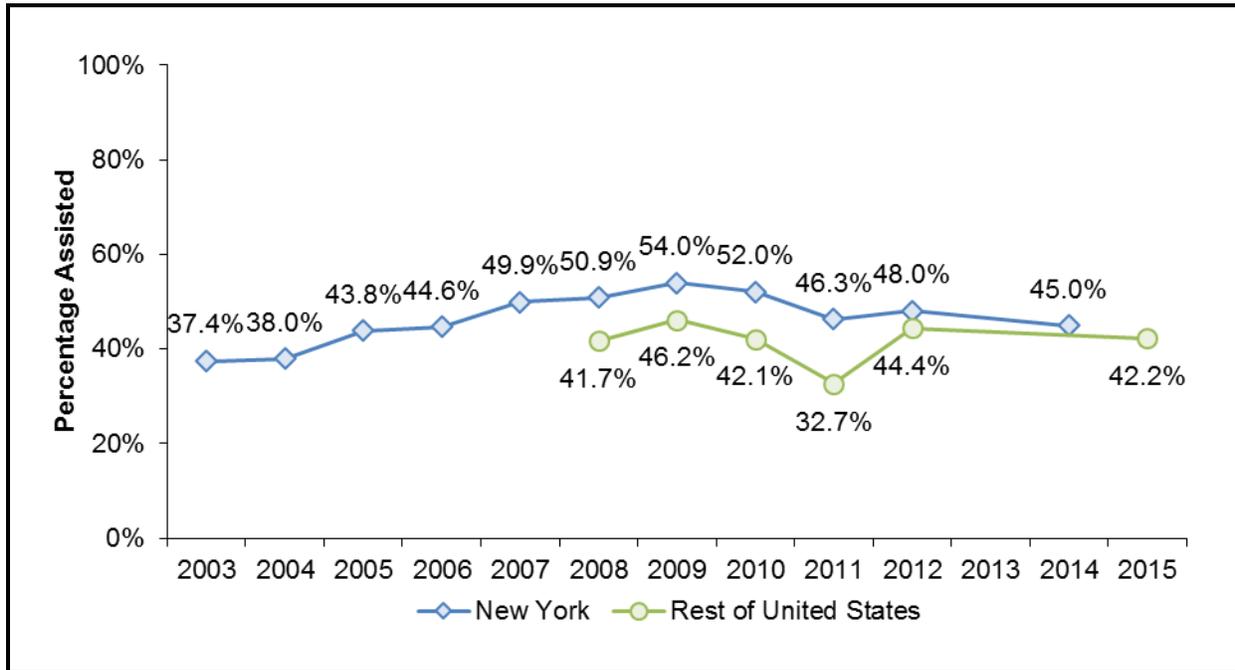
**Figure 19. Percentage of Adult Smokers Who Were Advised by Their Health Care Provider to Quit Smoking in the Past 12 Months, New York Adult Tobacco Survey 2003–2014 and National Adult Tobacco Survey 2008–2015**



Finally, in 2014, less than half of smokers in New York indicated that they received assistance in their efforts to quit smoking (Figure 20). Although there is a statistically significant upward trend in this measure from 2003 to 2014, assistance from health care providers peaked in 2009.

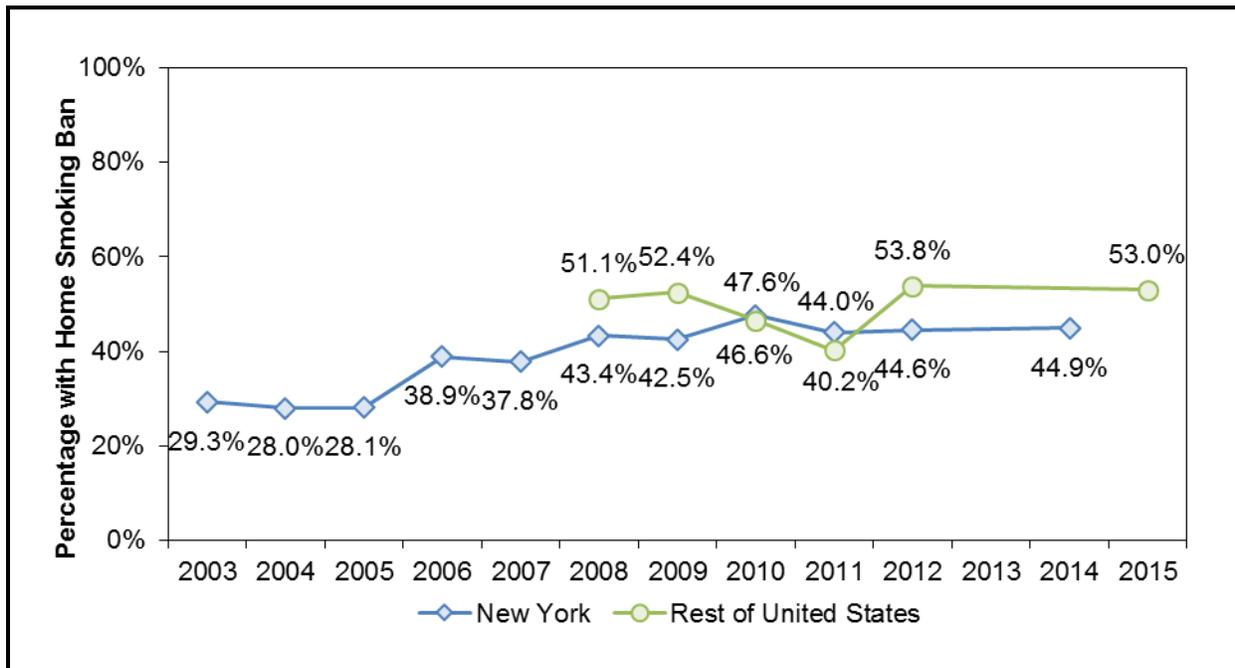
The percentage of smokers who report that they have a 100% smoke-free home policy has increased over time by approximately 50% (29% in 2003 to 45% in 2014) (Figure 21). Once again, this key outcome indicator has remained unchanged for several years.

**Figure 20. 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 2003–2014 and National Adult Tobacco Survey 2008–2015**



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

**Figure 21. Percentage of Adult Smokers with 100% Smoke-free Homes, New York Adult Tobacco Survey 2003–2014 and National Adult Tobacco Survey 2008–2015**



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

## *Local Tobacco Control Policies Adopted*

Policy change occurs over time, as the public, policy makers, and organizational decision makers are educated about tobacco use in their communities, the factors that contribute to tobacco use, and the need for policies to create environments that make in which healthy, nonsmoking choices are effortless (Frieden, 2011). In this section, we summarize the number of local POS, TFO, and SF MUH policies adopted since 2012 and the number of New Yorkers who are protected by these policies.

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). Since then, two additional municipalities (Columbia County and the City of Rochester) have adopted POS policies that restrict the type or location of tobacco retailers. These policies have the potential to reduce the influence of POS tobacco advertising on nearly 300,000 New Yorkers.

Between 2012 and 2015, 45 municipalities adopted policies that prohibit smoking near building entryways, protecting nearly 2 million New Yorkers. A total of 171 municipalities adopted a policy that prohibits smoking at beaches, parks, and/or playgrounds, affecting more than 6 million residents. During this same time, 343 policies were adopted (238 banned smoking on organization grounds, 26 at beaches and parks, and 160 in building entryways) by 20 colleges and 323 other organizations, including small businesses, major employers, libraries, medical centers, churches, and malls.

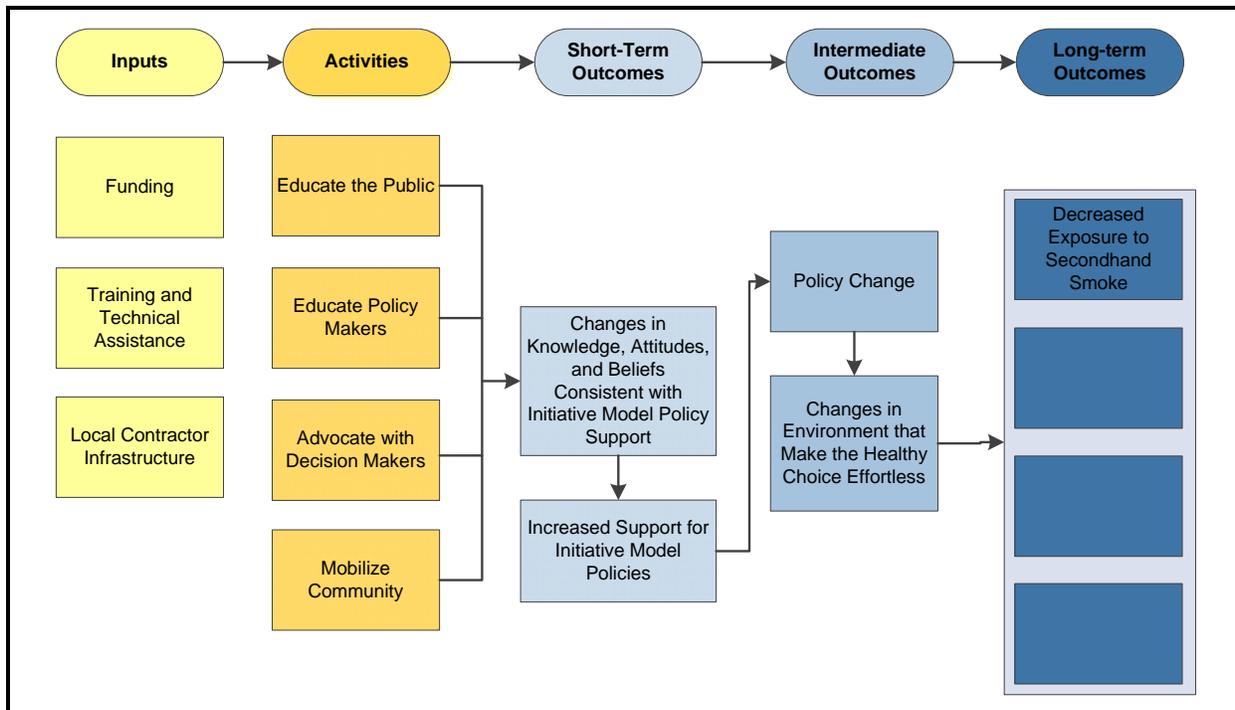
Since 2012, ATFC contractors reported that 167 apartment complexes/management companies adopted SF MUH policies. These policies ban smoking, creating 22,821 new smoke-free units. One hundred forty seven of these policies (88.0%), affecting 19,094 units, prohibit smoking in individual units and all indoor common areas.

## *Support for Tobacco Control Policies*

In 2009, we developed a theory of change describing how community contractor activities are expected to lead to policy change and how that policy change is expected to lead to decreased exposure to secondhand smoke, increased cessation,

decreased youth and young adult initiation, and continued denormalization of tobacco use. This theory of change has been modified over time to reflect changes in the Program’s focus and activities. Figure 22 provides an overview of the current Community Program theory of change. As this figure shows, ATFC contractors educate the public, policy makers, and decision makers about the problem of tobacco use in their communities and factors associated with tobacco use. For example, contractors focused on POS policy change educate policy makers about the research literature documenting the relationship between tobacco product marketing at the POS 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 hold this belief are more likely to support POS policies (Schmitt et al., 2012, 2014).

Figure 22. Theory of Change for NY TCP Community Program



In the absence of widespread POS policy change, it is important to monitor more proximal outcomes of contractor activities, such as changes in knowledge and beliefs consistent with the program’s messaging. For example, although community

contractors exerted a high level of effort on the POS initiative between 2009 and 2012, they had been unable to effect any POS policy change. However, our analyses showed that public support for POS policies increased significantly during this period and was higher than support nationally (RTI, 2013). This finding provided evidence that program activities were having an effect—building support for policy change. If we had not found these increases in support for POS initiative policies, we would look to earlier indicators, such as beliefs and awareness, for evidence that program activities were leading toward policy change.

In this section, we summarize support for POS, TFO, and SF MUH policies among the general public and local opinion leaders in New York.

## Data and Methods

We used the New York Adult Tobacco Survey (NY ATS) and the Local Opinion Leaders Survey (LOLS) to examine support for POS, TFO, and SF MUH policies. Where data are available for multiple years, we also examine changes in support for these policies over time.

NY ATS data included questions about support for POS policies beginning in 2010, and data span from that year through 2014, with the exception of 2013, when data were not collected. LOLS data were collected in 2011 and 2014. In each year, the LOLS sample was the frame of county-level elected officials plus the chief health officer at the county health department. For New York City (NYC), we identified all borough-level elected officials. In both years, we achieved a response rate of approximately 60%, with 1,108 participants completing the survey in 2014.

For each policy, participants were asked “*What is your opinion of a policy that would...*” and given the option to respond on a scale from 1 (*strongly disagree*) to 5 (*strongly agree*). Both NY ATS and LOLS participants responded to questions about the following policies:

- POS policies
  - Ban the display of tobacco products in stores.
  - Ban the sale of tobacco products in pharmacies.

- Limit the number of tobacco retailers in the community.
- Ban the sale of tobacco products in stores near schools.
- Ban redemption of coupons (2014 only).
- Ban two-for-one promotions (2014 only).
- Require that people be 21 years old to purchase cigarettes and other tobacco products (2014 only for NY ATS, not included in the LOLS).
- TFO policies
  - Ban smoking in building entryways.
  - Ban smoking in outdoor public places, such as beaches and parks.
- SF MUH policy
  - Ban smoking inside of residences in apartments or condo buildings (all years for NY ATS, only 2014 for LOLS).

In addition to POS policy support questions, 2014 LOLS participants were also asked how much they had heard about banning tobacco product sales in pharmacies (also asked in 2011), banning the use of coupons for tobacco products, and banning tobacco product promotions. If a participant opposed a coupon ban or a promotion ban, that participant was asked why he or she opposed it.

## Results

*POS policy support.* New Yorkers' support for POS policies was highest for raising the minimum age to purchase tobacco to 21 and banning the sale of tobacco products in stores near schools (Figure 23). More than half of adults in New York support banning tobacco displays in stores, banning tobacco sales in pharmacies, and limiting the number of stores that can sell tobacco. The two new POS policies—banning the redemption of coupons and the use of promotions—had the lowest support.

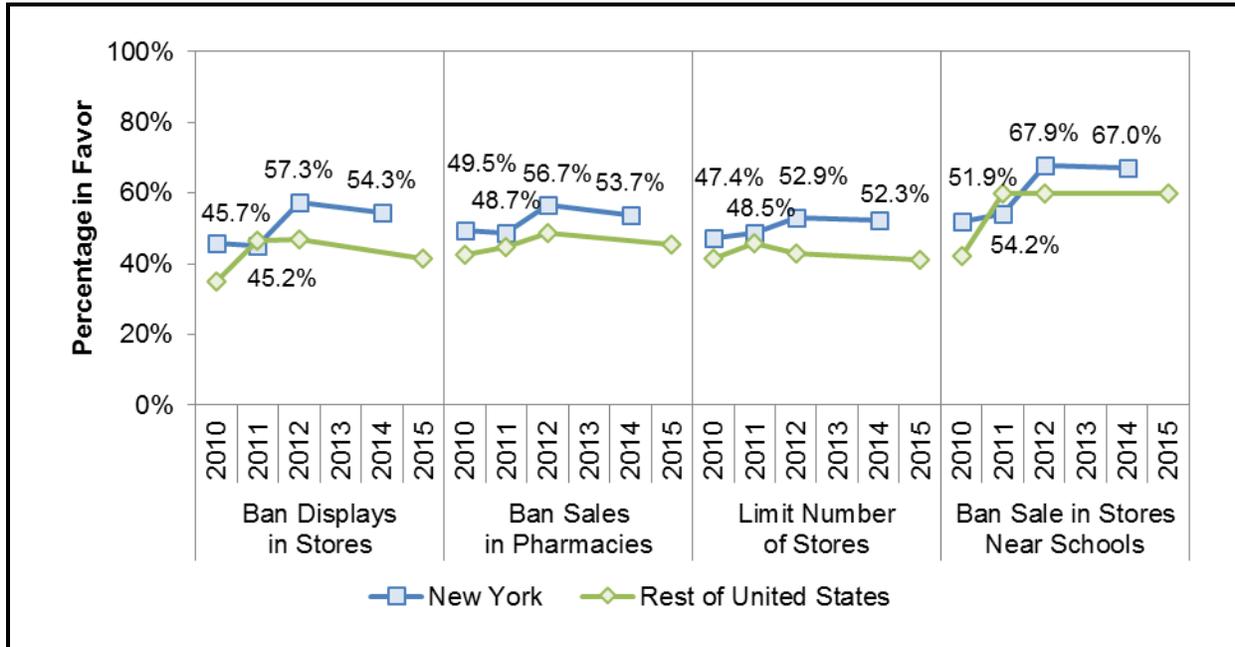
**Figure 23. Percentage of Public Who Somewhat or Strongly Support POS Policies, New York Adult Tobacco Survey 2014**



Figure 24 shows public support for the original four POS policies from 2010 through 2014. Support for all of these policies increased significantly between 2010 and 2014.

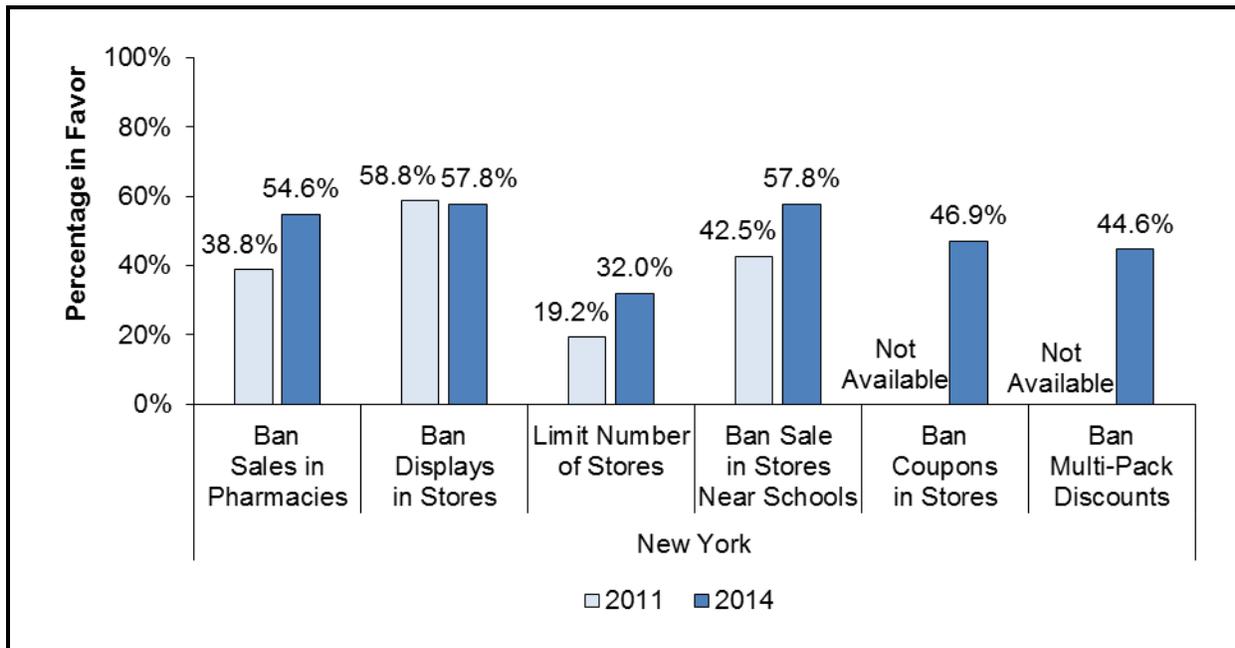
Figure 25 shows that New York local opinion leaders also support POS policies, with similarities to levels of support among the general public. The greatest proportion of leaders support the ban on tobacco product sales near schools and the display ban and the smallest proportion of leaders support the two new policies: banning the redemption of coupons and the use of promotions. Support for all POS policies increased significantly between 2011 and 2014, except the display ban for which support was already high.

**Figure 24. Support for Point of Sale Tobacco Policies among Adults, New York Adult Tobacco Survey 2010–2014 and National Adult Tobacco Survey 2010–2015**



Note: There is a statistically significant upward trend in support in New York State across all four policies. There is also a statistically significant difference between support in New York State and the rest of the United States for all four policies between 2014 and 2015. There is a statistically significant upward trend in support for banning displays in stores near schools in the rest of the United States.

**Figure 25. Percentage of Local Opinion Leaders Who Somewhat or Strongly Support POS Policies, New York Local Opinion Leader Survey, 2011 and 2014**

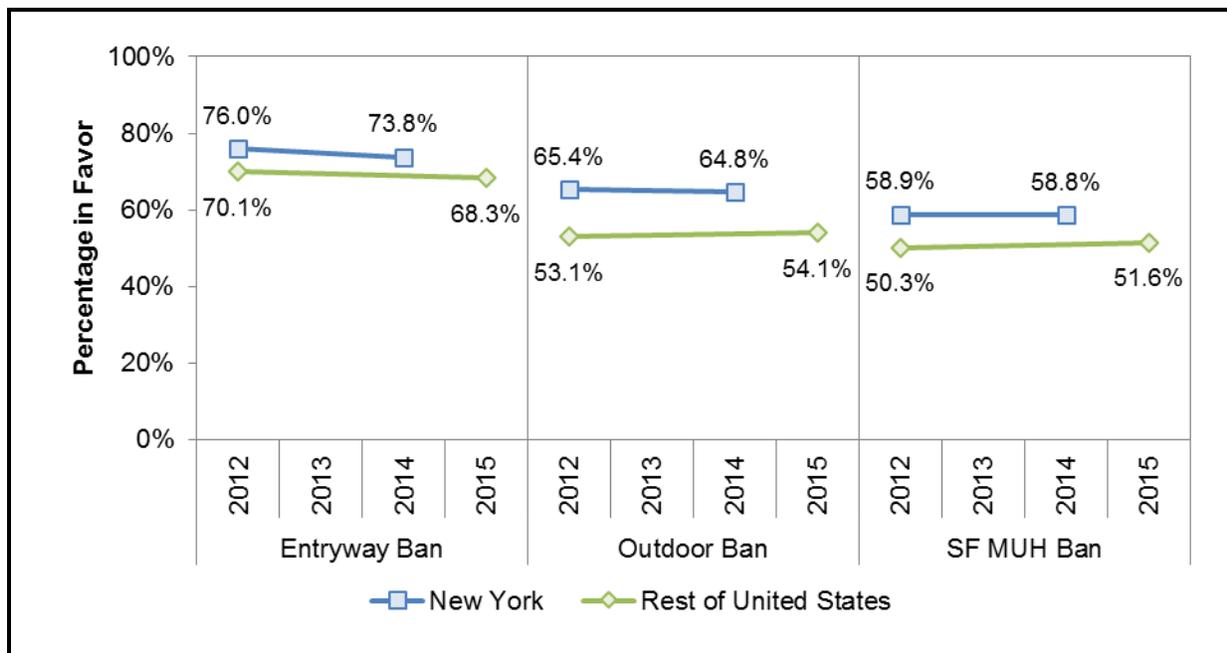


Note: There is a statistically significant increase in support for banning tobacco sales in pharmacies, limiting the number of stores that can sell tobacco in a community, and banning tobacco sales in stores in schools from 2011 to 2014.

*TFO policy support.* Figure 26 shows that support for both TFO policies (banning smoking in building entryways and banning smoking in outdoor public places) was higher among New York adults in 2012 and 2014 than it was among adults in the rest of the United States. The highest level of support for a TFO policy was for banning smoking in building entryways, supported by 73.8% of New York adults and 90.0% of local opinion leaders (Figure 27). The public and policy makers supported banning smoking at beaches and parks at nearly identical levels (64.8% and 64.4%, respectively).

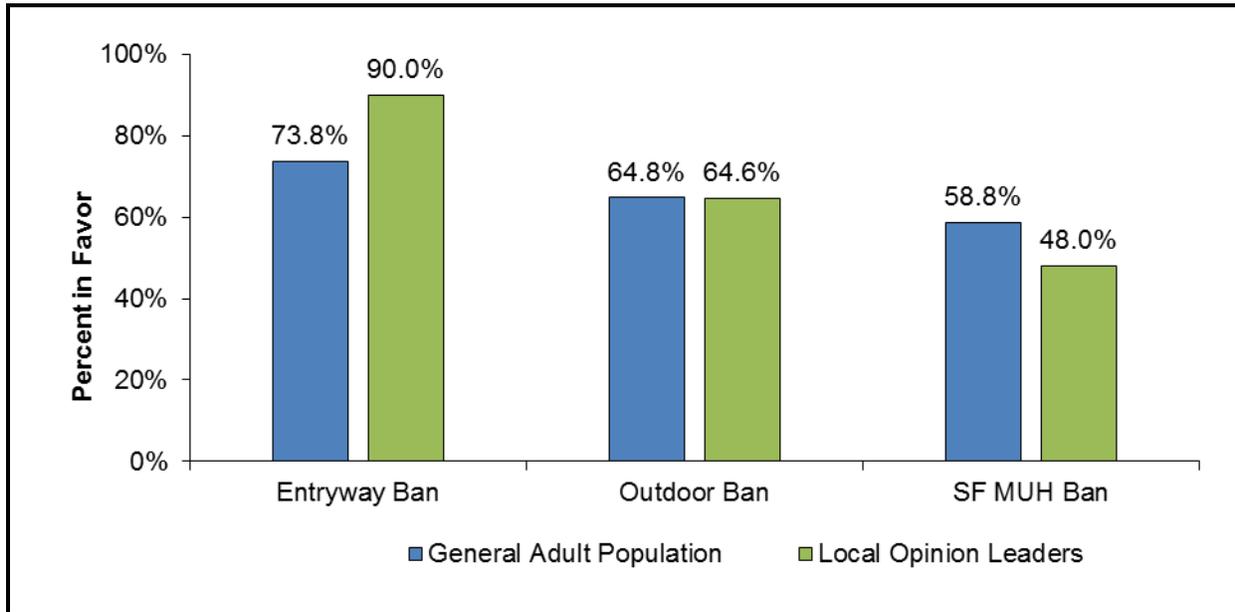
*SF MUH policy support.* Figure 26 shows that support for SF MUH was higher among New York adults than among other adults in the United States in 2012 and 2014. In 2014, 58.8% of New York adults and 48.0% of local opinion leaders favored banning smoking in MUH (see Figure 27).

**Figure 26. Support for TFO and SF MUH Policies among Adults, New York Adult Tobacco Survey 2012–2014 and National Adult Tobacco Survey 2012–2015**



Note: There are statistically significant differences between support in New York State and the rest of the United States for all three policies between 2014 and 2015.

**Figure 27. Percentage of Local Opinion Leaders and General Adult Population Who Somewhat or Strongly Support TFO and SF MUH Policies, New York Local Opinion Leader Survey, 2014 and New York Adult Tobacco Survey, 2015**



Note: There are statistically significant differences between New York adult and local opinion leader support for banning smoking in building entryways and for banning smoking in multi-unit housing.

## Discussion

ATFC contractors have continued to work toward tobacco control policies that will affect the greatest number of people by engaging municipalities, large businesses, and organizations that own or manage a large number of housing units. Since the last time the IER examined the community program (2012), ATFC contractors have educated more than 1,000 policy makers representing hundreds of lawmaking bodies; advocated with hundreds of organizational decision makers; and conducted nearly 3,000 public education activities.

These activities have resulted in significant TFO and SF MUH policy successes. Since the last time we reviewed the community program in an IER, more than 6 million more New Yorkers are covered by policies that ban smoking in building entryways and in beaches and parks. Since 2012, approximately 23,000 more housing units have become smoke-free. POS policy successes have been more challenging, with only two policies successfully adopted since 2012. However, there is evidence of program progress toward POS policy goals; since 2010, public support has significantly increased for all

four original POS model policies; and since 2011, policy-maker support has increased for all but one (the display ban) of the original POS model policies. Although support for the display ban did not increase, it was already high.

In 2014, ATFC contractors began educating decision makers about three new model policies: banning coupon redemption, banning multi-pack discounts, and increasing the age of sale from 18 to 21. All of these policies have been successfully implemented in other cities or states. Of these, the age of sale increase has the support of two-thirds of New Yorkers. Although the coupon redemption and multi-pack discount policies have lower levels of support (approximately one-third of New Yorkers and local opinion leaders), our recent analyses found that support for these policies was more similar across opinion leader political philosophies compared with support for other POS policies (Schmitt et al., 2015). The only other policy with a similar profile was the building entryway ban, where we suggested that the near-universal support for this policy accounted for the apparent consensus.

### *Cigarette Tax Avoidance: Reservation and Native Brand Purchases*

Increasing cigarette excise taxes is an effective way to prevent and reduce cigarette use (Chaloupka et al., 2012). However, smokers can reduce the impact of higher cigarette taxes through various means, including switching to discount cigarettes, smoking fewer cigarettes more intensely, and/or seeking low-tax or untaxed sources of cigarettes, like neighboring states, online retailers, or Native American reservations. Previous reports have shown that tax avoidance and evasion in New York State are quite prevalent and lead to significant revenue losses (Center for Public Health and Tobacco Policy, 2011; Davis et al., 2006; National Research Council and Institute of Medicine, 2015). It is estimated that up to 45% of packs consumed in New York are obtained through low or no-tax sources and that New York accounts for half of the \$2.95 billion in state cigarette excise taxes lost through tax avoidance and evasion in 2011 (National Research Council and Institute of Medicine, 2015).

Native American reservations have been a low-tax source of cigarettes for New York smokers. Before 2011, New Yorkers

were able to purchase cigarettes from retailers on Native American reservations without having to pay state and local excise taxes. Legislation passed in New York in 2010 required wholesale distributors to prepay excise taxes on packs of cigarettes, including those destined for Native American reservations. This legislation allowed for tax-free purchases of cigarettes by tribal members through a coupon system or quota system based on estimated demand among tribe members. After appeal, the law took effect in 2011 and consequently forced Native American reservation-based retailers to assess state excise taxes on cigarettes. In 2010, 35% of wholesale cigarette sales were made to tribal stores. By 2012, after implementation of the legislation, this percentage dropped to 0.01 (von Lampe et al., 2014).

To incentivize enforcement of tax collection on Native American reservations, revenue-sharing agreements have been employed in some states, including New York. According to a 2013 agreement between New York State and the Oneida Nation, sales to non-Native Americans must include a sales tax equivalent to or greater than New York State and local taxes and adhere to minimum pricing standards. Tax revenue generated from the cigarette sales are required to be used for programs similar to those of the state and surrounding counties.

This analysis describes smokers' reports of purchasing cigarettes from low-tax sources over time, assesses changes over time in types of cigarette brands purchased, describes characteristics of smokers who purchase low-tax cigarettes from reservations and purchase Native American brands, and explores the relationship between a smoker's distance from a reservation and cigarette purchasing habits.

## Data and Methods

We used NY ATS data from 2003 through the fourth quarter of 2014, with the exception that data were not collected in 2013. Analyses by demographic variables were conducted using data from Q4 2010 through Q4 2014 to provide an up-to-date summary of smoker purchasing habits.

To assess whether smokers purchased cigarettes from low-tax sources, we examined responses to the question, "In the past

12 months, have you or a friend or relative purchased cigarettes for your own use: at an Indian reservation?; at a duty-free shop?; in other states, not including Indian reservations?; from a website or on the Internet?"

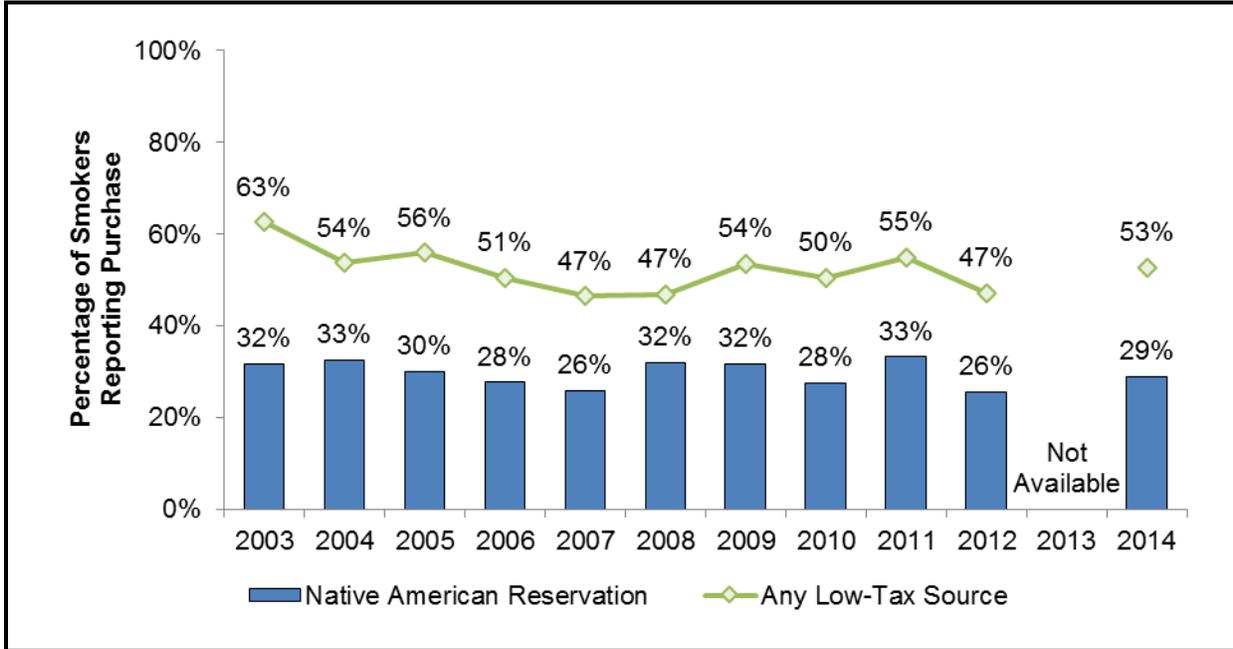
We determined brand preferences by examining responses to the question, "What is your usual brand of cigarettes?" Smokers' responses to this question were categorized into "premium," "Native American," and "discount" brand types. Brands were categorized as "premium" or "discount" using criteria established by Cornelius et al. (2013). The "Native American" brand category was assigned to brands that were manufactured on a reservation (e.g., Smokin Joes is made on a reservation and was considered a Native American brand; American Spirit was not categorized as a Native American brand because it is not made on a reservation). We categorized "other" open-text responses when feasible. Some open-text responses were excluded from analysis because there was insufficient information to identify place of production (798 of 8,103 open-text responses). Brand data were not collected via NY ATS for Q1 2008–Q3 2010.

Respondent distance to the nearest reservation was calculated using an ArcGIS geocoding service. Distances are based on a dataset containing locations of tribal reservations obtained from the U.S. Census. Esri ArcGIS software was used to calculate the distance between respondent mailing address and the closest feature in the dataset containing reservations. Distances are Euclidean distances (i.e., "as the crow flies"). Data were sufficient to calculate distances for 52% of NY ATS current smokers (6,029 of 11,716).

## Results

From 2003 to 2014, 53% of smokers purchased cigarettes from any low-tax source, and 30% of smokers purchased from Native American reservations. Over time, we observed a decreasing trend in the percentage of smokers who purchased from any low-tax source ( $p < 0.001$ ), but no significant change was observed over time in the percentage of smokers purchasing cigarettes from Native American reservations (Figure 28).

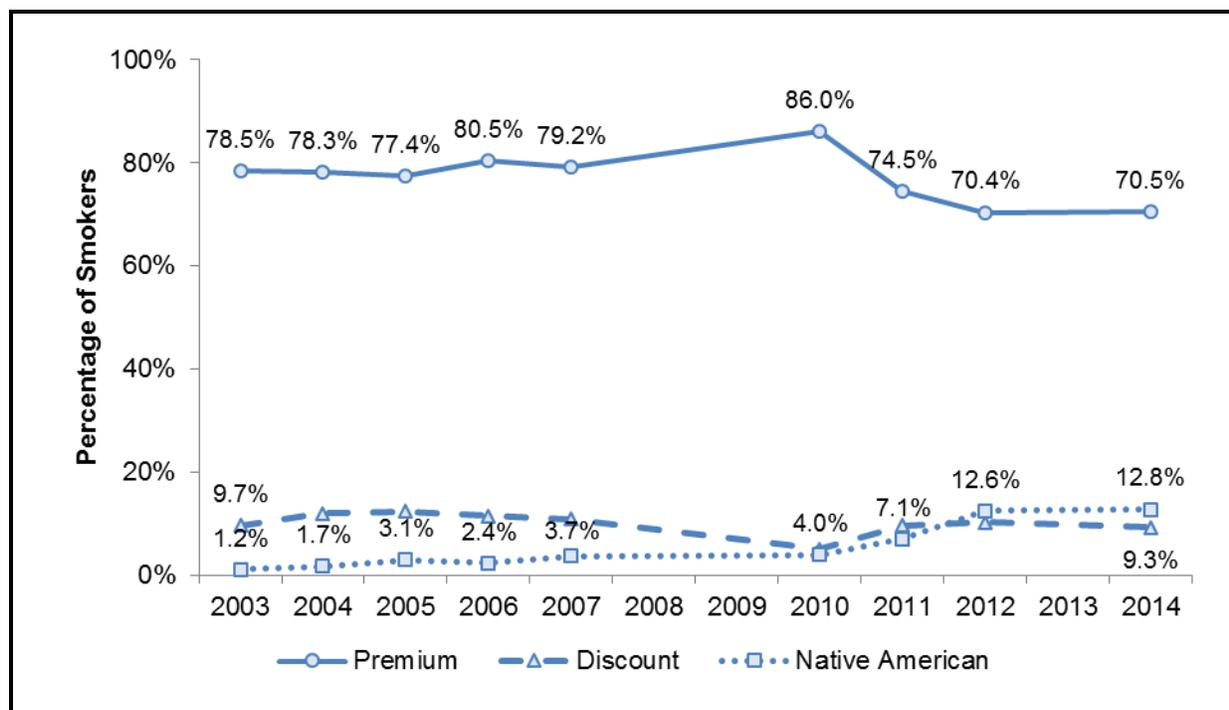
**Figure 28. Percentage of New York Adult Smokers Who Reported Purchasing Cigarettes from Low-Tax Sources, New York Adult Tobacco Survey 2003–2014**



During this period, the percentage of smokers reporting a premium brand as their preferred brand decreased significantly ( $p < 0.001$ ), while the percentage of smokers reporting a Native American brand increased significantly ( $p < 0.001$ ) (Figure 29). Compared with the period Q3 2003–Q2 2008, during which there was a \$1.50 excise tax on cigarettes, a significantly smaller percentage of smokers preferred premium brands in the periods Q3 2010–Q4 2012 and Q1 2014–Q4 2014 ( $p < 0.01$ ), when there was a \$4.35 excise tax. The opposite was true for Native American brands ( $p < 0.001$ ), which more smokers reported as their usual brand during periods with higher cigarette excise taxes.

Between Q4 2010 and Q4 2014, smokers who purchased cigarettes from low-tax sources tended to be younger, white (non-Hispanic), more educated, more affluent, and reside outside of New York City. Smokers who reported purchasing cigarettes from Native American reservations tended to be younger, white (non-Hispanic), more affluent, and reside outside of New York City.

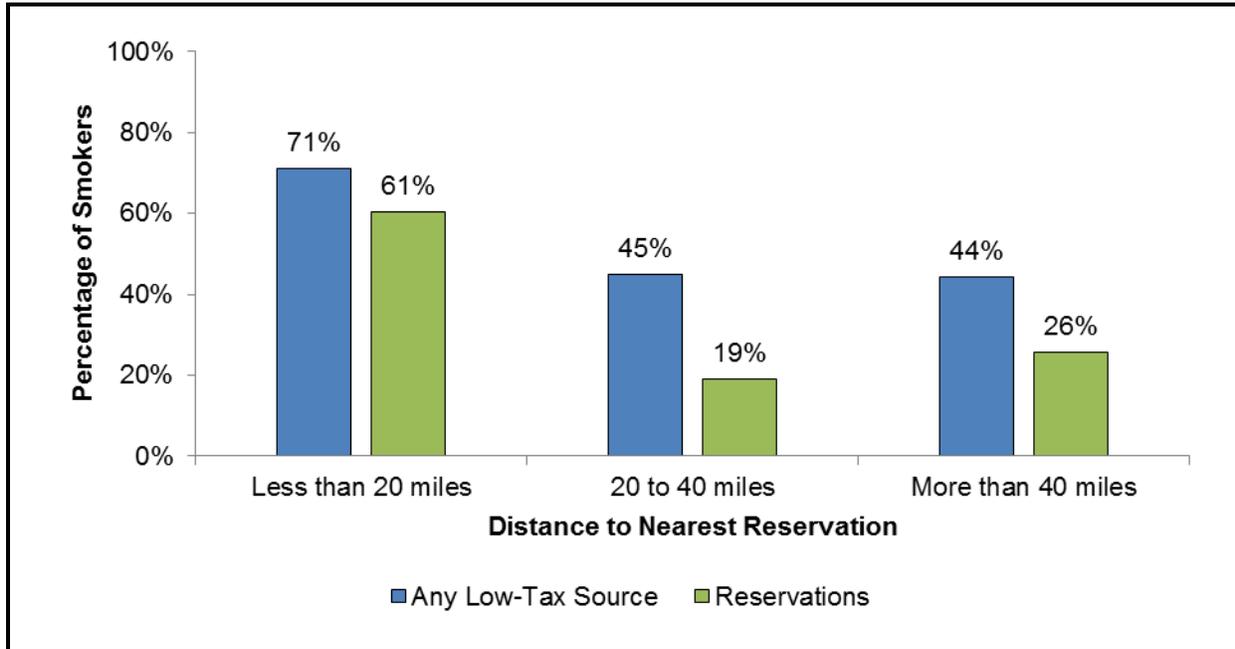
Figure 29. Usual Cigarette Brand Type, New York Adult Tobacco Survey 2003–2014



Preferred brand type was associated with several demographic characteristics. Young adults, aged 18 to 24, preferred Native American brands more than adult smokers aged 25 or older. Smokers younger than age 40 preferred premium brands more than smokers older than age 40. Older smokers reported preferring discount brands at higher rates than Native American brands. A larger percentage of white (non-Hispanic) smokers preferred discount or Native American brands than smokers of all other racial/ethnic groups. Black and Hispanic smokers were more likely to prefer premium brands than their white (non-Hispanic) counterparts. Smokers with a high school diploma or GED were more likely to prefer Native American brands than smokers with a college degree.

Proximity to a reservation was significantly associated with purchasing cigarettes from reservations or any low-tax source. As shown in Figure 30, 71% of smokers who lived within 20 miles of a reservation reported purchasing cigarettes from any low-tax source, and 61% reported purchasing from a reservation specifically. In comparison, 45% of smokers living 20 to 40 miles away from a reservation reported purchasing from any low-tax source, and 19% reported purchasing from a

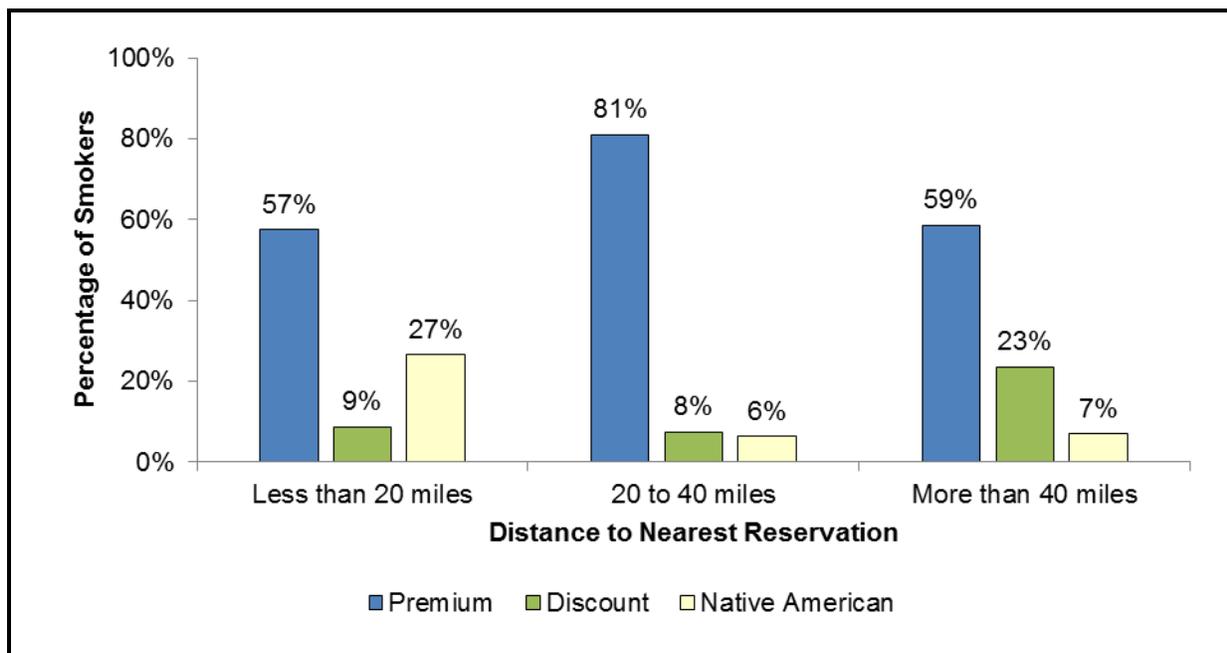
**Figure 30. Percentage of Smokers Who Purchase Cigarettes from a Low-Tax Source by Distance from Reservation, New York Adult Tobacco Survey 2010–2014**



Native American reservation. Similarly, 44% of smokers who lived more than 40 miles from a reservation reported purchasing from a low-tax source, and 26% reported purchasing from a reservation.

Brand preference was also strongly correlated with distance from a reservation. The percentage of smokers who preferred Native American brands was three times higher among those living less than 20 miles from a reservation (27%) than among those living 20 to 40 miles from a reservation (6%) and those living more than 40 miles from a reservation (7%) (Figure 31). Smokers living more than 40 miles from a reservation preferred discount brands at higher rates (23%) than those living within 20 miles of a reservation (9%) and those living 20 to 40 miles from a reservation (8%). Premium brands were preferred at higher rates among those living 20 to 40 miles from a reservation (81%) compared with those living within 20 miles of a reservation (57%) and those living more than 40 miles from a reservation (59%).

**Figure 31. Percentage of Smokers Who Reported Each Usual Brand Type, by Distance from Reservation, New York Adult Tobacco Survey 2010–2014**



## Discussion

More than 50% of New York smokers engage in tax avoidance. The most commonly reported low-tax cigarette source is reservations. Purchasing patterns and brand preferences are related to smoker demographics and level of tobacco consumption. Younger smokers more often reported purchasing on reservations and indicating a Native American brand as their usual brand than older smokers. Smokers' proximity to a reservation is associated with purchasing from a low-tax source and reporting a Native American usual brand.

The percentage of smokers in New York who reported purchasing cigarettes from a reservation did not change over time. However, the percentage of New York smokers reporting a Native American brand as their usual brand increased. The fact that Native American brand preference increased while purchases from reservations stayed flat may reflect the shift in tax policy that requires cigarette excise taxes to be applied at the wholesale level. Tribes have increased production of their own cigarettes, which may not be taxed—even for non-tribal members. Revenue-sharing agreements have been one way of further incentivizing Native American reservations to enforce

and collect excise taxes. Tax avoidance remains a barrier to New York's cigarette excise tax achieving its intended health benefits.

## Discussion

### *Progress in Changing Tobacco Use*

Patterns of tobacco use today are significantly different from 15 years ago. During this period, the prevalence of smoking in New York has declined markedly among youth and steadily among adults. As of 2014, the prevalence of current smoking was 14.5% among adults, 7.3% among high school students, and 1.1% among middle school students. The drop in adult smoking prevalence below 15% is noteworthy as this is a stated objective of NY TCP (to decrease adult smoking prevalence below 15% by December 31, 2018). Also noteworthy is that smoking prevalence has fallen below 20% (19.9%) among those with low income (less than \$25,000) and below 24% (23.3%) among those with poor mental health (defined as those who have ever been told they have a depressive disorder)—both are stated objectives of NY TCP to reach by December 31, 2018. Despite the steady declines in smoking among adults, differences remain across demographic groups. The prevalence of smoking remains relatively high among those with relatively low education and/or income, racial/ethnic minorities, and those with poor mental health.

The average number of cigarettes smoked per day has declined substantially since the start of the NY TCP in 2003, yet this metric has not fallen significantly in the last 7 years. Similarly, the percentage of adult smokers in New York who have made a quit attempt in the past year increased by 31.5% from 2003 to 2014 (from 46.3% to 60.9%). Despite this long-term improvement, this percentage has not changed since 2007. The percentage of smokers making quit attempts using evidence-based methods (e.g., counseling, NRT, pharmacotherapy) has also increased. From 2003 to 2014, the percentage making an evidence-based quit attempt in the past 12 months increased by 52.5% compared with a 34.4% increase for non-evidence-based methods.

The use of e-cigarettes, vapor pens, e-hookahs, and other electronic vapor products has more than doubled among adults

in New York from 2012 to 2014 (3.1% to 6.5%). As of 2014, most users of electronic vapor products also smoke cigarettes. Rates of current use and dual use were similar between New York (2014) and the rest of the country (2015).

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 declined in New York by 73% among high school students and 89% among middle school students. The prevalence of cigar use also declined markedly in New York among high school students (56%) and middle school students (84%). The prevalence of smokeless use among youth has remained relatively low and stable. The prevalence of hookah use has increased somewhat over time in New York among middle school students. In recent years, the prevalence of e-cigarette use has increased dramatically among adolescents. In 2014, youth use of e-cigarettes was higher than current cigarette smoking in New York.

### *Health Communications*

NY TCP has focused 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. In 2014, NY TCP continued to use message strategies that have been successful in the past several years, with campaigns that primarily focus on promoting cessation. NY TCP's selection of message strategies is appropriate in light of the evidence base and available, existing television advertisements. Key outcome indicator variables suggest that the program is maintaining reasonable levels of message awareness consistent with the budget allocated to paid advertising. However, in light of changing patterns of tobacco use, such as multiple tobacco product use and increasing use of e-cigarettes and other vapor products, the Program may want to consider whether messages focused on other tobacco product use are warranted as a complement to smoking-related messages.

In addition to examining the types of messages, in the past year, we have begun to examine the paid media buying strategy used to promote NY TCP messages. We have done this by collecting data on smokers' media use patterns and

comparing them to the paid media strategy. Early indications from these data suggest that there are opportunities to reach smokers more efficiently. For example, awareness of NY TCP messages does not differ significantly by income, but given the disparities that exist by income, it would be optimal to reach lower income populations at higher levels than those with higher incomes.

### *Cessation Interventions and Health Systems Change*

To promote cessation, NY TCP employs a multistrategy approach by working to institutionalize changes in health systems and offering telephone-based smoking cessation counseling through the New York State Smokers' Quitline. NY TCP funds contractors to promote health systems changes in organizations that serve populations disproportionately affected by tobacco use, such as FQHCs, that primarily serve those with low income, and mental health treatment facilities. The goal of systems change is to increase the number of health care provider organizations that have policies and systems to facilitate screening all patients for tobacco use, provide brief advice to quit at all visits, and provide assistance to help patients quit successfully.

In New York, the majority of smokers report that their provider asked if they smoke and advised them to quit. From 2003 to 2014, there has been a statistically significant upward trend in smokers' reports of receiving provider assistance with a quit attempt (e.g., discussing withdrawal symptoms, suggesting setting a quit date, discussing stop-smoking medication options). However, only about half of smokers in New York who visited a health care provider in the past 12 months indicated that they received quit assistance from a health care provider. Although these numbers are similar to the rest of the United States, there is room for improvement to increase health care provider assistance with quit attempts. NY TCP's existing health systems change efforts are aligned with the evidence base and their efforts prioritize systems changes in health care organizations that serve populations disproportionately affected by tobacco use.

## *Statewide and Community Action*

The community program has made impressive progress toward denormalizing tobacco use through the adoption of TFO policies in municipalities, colleges, and businesses throughout the state. Likewise, the continued focus on advocating for SF MUH with housing authorities, realty management companies, and large complexes has created a housing market that protects 23,000 more families from secondhand smoke. We recommend that the program continue with this successful approach to the TFO and SF MUH initiatives.

Progress toward POS policy goals has been less dramatic; however, increases in support for POS policies suggest that Program efforts, successful adoption of POS policies in other states, and media coverage of POS issues are creating an environment more amenable to POS policies than in the past. Data from the NY ATS and LOLS, along with the growing literature focusing on POS policies, provide the basis for the POS policy recommendations that follow.

We concur with the Program's decision to continue educating the public and policy makers about the influence of tobacco displays and marketing at the POS, despite consensus among tobacco control lawyers that a display ban is unlikely to be successfully defended in any expected challenge by the tobacco industry. Our analyses show that this belief predicts public and policy-maker support for POS model policies (Schmitt et al., 2012, 2015).

We also recommend that the Program continue its focus on educating policy makers about pharmacy bans, despite a recent disappointment in Albany, where such a policy was adopted but subsequently vetoed. More than half of New York adults and policy makers currently support a policy that would ban tobacco sales in pharmacies, and policy-maker awareness of this policy option increased significantly between 2011 and 2014. Banning tobacco sales in pharmacies is increasingly considered normative (McDaniel & Malone, 2014), likely as a response to the number and media coverage of pharmacy ban policies; San Francisco's 2008 pharmacy ban withstood legal challenges from the tobacco industry (California LGBT Partnership, 2010) and was followed by pharmacy bans in 80 Massachusetts municipalities (Center for Public Health Systems Science, 2014)

and CVS' decision to stop selling tobacco products in 2014. Given the lack of policy change in New York communities, despite a high level of support for a pharmacy ban, we reviewed case studies of success in California and Massachusetts. We concluded that RTI and the Program are already using recommended key messages and counterarguments. If resistance continues, we recommend conducting focus groups with ATFC contractors (and possibly other stakeholders, such as Albany elected officials) to better understand and subsequently counter barriers to adopting pharmacy bans.

Although there is significant support for banning the sale of tobacco products in stores near schools among the public and policy makers, we recommend that the Program proceed with caution on this policy goal. To date, few of these policies have been completely adopted and implemented; the city of Chicago adopted a ban on the sale of flavored tobacco products within 500 feet of schools in July 2014 (City of Chicago, 2016), but this law is not yet fully implemented (Tobacco Control Legal Consortium, 2015). Such a policy is currently being discussed in Berkeley, California, but no action has been taken (Wang, 2015). While this policy focus on children provides the basis for a strong persuasive message, open-text responses in our 2011 LOLS suggested that, before supporting such a policy, local elected officials would need reassurance that it would be fairly implemented and not have significant negative effects on the value of a business, particularly small businesses.

We recommend focusing efforts on raising the minimum age for tobacco product purchases. This policy was adopted in New York City and has significant support among the New York public, similar to the 70.5% of support for it recently documented at the national level (Winickoff et al., 2015). In contrast to many other POS policies where effectiveness is either documented outside of the United States or not available, a recent study provided evidence that this policy is effective and these findings can be used in program messaging; Kessel-Schneider and colleagues (2015) reported reductions in 30-day smoking among youth and decreased cigarette purchases relative to comparison communities between 2006 and 2010 in Needham, Massachusetts, which raised the age of sale to 21 in 2005. In addition, Hawaii recently raised the age of tobacco sales to 21 (Campaign for Tobacco-Free Kids, 2015),

providing precedent should the program want to consider recommending this as a statewide policy. Between the available evidence, IOM (2015) recommendations for the efficacy of this policy, and the precedent set by Hawaii, the community program has strong arguments to build additional support for this policy.

Based on findings from the most recent LOLS (Schmitt et al., 2015), we believe that the Program has an opportunity to frame the arguments and messaging in support of both a ban on coupon redemption and multi-pack discounts. Unlike nearly all other POS model policies, where self-identified liberals were more supportive of a policy than were self-identified conservatives, we found little difference in support by political philosophy for these policies or high levels of strong anti-government sentiment associated with them. With relatively low levels of support among the public and policy makers (approximately one-third of each group supports these policies), the Program has a unique opportunity to set the agenda for discussion of these policies and build future support for them.

### *Programmatic Recommendations*

#### *Overall Recommendations*

- Increase NY TCP funding to a minimum of one-half of CDC's recommended funding level for New York (\$203M) per year. This represents a small percentage of New York State's annual revenue from tobacco taxes and MSA payments.
- Continue to develop and implement interventions to reduce disparities in smoking rates.
- Continue to enhance surveillance of e-cigarettes among youth and adults to better understand how they are influencing patterns of tobacco product use and population health.

#### *Health Communication Recommendations*

- Investigate potential strategies to curb increased use of e-cigarettes among youth.
- Increase awareness of antismoking messages among smokers to at least 60%.

- Invest additional funds in media campaigns to support community contractors' policy change efforts.
- Increase the efficiency of the paid media strategy by reflecting current data on smokers' media use patterns.

### *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 tobacco users, such as community health centers.
- 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.

### *Statewide and Community Action Recommendations*

- Develop new messaging to build support for POS policies. Such messages could augment the current messages that focus on the link between exposure to tobacco marketing at the POS and youth smoking.
- Add raising the minimum age for tobacco product purchases to 21 as a policy option for contractors.
- Conduct focus groups to better understand and subsequently counter barriers to adopting bans on tobacco sales in pharmacies.
- Continue focusing SF MUH efforts on decision makers with responsibility for a large number of units, such as housing authorities, realty management companies, and managers of large apartment complexes.

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