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# 2013 Independent Evaluation Report of the New York Tobacco Control Program

Prepared for

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

Prepared by

**RTI International**  
3040 E. Cornwallis Road  
Research Triangle Park, NC 27709

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## Executive Summary

**N**ew York State has a long history of strong tobacco control policies and programmatic interventions that support a tobacco-free norm. For example, New York State has had a comprehensive smoke-free law for more than a decade and has the highest state cigarette excise tax in the country. Several key outcome indicators suggest that New York has outperformed the rest of the United States. As of 2012, the prevalence of adult smoking is lower in New York than nationally. However, in recent years, this progress has slowed, and the gap for several of these indicators has narrowed or been eliminated between New York and the rest of the United States. This trend toward national averages is not surprising with per capita funding for the New York Bureau of Tobacco Control (NY BTC) converging with the national per capita level of funding for tobacco control programs. In 2007, funding for NY BTC was more than double (117% higher) that of the rest of the United States, while in 2012 it was only 33% higher. In addition, while the state excise tax is the highest in the nation, we have demonstrated that tax avoidance is prevalent, which erodes the public health benefits of the tax.

Although smoking prevalence has declined over time and is lower than the national average, smoking remains disproportionately high among certain vulnerable populations, like people with poor mental health. It is unclear whether high cigarette excise taxes and smoke-free indoor spaces have the same positive influence on smoking in this population as they do on smokers more broadly. What is clear is that NY BTC's tobacco-focused health communication efforts in the past have led to increases in quit attempts among smokers overall and among various income and education groups (Farrelly et al., 2012). However, in 2012, just over one-third of smokers had seen one of NY BTC's antismoking ads, down from a peak of 53% in 2007. To continue to reinforce smoke-free norms and positively affect key outcome indicators will require more consistent and broadly disseminated health communication efforts. As we have noted previously, such campaigns should be viewed as a core, effective public health strategy.

Greater support for health communication efforts could also help reduce the influence of point of sale (POS) tobacco marketing on youth. The goals of NY BTC's POS initiative are to

support 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, and/or prohibit the sale of tobacco products in pharmacies. New Yorkers' support for these policies has grown in the last 3 years and is greater than support for these policies nationally. However, to date, very few policies have passed at the local level.

Currently, NY BTC funding of \$40 million is just 2% of the \$2.35 billion in annual tobacco tax revenue and Master Settlement Agreement (MSA) payments. Increasing this to just 11% (\$254.3 million) would meet the Centers for Disease Control and Prevention's (CDC's) recommended funding level for tobacco control. If funding could be increased steadily over time to meet CDC's recommendation, it would give NY BTC time to build the capacity to use these additional funds efficiently.

### *Key Evaluation Findings*

- From 2009 to 2012, the prevalence of adult smoking in New York declined by 23% compared with 13% nationally.
- Although the prevalence of smoking among adults overall has dropped to 16%, it is considerably higher for those with poor mental health at 26%.
- From 2000 to 2012, the prevalence of smoking declined by 69% among middle school students and 56% among high school students in New York. National declines were similar. As of 2012, smoking rates were comparable between New York and the United States at both grade levels.
- Cigarette consumption declined by 30% among New York adult smokers from 2003 to 2012 and was 16% lower than the rest of the United States in 2012. However, cigarette consumption in New York has remained stable since 2008.
- The percentage of adult smokers in New York who made a quit attempt in the last year increased 37% from 2003 to 2012, with little change since 2007. As of 2012, the prevalence of making a quit attempt was similar between New York and the rest of the United States, with the national *Tips From Former Smokers* campaign

likely contributing to a recent increase in the national quit rate.

- In 2012, 48% of adult smokers reported that their health care provider assisted them in quitting smoking in the past year, a 28% increase over the 2003 rate. The rate of assistance was similar between New York and the rest of the United States in 2012.
- Finally, New Yorkers' support for policies restricting POS cigarette sales and advertising (i.e., tobacco product displays, pharmacy sales, the number of tobacco retailers, and tobacco sales near schools) has increased in recent years and is greater in New York than the rest of the United States.

RTI's key programmatic recommendations are as follows:

- Increase NY BTC funding to a minimum of one-half of CDC's recommended funding level for New York (\$254.3 million) to \$127.2 million per year. This represents less than 6% of New York's annual revenue from tobacco taxes and MSA payments.
- Develop and implement interventions to address disparities in smoking rates, particularly for those with poor mental health.
- Consistent with CDC's Best Practices (CDC, 2014) recommendations, reach 75% awareness of antismoking messages among smokers.
- Invest additional funds in media campaigns to support community contractors' policy change efforts.
- Continue directing Cessation Center contractors to focus their efforts on organizations that serve high proportions of tobacco users, such as community health centers and mental health programs.
- Continue to emphasize the importance of community contractor efforts to actively engage youth and allied organizations and individuals in their efforts, particularly those invested in reducing tobacco-related disparities.



## Introduction

The New York Bureau of Tobacco Control (NY BTC) employs three key strategies consistent with the large evidence base for tobacco control (CDC, 2014; NCI, 2008; USDHHS, 2000, 2012; Zaza, Briss, & Harris, 2005) to change social norms and reduce tobacco use: health communication; cessation interventions; and statewide and community action aimed at policy, systems, and environmental changes. As reported in the 2012 Independent Evaluation Report (IER) (RTI, 2012), from 2003/2004 to 2011, the prevalence of smoking among adults declined by 13% in New York compared with 9% nationally. The decline in New York is smaller than previously reported as a result of methodological changes to the Behavioral Risk Factor Surveillance System (BRFSS). However, this decline was not uniform across population groups. Over this same period, adult smoking prevalence declined by 16% among Caucasians, while there were no statistically significant changes among African Americans, Hispanics, low-income adults, or adults with poor mental health in New York.

While other key outcome indicators have declined over time, we also noted in 2012 that progress in many of these outcomes has slowed or even reverted after 2007. For example, from 2003 to 2011, quit intentions and quit attempts in the past year increased among smokers, and daily consumption declined. However, these measures leveled off after 2007. As of 2011, quit intentions and adult daily cigarette consumption were similar between New York and the rest of the United States, while the prevalence of making a quit attempt in New York remained higher than the rest of the country. Also noteworthy, from 2007 to 2011, adult use of cigars and smokeless tobacco increased.

From 2000 to 2010, smoking prevalence declined by 70% among middle school students and 54% among high school students—rates of decline that outpaced the nation as a whole. Among adults, smoking prevalence declined 28% from 2003 to 2010, almost three times the decline in the United States (10%) over this same period.

In this report, we summarize the contextual influences that can affect NY BTC's progress, describe NY BTC's approach to

tobacco control, examine trends in key outcome indicators, and address the following critical evaluation questions for NY BTC:

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

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 Bureau of Tobacco Control – Context and Programmatic Approach

**I**n this section, we first describe the tobacco control context in which NY BTC operates and then describe the Bureau’s current approach to tobacco control.

### *Tobacco Control Policy Environment*

New York has been a national leader with respect to tobacco control policies. New York’s cigarette excise tax is now the highest in the country and is nearly \$3 more than the national average tax; all New Yorkers are covered by a comprehensive smoke-free air law (workplaces, restaurants, and bars), compared with 49% of the population nationally; and per capita funding for tobacco control is higher in New York (\$2.31) than in all other states (\$1.74) (Table 1). This is a significant change from the peak funding for NY BTC in 2007 of \$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 2, 2013)	\$4.35	\$1.53
Percentage of the state population covered by comprehensive <sup>a</sup> smoke-free air laws (December 31, 2012)	100%	47.5%
Annual per capita funding for tobacco control (FY 2012)	\$2.31	\$1.74 (excluding New York)

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

## Program Budget

Each year, New York State receives significant revenue from cigarette taxes and Master Settlement Agreement (MSA) payments. These two sources total approximately \$2.35 billion for FY 2012–2013 (Table 2). Allocating just 11% of the annual revenues from cigarette taxes and MSA payments to tobacco control programming would meet the Centers for Disease Control and Prevention’s (CDC’s) recommended funding level for NY BTC of \$254.3 million. The current NY BTC budget of \$40.1 million is only 16% of the CDC recommendation and represents less than 2% of annual cigarette tax and MSA payments.

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

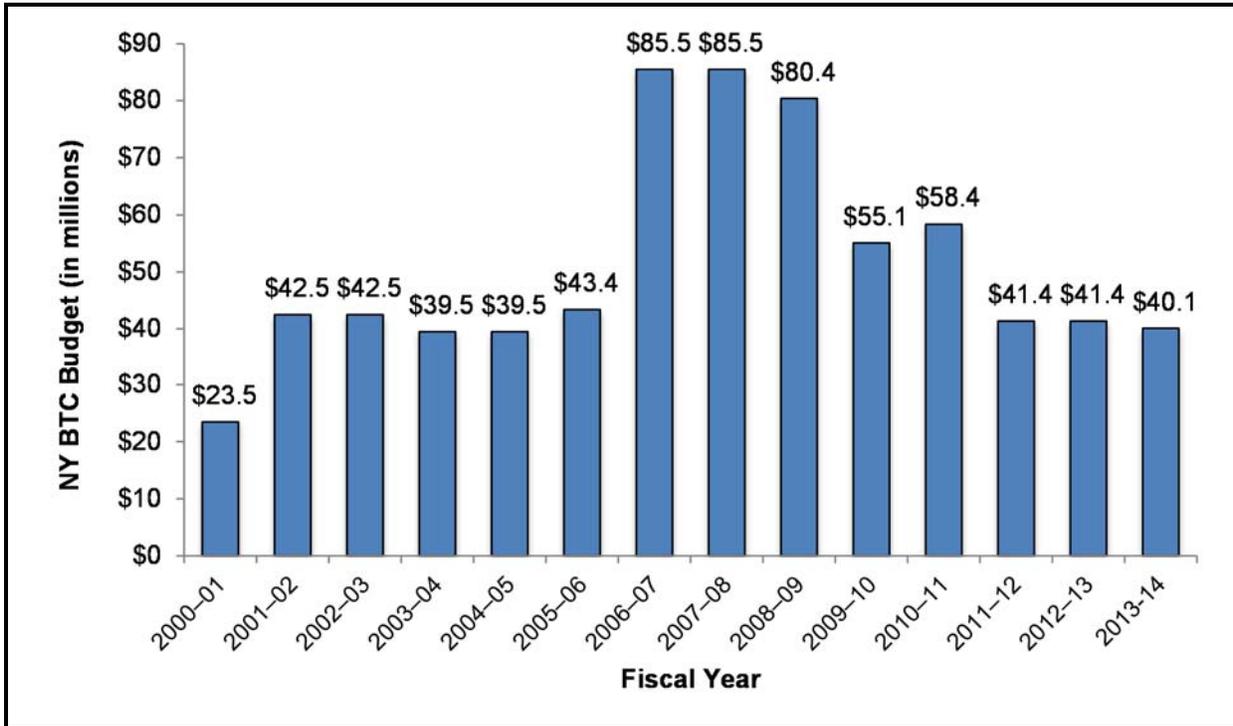
Revenue/Expenditure Category	Annual Revenue/Expenditure
Revenue from state cigarette excise tax (FY 2013)	\$1,603,700,000
Revenue from MSA payments (FY 2013)	\$746,500,000
Estimated cigarette advertising and promotions in New York State (CY 2011) by five major cigarette manufacturers	\$216,586,005
New York Bureau of Tobacco Control budget (FY 2013–2014)	\$40,129,898

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

In addition to falling well below CDC’s recommended funding levels, NY BTC is outspent by tobacco company advertising and promotional efforts. Tobacco companies spent \$8.4 billion nationally on advertising and promotions in 2011 (Federal Trade Commission, 2013). If these expenditures are spent in proportion to cigarette sales, then this translates to \$217 million spent on advertising and promotions overall in New York State. Of this, an estimated \$181 million is for price reductions and retail-value-added bonus cigarettes (e.g., buy two packs, get one free).

The approved budget for FY 2013–2014 is similar to the FY 2012–2013 budget of \$41.4 million. The longer-term pattern of NY BTC funding is shown in Figure 1 and provides context for interpreting the longer-term trends in key outcome indicators presented below. Funding for FY 2011–2012, FY 2012–2013, and FY 2013–2014 is similar to the funding levels prior to FY 2006–2007, when funding increased to \$85.5 million.

Figure 1. NY BTC Funding FY 2000–2001 to FY 2013–2014



Note: NY BTC = New York Bureau of Tobacco Control

Table 3 shows the budget for FY 2012–2013 and FY 2013–2014 by program component. Although the overall budget is similar across these two years, fewer resources are spent on cessation interventions, media placement, and surveillance and evaluation.

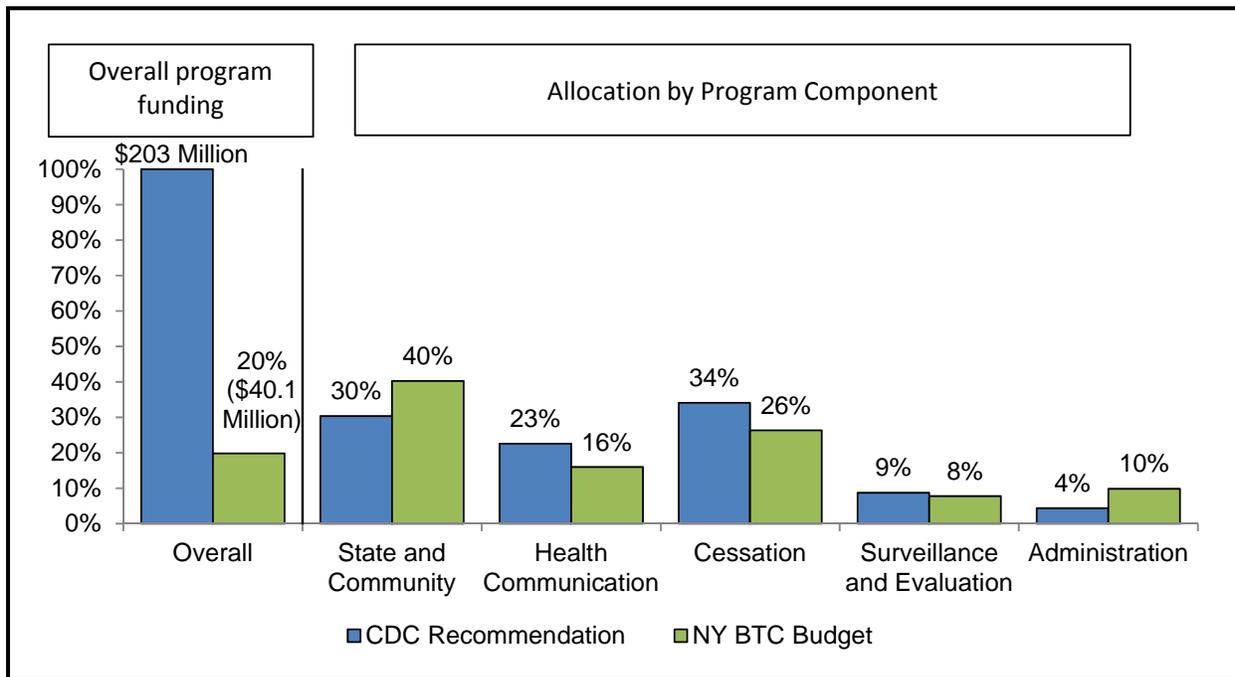
Figure 2 illustrates how the distribution of the FY 2013–2014 NY BTC budget compares with CDC Best Practices recommendations overall and by program component (CDC, 2014). Overall, NY BTC funding is much lower than the CDC recommended level. The allocation for state and community programs is 40%, compared with the CDC recommendation of 30%. NY BTC allocates 16% of funds for health communication, compared with CDC’s recommended 23%. Similarly, NY BTC allocates 26% for cessation funding, compared with the recommended 34%. The allocation for surveillance and evaluation (8%) is slightly less than the recommended percentage (9%). As noted in the 2010, 2011, and 2012 IERs, funding for media placement was reduced disproportionately to preserve capacity for community programs. As a result, statewide programs constitute 42% of the budget, compared

**Table 3. NY BTC Budget for FY 2012–2013 and FY 2013–2014**

Program Component	2012–2013 Expenditure Plan	2013–2014 Expenditure Plan
<b>State and Community Interventions</b>	<b>\$11,512,922</b>	<b>\$11,407,604</b>
Community Partnerships	\$8,145,810	\$8,145,810
Reality Check	\$2,360,024	\$2,360,024
Center for Public Health and Tobacco Policy	\$480,500	\$480,500
Training	\$526,588	\$421,270
<b>Enforcement</b>		
Clean Indoor Air Act and Adolescent Tobacco Use Prevention Act Enforcement	<b>\$4,795,346</b>	<b>\$4,724,950</b>
<b>Cessation Interventions</b>	<b>\$11,624,378</b>	<b>\$10,552,229</b>
Cessation Centers	\$5,502,890	\$5,502,890
Quitline	\$4,721,488	\$4,249,339
Nicotine replacement therapy	\$1,400,000	\$800,000
<b>Health Communication Interventions</b>		
Media placement	<b>\$6,898,340</b>	<b>\$6,389,613</b>
<b>Surveillance and Evaluation</b>		
Independent evaluation	<b>\$3,372,282</b>	<b>\$3,118,502</b>
<b>Administration</b>		
Tobacco control and cancer services	<b>\$3,211,732<sup>a</sup></b>	<b>\$3,937,000</b>
<b>Total</b>	<b>\$41,415,000</b>	<b>\$40,129,898</b>

<sup>a</sup> This item includes \$1,010,005 for the cancer surveillance improvement project.

**Figure 2. NY BTC 2013–2014 Budget Versus CDC Recommendations**



Note: CDC = Centers for Disease Control and Prevention; NY BTC = New York Bureau of Tobacco Control

with the CDC recommended 35%. 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 BTC is built on the social norms change model, which posits that reductions in tobacco use are achieved by creating a social environment and legal climate in which tobacco becomes less desirable, less acceptable, and less accessible (CDC, 2014; Frieden, 2010; NCI, 1991; USDHHS, 2000). NY BTC's current primary goal is to reduce the prevalence of smoking to 15% among adults and the rate of any tobacco use (i.e., cigarettes, cigars, smokeless tobacco) to 15% among high school students by 2017. California was one of the first state tobacco control programs to take a social norms approach and achieved a substantial decline in smoking among adults and youth (CDHS, 1998). New York's strong tobacco control environment will likely maintain current antitobacco norms and tobacco use prevalence rates. However, NY BTC 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, Stratton, & Wallace, 2007).

NY BTC's community action goals focus on promoting evidence-based policies at the local level to decrease exposure to secondhand smoke and reduce the social acceptability of tobacco. NY BTC efforts prioritize policy changes that affect the largest proportion of the population. Local policy goals include increasing the number of tobacco-free multi-unit dwellings in the state and the number of tobacco-free outdoor public spaces, such as beaches, parks, and building entryways. One of the innovative areas NY BTC has focused on in recent years is reducing youth exposure to tobacco product marketing by changing the tobacco retail environment. In support of these efforts, NY BTC has developed and promoted consistent messaging, technical assistance, and support to contractors.

Local contractors educate the public and local policy makers about the effects of tobacco marketing at the point of sale on youth initiation and the need for local policies to reduce that exposure. We describe NY BTC's major programmatic efforts below.

### *Administration and Support*

NY BTC's programmatic efforts are supported by administration, training and technical assistance, and surveillance and evaluation. NY BTC administration focuses on driving overall programmatic strategy, building and maintaining an effective tobacco control infrastructure, providing technical assistance and guidance, and managing the effective and efficient investment of state tobacco control funding. To ensure that policy goals are met, NY BTC 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. The messages are communicated by community contractors and via earned and paid media.

Leadership changes and contract processing delays have posed challenges for NY BTC and the independent evaluation. In early 2012, the NY BTC Director and Assistant Director took other positions. The Director position remained vacant until May 2013, while the Assistant Director position was filled in January 2013. The evaluation of NY BTC was expected to continue seamlessly from the closure of one 5-year evaluation contract to the commencement of the next 5-year evaluation contract in January 2013. However, there were extensive delays in the announcement of the contract award and processing of the contract. As a result, there was no contract for independent evaluation activities during 2013, including ongoing surveys that have previously tracked tobacco-related outcomes on a quarterly basis. This gap in continuity of the independent evaluation disrupts the provision of informed, actionable feedback to the Bureau and limits the evaluation's ability to analyze trends over time.

### *Health Communication*

NY BTC uses health communication strategies to motivate tobacco users to stop using tobacco, promote smoke-free

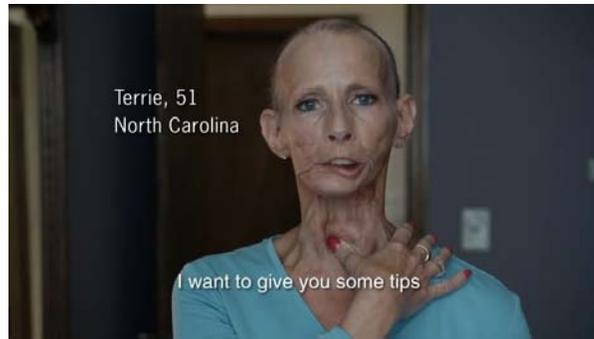
**Figure 3. CDC Tips Ad Image**

homes, deglamorize tobacco use, and educate community members and decision makers about tobacco control. There is growing evidence that antismoking campaigns are effective in reducing cigarette smoking among youth (USDHHS, 2012) and adults (Farrelly et al., 2012; NCI, 2008; Wakefield et al., 2011; Wakefield, Loken, & Hornik, 2010). NY BTC 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., 2012). Nearly all messages include the New York State Smokers' Quitline telephone number and Web site address.

During the first half of 2012, NY BTC continued previously used strategies with cessation- and secondhand smoke-focused campaigns. NY BTC's cessation-focused advertising consisted of three ads designed to motivate tobacco users to quit: "What's Worse," "Scared," and "Carotid." "What's Worse" and "Scared" focus on the emotional consequences of children learning their parents will die of smoking. "Carotid," one of the most graphic ads the campaign has aired to date, shows the dissection of a carotid artery and removal of fatty deposits from the artery.

During the spring of 2012, NY BTC also aired the secondhand smoke-focused ads "Inhaler" and "Father Smoking," which portray the negative health consequences for children exposed to secondhand smoke. All of these television ads were also supported with complementary radio and Internet ads that were aired during the same time.

In addition, three ads from the CDC *Tips* cessation advertising campaign aired during 2012. "Anthem" shows several individuals describing everyday activities with a tracheostoma, along with "tips" for caring for them (e.g., suction out your tube before you eat, CPR is mouth-to-stoma, be careful shaving). "Terrie" features the story of a woman who speaks through a tracheostoma (Figure 3). She describes some "tips" for getting ready in the morning, including putting in false teeth, putting on a wig, and attaching a hands-free device. "Roosevelt" tells the story of a 51-year old former smoker from Virginia who suffered a heart attack at 45. He offers the "tip" to "do your heart a favor, and quit now."



### *Health Systems Interventions*

NY BTC promotes cessation from tobacco use via a multistrategy, evidence-based approach that includes health systems change, telephone-based smoking cessation counseling, and health communication. Health systems change approaches include updating health care organizations' systems to ensure that patients are asked about tobacco use and provided assistance with quitting, promoting the Medicaid benefits for smoking cessation, and encouraging private health plans to expand tobacco cessation coverage. The New York State Smokers' Quitline offers tobacco cessation counseling, provides access to nicotine replacement therapy, and serves as an information clearinghouse for cessation. Below, we describe NY BTC cessation interventions in more detail, addressing Cessation Centers, the New York State Smokers' Quitline, and reduced patient costs for treatment.

### **Cessation Centers**

During 2012, NY BTC funded 19 Cessation Centers to increase the number of health care provider organizations that have systems to screen all patients for tobacco use, provide brief advice to quit at all visits, and provide assistance to help patients quit successfully. Evidence demonstrates that brief advice to quit smoking by a health care provider significantly increases the odds that a smoker will quit. Cessation Centers partner with health care organizations across New York State to help with changes to improve tobacco cessation intervention, offer provider training, provide guidance on system improvement, and provide technical assistance. To extend the reach of their message, the Cessation Centers have used a

media campaign (“Don’t Be Silent About Smoking”) aimed at health care providers.

Earlier in their 10-year history, Cessation Centers targeted medical practices, where the majority of smokers report getting regular care, thus providing opportunities for intervention on a routine basis. Consistent with RTI recommendations, NY BTC instructed Cessation Centers to work with organizations that serve higher proportions of tobacco users. Specifically, NY BTC redirected the focus of Cessation Center initiatives from medical practices to community health centers and programs that serve individuals with severe mental illness. Cessation Centers’ new objectives specific to community health centers and programs serving individuals with severe mental illness who live in the community (specifically Personalized Recovery-Oriented Services programs) went into effect in August 2012. Cessation Centers provide these organizations with guidance, training, and assistance on systems-level changes that support the assessment and treatment of tobacco dependence.

Community health centers served more than 1.5 million New Yorkers in 2012, with 86.3% of patients at or below 200% of the poverty level (CDC, 2014). Because populations with low socioeconomic status use tobacco at higher rates than the general population, working with community health centers provides a significant opportunity for Cessation Centers to target their efforts. Similarly, people with mental health disorders have disproportionately high rates of tobacco use. Personalized Recovery-Oriented Services programs serve individuals with mental health disorders in an outpatient setting and focus on helping clients set, prepare for, and achieve their life goals. Cessation Centers’ relationships with these programs may also help with efforts to promote a policy requiring tobacco-free services across Office of Mental Health facilities, similar to the regulatory changes that the Office of Alcoholism and Substance Abuse Services passed in 2007.

### **New York State Smokers’ Quitline**

The New York State Smokers’ Quitline was established in 2000 and provides individualized telephone counseling to adult smokers who want to quit. In addition, the Quitline offers free 2-week nicotine replacement therapy starter kits by phone or Internet to eligible clients, prerecorded telephone messages

covering a range of stop-smoking topics, and a Quitsite Web site with interactive features. For health care providers, the Quitline offers free cessation continuing medical education programs and a Refer-to-Quit program for tobacco-using patients. 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. During 2012, the Quitline reported receiving 176,404 calls and having 733,839 visits to their online quitsite.

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

NY BTC has worked with the Medicaid program to expand coverage for smoking cessation counseling and pharmacotherapy and has reached out to New York-based health plans to encourage them to provide greater support for smoking cessation. Fee-for-service Medicaid covers all first-line, FDA-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. NY BTC and the Cessation Centers continue to encourage health plans to expand coverage and promotion of cessation services to their members.

### ***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 BTC's community action efforts focus on policies at the local level with the potential to reduce smoking 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 (Institute of Medicine, 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 33 Community Partnerships and 17 Reality Check Youth Partners. Community Partnerships are strongly encouraged to work closely with the Reality Check in their catchment area and to actively and publicly involve youth in their activities.

Community contractors conduct four types of strategies: community education (including paid media), community mobilization, government policy-maker education, and advocacy with organizational decision makers. Community education strategies include events, earned media, and other types of information dissemination. Community mobilization activities include educating and working with other community organizations and influential individuals to incorporate key tobacco control messages and objectives into their own education and advocacy activities. Government policy-maker education activities include one-on-one meetings with policy makers and testimony at public hearings. Organizational decision-maker education activities may include one-on-one meetings with key stakeholders, such as major employers or real estate managers. As part of decision-maker education, contractors may also provide technical assistance in support of policy development and implementation. Each year, Community Partnership contractors allocate 10% of their budget to paid media, which funds a coordinated media campaign in communities across the state. Figure 4 shows a retail POS-related ad that community contractors have used.

During 2012, Community Partnerships focused their efforts on three initiatives: POS, Tobacco-free Outdoors (TFO), and Smoke-free Multi-Unit Housing (MUH). Reality Check contractors focused their efforts on the POS initiative and the MUH initiative.

Figure 4. Community Contractor Print Advertisement Focused on Retail Point-of-Sale Tobacco Marketing



*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 density of tobacco retailers in high school neighborhoods has been associated with experimental smoking (Leatherdale & Strath, 2007; McCarthy et al., 2009), and exposure to tobacco product marketing at the POS has been consistently associated with increased youth smoking initiation and susceptibility to smoking (Henriksen et al., 2010; Paynter & Edwards, 2009; Slater et al., 2007). Citing the Paynter and Edwards study, the 2012 Surgeon General’s Report concluded that “the addictiveness of tobacco, the severity of the health hazards posed by smoking, the evidence that tobacco marketing and promotion encourages children to start smoking, and the consistency of the evidence that it influences children’s smoking justify banning advertising and displays of tobacco products at the point of sale” (p. 544).

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, and/or prohibit the sale of tobacco products in pharmacies. POS policy efforts face significant opposition from retailers and the tobacco industry. In spite of this, community

contractors have achieved some successes and continue to push for additional changes in social norms and POS policies. In April 2012, the village of Haverstraw, New York, passed the first tobacco retail display ban in the United States. Community contractors mobilized community members to support an initiative to protect youth in their area from tobacco marketing. The law was rescinded after seven tobacco companies and the New York Association of Convenience Stores filed a federal lawsuit against the village that challenged the law's constitutionality.

The POS initiative continues to break new ground in community tobacco control and serve as a model for other state programs. This initiative has been characterized by effective communication and a high level of coordination between NY BTC, the Center for Public Health and Tobacco Policy, Center for Tobacco-Free New York, RTI, and the community contractors. NY BTC and evaluation staff have been invited to present information and findings about the initiative to science and practice stakeholders.

*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 building entryways. Well-enforced local policies that prohibit tobacco use in these outdoor public places communicate that tobacco use is not acceptable to children and adolescents (Institute of Medicine, 2007). During the 2011–2012 reporting period, community contractors reported the adoption of 227 new tobacco-free outdoors policies. These include 129 policies prohibiting smoking on grounds or near entrances of community colleges, museums, and other businesses. During this time, community contractors also reported 98 tobacco-free outdoor policies adopted by municipalities, most of which prohibit smoking at parks, playgrounds, and beaches across the state.

*MUH initiative:* The goal of the MUH initiative is to eliminate exposure to secondhand smoke by increasing the number of smoke-free homes. The policy goal for this initiative is to increase 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). During 2011–2012, community contractors reported the adoption of 52 new policies prohibiting smoking in multi-unit dwellings; these policies protect over 5,000 units.

## Key Evaluation Questions

This section addresses NY BTC progress from 2003 to 2012 in achieving its statutorily mandated outcomes of reducing tobacco use and reinforcing antitobacco attitudes. Where available, data are presented for the remaining United States to allow comparisons with New York. Because the independent evaluation was not active in calendar year 2013, our key evaluation questions are somewhat more specific than in the past and focus on monitoring trends in key outcomes:

- How has the Bureau influenced trends in tobacco use from 2003 to 2012? Specifically, we examine trends in the following indicators:
  - percentage of adults who currently smoke in New York and the United States,
  - percentage of adults who currently smoke in New York by mental health status,
  - number of cigarettes smoked per day by 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,
  - percentage of adults who currently use smokeless tobacco and smoke cigars,
  - percentage of youth who currently smoke in New York and the United States, and
  - percentage of youth who currently use smokeless tobacco and smoke cigars in New York and the United States.
- How have other key outcome indicators changed over time? Specifically, we examine trends in the following:

- percentage of adult smokers who confirmed awareness of at least one paid advertisement in New York;
- percentage of adults who have heard of the New York State Smokers' Quitline in New York and who have heard of 1-800-QUIT-NOW in the rest of the United States (Quitline awareness);
- annual New York State Smokers' Quitline call volume;
- percentage of adult smokers who report that their health care provider asked about their tobacco use, advised them to quit, and assisted them in their attempt to quit in New York and the rest of the United States;
- percentage of adult smokers who report that their homes are 100% smoke-free in New York and the rest of the United States; and
- percentage of adults who support various POS policies in New York and the rest of the United States.

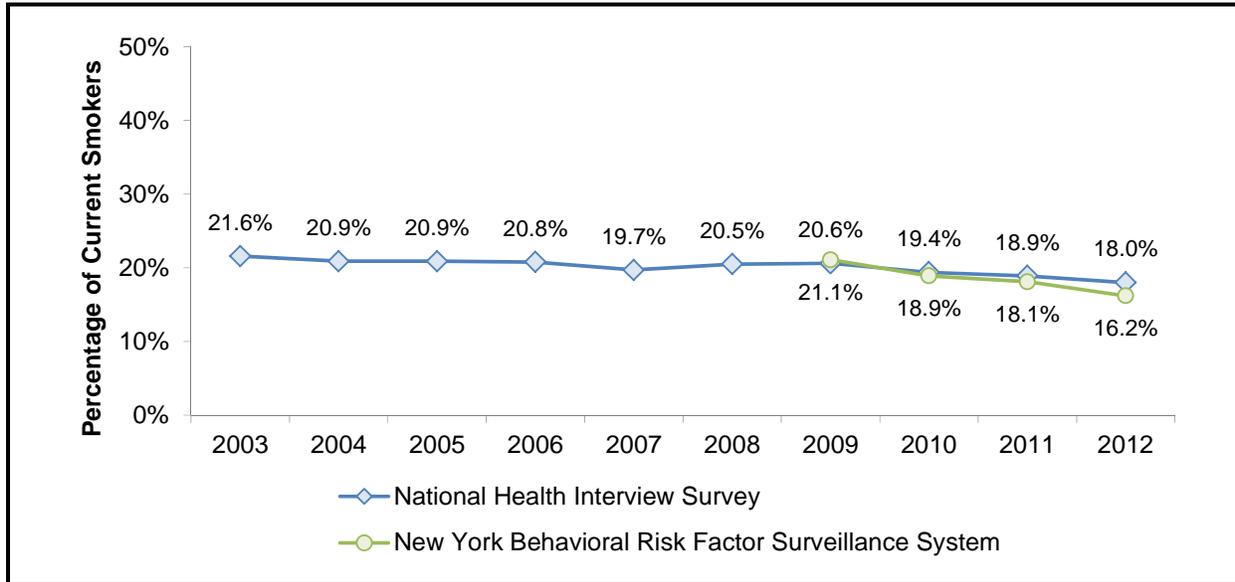
### *Adult Tobacco Use Measures*

In 2009, CDC piloted a new weighting and data collection methodology for the BRFSS in several states, including New York State. This new approach became the standard approach in all states in 2011. These changes made comparisons of smoking prevalence with previous years difficult. As a result, we present the trend from 2009 to 2012 along with the longer-term trend in adult smoking nationally from the National Health Interview Survey (NHIS). As of 2012, the prevalence of smoking was lower in New York than nationally (Figure 5).

Beginning in 2012, the New York BRFSS included several more detailed questions about adults' mental health. These include the following:

- Have you ever been told you have a depressive disorder?
- Are you limited in any way because of physical, mental, or emotional problems?
- Are you now receiving treatment for any type of mental health condition or emotional problem?

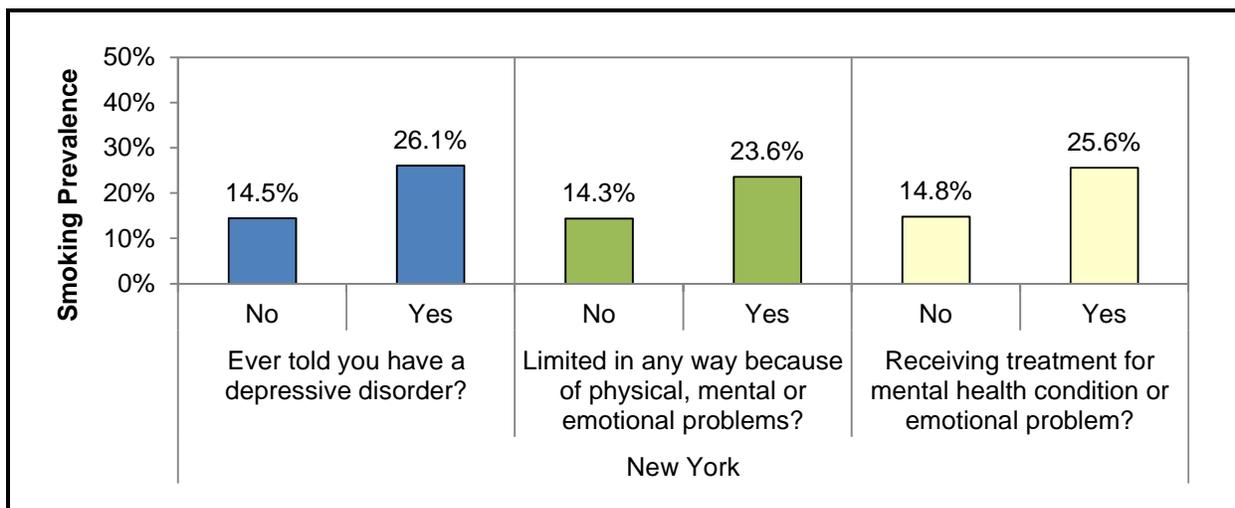
**Figure 5. Percentage of Adults Who Currently Smoke in New York (Behavioral Risk Factor Surveillance System) and Nationally (National Health Interview Survey), 2003–2012**



Note: There is a statistically significant difference in smoking prevalence between New York State and the United States in 2012.

In the 2011 IER, we estimated that smoking prevalence was higher for adults who reported often feeling “sad, blue, or depressed in the past 30 days” (31.8% vs. 16.1% for others). Using the three measures noted above, we see a similar pattern, with smoking prevalence ranging from 24% to 26% (Figure 6).

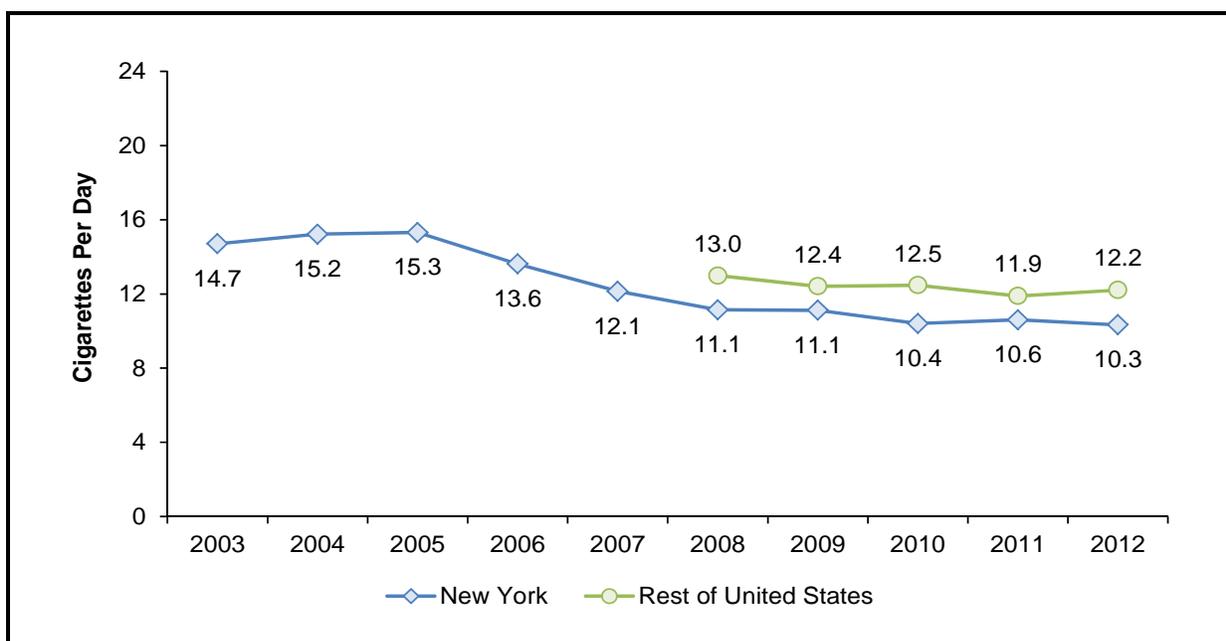
**Figure 6. Percentage of New York Adults Who Currently Smoke, by Mental Health Status, Behavioral Risk Factor Surveillance System 2012**



Note: There is a statistically significant difference between those that have ever been diagnosed with poor mental health, those reporting poor physical or mental health, and those receiving treatment for poor mental health compared with their counterparts in 2012.

Daily cigarette consumption among adult smokers has declined by 30% from 2003 to 2012 in New York, while holding steady nationally since 2008 (Figure 7). However, 95% of this decline occurred between 2003 and 2008. As of 2012, daily consumption was 16% lower in New York than the rest of the United States.

**Figure 7. Average Daily Cigarette Consumption by Current Smokers, New York Adult Tobacco Survey 2003–2012 and National Adult Tobacco Survey 2008–2012**

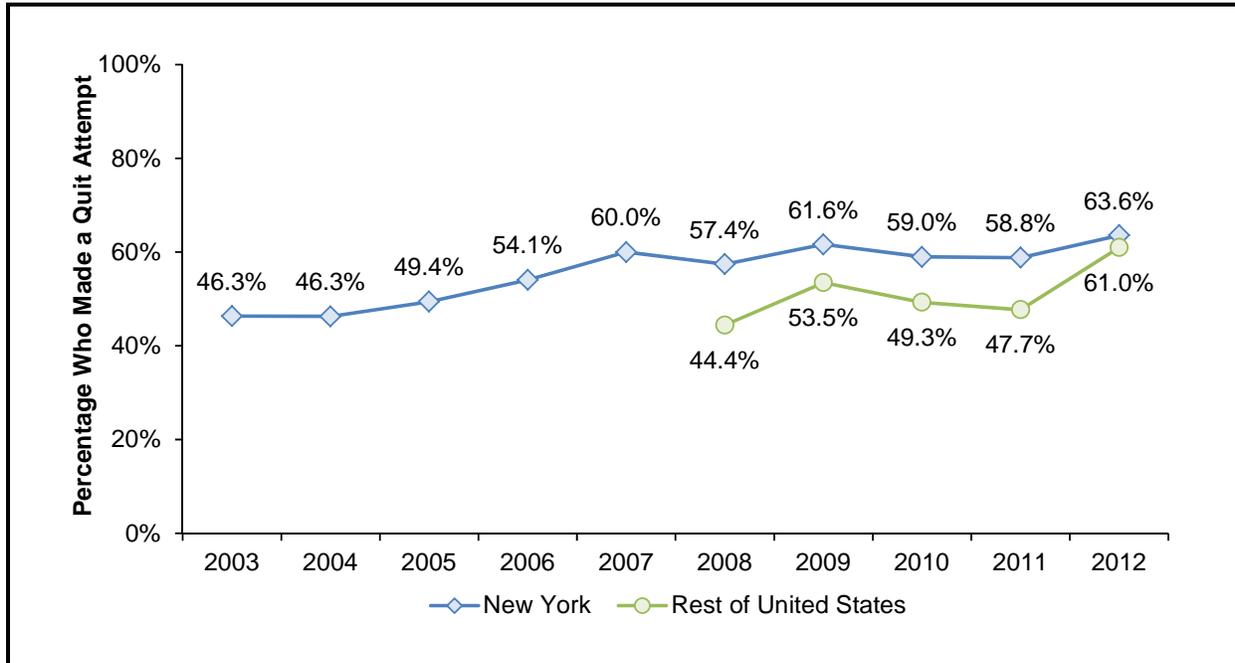


Note: There is a statistically significant downward trend in New York. There is a statistically significant difference between cigarette consumption in New York and in the rest of the United States in 2012.

Since 2003, the percentage of smokers in New York who have made a quit attempt in the past year has increased by 37%, with the biggest change occurring from 2003 to 2007 (Figure 8). Some of this increase has been attributed to NY BTC’s tobacco-focused public education campaign that features graphic and emotional depictions of the health consequences of smoking (Farrelly et al., 2012). Although the prevalence of making a quit attempt has been higher in New York than the rest of the nation in the past, this gap was closed in 2012. It is not clear what would explain such a large increase (28%) in one year. However, one likely contributor was the 2012 launch

of CDC's *Tips* campaign that reported a 13% national increase in quit attempts following the first 3 months of the campaign (McAfee et al., 2013).

**Figure 8. Percentage of Adult Smokers Who Made a Quit Attempt in the Past 12 Months, New York Adult Tobacco Survey 2003–2012 and National Adult Tobacco Survey 2008–2012**

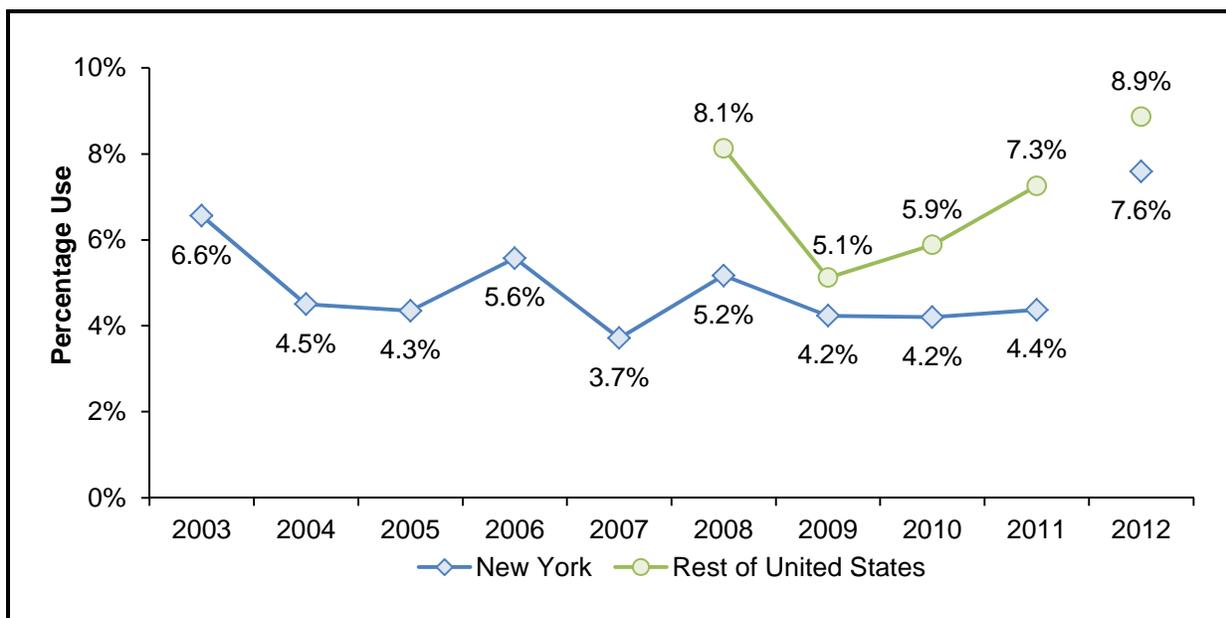


Note: There is a statistically significant upward trend among smokers in New York and the rest of the United States.

Beginning in 2013, the NHIS added "rarely" to the response options for questions about the use of non-cigarette tobacco products, including smokeless tobacco and cigars. In anticipation of this change, we changed the New York Adult Tobacco Survey (NY ATS) in the fourth quarter of 2011 and the National Adult Tobacco Survey (NATS) in 2012. For comparability with the 2011 NATS, we exclude the fourth quarter of 2011 from Figures 9 and 10. The inclusion of "rarely" had a substantial effect on the prevalence of cigar use, especially in New York, where the prevalence of current use increased from 4.4% in 2011 to 7.6% in 2012. A closer examination of the 2012 data indicates that "rarely" was the most common option at 4%, followed by "some days" at 2.2% and "every day" at 1.4%. In 2011 (excluding the fourth quarter when the "rarely" option was added), 3.4% reported using cigars "some days," while 1% used cigars "every day."

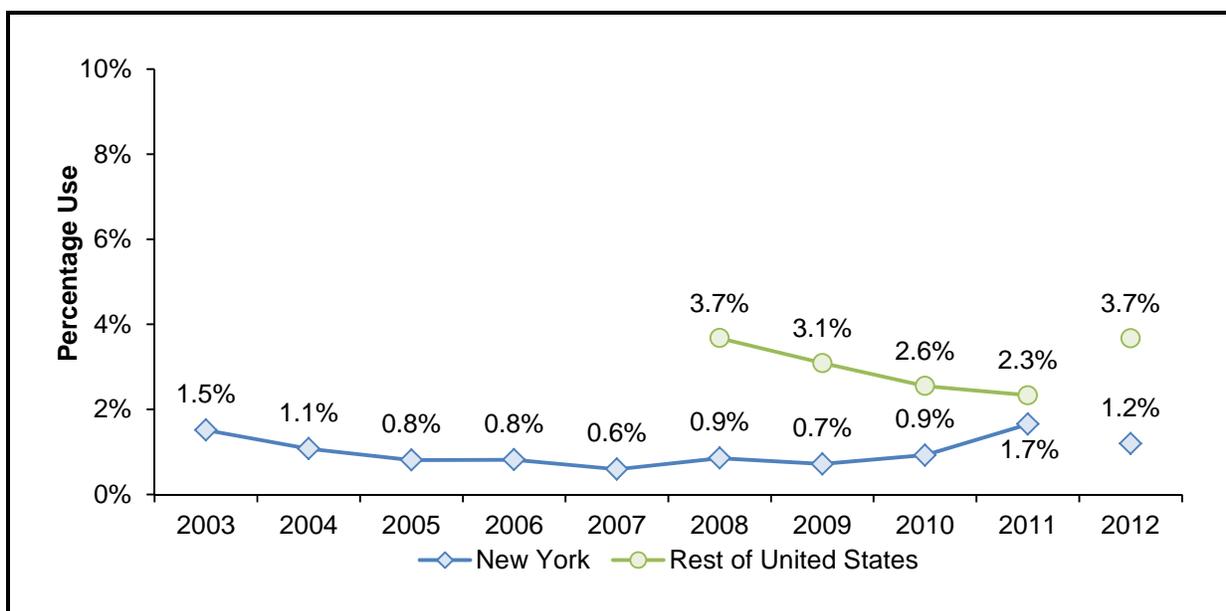
The change in the response options for smokeless tobacco use appears to have little influence on overall prevalence in New York State (1.7% in 2011 vs. 1.2% in 2012), although 0.7% indicated in 2012 that they rarely use smokeless tobacco.

**Figure 9. Percentage of Adults Who Currently Smoke Cigars, New York Adult Tobacco Survey 2003–2012 and National Adult Tobacco Survey 2008–2012**



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."

**Figure 10. Percentage of Adults Who Currently Use Smokeless Tobacco, New York Adult Tobacco Survey 2003–2012 and National Adult Tobacco Survey 2008–2012**



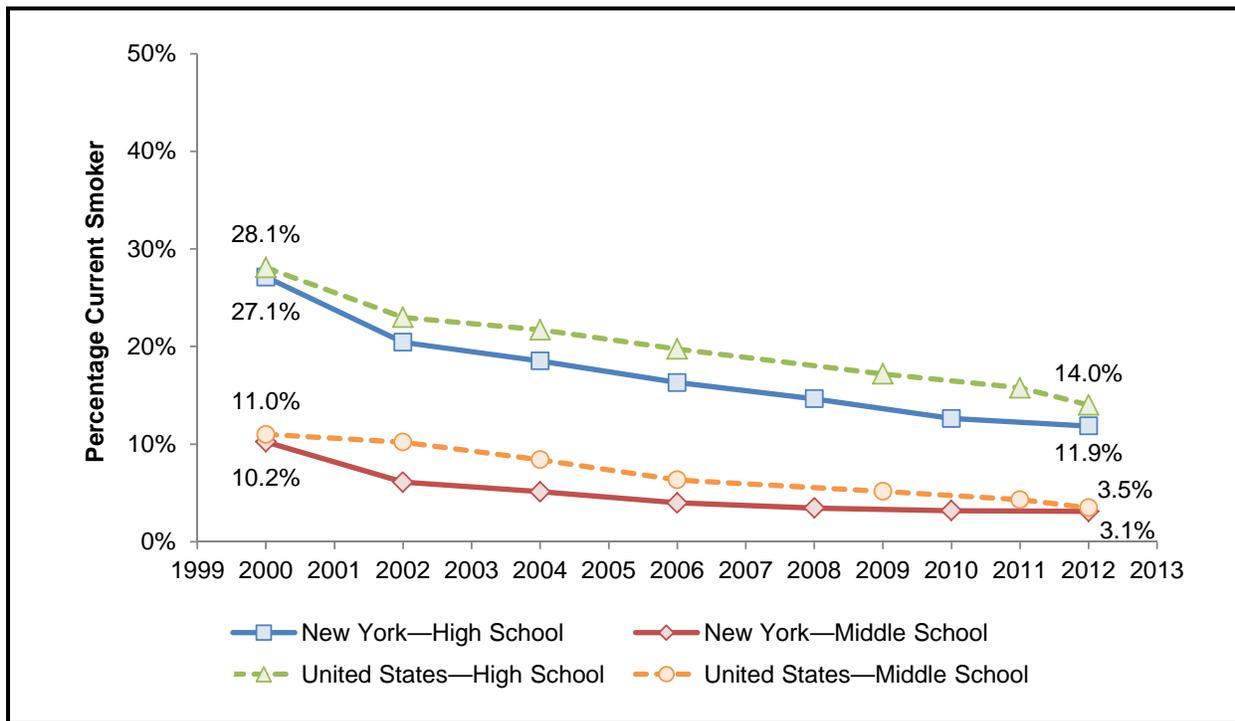
Note: In 2012, the data include “rarely” as an additional response option for current smokeless tobacco use in addition to “Every day,” “Some days,” and “Never.” There is a statistically significant difference between New York and the rest of the United States in 2012.

Although use in the rest of the country has increased more than 50%, this change is not statistically significant.

### Youth Tobacco Use Measures

Our data on youth tobacco-related indicators come from the biannual New York and national Youth Tobacco Surveys—self-administered school-based surveys of middle and high school students. Since 2000, current smoking rates have declined significantly in New York and nationally. In New York, smoking rates have declined by 69% among middle school students and 56% among high school students. Nationally, the comparable rates declined by 69% and 50%, respectively (Figure 11).

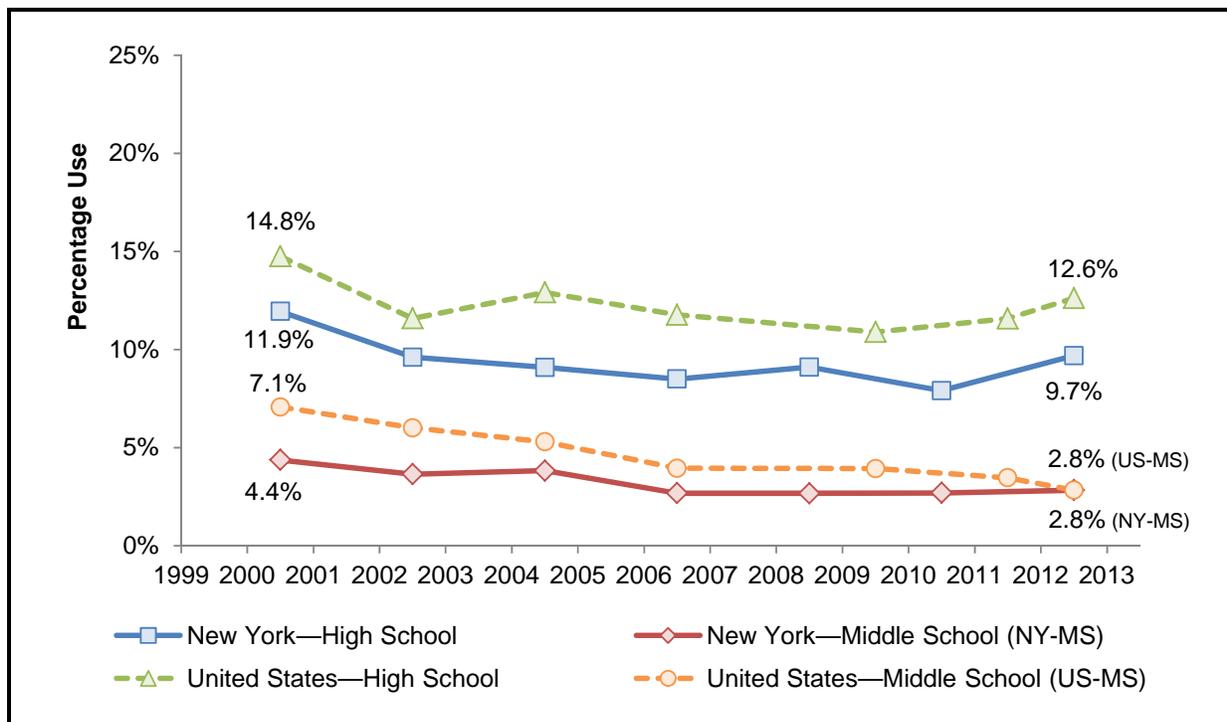
**Figure 11. Percentage of Middle and High School Students Who Currently Smoke in New York and Nationally, New York Youth Tobacco Survey 2000–2012 and National Youth Tobacco Survey 2000–2012**



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

From 2000 to 2012, cigar use among middle school students declined by 36% in New York and by 61% nationally (Figure 12). While the prevalence of use among middle school students was the same in New York and nationally in 2012 at 2.8%, it was considerably lower in New York than nationally in 2000.

**Figure 12. Percentage of Middle and High School Students Who Currently Smoke Cigars in New York and Nationally, New York Youth Tobacco Survey 2000–2012 and National Youth Tobacco Survey 2000–2012**

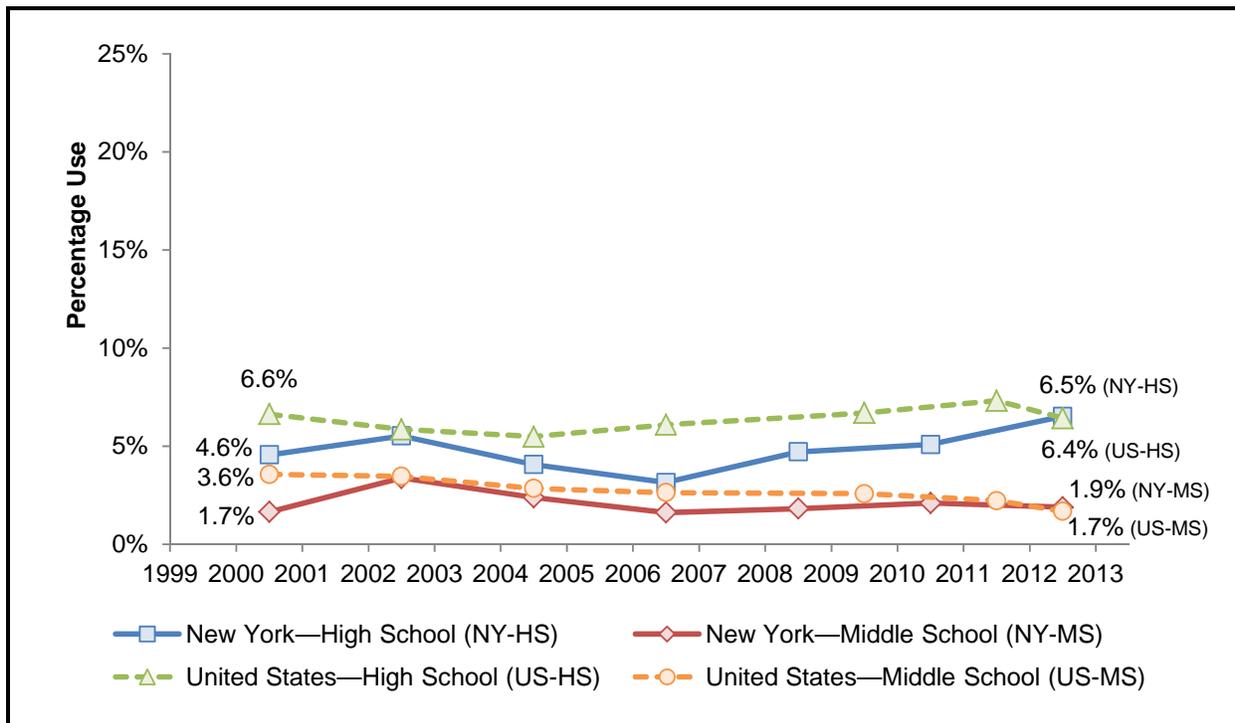


Note: There is a statistically significant downward trend among middle and high school students in New York and in the United States.

Among high school students, there was a statistically significant and modest downward trend in cigar smoking in New York and nationally from 2000 to 2012 (Figure 12). As of 2012, cigar use was lower in New York than nationally, and use of smoked tobacco products (i.e., cigarettes and/or cigars) was similar in New York and nationally. In 2012, the prevalence of smoking cigarettes and/or cigars was 15.2% among high school students in New York and 19.2% nationally (data not shown). The corresponding prevalence rates for middle school students in 2012 were 5.2% in New York and 6.0% nationally.

Use of smokeless tobacco has remained steady among middle and high school students in New York over time and remains at relatively low levels. Nationally, use among high school students has also remained stable over time, while use among middle school students declined by 53% (from 3.6% to 1.7%). As of 2012, there are no differences in smokeless tobacco use between New York and the United States for middle or high school students (Figure 13).

**Figure 13. Percentage of Middle and High School Students Who Currently Use Smokeless Tobacco in New York and Nationally, New York Youth Tobacco Survey 2000–2012 and National Youth Tobacco Survey 2000–2012**

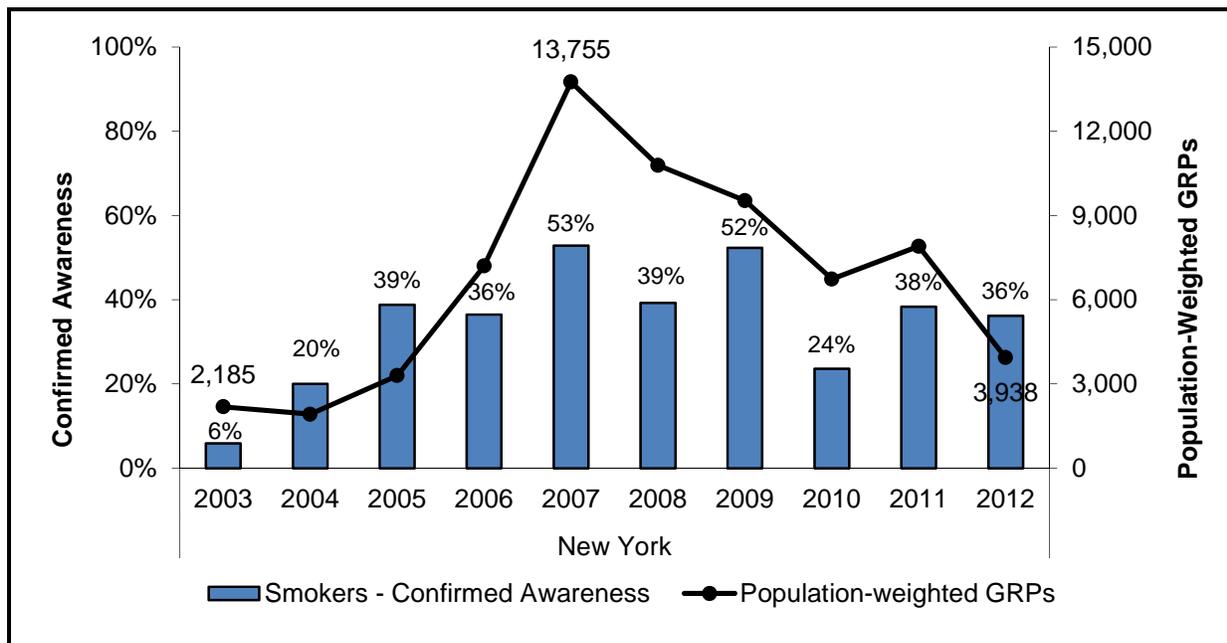


Note: There is a statistically significant downward trend among middle school students in the United States.

### Trends in Other Key Outcome Indicators

Awareness of NY BTC’s tobacco-focused public education efforts is a key programmatic metric, as it reflects the reach of these efforts statewide. Awareness of NY BTC-sponsored ads among smokers was 36% in 2012 (Figure 14). This drop in awareness from 2011 is consistent with the drop in the media buy, as reflected in gross rating points (GRPs) (i.e., potential ad impressions). As noted above, CDC’s *Tips* campaign launched in 2012. Including awareness of this campaign, average awareness among smokers in New York for the year was 42%.

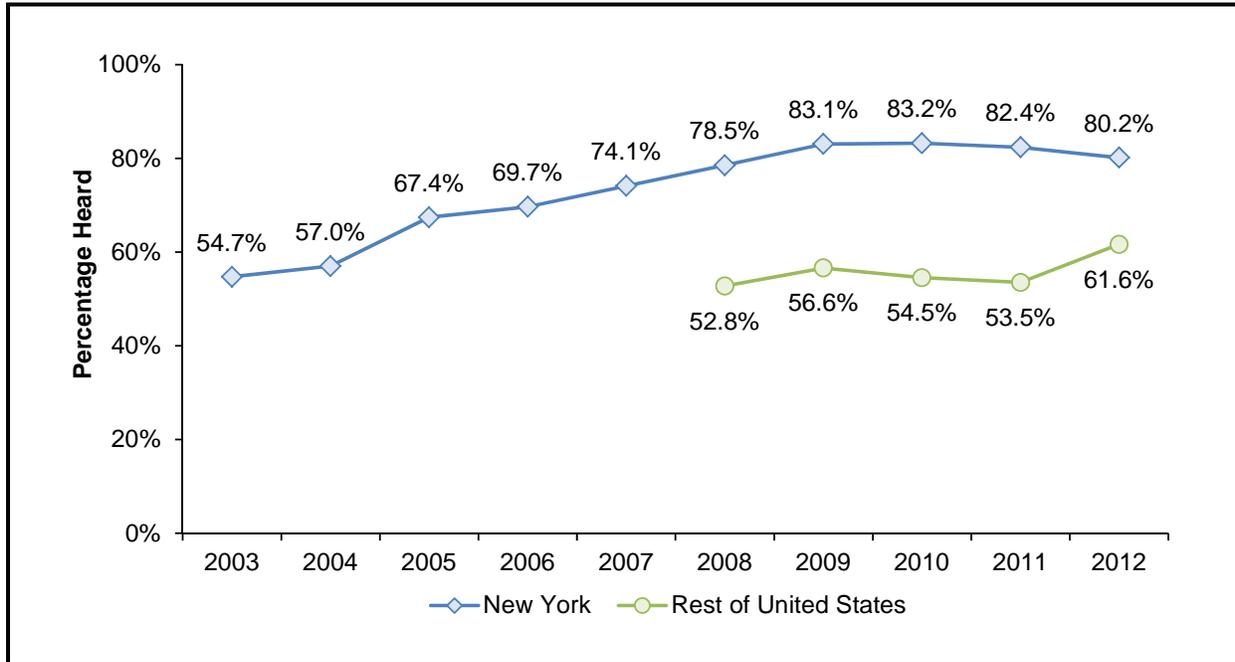
**Figure 14. Confirmed Awareness of Paid Advertisements among Smokers and Population-Weighted Statewide Average Gross Rating Points (GRPs), New York Adult Tobacco Survey 2003–2012**



Awareness of the New York State Smokers’ Quitline has been steady at over 80% in recent years and is significantly higher than awareness of any telephone quitline in the remaining United States (Figure 15). The increase in awareness from 54% to 62% nationally is likely attributable to the CDC *Tips* campaign.

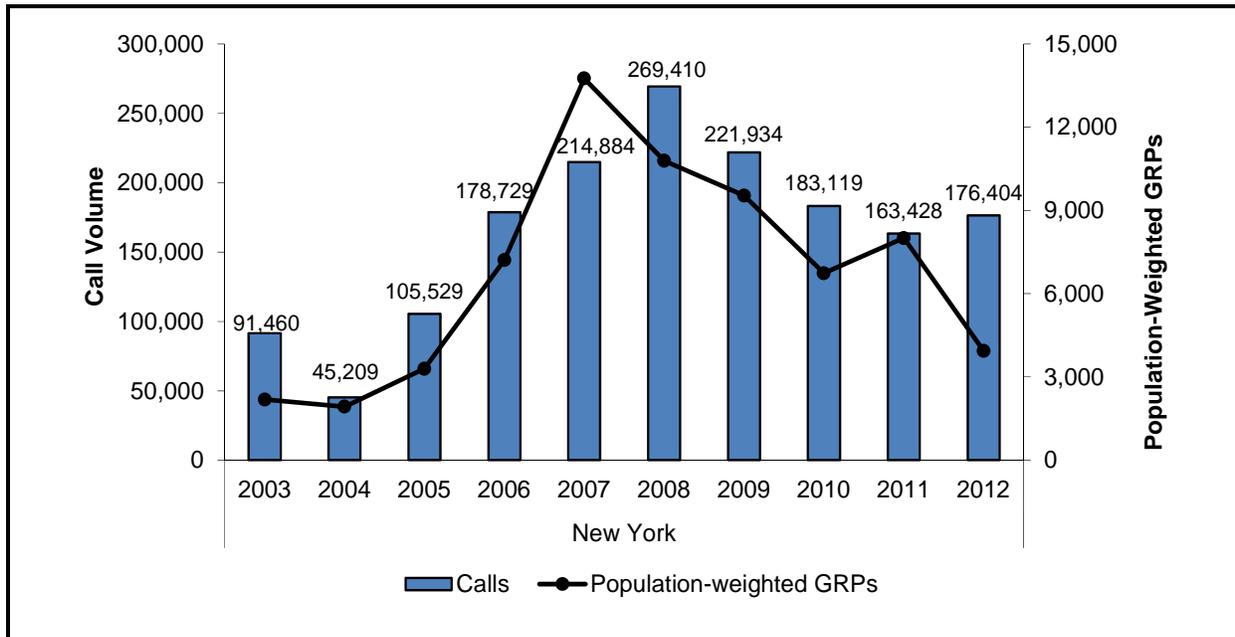
Turning to the New York State Smokers’ Quitline, we see that call volume held steady from 2011 to 2012, despite the drop in GRPs. Again, this is likely due to CDC’s *Tips* campaign that promoted 1-800-QUIT-NOW, the national quitline. New Yorkers’ calls to 1-800-QUIT-NOW get transferred to the New York State Smokers’ Quitline. To assess the impact of *Tips* ads on calls to the New York Quitline, we examined the level of calls through 1-800-QUIT-NOW while the *Tips* campaign was active (March–June 2012) and inactive. While *Tips* was active, there was an average of 2,548 calls per month to 1-800-QUIT-NOW. While *Tips* was off the air, this average dropped to 431 calls per month. As a result, we estimate that the *Tips* campaign was responsible for an additional 8,465 calls to the New York State Smokers’ Quitline via 1-800-QUIT-NOW (Figure 16).

**Figure 15. Percentage of Adult Smokers Who Have Heard of Quitline, New York Adult Tobacco Survey 2003–2012 and National Adult Tobacco Survey 2008–2012**



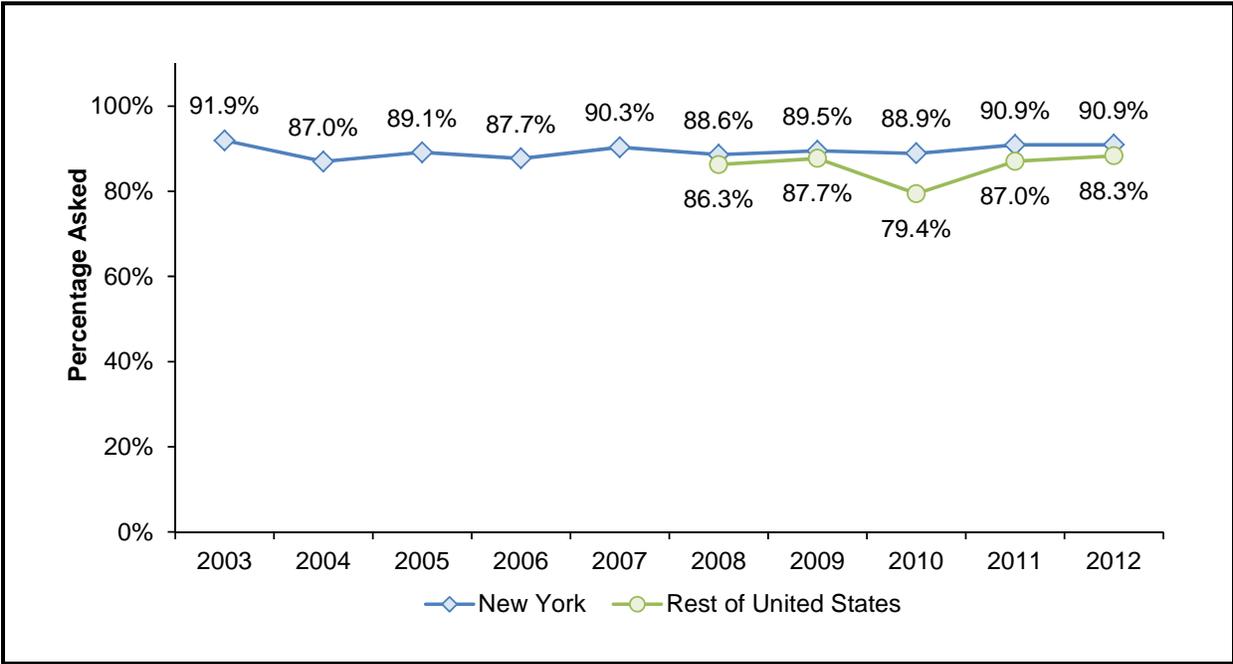
Note: New York smokers were asked if they had heard of the New York State Smokers’ Quitline. Smokers in the rest of the United States were asked if they had heard of any telephone quitlines, such as 1-800-QUIT-NOW. There is a statistically significant upward trend among New York smokers. There is a significant difference between smokers in New York and the rest of the United States in 2012.

**Figure 16. Annual New York State Smokers’ Quitline Call Volume and Population-Weighted Statewide Average Gross Rating Points (GRPs), 2003–2012**

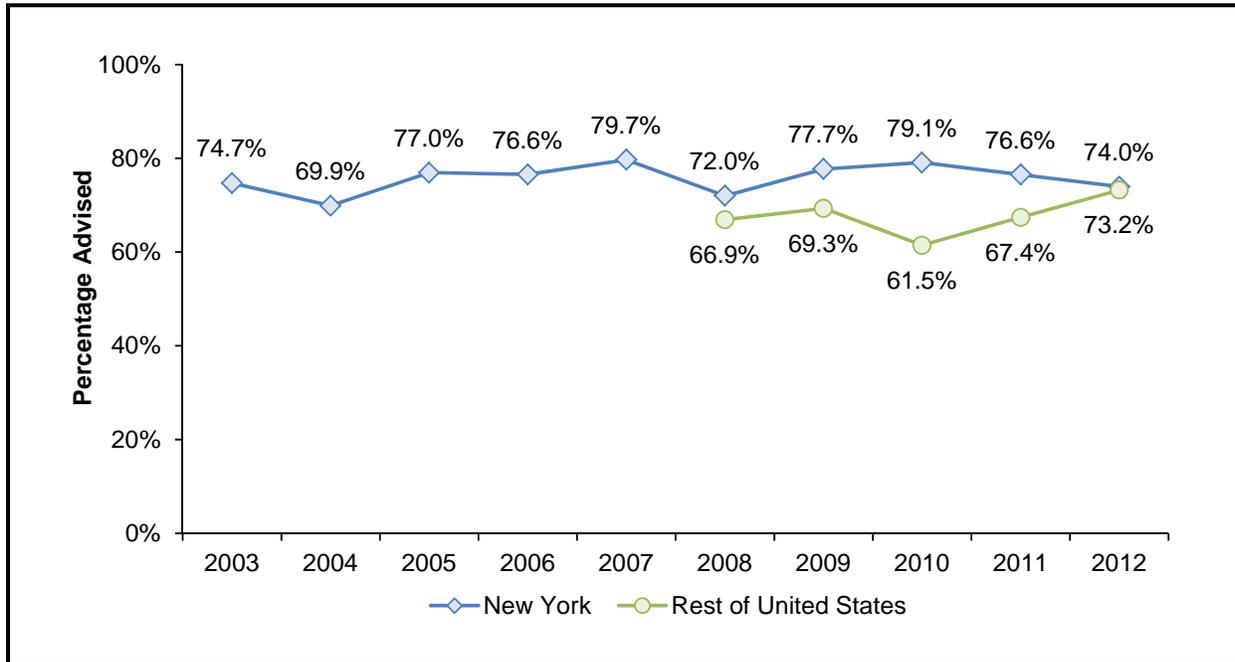


Figures 17 to 19 illustrate health care providers' support for smokers' efforts to quit smoking in the past 12 months. The percentage of adult smokers in New York who report that their health care provider asked about their tobacco use at their last visit has remained at approximately 90% for the past decade. Nationally, this percentage has also remained stable and similar to the level in New York in recent years. Similarly, the percentage of smokers who report that they were advised to quit by their health care provider has remained stable over time at approximately 75% in New York. In the last few years, this percentage has converged between New York and the rest of the United States.

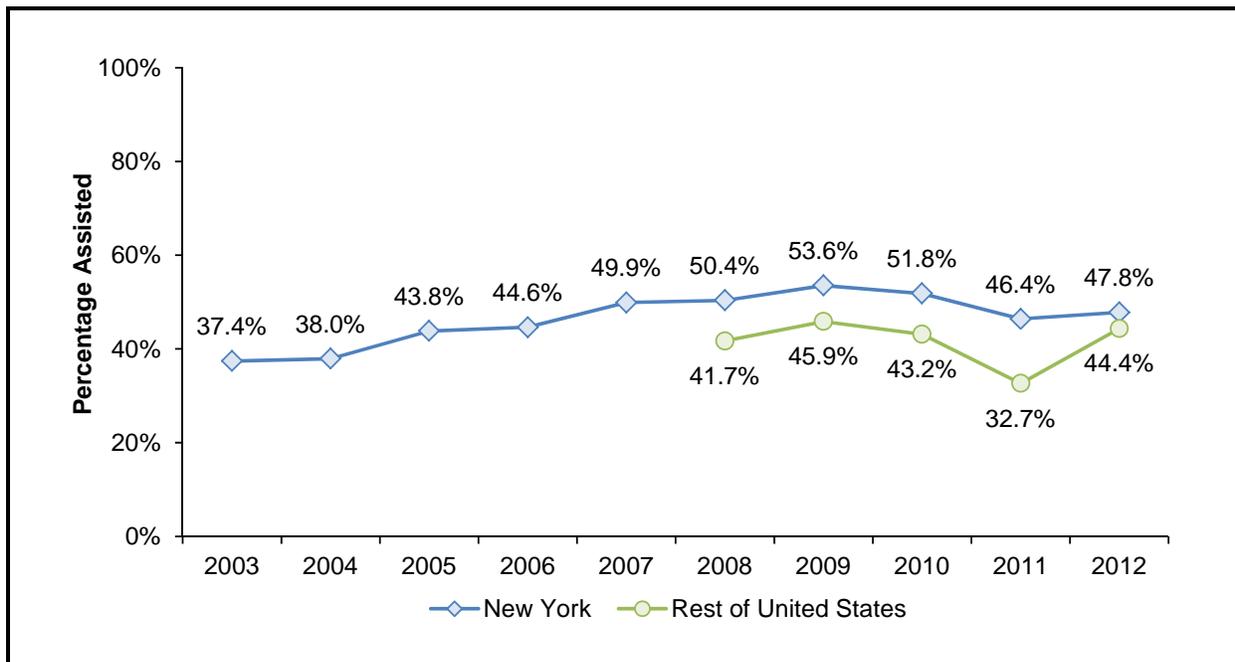
**Figure 17. Percentage of Adult Smokers Who Were Asked About Their Tobacco Use by Their Health Care Provider in the Past 12 Months, New York Adult Tobacco Survey 2003–2012 and National Adult Tobacco Survey 2008–2012**



**Figure 18. 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 2003–2012 and National Adult Tobacco Survey 2008–2012**



**Figure 19. 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 2003–2012 and National Adult Tobacco Survey 2008–2012**



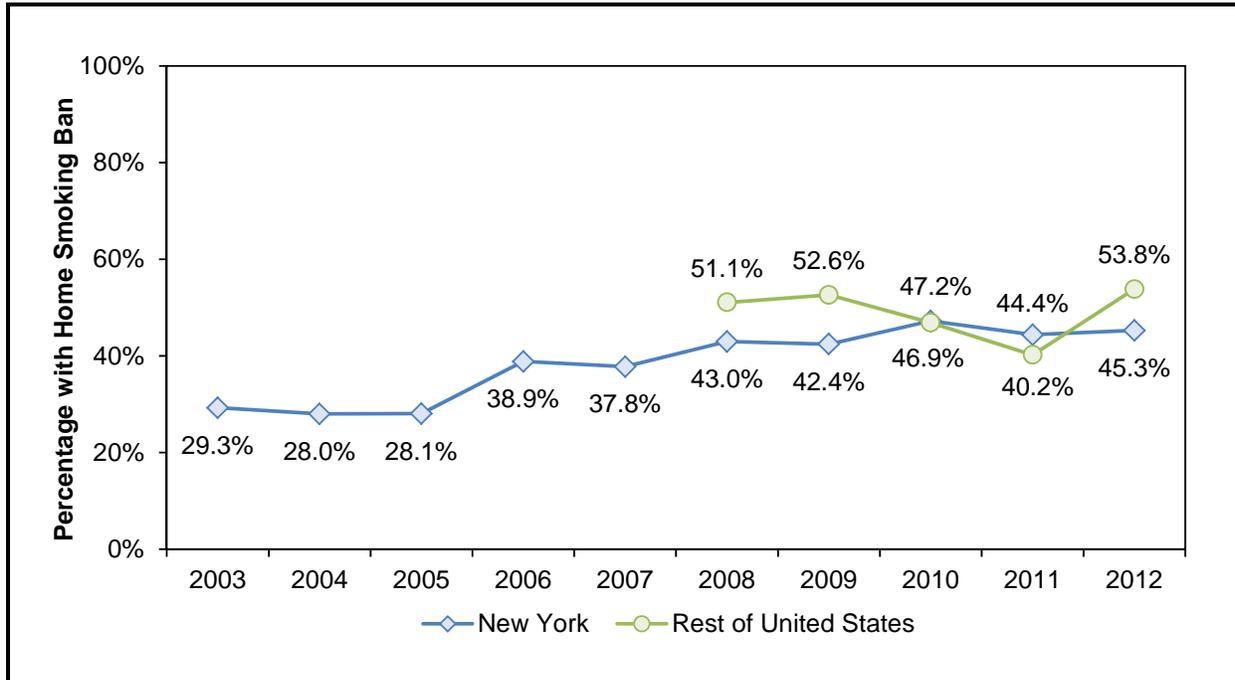
Note: There is a statistically significant upward trend among New York smokers.

Finally, the percentage of smokers who report that their health care provider offered assistance in their efforts to quit smoking has increased in the past decade in New York. However, after increasing 43% (from 37% to 54%) from 2003 to 2009, there has been no change. As of 2012, a similar percentage of smokers in New York and the rest of the United States indicate they received assistance with quitting in the past 12 months.

The U.S. Surgeon General recently concluded that there is no risk-free level of exposure to tobacco smoke and that the duration and level of exposure to tobacco smoke is directly related to the risk and severity of disease (USDHHS, 2010). Because New York's Clean Indoor Air Act restricts smoking in nearly all public indoor spaces, the remaining primary source of exposure to secondhand smoke is in the home, especially for children (CDC, 2010). One of NY BTC's goals is to reduce New Yorkers' exposure to secondhand smoke. A marker of this progress is the percentage of smokers who report that smoking is not allowed anywhere in their home at any time. Since 2003, the percentage of smokers who report that their home is smoke-free has increased by 55% (29% to 45%) in New York (Figure 20). However, there has been little change in this indicator in recent years, and the percentage of smokers with smoke-free homes is similar between New York and the rest of the United States as of 2012.

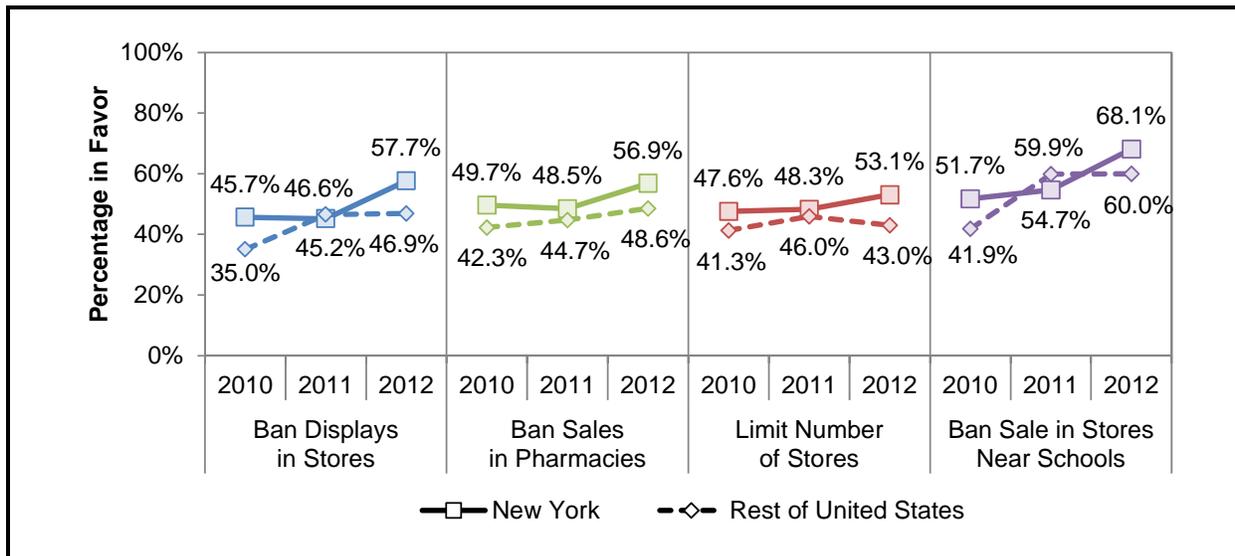
Our final series of key outcome indicators show support for POS tobacco policies that have been the focus for statewide and community action in recent years. Specifically, starting in 2010, we asked New Yorkers to indicate whether they favor policies that would (1) ban tobacco product displays, (2) ban the sale of tobacco products in pharmacies, (3) limit the number of stores that sell tobacco products, and (4) ban the sale of tobacco products in stores near schools. From 2010 to 2012, there was a statistically significant upward trend in support for all four policies in New York State. In the rest of the United States, there is an upward trend in all but one of the policies—limiting the number of stores that sell tobacco. In 2012, there is more support for all four of these policies in New York compared with the rest of the United States (Figure 21).

**Figure 20. Percentage of Adult Smokers with 100% Smoke-free Homes, New York Adult Tobacco Survey 2003–2012 and National Adult Tobacco Survey 2008–2012**



Note: There is a statistically significant upward trend among New York smokers. There is a significant difference between smokers in New York and the rest of the United States in 2012.

**Figure 21. Support for Point of Sale Tobacco Policies among Adults, New York Adult Tobacco Survey 2003–2012 and National Adult Tobacco Survey 2008–2012**



Note: There is a statistically significant upward trend in support across all four policies in New York. There is a statistically significant upward trend in support for banning displays in stores, pharmacy sales, and sales in stores near schools in the rest of the United States. There is a statistically significant difference between New York and the rest of the United States across all four policies in 2012.

## Discussion

### *Progress in Changing Tobacco Use*

Consistent with the 2011 IER, we found that key outcome indicators illustrate that New York has reduced tobacco use over time and that several of these indicators in New York compare favorably to the rest of the United States. However, it also appears that trends from 2007 to 2012 have slowed compared with the period from 2003 to 2007.

The prevalence of adult smoking in 2012 is lower in New York than nationally. However, adult smoking prevalence and recent decreases in prevalence are not uniform across all population groups. In particular, those with poor mental health have significantly higher smoking prevalence rates than the general population. Surveys of the general New York population found that approximately 25% of those with poor mental health currently smoke, and CDC has reported that 33% of New Yorkers with any mental illness smoke (CDC, 2013); rates are likely even higher among those with serious mental illness. It is possible that the tobacco control strategies that have been implemented over the past decade are effective, but have not reached this population with sufficient intensity to reduce smoking. Alternatively, it is possible that these strategies are not as effective with people with poor mental health as they are with other populations. The high smoking rates among this disparately affected population are similar to those documented in the rest of the United States and pose a significant challenge to further reducing smoking rates in New York. However, the path forward for NY BTC is not yet clear.

The prevalence of youth cigarette smoking has continued to decline. Cigarette smoking among high school students has decreased by 56% in New York and by 50% nationally since 2000. Among middle school students, the prevalence of smoking declined by 69% from 2000 to 2012 in New York and nationally. As of 2012, only 3% of middle school students smoked in the past month, similar to the national rate. Declines in youth smoking in New York have been impressive, and the prevalence of smoking is so low among middle school students that there is little room for improvement. Although there is a modest downward trend in cigar smoking among middle and high school students both in New York and nationally since

2000, current cigar smoking appears to be leveling off or increasing in recent years. As of 2012, 12% of New York high school students smoke cigarettes and 10% smoke cigars, and the prevalence of smoking either product is 15%. As a result, greater attention needs to be paid to adolescent smoking of all tobacco products.

Other indicators of tobacco use in addition to the prevalence of smoking help us paint a fuller picture of the progress that NY BTC has made over this time period. Daily cigarette consumption by adult smokers declined by 30% from 2003 to 2012, but the pace of the decline slowed after 2007. Smokers' quit attempts increased from 2008 to 2012, but as of 2012, the prevalence of making a quit attempt is no longer higher in New York than the rest of the United States.

With respect to other tobacco use, although the prevalence of cigar use nearly dropped by half from 2003 to 2007, it increased between 2007 and 2011. A 2012 change in measurement of current cigar use to include those who report using cigars "rarely" resulted in an apparent increase in cigar use. While cigar use is not very prevalent overall, it is again important to consider all smoked tobacco products, given their continued use and considerable negative health effects. Smokeless tobacco use declined from 2003 to 2007 and then increased by 2011. In 2012, the rate of smokeless tobacco use remained relatively low and is lower in New York than nationally.

It seems clear that progress in reducing tobacco use has slowed in recent years, concomitant with a return to funding levels in the range of \$40 million for NY BTC programming. In addition, while New York key outcome indicators have in many areas been more positive than national rates, these gaps are closing. Again, some of this narrowing is due to funding for NY BTC becoming more similar to the average in all other states. In addition, the emergence of CDC's *Tips* campaign likely had a positive influence on quit rates nationally. It is not surprising that many key outcome indicators have leveled off, and it is unlikely that the state will see significant changes in the indicators without increased funding and continued policy implementation to reinforce ongoing program efforts. Further, increased resources and enhanced collaborations will be necessary to bring down the consistently disproportionate

tobacco use rates among certain population groups, most notably those with poor mental health.

### *Health Communications*

The independent evaluation has established strong and convincing evidence that NY BTC's public health communication efforts have had a positive influence on call volume for the New York State Smokers' Quitline, cigarette consumption, and quit attempts among smokers. As the amount of funds dedicated to public health communication increased from 2006 to early 2008, Quitline call volume increased markedly and the prevalence of smokers making a quit attempt increased. NY BTC's selection of television advertisements has also evolved over time in favor of advertisements that feature strong emotional and/or graphic messages that have been shown to be more effective than other strategies. This strong evidence base illustrates that a strong investment in health communication is an essential component of a strong tobacco control program. The national *Tips* campaign reinforces New York's current health communication approach and offers an opportunity to approach recommended campaign levels. The *Tips* campaign may be responsible for narrowing the gap between New York and the rest of the country for quit attempts and awareness of quitlines.

### *Cessation Interventions and Health Systems Change*

NY BTC promotes smoking cessation via multiple strategies, including cessation-focused health communication, direct counseling services through the New York State Smokers' Quitline, social norm changes through smoke-free indoor and outdoor policies and higher cigarette prices, and systems-level changes in health care organizations to promote cessation interventions for all tobacco users. The health systems change strategy is the focus of the Cessation Centers. As of August 2012, Cessation Centers primarily focus their efforts on organizations that serve higher proportions of tobacco users, such as community health centers and programs that serve individuals with severe mental illness. Cessation Centers provide these organizations with guidance, training, and assistance on systems-level changes that support the screening

and treatment of tobacco dependence. This type of systems-level approach allows for sustainable changes that reach a greater proportion of smokers statewide. However, this strategy could benefit from additional mobilization of allied organizations and increased resources devoted to media campaigns (e.g., Talk to Your Patients) aimed at health care providers to prompt them to do more to support smoking cessation.

### *Statewide and Community Action*

Successful implementation of a comprehensive tobacco control program requires investment in local-level policy change efforts. Consistent with past successes in tobacco control policy change, where statewide support must be built within communities across the state, the Bureau spends a high proportion of its funding (40%) on interventions that are delivered primarily at the community level. It is at this level where New York's community contractors are raising awareness of and building support for the next generation of tobacco control policies, including POS, TFO, and MUH initiatives.

NY BTC's community efforts have resulted in high levels of support for policies, with significant increases from 2010 to 2012 across four POS policy areas: banning tobacco product displays in stores, banning tobacco sales in pharmacies, limiting the number of stores that can sell tobacco, and banning tobacco sales in stores near schools. Additionally, support for these POS policies is higher in New York than nationally. Although POS policy change efforts have been fairly slow to see changes in outcomes, these data point to the likelihood that community contractors' efforts are effectively shifting support for POS policies.

POS policy change faces unique challenges, as it counters current norms in the retail environment: tobacco product marketing that is disproportionate to tobacco use prevalence and excessive compared to other product marketing. Tobacco product marketing at the POS remains the most influential factor in youth tobacco use initiation without a widely implemented tobacco control intervention to counter it. The 2009 federal Family Smoking Prevention and Tobacco Control Act gives states and communities the authority to change the time, place, and manner of cigarette advertising at the POS.

While policies to reduce exposure to tobacco product marketing at the POS have always been included in tobacco control goals, the majority of the public and policy makers are unfamiliar with the research literature and the policy solutions. NY BTC's sustained messaging and efforts in this area will continue to be important to ensure the further decline of tobacco use in the state. Investment in a media campaign to better educate the public about youth tobacco use and tobacco industry marketing at the POS would help build the required public support for POS policies.

### *Programmatic Recommendations*

#### *Overall Recommendations*

- Increase NY BTC funding to a minimum of one-half of CDC's recommended funding level for New York (\$254.3 million) to \$127.2 million per year. This represents less than 6% of New York's annual revenue from tobacco taxes and MSA payments.
- Develop and implement interventions to address disparities in smoking rates, particularly for those with low incomes, low educational attainment, and mental illness. This could involve collaborating with other state programs to leverage existing systems and expand the Bureau's reach, such as the Office of Mental Health and the New York State Medicaid Office. These collaborations could enhance efforts to promote cessation resources and implement policy and systems change in settings most relevant for this disparately affected population. The persistence of high prevalence rates and the additional financial, medical, and social challenges faced by those with mental illness may also require targeted efforts with additional funding to achieve real reductions in their tobacco use.

#### *Health Communication Recommendations*

- Consistent with CDC's Best Practices recommendations, reach 75% awareness of antismoking messages among smokers by investing \$40 million per year in antismoking television advertising or ensuring that state campaigns build on existing national campaigns to help achieve the recommended level of reach.
- Invest additional funds in media campaigns to support community contractors' policy change efforts.

### *Health Systems Change Recommendations*

- Continue directing Cessation Center contractors to focus their efforts on organizations that serve high proportions of tobacco users, such as community health centers and mental health programs.
- Reinstate past health care provider media campaigns to increase awareness of statewide cessation resources and prompt providers to encourage smokers to quit.

### *Statewide and Community Action Recommendations*

- Consider developing and implementing a statewide media campaign to educate the public about youth tobacco use and the need to address it, including both cigarettes and cigars. Such a campaign could also include messaging support for the POS initiative, such as information about how tobacco product marketing at the POS increases youth smoking.
- Continue to work with the Center for Public Health and Tobacco Policy at New England Law in Boston to develop additional model policies and strategies for local communities that can withstand legal challenges by the tobacco industry.
- Continue to monitor and support required contractor community mobilization of allied organizations and individuals to ensure that contractors engage their partners in planning, leading, and implementing tobacco control activities.
- Continue to engage youth members of Reality Check and other youth-focused organizations in community education, government policy-maker education, and decision-maker advocacy activities focused on POS and TFO policy change.
- Work with contractors to identify and build collaborations with organizations and individuals representing groups disproportionately affected by retail tobacco marketing and tobacco use in their catchment areas. Ensure that contractors engage these organizations in community education, government policy-maker education, and decision-maker advocacy activities.



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