



SMOKING CESSATION OPPORTUNITIES
FOR PUBLIC HOUSING RESIDENTS
WHITEPAPER:
MARICOPA COUNTY, ARIZONA

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Executive Summary

The purpose of this Whitepaper was to determine how best the Arizona Department of Health Services, Bureau of Tobacco and Chronic Disease can capitalize on the opportunity of the HUD final rule to assist disparate populations in Maricopa County quit smoking. The Southwest Interdisciplinary Research Center (SIRC) examined that overall issue and answered a series of questions about the attitudes and behaviors of public housing residents on smoking and smoking cessation.

Several methodologies were used to collect primary data. Thirty key informants from nine organizations participated in telephone interviews. The SIRC team also administered paper questionnaires in both English and Spanish to adult residents living in multiunit public housing units either managed or contracted by the City of Phoenix and the Housing Authority of Maricopa County for a total of 2,933 possible households. Overall, 336 surveys were completed by adult participants of which 67 were in Spanish. In addition, three focus group discussions were conducted in August 2017 with 17 adults at three public housing sites.



The findings from surveys, focus groups and key informant interviews provided insights as to the attitudes and behaviors of the target group of public housing residents as well as those who provide support services to this group.

- In Maricopa County only 25% of adult residents in public housing currently smoked. This is 8 percentage points lower than the U.S. prevalence which showed the public housing smoking rate at 33%.
- A majority of Maricopa County public housing residents favored a smoke-free policy; 65% supported a smoke-free policy while 25% were opposed to such a policy.
- ASHLine was known by just over half of public housing residents (54.5%) and its services were not well known to residents nor to health providers and Federally Qualified Health Center (FQHC) staff.
- Public housing residents seem to be educated on the hazards of smoking. Individuals who quit cigarette smoking said they did so mainly to be healthier (53%) and those who smoked already know that they would be healthier not smoking (70%), as that is the number one reason they would quit, followed by the expense.

- Residents were concerned with safety and privacy, especially for those who do not wish to quit.
- The key informants expressed issues with getting buy-in from the leadership teams of providers for ASHLine due to competing workload and priorities; smoking is often not considered a top health concern.
- Provider key informants felt that ASHLine does not provide medication for their clients; the four weeks of nicotine replacement therapy twice a year is not enough to help their clients quit smoking.

“Don’t want to be told what to do; we’re not hurting anyone but ourselves.”

quote from resident-focus group participant

“If they start buying my cigarettes then they can tell me to quit.”

quote from resident-focus group participant

The recommendations provided are possible steps that can be taken at multiple levels – individual, organizational, and environmental – to impact smoking among the public housing population, and other underserved groups, in Maricopa County. It was very clear that the individuals and the support services needed to overcome the barriers to quitting entail much more than an educational campaign on the hazards of smoking, which individuals seem to understand already. The recommendations were grouped into four categories:

- **Provide direct services to public housing residents:** for example, making it known that cessation medications are available and affordable, and providing supports including transportation to medical providers or navigators to help people access services are ways to help facilitate the cessation for those who wish to do so.
- **Provide support services to housing staff:** for example, providing staff with up-to-date information on that medical and cessation services that are nearby to which they can refer residents, treating residents with cultural sensitivity and being flexible in policy implementation.
- **Provide support services to ASHLine and other health provider staff:** for example, distributing information more broadly to medical and health providers and support personnel so they are more knowledgeable about insurance coverage and other financial options; being culturally sensitive and respectful or public housing residents, and providing additional outreach and follow-up services.
- **Implement new policies or procedures:** for example, using Comprehensive Tobacco Policies as well as multiple evidence-based interventions and prevention programs approaches helps to fit solutions to the location, demographics, needs and resources of the target population.

“If they want to smoke let them smoke, they’re over 21- there’s nothing else you can do – you can’t be around them all the time.”

quote from resident-focus group participant

Overview

The American Lung Association partnered with the Office of Evaluation and Partner Contracts at the Southwest Interdisciplinary Research Center (SIRC) to develop a comprehensive Whitepaper based upon research conducted across Maricopa County. The purpose of this study was to identify how the Arizona Department of Health Services (ADHS) and its Bureau of Tobacco and Chronic Disease (BTCD) can capitalize on the opportunity of the Housing and Urban Development (HUD) final rule, to assist disparate populations living in multiunit Public Housing Authority (PHA) properties in Maricopa County to quit smoking. HUD plans to make all their properties smoke-free by July 30, 2018.

This Whitepaper details the final results of 30 key informant interviews, 336 surveys and three focus groups conducted between April 2017 and September 2017. Further, it elaborates on key themes and presents recommendations for cessation activities with this population.

Methodology

Data were collected through a mixed-methods approach consisting of a literature review, key informant interviews, surveys, and focus groups. All data collection followed consent procedures as required by ASU's Institutional Review Board (IRB). Each method is described below in the order in which they were conducted. All of the measurement instruments used were developed specifically for this study; questions were informed by a review of existing research.

Key Informant Interviews

Thirty key informants participated in telephone interviews. These informants represent the following organizations:

- Adelante Healthcare
- Arizona Smokers' Helpline
- Circle the City
- City of Phoenix, Housing Department
- Housing Authority of Maricopa County
- Maricopa County Healthcare for the Homeless
- Native Health
- Terros Health
- Valle del Sol

Key informants were asked questions about programs and services their organization provides; their experiences with client engagement; barriers with the most vulnerable populations (e.g. single parents, individuals with disabilities, refugees/immigrants, etc.); existing smoking cessation programs and services embedded within their organization; their partnership with Arizona Smokers' Helpline (ASHLine); and any other community factors (e.g. homelessness, substance abuse, etc.) that affect or might affect programmatic efforts in their community.

Surveys

The SIRC team administered paper questionnaires in both English and Spanish to adult residents living in multiunit public housing units in Maricopa County. Questions were developed using various local, national and international scales and reports, such as the Global Tobacco Surveillance System (GATS)¹ designed by the World Health Organization and the Centers for Disease Control, such as the Behavioral Risk Factor Surveillance System (BRFSS)² and the National Survey of Drug Use and Health (NSDUH)³. Questions were divided into seven categories: community/environment, tobacco use, cigarette smoking behaviors, other tobacco products, cessation motivation/intent, general health, and secondhand smoke. Furthermore, survey participants were asked to complete a demographic questionnaire to provide insight on general participant characteristics (gender, age, language) and trends in aggregate form.

Public housing units were either managed or contracted by the City of Phoenix and the Housing Authority of Maricopa County (HAMC). The City of Phoenix and HAMC had 13 properties each (2,481 units and 452 units respectively) for a total of 2,933 possible households. Recruitment flyers were distributed by public housing management to residents a few days before administration of the questionnaire. The recruitment flyers served to notify residents when the SIRC team would be on site to administer surveys. The only eligibility requirements were that interested participants had to be over the age of 18 and be residents of public housing. The SIRC team went door-to-door to each resident, identifying interested participants and administering questionnaires in person.

Overall, the SIRC team visited 2,933 units and received 336 completed surveys from adult participants of which 67 completed the questionnaire in Spanish. Statistically speaking for a population of 3,000, a sample size of 341 returned surveys would provide a 95 percent level of confidence⁴; with 336 returned surveys, these results should provide the high level of confidence needed from which to draw conclusions about the characteristics and attitudes of the public housing population in Maricopa County.

Focus Groups

Following the survey administration, the SIRC team conducted three focus groups in August 2017. The focus groups provided an opportunity to elaborate further on responses provided in the questionnaires. Similarly to the survey recruitment process, public housing management of selected sites (see Venues) distributed recruitment flyers to residents a few days before the focus group discussions were to occur. The flyers provided residents an opportunity to register in advance by contacting the SIRC team, or they could choose to show up day of the discussion. The only eligibility requirements were that interested participants had to be over the age of 18 and be residents of public housing. A total of 17

¹ Global Adult Tobacco Survey Collaborative Group. *Tobacco Questions for Surveys: A Subset of Key Questions from the Global Adult Tobacco Survey (GATS), 2nd Edition*. Atlanta, GA: Center for Disease Control and Prevention, 2011.

² Centers for Disease Control and Prevention (CDC). *Behavioral Risk Factor Surveillance System Survey Data*. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2015.

³Center for Behavioral Health Statistics and Quality. (2016). 2015 National Survey on Drug Use and Health: Detailed Tables. Substance Abuse and Mental Health Services Administration, Rockville, MD.

⁴ Isaac, S., & Michael, W.B. (1997). *Handbook in research and evaluation* (3rd ed.). San Diego: EdiTS

adults, ranging from 34 to 93 years (average = 59 years), participated in the discussions. English was noted as the primary language for 75% of the participants, and 13% of the participants also spoke Spanish. See Table 2 for additional participant characteristics.

Consent. Per IRB requirements, participants were fully informed of any risks, benefits and expectations associated with their participation. They were asked to sign an IRB approved consent form and were provided with a copy for their records. SIRC's copy of the form was kept separate from and unlinked to any personal data provided by the focus group participants.

Facilitation. Focus groups were moderated by trained SIRC facilitators (staff and graduate students). Each focus group had at least one facilitator and one note-taker. Two groups were offered in English and one group in Spanish. All facilitators and note-takers received training regarding the discussion guides and running focus groups prior to data collection to ensure consistency in the facilitation process across groups.

Venues. SIRC worked with the City of Phoenix and Housing Authority of Maricopa County (HAMC) to identify and reserve appropriate locations for focus groups. Venues were selected based on interest and engagement in the study and included:

- Rose Terrace Properties (HAMC)
- Fillmore Gardens (City of Phoenix)
- Matthew Henson Senior (City of Phoenix)

Record-Keeping. Trained note-takers recorded detailed notes during each session. These notes served as the primary documents for analysis. Focus groups were also audio recorded to ensure that any gaps in note-taking could be filled and any key quotes from participants could be described verbatim.

Supplementary Questionnaire. Because age, marital status, place of residence/geographic proximity to resources, and other background characteristics can have important impacts on individuals' resource utilization and perspectives, focus group participants were asked at the beginning of each group to complete a supplementary questionnaire that assessed such factors.

Resource Mapping

The maps in this report (Appendix A) detail the community resources available surrounding City of Phoenix and Housing Authority of Maricopa County properties. This includes: medical facilities, community centers, libraries, and post offices.

These maps were produced using the Maricopa Association of Governments (MAG) Neighborhood Explorer, updated in 2016. Along with the maps, lists of resources are outlined in the legend to describe possible new targets for recruitment and materials.

Process, Challenges & Limitations

The problems that arose during this study were mostly in regards to collecting information directly from the public housing residents, both from surveys and focus groups. The additional staff assistance anticipated from City of Phoenix Housing staff and other local health providers for data collection did not materialize; people were not available during the summer, had been given other assignments, or wanted to be reimbursed for their help in distributing information. SIRC staff and students stepped-in to conduct all of the data collection. Scheduling with the housing sites to host SIRC in the data collection process also took two months longer than anticipated.

Further, residents did not want to talk with researchers, and often shied away from responding to a knock on the door or an invitation to pick up a survey; many residents with whom SIRC researchers spoke saw no direct benefit to taking the time to respond. SIRC researchers began leaving the survey and a self-addressed stamped envelope for residents who indicated they would complete the survey later, just not at the time of the visit. A total of 582 surveys were left with residents to complete and mail back to the SIRC team anonymously. Thus because of lack of people for data collection, the additional time it took to schedule the on-site data collection, and the residents' lack of motivation to complete the survey, not as many surveys were collected as anticipated although the final number of 336 surveys compares favorably to the desired 341 needed to provide the 95% level of confidence desired. Also, the number of respondents to individual questions differs, and needs to be taken into account for when seeking to generalize the findings to the population.

Focus groups were scheduled and re-scheduled to try to attract more residents; incentives beyond a snack were not offered and probably would have increased attendance. In two instances, the groups were very small. However, SIRC was able to engage with residents in an open-ended discussions at three sites.



Background Research

This Whitepaper contains a summary of research literature pertaining to smoking and smoking cessation in the context of public housing. Particular attention is paid to smoking cessation programs and their relative effectiveness.



Smoking Cessation Programs

In June 2000, a report was prepared on the *Clinical Practice Guidelines: Treating Tobacco Use and Dependence*. The U.S. Public Health Service urged healthcare insurers and group purchasers to offer benefit coverage for effective counseling and pharmacotherapeutic treatments. This report described that patients who smoked looked to their healthcare providers for smoking cessation advice. It also stated that these individuals who attempted to quit cigarette smoking were more successful when their doctors and other healthcare providers encouraged them through this process. However, only half of smokers who visited with doctors had even been encouraged to quit. Indeed, the doctors reported that they have time pressures, too much paperwork, do not have the proper training, and lack incentives to spend time on this with patients; these are just a few barriers to why doctors did not provide counseling.⁵

One way to provide compensation to both patients and health care providers is by having acceptable health insurance coverage. By doing this, individual quit rates would increase making it a vital piece in an effective, comprehensive smoking cessation strategy. However, in order for this to happen providers need to have a better understanding of the available therapeutic and health benefit coverage options and resources for their clients. If they do this, it would significantly help the health care providers and their staff to do three things. First, they need to know what questions to ask concerning the available coverage and the restrictions of those coverages. By doing this it would help to maximize both their reimbursement and their patients' current benefits. Second, they need to increase their awareness of referral resources. Third they must effectively advocate for enhanced insurance coverage.⁶

A useful treatment plan for smoking cessation may include several things. For example, plans may include over-the-counter (OTC) prescription pharmacotherapies, as well as counseling/behavioral interventions such as, pharmacotherapies. There are two lines of drugs for a successful treatment plan. The first-line of drugs include: bupropion (Zyban), nicotine gum, nicotine inhaler, nicotine nasal spray, and nicotine patch. The second-line include drugs such as clonidine and nortriptyline. However, the key to all of this is the counseling/behavioral interventions because these usually involve problem-solving, social support, and helping "quitters" to obtain social support.⁷

The Cost-effectiveness of Three Smoking Cessation Programs

Smoking Cessation Class: This program was designed by Stanford Five City Project staff and implemented by a county health department. The classes included eight one hour sessions, the first

⁵ The information provided in this section comes from Dianne Barker et al.'s reported "Reimbursement for Smoking Cessation Therapy: A Healthcare Practitioner's Guide." This technical report is available online at: <http://www.tcsg.org/tobacco/cessation/ReimGuide2ndEd.pdf>.

⁶ Ibid.

⁷ Ibid.

five offered in consecutive weeks and the last three offered every other week; attendance ranged from 8-25 participants. Quitting techniques included behavioral problem solving, self-monitoring, tapering, deep muscle relaxation, goal setting, and group social support. Before leading a class, instructors received two to three hours of training and attended a class led by another instructor.⁸

Incentive-based Smoking Cessation Contest: This program was a six-week community smoking cessation contest. Smokers enrolled in the contest provided verification of their smoking status and then attempted to quit by a predetermined day. Following a six-week period, a random drawing was held for the grand prize (a trip for two to Hawaii) and 21 other donated prizes. All winners had to verify their non-smoking status by submitting to a carbon monoxide assessment. One month following the drawings, a questionnaire was sent to all entrants assessing smoking status and habits. A large majority of the participants quit on their own although self-help materials and smoking classes were available to them. The contest was promoted through television, radio, newspapers, posters, schools, and word of mouth. Phone surveys indicated that 60 percent of the community population was aware of the contest.⁹

Self-help Quit Smoking Kit: The third program was a four-step self-help quit kit containing four "tip sheets" and an introductory page. Each tip sheet had two sides, one providing general information and the other providing tips on quitting and specific action steps to take. Tips included use of substitutes for smoking, social support, public commitment, planning, record keeping, and goal setting. A heart-shaped magnet is included in the kit for use in posting each of the tip sheets on a refrigerator or other prominent place. The kit can be distributed through a variety of channels, including libraries, health agencies, and physician offices.¹⁰

Group Behavior Therapy Programs for Smoking Cessation

Group treatment is a familiar method when it comes to providing smoking cessation interventions. There are four purposes when it comes to group treatment: 1) to evaluate the reasons for group members' behavior, 2) to offer a chance for social learning, 3) to create emotional experiences, and 4) to report material and to teach new skills. The implementation of smoking cessation programs in groups continues to be a popular method of delivering behavioral interventions and typically include such methods as coping and social skills training, contingency management, self-control, and cognitive-behavioral interventions. The use of a group format for the delivery of a behavioral intervention lies between self-help methods that have minimal therapist contact and intensive individual counselling/therapy, and thus a group might offer better cessation rates than the former with lower costs per smoker than the latter.¹¹

There may be a specific therapeutic benefit of the group format in giving people who smoke the opportunity to share problems and experiences with others attempting to quit. This might lead to increased quit rates even compared to individual face-to-face methods. More recent research has focused on identifying the components that contribute most to the success of the intervention. In particular, there is interest in ways to enhance programs with components which could be specifically helpful for those with poor success rates for quitting, such as people with histories of

⁸ The information provided in this section comes from David Altman et al.'s "The cost-effectiveness of three smoking cessation programs" in the *American Journal of Public Health*, vol. 77, no. 2 (1987): 162-165.

⁹ Ibid

¹⁰ Ibid.

¹¹ The information in this section comes from Lindsay Stead and Tim Lancaster's "Group behaviour therapy programmes for smoking cessation" in *The Cochrane Library* no. 2 (2009).

depressive disorder or substance abuse. These group benefits may occur in addition to assessing the advantage of generic group behavior therapy for smoking cessation.¹²

Predictors of Smoking Intentions and Smoking Status among Nonsmoking and Smoking Adolescents

A study completed in Memphis with 7th to 12th graders examined what the predictors of smoking purposes were among current adolescent nonsmokers and smokers, as well as assessing the risk factors that were linked to an individual's smoking status. This study put an emphasis on how to offer an analysis of the cognitive-motivational factors. The youth were categorized into two groups, either 1) smokers or 2) nonsmokers based upon if the youths smoked in the last month or not.¹³ To further explain this risk continuum, the youths within these two groups were then divided again based on the scores which showed their personal purpose on why they smoked or not. The nonsmokers were divided based on their future intentions to smoke. The smokers were divided based on their future intentions to quit. This study explained some reasons why youths smoked were due just to being over the age of 16, seeing a parent smoke, instrumental value, rebelliousness, knowledge, perceived vulnerability, optimism, and peer smoking. Peer smoking was large reason given; all students who were in smoking groups described that they had at least one best friend who smoked.¹⁴

Youth who smoked were perceived to have higher vulnerability and perceived instrumental value scores than nonsmokers. Nonsmokers who had one or more friends who smoked perceived greater instrumental value associated with smoking. Moreover, they had lower tobacco-related knowledge scores and reported greater intentions to smoke. Youth who smoked with lower intentions to quit perceived to have a greater instrumental value to smoking and were at higher risk to continue smoking.¹⁵

The Effects of Tobacco Policies on Vulnerable Populations in Arizona

In 1973, Arizona was the first state in the U.S. to pass a state clean indoor air law and in 1994 Arizona voters established its first tobacco control program.¹⁶ This is significant as the Centers for Disease Control (CDC) estimates that 47.7% of adult every day smokers in Arizona quit smoking one or more days in 2015.¹⁷ Also according to the CDC's annual Behavioral Risk Factor Surveillance System 2015 survey, there are over a million adult smokers in Arizona; more than half of adult smokers tried to quit within the past year; and currently, around 2% of adult men and 0.5% of adult women use smokeless tobacco.

From 2011 to 2015, smoking rates in Arizona fell from 19.3% to 14%.¹⁸ As a result, Maricopa County is below the national average which is 15.4% of adults reporting they smoke on a regular

¹² Ibid.

¹³ The information in this section comes from Vida Tyc et al.'s "Predictors of smoking intentions and smoking status among nonsmoking and smoking adolescents" in *Addictive behaviors* vol. 29, no. 6 (2004): 1143-1147.

¹⁴ Ibid.

¹⁵ Ibid.

¹⁶ Bialous, S. A., & Glantz, S. A. P. D. (1997). Tobacco control in Arizona, 1973-1997.

¹⁷ CDC, Behavioral Risk Factor Surveillance System, State Tobacco Activities Tracking and Evaluation System, 2015

¹⁸ Arizona Department of Health Services. ASHLine Annual Report, Retrieved at <http://www.azdhs.gov/documents/prevention/tobacco-chronic-disease/tobacco-free-az/reports/2017-ashline-annual-report.pdf>

basis.¹⁹ While significant reductions in tobacco use have been realized, the battle toward a tobacco-free Arizona is far from over. In Arizona, there have also been real costs in terms of dollars. According to a state specific study, the annual direct costs to the Arizona economy attributable to smoking were in excess of \$5 billion, including workplace productivity losses of \$1.2 billion, premature death losses of \$1.9 billion, and direct medical expenditures of 1.8 billion.²⁰

The Arizona Smokers' Helpline (ASHLine) currently reaches only 1.6% of tobacco users in the state and relapse rates are not well defined.²¹ The majority of ASHLine clients (72%) reside in Maricopa and Pima counties, with the majority of ASHLine clients in FY17 being female (56%), and NonHispanic (79%).²² With regard to insurance coverage and poverty, the percentage of ASHLine clients reporting household income below the Federal Poverty Level was highest in 2013, while the percentage of clients enrolled in AHCCCS was lowest in the same year. In contrast, 2014 saw the percentage of clients enrolled in AHCCCS increase from 15.4% to 25.3%.²³ Quitlines are well-established as an evidence-based standard of care for tobacco cessation. However, as the prevalence of smoking has declined over time, some evidence exists that the clientele for quitlines may have shifted demographically.

A recent article points to the particular vulnerabilities low-income and federally assisted housing adults experience with cigarette smoking.²⁴ In general, these adults experience higher exposure to secondhand smoke and are particularly susceptible to the adverse effects of cigarette smoking. In their national health study of over 5,000 HUD-assisted adults, about a third of the individuals in their study were smokers of which over 80 percent were daily smokers. Half of these smokers had attempted to quit. The researchers found that smokers tended to be younger adults (25-44), non-Hispanic white persons, and persons who had children in their homes. They also found that those who smoked were more likely to suffer from worse health, asthma, chronic obstructive pulmonary disease (COPD), disability, and serious psychological distress. Smokers also reported missing more days of work and visiting the emergency room more often. The authors concluded their article by advocating for evidence-based interventions, prevention programs, and control measures, such as smoke-free policies.

Low socioeconomic groups of women and men reveal to have higher smoking rates. The reason for this is because tobacco control policies have not been created to deal with specific at-risk sub-populations. Therefore, these policies have not captured the effective response to tobacco use and smoke exposure in diverse groups. There is evidence that shows women process some elements of

19 Syamlal G, King BA, Mazurek JM. Tobacco Use Among Working Adults - United States, 2014–2016. *MMWR Morb Mortal Wkly Rep* 2017;66:1130–1135.

20 Rumberger, J. S., Hollenbeak, C. S., & Kline, D. (2010). Potential costs and benefits of smoking cessation: an overview of the approach to state specific analysis. *NY Am Lung Assoc*.

21 Arizona Department of Health Services. ASHLine Strategic Plan, Retrieved at <http://www.azdhs.gov/documents/prevention/tobacco-chronic-disease/tobacco-free-az/reports/ash-line-strategic-plan-2015.pdf>

22 Arizona Department of Health Services. ASHLine Annual Report, Retrieved at <http://www.azdhs.gov/documents/prevention/tobacco-chronic-disease/tobacco-free-az/reports/2017-ashline-annual-report.pdf>

23 Ibid

24 The information in this section comes from Veronica Helms, et al.'s "Cigarette smoking and adverse health outcomes among adults receiving federal housing assistance." *Preventive Medicine*, vol. 99, (June 2017). 171-177.

tobacco smoke differently than men. Thus, women may be more vulnerable to chronic respiratory diseases such as, COPD and lung cancer.²⁵

Life expectancy is reduced for all Arizonans who smoke including adolescents with over 115,100 Arizona youth age 0-17 projected to die from smoking.²⁶ The 2016 Arizona Youth Survey shows the Arizona students can access tobacco products easily with 68.7% of 12 graders reporting that cigarettes are easy to get, 32.8 % reported lifetime use of cigarettes, and 36.8% reported lifetime use of E-cigarettes.²⁷

Impact of Tobacco Policies

Comprehensive tobacco control policies have been effective in decreasing tobacco use. The tobacco control movement was developed to assess the numerous methods on how to cut, reduce or eliminate the use of tobacco over the past 50 years. The main conclusion from these studies was that a comprehensive approach would be the most effective method in decreasing tobacco use frequency rates within a certain population. “These methods may include a wide range of policies, such as those dealing with tax and price, restrictions on smoking locations, sales to minors, advertising and marketing enforcement, community programs, and surveillance”.²⁸ Comprehensive Tobacco Policies also known as CTPs have managed to decrease significantly the frequency of smoking in certain populations. In several states “demoralization” has been inserted as an element of CTPs. This helps to transform the perception of smoking into a socially unacceptable activity. To help with this idea there were “social marketing and health promotion campaigns on both prevention and cessation.”²⁹

The tobacco industry establishes itself through U.S. media sources and has been known to target vulnerable groups, such as youth, women, ethno-cultural groups, gays and lesbians. It has been shown that comprehensive tobacco control policies clearly increase the overall population health, which includes the vulnerable groups. But it is also true that the strategies and the implementation of broad-based policies do not necessarily accommodate inequities or adjust the policy in relations to the disadvantaged groups. As the overall prevalence of smoking continues to decline in the U.S. and in Arizona, it is important to understand whether these reductions are experienced proportionally or disproportionately across these at-risk groups.

²⁵ Greaves, L., & Hemsing, N. (2009). Women and tobacco control policies: Social-structural and psychosocial contributions to vulnerability to tobacco use and exposure. *Drug and alcohol dependence*, 104, S121-S130.

²⁶ Center for Disease Control. Best Practices for Comprehensive Tobacco Control Programs, Arizona. Retrieved at https://www.cdc.gov/tobacco/stateandcommunity/best_practices/pdfs/2014/states/arizona.pdf

²⁷ Arizona Criminal Justice Commission. Arizona Youth Survey 2016. Retrieved at <http://www.azcjc.gov/community-data-portal>

²⁸ Ibid.

²⁹ Ibid.

Research Results

Key informant interviews

ASHLine Background

The ASHLine provides services to medical and behavioral health providers that work with various populations in Maricopa County (i.e., substance abuse, prison population, homeless population, homeless shelters, FQHC's and RHBA's). The ASHLine also provides cessation services to anyone across the State of Arizona for free (including seasonal residents). They work with employers and clients including helping them navigate the healthcare system and the process of getting nicotine-related support.

Anyone is eligible for medication support except for Medicaid recipients because BTCDC covers them. Most of ASHLine's clients are middle age to senior (40's plus), white, women, English-speaking who have been smoking since 18 years of age.

Services include:

- Free evidence-based support through coaching
 - ASHLine takes calls from individuals seeking support
 - ASHLine takes referrals from medical providers – as soon as they get a referral, outbound calls to clients are made within 24 to 48 hrs. ASHLine will attempt up to seven times within ten days to reach clients. Note: *Research shows this referral strategy is more effective than providing the ASHLine number to clients and leaving it up to them to call for services.*
- Nicotine containing products and medication support limited to 4 weeks of nicotine therapy (delivered in 2 week increments) to help get people started in the smoking cessation process but does not help them quit smoking altogether
 - Medicare patients get 12 weeks of nicotine replacements through their providers, although these individuals are often unaware of this and healthcare providers may be as well
- Behavioral health support via phone, web and print
 - ASHLine provides lots of education to clients – sometimes health plans do not know that they can offer nicotine plans
- ASHLine trains health centers on tracking and referring clients – all information goes to the ASHLine database – health centers fax the information/referral and ASHLine puts it in the system; working on online referrals system

ASHLine is publicly funded through tobacco tax (primary) and CDC funding through the State of Arizona.

Outreach

ASHLine's works with providers and clinical level staff primarily: not directly with public housing tenants. The interviews were conducted via phone, email, and face-to-face conversations. Most coaches are former smokers as well.

Barriers Expressed

ASHLine would like to expand outreach to residential housing and places where resource insecure populations tend to go (i.e. food banks) and expand services to be available 24/7. More staff and funding for staff are needed at ASHLine.

Provider Level. The key informants expressed issues with getting buy-in from the leadership teams of providers. The main resistance to buy-in is the current and competing workload and priorities of the leadership teams. Smoking is often not considered a top health concern.

Providers also feel that ASHLine does not provide medication for their clients. Currently, ASHLine provides four weeks of nicotine replacement therapy twice a year. Providers do not feel the replacement therapy is enough to help their clients quit smoking.

Client Level. Clients may lack desire to quit smoking. They may also have other competing needs to address before quitting smoking. They may have other health-related issues that they regard as more important than smoking.

Additionally, because ASHLine is a quitline service, only clients with reliable phone communication can use it. This may be difficult for individuals who are resource insecure, such as low SES and those who live in treatment facilities limiting phone use. Further, it is difficult to call clients back with unreliable phones (e.g., if minutes on the phone is an issue).

Clients are less likely to quit if they are frustrated having to navigate the healthcare system. ACCCHS members must get their prescriptions through healthcare providers, but lack of knowledge of the system can cause access issues.

There remains a lack of awareness regarding ASHLine and other smoking cessation services available for free to individuals. There are misconceptions in the public about coaches. Some believe ASHLine coaches are untrained volunteers – coaches are highly trained – or that once they use ASHLine services, they must then commit to coaching others. There are not a lot of funds available to debunk these myths.

There remains issue regarding cultural sensitivity. For example, among Native Americans, trust is a barrier and individuals may use various forms of smoking for ceremonies.

Finally, there are restrictions on covering Medicaid recipients. An estimated 30% of all smokers are on Medicaid.

Overcoming Barriers and General Suggestions

- A top-down approach was deemed best by the key informants. ASHLine needs to get buy-in from senior provider leaders. These senior leaders can then garner buy-in from

- the rest of their teams, which can spread the buy-in across organizations and reach the clients.
- More staffing is needed to cover Internet technology level issues (e.g., electronic health records). The addition of more coaching staff would allow ASHLine to call more providers. Additional coaching staff with more diverse backgrounds would allow coaches to work with different populations.
 - An incentive program or package of programs can be created to encourage clinical staff and providers.
 - ASHLine recently launched a text line, which might help to reach the younger population as the current population who tends to use ASHLine services are middle age to senior (40's plus) white women.
 - Although they primarily serve English-speaking clients, ASHLine does contract out to provide services in Spanish and in some cases, Asian languages (as is done in California)
 - Extended hours are also being offered to fit better around clients work schedules.
 - Tax increases and smoking policies would be great, because they educate the public of the harm of smoking and encourage them to quit or seek resources to help them.

Federally Qualified Health Center (FQHC) Background

FQHCs serve low SES, homeless and other clients who live in public housing. Some FQHCs identify smoking behaviors during intakes/screenings, while others have mobile clinics and bus services that go to some public housing sites. Typically, when clients are screened and identified as smokers, FQHCs refer them to services and clinics.

ASHLine is used but does not receive large volumes of calls from these individuals despite having ASHLine come in and provide information about their services and free vouchers for smoking cessation services.

The American Lung Association, like with ASHLine, does outreach for holding classes but many clients do not have phones and it is hard to reach them or remind them of appointments.

Outreach

Not all FQHC outreach specifically to public housing residents/communities. Outreach is done at health fairs, backpack events, women's health events, and through health coaches who outreach by phone. Word of mouth is a primary outreach strategy. FQHCs try to build rapport/networks with other community organizations for referral purposes.

Barriers Expressed

- FQHCs have difficulties reaching their populations of interest. Individuals in need tend to come in for healthcare only when they are very sick and exhausted all other resources.
- They often do not know what services are available to them.
- There is a lack of health literacy in general.
- Clients do not necessarily make smoking cessation a high priority. A majority of clients who smoke are not interested in quitting. Smoking is seen as a relief for many homeless

individuals, who have many other problems that they view as more immediate. It is difficult to engage with individuals with substance abuse issues.

- Some FQHCs have identified that the process of asking clients about their smoking behavior is uncomfortable for the clinician.
- It also can be difficult for clients to come to educational classes, especially multi-session classes. Long-term engagement is a major issue. Engagement can be harder in the summer months, especially due to the heat.
- Structural constraints to participation include:
 - Transportation,
 - Lack of childcare (especially for single parents), and
 - Consistent knowledge of clients' locations. Clients tend to be very mobile with frequent address and phone number changes making it hard to stay in touch/follow-up.
 - Disabled individuals may find travel to clinics especially difficult.
 - The uninsured are hard to reach because of their financial burdens.
- There can be issues with language barriers or immigration concerns that prevent engagement with certain client populations.
- Like with ASHLine, there are cultural barriers with reaching Native Americans. FQHCs noted issues with reaching refugee populations.
- The environments the clients navigate have many individuals or peers who are smokers.
- Nicotine replacements often get sold on the streets, which is why when some homeless persons come to classes, they may only be there for the patch, not the education.

Overcoming Barriers and General Suggestions

FQHCs had suggestions regarding how to overcome the aforementioned barriers.

- Try to find resources to address barriers like transportation
- Extend hours
- Offer mobile clinics and offering breakfast have helped to bring clients in to get care
- Better word of mouth
- Develop peer support services (must get staff out in the community to find out why individuals are not engaged)
- Sliding e-scale – charge clients for services based on their income
- Try to reach individuals where they are at (e.g., Churches)
- Expedite services once they get in the door



The FQHCs had other suggestions for improving services and giving their clients more hope. They desired to connect clients and teach them how to take care of themselves to be self-sufficient (e.g., budgeting).

- Housing needs are the ultimate self-sufficient strategies, but clients need to know and learn how to maintain their housing and pay their rent among other things. FQHCs could also teach clients how to access help in various and creative ways.
- FQHCs highlighted the importance of follow-up post treatment. Smoking support groups were seen as helpful. Clients need a support system to change their mentality in order to quit the substance. They also need a better routine.
- There also needs to be a follow-up system on clients who were referred to ASHLine. There should be a way to capture the impact of ASHLine services on their clients. FQHCs are unsure how many clients have been referred and how many are using their services.
- Another suggestion was to embed a smoking counselor in clinics in high volume smoking areas. One suggested a pediatrician's office might work to catch issues early.
- A final suggestion was to provide more free material to get individuals in the door. Nicotine samples were seen as helpful.

Public Housing Staff Background

The new smoke-free policy went into effect for City of Phoenix as of July 1, 2017. The majority of public housing sites (except one, at the time of the interview) were completely smoke-free according to the HUD final rule. All properties had some form of a smoke-free policy implemented despite resistance from clients. Regardless of the policy, residents “do what they want to do.”

The properties that expressed the most challenges with rule enforcement were public housing properties that served seniors and people with disabilities. Some properties placed the smoke-free policy and enforcement at equal priority to other policies, but this view was not consistent across all properties in part because they do not see smoking as an issue of concern on their sites. Long-time smokers with no intention to quit felt the policy was impeding on their rights, and they felt particularly targeted. Property staff persons have not pushed for evictions because these residents do not have anywhere else to go and are already one of the most vulnerable populations.

Some properties do not have smoking cessation programs/services and not sure if they are interested in providing them because they feel there is already a lot of information widely distributed.

Outreach

Public housing residents are informed of services, policy changes, and nearby events through email, mass mailing, posting bulletins at the office/community center, door-to-door communications, told at the time they have to pay rent, distribution of quarterly newsletters, and discussions at monthly staff-resident meetings. Education materials are available at most sites in the office. Interns also help individuals with referrals. ASHLine and/or American Lung Association staff persons have come to most property sites to provide education and materials, but there has always been a very low turnout.

Barriers Expressed

Public housing staff expressed a number of barriers to reach and engage clients.

- Clients say they want services, but then do not show up.
- Structurally, transportation remains a challenge for clients, especially the elderly and disabled.
- On site, some properties do not have designated smoking areas. There are issues with coverage from the heat, issues with safety, and lack of spaces 25 feet from entryways where smoking is allowed.
- It is challenging to get residents to stop smoking in their housing units. Inside their homes, some individuals feel entitled to smoke in their own spaces. Staff persons do not feel equipped to enforce policy, specifically when dealing with violators.
- There appears a lack of motivation from residents to quit smoking. Long-term smokers are more stubborn about quitting.
- Lack of funds prevents individuals from affording smoking cessation medication.
- Staff persons expressed difficulty when trying to reach residents, because they do not want to be bothered even with free material.
- Cultural competence/sensitivity and navigation is important but difficult. Staff persons need to work a little harder to reach and assistant refugee populations, especially those with language barriers; staff persons usually must work with community partners that provide interpretation services.

Overcoming Barriers and General Suggestions

Public housing staff noted some strategies and suggestions to overcome the aforementioned barriers.

- Overall, they felt that public housing staff need to have persistent dialogue with their residents, but efforts can be made when individuals move in and during their time in the housing units.
- Public housing staff suggested that new residents could be provided with smoking cessation materials with their move in packets. This provision of materials can occur in addition to new residents signing their lease agreements, which inform them about the smoke-free policy and instructions regarding the rules.

- Regarding events, public housing staff persons have noted that advertising the day of or day before sometimes works at attracting residents. Incentives and prizes for attending events have also worked to get residents motivated to come to educational classes.
- Public housing staff also emphasized reaching out to community agencies to help provide services to clients.
- Staff persons still remain unsure how to prove that their residents are smoking inside their apartments; they are particularly concerned about the elderly and disabled. They also are unsure about how many violations must occur before residents are/should be evicted. They wonder if fines are better than evictions, while also feeling that individuals are going to smoke regardless of the smoke-free policy.
- Some staff work with residents to agree on a designated smoking area, but this can be challenging when such a space does not already exist.



Surveys

Sample Characteristics

A summary of the 336 survey participants' characteristics is shown in Table 1. Of respondents, two-thirds identified as female; just over one-third each identified as Hispanic/Latino and White. Over half had no more than a high school education or GED; almost half were widowed, separated or divorced. Just under half were the parent of a minor child. Only 13% worked full or part-time, and a third were retired. Seventy-five percent identified as non-smokers. While City of Phoenix represented 85% of the housing units, 76% of the respondents lived in various City housing units. AHCCCS was named as health insurance provider by 67% of the participants, and 78% indicated they had received routine medical care in the past 12 months.

Table 1: Survey Participant Characteristics (n = 336)

Characteristic	Number	Percentage
Gender¹		
Male	97	30%
Female	217	68%
Transgender	3	1%
Identifies as LGBTQ	21	7%
Race/Ethnicity²		
American Indian/Alaska Native	10	3%
Asian/Pacific Islander	4	1%
Black/African American	74	24%
Hispanic/Latino	110	35%
White	123	39%
Education		
Less than high school	51	16%
High school or GED	117	37%
Some college or associate degree	94	30%
Bachelor degree or higher	23	7%
Marital Status		
Married	33	11%
Widowed, separated, or divorced	148	47%
Never married	118	38%
Living with partner	16	5%
Parent of child under 18	159	47%
Qualified for free/reduced lunch	72	29%
Employment		
Full-time	20	6%
Part-time	24	7%
Unemployed	60	18%
Retired	113	34%
Unable to work	84	25%
Smoking Habits		
Smoker	74	25%
Non-smoker	227	75%

Location*		
City of Phoenix	256	76%
Fillmore Gardens	39	12%
Foothills Village	3	1%
Frank Luke/Aeroterra	4	1%
Luke Krohn	43	13%
Marcos de Niza	6	2%
Maryvale Parkway Terrace	22	7%
Matthew Henson and Symphony	25	7%
McCarty on Monroe	8	2%
Pine Towers	22	7%
Sidney P. Osborn	24	7%
Summit Apartments	11	3%
Sunnyslope Manor	29	9%
Washington Manor	20	6%
Housing Authority of Maricopa County	72	21%
Baden Homes	2	1%
Casa Bonitas	8	2%
Clara-Feldstadt (1 and 2)	7	2%
Father Fidelis Homes	7	2%
Flora Statler Homes	3	1%
John Hammond Homes	0	0%
John Holler Homes	2	1%
Paradise Homes	0	0%
Parkview Estates	12	4%
Rose Terrace	31	9%
Varney Homes	0	0%
Villa Monte Rosa	0	0%
Unknown/Missing	8	2%
Health Insurance (n= 288)		
AHCCCS/Medicaid	193	67%
Employer-Provided Health Insurance	12	4%
School, Professional Association, Trade Group, or Other Organizational Insurance	2	1%
Directly Purchased Insurance	2	1%
Medicare	96	33%
Medigap or Medicare Supplement	15	5%
Indian Health Service, Tribal Health Programs or Urban Indian Clinic	1	< 1%
Military Health Plan	7	2%
Arizona Long Term Care System	6	2%
High Deductible Health Plan	2	1%
Uninsured	8	3%
Routine Medical Care in Past 12 Months (n=292)	229	78%

Note: Due to some missing data (e.g., skipped or unanswered questions) and multiple response options, numbers do not always add to 336 or 100 percent. Percentages reported are calculated from the total number of participants who answered that specific question.

*Refers to self-reported location of residence rather than where the survey was administered.

¹Men were statistically more likely to be smokers than women ($\chi^2 = 16.391$, $\phi = .235$, $p < .01$).

²Hispanic individuals were less likely to be smokers than non-Hispanic persons ($\chi^2 = 13.869$, $\phi = -.218$, $p < .001$). White individuals were more likely to be smokers ($\chi^2 = 5.667$, $\phi = .139$, $p < .05$).

Awareness and Utilization of ASHLine

There remains room for increased *awareness and utilization of ASHLine*. Again, it is important to note that only 25% of those surveyed reported that they are smokers. Still this figure is higher than the U.S. national average for all smokers of around 15.4%.³⁰

ASHLine Awareness. The majority of surveyed individuals had not heard of ASHLine (54.5%), and only 45.5% of individuals surveyed had heard of ASHLine.

ASHLine Utilization. Only 5% ($n = 16$) of individuals had used ASHLine's services in the past.

Perceptions of the Neighborhood and Tobacco Use in the Neighborhood

This next section focuses on *perceptions of the neighborhood and tobacco use in the neighborhood*. The distribution of agreement ratings is provided in Table 3. There was a great deal of ambivalence among respondent answers (i.e., many individuals neither agreed nor disagreed).

Housing unit safety. The majority of surveyed individuals (59%) felt safe being outside alone near their housing units, while 22% did not feel safe.

Neighborhood values. Only 25% of individuals believed they shared values with the people in their neighborhood, while 34% believed that they did not share the same values with the people in their neighborhood.

Willing to help their neighbors. A large proportion but not a majority (43%) of surveyed individuals indicated that people in their neighborhood are willing to help their neighbors. 23% of the individuals indicated that people in their neighborhood are not willing to help.

Close-knit neighborhood. Only 34% of individuals indicated that they lived in a close-knit neighborhood, while 30% disagreed believing the neighborhood is not close-knit.

No tobacco-related litter. More individuals (44%) felt that tobacco-related litter was present outside their housing units than those who felt the properties were litter-free (39%).

Secondhand smoke. A large proportion but not a majority (43%) of surveyed individuals indicated that secondhand smoke was not a problem where they live, while 38% indicated that it might be a problem.

Perceptions of smoking cigarettes. Just over one-third (36%) of surveyed individuals indicated that their neighbors viewed smoking cigarettes as harmful, while only 25% of individuals felt their neighbors did not see smoking cigarettes as harmful.

Perceptions of smoking other tobacco products. Only about one-third (32%) of surveyed individuals indicated that their neighbors view smoking other tobacco products as harmful,

³⁰ This information comes from the Centers for Disease Control and Prevention. [Cigarette Smoking Among Adults—United States, 2005–2015](#). *Morbidity and Mortality Weekly Report*, Vol. 65 no. 44 (2016):1205–11.

while only 25% of individuals felt their neighbors did not see smoking other tobacco products as harmful.

Table 2: Distribution of Ratings for Survey Items Asking for Agreement

Survey Items	Strongly Disagree	Disagree	Neither Disagree Nor Agree	Agree	Strongly Agree
Safe alone outside	10%	12%	18%	45%	15%
Shared neighborhood values	11%	23%	42%	21%	4%
Willing to help their neighbors	10%	13%	35%	34%	9%
Close-knit neighborhood	12%	18%	36%	29%	5%
No tobacco-related litter	18%	26%	18%	30%	9%
Second hand smoke is not a problem	21%	17%	20%	34%	9%
Smoking cigarettes seen as harmful by neighbors	8%	17%	40%	27%	9%
Smoking other tobacco products seen as harmful by neighbors	8%	17%	43%	23%	9%

Current and Past Tobacco Use

This section outlines the rates of *current and past tobacco use* by the individuals surveyed.

Cigarette Current Use. Only 25% of survey respondents (n=301) currently were smokers.

Cigarette Past Use. A large proportion (44%)³¹ of those surveyed had used tobacco previously (i.e., at least once). Of those individuals, 96% of those individuals had smoked at least 100 cigarettes. There were 47% of individuals who have smoked or currently smoke had smoked a cigarette in the past 30 days (13% in past 12 months, but not 30 days; 40% in lifetime, but not past 12 months).

Menthol Cigarette Use. A third (33%) of individuals who had used tobacco before or currently use tobacco had smoked menthol cigarettes for six months or more. Only 19% of the current smokers smoke menthol cigarettes all of the time they smoke (2% most of the time; 14% some of the time; 15% rarely).

Number of Cigarettes Smoked. On days when individuals smoke cigarettes, most individuals smoke five or fewer (44%); 26% smoke six to 10 cigarettes, 20% smoke 11 to 20 cigarettes, 1% smoke 21 to 30 cigarettes, 7% smoke 31 to 40 cigarettes, and 1% smoke 41 or more cigarettes.

³¹ n = 147 out of 266 individuals who responded to this question. The figure of 147 is used for calculating lifetime/past use and menthol cigarette use figures.

Cigarette Age First Smoked. Of the individuals who responded to question regarding when they started smoking ($n = 99$), the average age when individuals started smoking was 19. The earliest reported age was nine years of age, and the oldest reported age was 60.

E-Cigarette or Other Use. Of the 154 individuals who responded to the question use of use, the majority (58%) of individuals indicated they had never used e-cigarettes or any tobacco product other than cigarettes (e.g., cigars, cigarillos, pipes, hookah, smokeless or chewing tobacco, etc.); 14% of individuals reported using e-cigarettes/other in the past 30 days; 8% reported using in the past 12 months but not 30-day use.; and 20% had lifetime use but not past 12 month use.

Age of First Tried of E-Cigarettes or Other. Of the individuals who responded to the question regarding when they first tried an e-cigarette or other tobacco product ($n = 61$), the average age of first use was 27 years. The youngest age of first use was 10, and the oldest age was 65. Further, 30% of individuals had first used e-cigarettes/other when they were 17 years of age or younger and 42% of individuals first used e-cigarettes/other between the ages of 18 and 25.

Age of First Started to Use of E-Cigarettes or Other Regularly. Of the individuals who responded to the question regarding when they first used e-cigarettes or other tobacco product ($n = 67$) *regularly*, the average age of first use was 27 years. The youngest age of first use was 10, and the oldest age was 65. Of individuals, 34% had first used e-cigarettes/other regularly when they were 17 years of age or younger; 35% of individuals first used e-cigarettes/other regularly between the ages of 18 and 25.

E-Cigarettes or Other Tobacco Use. Of individuals surveyed, 18 indicated that they had used tobacco products aside from cigarettes (e.g., e-cigarettes/other tobacco) in the past 30 days. In addition, 13 individuals reported they used flavored tobacco products and 22 individuals reported that they had used e-cigarettes in the past year.

Reasons for quitting

This section outlines the reasons for quitting *tobacco use* by the individuals surveyed.

Table 3: Reasons for Quitting Smoking

Reasons of Quitting	Yes	No
To Be Healthier	53%	47%
Too Expensive	33%	67%
Dissatisfied with Dependency	28%	72%
Health Problems	19%	81%
Too Inconvenient	17%	83%
Concern for Others' Health	15%	85%
Concern Shown by Others	11%	89%

Quitting Smoking Cigarettes. There were 72 individuals who shared their reasons for quitting.³² The percentages are depicted in Table 3. The top reason for quitting was to be healthier. The second most popular reason was that smoking was too expensive, and the third most popular reason was that they were dissatisfied with their dependency on tobacco.

Quitting E-Cigarettes or Other Tobacco. Fifty individuals shared their reasons for quitting. The proportions are depicted in Table 4. The top reason for quitting was to be healthier. The second most popular reason was that smoking was too expensive, and the third/fourth most popular reason was that they were dissatisfied with their dependency on tobacco and concerned about health problems.

Table 4: Reasons for Quitting E-Cigarettes or Other Tobacco

Reasons of Quitting	Yes	No
To Be Healthier	52%	48%
Too Expensive	30%	70%
Dissatisfied with Dependency	22%	78%
Health Problems	22%	78%
Concern for Others' Health	18%	82%
Concern Shown by Others	14%	86%
Too Inconvenient	12%	88%

Quitting Any Tobacco Products (e.g. cigarettes, cigars, cigarillos, pipes, hookah, smokeless or chewing tobacco, or e-cigarettes). There were 57 individuals who shared their reasons for wanting to quit using tobacco of any kind. The percentages are depicted in Table 5. The top reason for wanting to quit was to be healthier. The second most popular reason was that smoking was too expensive, and the third/fourth most popular reason was that they were dissatisfied with their dependency on tobacco and concerned about health problems.

Table 5: Reasons for Wanting to Quit Using Any Tobacco Products

Reasons of Quitting	Yes	No
To Be Healthier	70%	30%
Too Expensive	49%	51%
Health Problems	30%	70%
Concern Shown by Others	28%	72%
Dissatisfied with Dependency	28%	72%
Concern for Others' Health	26%	74%
Too Inconvenient	26%	74%

When examining these reasons for quitting or wanting to quit, there are some similarities and differences. The first reason in each instance is To Be Healthier, thereby acknowledging that people

³² The first item "to be healthier" had 73 individuals respond. The other items had only 72 respondents.

are generally aware of the health hazards of smoking, and that to some degree, tobacco education information is general knowledge. The second reason for quitting or wanting to quit is that smoking is too expensive and smoking costs are barriers.

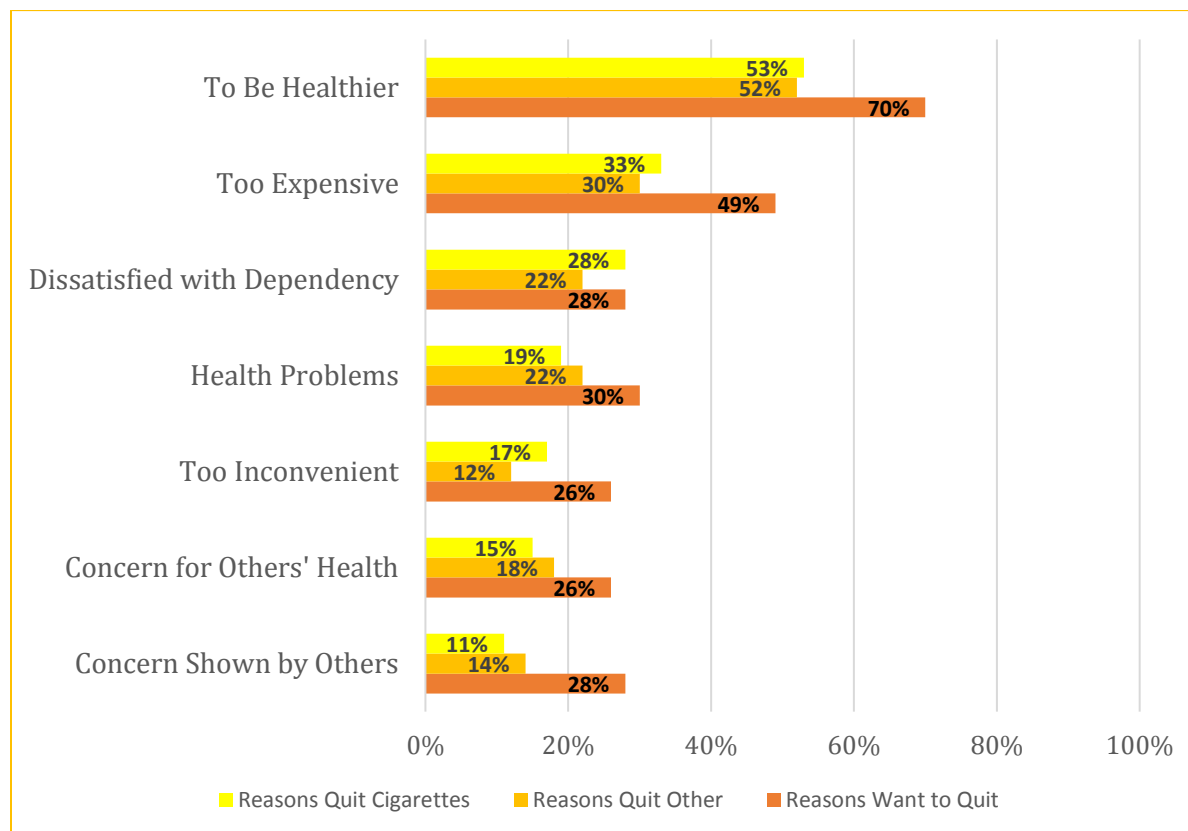


Figure 1: Reasons for Quitting or Wanting to Quit

Plans, Attempts, Strategies, and Successes at Quitting

This section outlines the plans, attempts, strategies, and successes of individuals at quitting *tobacco use*.

Years Smoke Free. Of the individuals who quit and shared how long it had been since they last smoked ($n = 51$), the average was 14 years smoke free. Of these, 25% of individuals had only been smoke free for a year or less, and 25% of individuals had been smoke free for two to nine years. Half (50%) of individuals had been smoke free for at least 10 years.

Years Other Tobacco Free. Of the individuals who quit other tobacco products and shared how long it had been since they last used such products ($n = 38$), the average was 21 years of being other tobacco free. Of these individuals, 18% had only been other tobacco free for a year or less, and 5% of individuals had been other tobacco free for two to nine years. Another 52% of individuals had been other tobacco free for at least 20 years.

Plans to Quit Smoking. Of the 63 respondents who responded about their plans to quit smoking cigarettes, 33% of individuals had no plans to quit. Further, 10% planned to quit within the month, 21% planned to quit within six months, and 14% planned to quit within the year; 22% planned to quit but not within the next year.

Serious Attempts. Of the 105 respondents who responded about their serious attempts to quit smoking cigarettes, 39% ($n = 41$) made serious attempts at quitting.

Strategies. Table 6 outlines the strategies used by 56 individuals who made attempts at quitting. Quitting 'cold turkey' was the most popular strategy for quitting followed by nicotine replacement therapy.

Table 6: Strategies for Quitting Cigarettes

Strategies for Quitting	Yes	No
Quit 'cold turkey'; no help	59%	41%
Nicotine replacement therapy	27%	73%
Brief help by a doctor/healthcare professional	14%	86%
Prescription for non-nicotine medication	13%	88%
Telephone helpline/counseling	11%	89%
Self-help guides/other materials	9%	91%
E-Cigarettes	7%	93%
Online programs	5%	95%
Behavioral therapy	4%	96%
Acupuncture	4%	96%
Hypnosis	2%	98%
Laser therapy	0%	100%
Individual or group in-person counseling	0%	100%

E-Cigarettes and Quitting. E-cigarettes were not a popular strategy for quitting. Indeed, 91 individuals responded to a particular item regarding using e-cigarettes to quit smoking. Of these, 14 individuals (15%) used e-cigarettes in the past to quit, but do not use them now. Five individuals (6%) used on occasion used them to help quit smoking. Two (2%) individuals used them daily to help them quit smoking.

Other Tobacco Products and Quitting. Other tobacco products were not a popular strategy for quitting. In total, 91 individuals responded to a particular item regarding using other tobacco products to quit smoking. Nine individuals (10%) used other tobacco products in the past to quit, but do not use them now. Four individuals (4%) on occasion used them to help quit smoking. Two (2%) individuals use them daily to help them quit smoking.

Plans to Quit E-Cigarettes and Other Tobacco. Of the 29 respondents who responded about their plans to quit e-cigarettes and other tobacco, 24% of individuals had no plans to quit; 7% planned to quit within the month; 24% planned to quit within six months, and 28% planned to quit within the year, while 22% planned to quit but not within the next year.

Strategies. Table 7 outlines the strategies used by 59 individuals who made attempts at quitting.³³ Quitting ‘cold turkey’ was the most popular strategy for quitting followed by Nicotine replacement therapy.

Table 7: Strategies for Quitting E-Cigarettes and Other Tobacco Products

Strategies for Quitting	Yes	No
Quit 'cold turkey,' no help	56%	44%
Nicotine replacement therapy	34%	66%
Prescription for non-nicotine medication	19%	81%
Telephone helpline/counseling	16%	84%
Self-help guides/other materials	14%	86%
Brief help by a doctor/healthcare professional	14%	86%
E-Cigarettes	10%	90%
Individual or group in-person counseling	8%	92%
Acupuncture	8%	92%
Behavioral therapy	7%	93%
Online programs	5%	95%
Hypnosis	3%	97%
Laser therapy	0%	100%

Confidence in Quitting Ability. Of the 58 respondents who responded about their confidence in being able to quit, 35% of individuals were very confident they could quit. Only 19% of individuals were confident, and 22% were moderately confident in their ability to quit. While 12% were slightly confident. Finally, 12% were not at all confident that they could quit.

Motivating Persons, Places, or Communities. There were 71 participants responded about influential persons, places, or communities that motivated them to quit. Table 8 shows the influential persons, places, and communities. Most influential was the doctor/healthcare practitioner followed by housing facility. Third most popular was online.

Table 8: Influential Persons, Places, and Communities

Motivating Persons, Places, and Communities	Yes	No
Doctor/Healthcare Practitioner	55%	45%
Housing Facility	49%	51%
Online (Website)	31%	69%
Local Community Center	23%	77%
Government Assistance Office	23%	77%
Library	17%	83%
Church	15%	85%
Schools	10%	90%
Post Office	8%	92%

³³ The first item “telephone helpline/counseling” and seventh item “Nicotine replacement therapy” had 58 individuals respond. The rest had 59 respondents.

Health and Healthcare Utilization

This section outlines the *health and healthcare utilization* of the survey respondents.

General Health. The majority (61%) of surveyed individuals noted that their health was at least good. Of individuals, 9% reported that they were in excellent health, 15% of individuals reported their general health as very good, while 37% reported their general health as good, 29% of individuals reported their general health as fair, and 10% of individuals reported their general health as poor.

Chronic Health Conditions. Table 9 reports the rates of chronic health conditions among the survey respondents. Diabetes, asthma, rheumatoid arthritis, and obesity were the most prevalent conditions reported. These answers for having a chronic disease were also calculated by those who were current smokers. Less than 10% of respondents said that they both smoked and had any one specific chronic condition (Table 10 and Figure 2).

Table 9: Chronic Health Condition Rates ³⁴

Health Conditions	Yes	No
Diabetes	40%	60%
Asthma	25%	75%
Rheumatoid Arthritis	25%	75%
Obesity	24%	76%
Heart Disease	18%	82%
Chronic Bronchitis, Emphysema, COPD, or Other Lung Disease	17%	83%
Stroke	7%	93%
Cancer: lung, mouth, nose, throat, trachea, esophagus, stomach, pancreas, kidneys, ureters, bladder, cervix, bone marrow, or blood	6%	94%
Gum Disease	6%	94%

Table 10: Chronic Health Condition Percentages for Current Smokers

Yes, Has Health Condition	Yes, Current Smoker	
	Number	Percent
Diabetes	16	8%
Asthma	6	3%
Rheumatoid Arthritis	8	4%
Obesity	10	5%
Heart Disease	7	4%
Chronic Bronchitis, Emphysema, COPD, or Other Lung Disease	9	5%
Cancer	7	4%

³⁴ Around $n = 219$ and 220 individuals responded to these items.

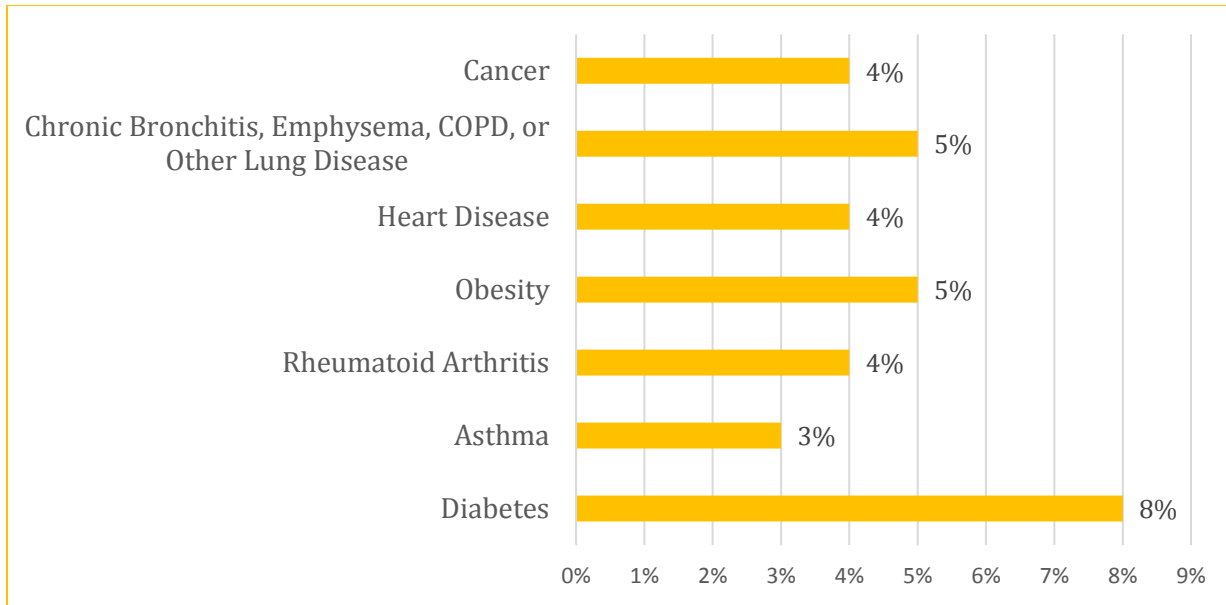


Figure 2: Percentage of Current Smokers Who Have Chronic Health Condition

Medical Doctor Advice and Visits. Of the 219 respondents, 19% received advice to quit using tobacco products; 18 individuals visited the doctor or hospital for tobacco-related health issues.

Doctor and Health Care Visits. The majority (86%) of individuals had visited a doctor or other health care provider in the past 12 months. Many residents indicated that they did get regular medical care in the last 12 months, 184 respondents provided some categorization of who provided this care. Some indication that they visited a primary care physician was provided by 82 respondents (45%). Many respondents (48), 26% mentioned that they went to a clinic for medical services and other types of medical centers were mentioned by 54 (29%) of respondents. Table 11 lists many of these health providers by name.

Table 11: Doctor and Health Care Visits

	Number	Totals	Percent
PCP Total		82	45%
PCP Named	56		30%
PCP Unknown	26		14%
Clinics Total		48	26%
Unknown Clinics	6		3%
AZ Pain Center, Cigna Medical	2		1%
B-Healthy Medical clinic	1		1%
Banner Health	14		8%
Blue Cross, Blue Shield Advantage	1		1%
BWUC	1		1%
Clinica de la Familia	5		3%
Community Care or Bridges at CASS Homeless Shelter	1		1%
Edward Medical Center	1		1%
Guadalupe Family Health	1		1%
Highland Medical	1		1%
Honor Health	4		2%
Mountain Park Health Center	5		3%
Pueblo Family Physicians	1		1%
South Central Clinic	1		1%
Southwest Network	1		1%
Southwest Women's Center	1		1%
Wesley Community Service	1		1%
Other Named Medical Centers Total		54	29%
John C Lincoln	1		1%
Maricopa Medical Centers	37		20%
St. Joseph's Medical Hospital	4		2%
St.Lukes	1		1%
Terros	1		1%
VA Clinic & Hospital	8		4%
Valle del Sol	1		1%
Walmart, CVS, Walgreens	1		1%
Total	184	184	100%

* Percentages may not add up to 100 based on the numbers that were provided

Housing and Smoking

This section outlines the answers regarding *housing and smoking* among the survey respondents.

Smoking in Home. The majority of respondents (93%) had not had individuals smoke inside their home in the past three months, and 93% never have anyone smoke inside their home. A few (8) respondents reported having individuals smoke inside their home daily. One respondent had a person who weekly smoked in their home. Two reported smoking occurring monthly, and ten individuals reported smoking inside the home occurring less than monthly.

Housing Unit Smoking Rules. The majority of respondents (88%) reported that no one is allowed to smoke anywhere inside their home. Five percent reported that smoking/tobacco use is permitted in some place or at sometimes inside their home. Three percent reported that smoking/tobacco use is permitted anywhere inside their home. Five percent did not know the rules pertaining to smoking/tobacco use.

Perceptions of Smoking Inside Housing Unit Rules. Nine percent of individuals felt smoking should be allowed inside all housing units or living areas while 22% believed it should be allowed inside some housing units. The majority (69%) felt it should not be allowed at all inside housing units.

Perceptions of Smoking in Common Areas Rules. Only 3% of respondents felt that smoking should be allowed in all indoor common areas and 11% believed smoking should be allowed in some indoor common areas. The majority (87%) felt it should not be allowed at all in any indoor common areas.

Exposure to Secondhand Smoke. The majority of respondents (57%) reported never being exposed to secondhand smoke. In addition, 16% reported rare exposure to secondhand smoke. About 14% reported sometimes being exposed, while 6% and 8% reported exposure often or all of the time, respectively.

Favorability of Smoke-Free Policy. The majority of survey respondents (65%) were in favor of a smoke-free policy within their housing complex. However, 25% were against such a policy, and 11% were not sure if they favored or did not favor such a policy. A subset of individuals ($n = 230$) responded to their thoughts regarding a partial ban. Indeed, 63% supported a full indoor and outdoor ban while 31% supported an indoor-only ban, and 6% supported an outdoor-only ban.

Focus Groups

Sample Characteristics

Three focus groups were conducted in August 2017. A total of 17 adults, ranging from 34 to 93 years (average = 59 years), participated in the discussions; however only 13 completed demographics forms. English was noted as the primary language for 75% of the participants, and 13% of the participants also spoke Spanish. Of respondents, two-thirds identified as female; approximately half were Hispanic/Latino and 42 percent White. About half had no more than a high school education or GED; two-thirds were widowed, separated or divorced. One-third were the parent of a minor child. Only 8% worked full or part-time, and half were retired. Two-thirds identified as non-smokers. AHCCCS was named as health insurance provider by 64% of the participants, and 73% indicated they had received routine medical care in the past 12 months. A summary of participant characteristics is shown in Table 12.

Table 12: Focus Group Participant Characteristics (n = 13)

Characteristic	Number	%
Gender		
Male	4	33%
Female	8	67%
Transgender	0	0%
Identifies as LGBTQ	1	10%
Race/Ethnicity		
American Indian/Alaska Native	0	0%
Asian/Pacific Islander	0	0%
Black/African American	0	0%
Hispanic/Latino	6	50%
White	5	42%
Preferred not to answer	1	8%
Education		
Less than high school	1	8%
High school or GED	5	42%
Some college or associate degree	5	42%
Bachelor degree or higher	1	8%
Marital Status		
Married	2	17%
Widowed, separated, or divorced	8	67%
Never married	2	17%
Living with partner	0	0%
Parent of child under 18	4	36%
Qualified for free/reduced lunch	4	36%
Employment		
Full-time	1	8%
Part-time	0	0%
Unemployed	0	0%
Retired	6	50%
Unable to work	3	25%
Volunteer	1	8%

Smoking Habits		
Smoker	4	33%
Non-smoker	8	67%
Health Insurance		
Arizona Health Care Cost Containment System/Medicaid	7	64%
Medicare	4	36%
Medigap or Medicare Supplement	2	18%
Arizona Long Term Care System	1	9%
Gotten Routine Medical Care in Past 12 Months	8	73%

Note: Due to some missing data (e.g., skipped or unanswered questions) and multiple response options, numbers do not always add to 13 or 100 percent. Percentages reported are calculated from the total number of participants who answered that specific question.

Neighborhood

Participants were asked to mention something they liked about their neighborhood that mattered to them as a way to begin the discussion of what did and did not work in their environment. Several major themes existed.

- Stores/Shopping: Grocery store, shops nearby, bank, restaurants, Family Dollar store
- Services: Church, hospital across the street, doctor
- Transportation: Bus line close by, van takes us to grocery store
- People: People accepted people for who they are, gathering places, family, friends

Awareness and Utilization of ASHLine/Medical Care

There remains room for increased *awareness and utilization of ASHLine*.

ASHLine Awareness. The majority of interviewed individuals had heard of ASHLine ($n = 8$).

ASHLine Utilization. Only two individuals had used ASHLine’s services in the past.

Three of the focus group participants who did not currently smoke were smokers in the past.

One individual commented that there were “Very nice people at the ASHLine,” but that the service did not work for them, because they were addicted still to smoking cigarettes.

The individuals in the focus groups mentioned three places they received medical care:

- Primary care doctor
- Cigna
- Maricopa County clinics

Reactions to Smoking

Focus group participants were asked to respond to the prompt, *When I say ‘smoking’ what is the first thing that comes to mind?* Key reactions focused on perceptions of smoking, smokers and smoking areas.

Perceptions of Smoking. One smoker described that smoking goes well with coffee. Another individual mentioned that smoking is very bad for you, but it is not going to change overnight. Another individual noted that they did not want to be around people who smoked. Two individuals commented that they do not like being around people who smoke because of the smell.

One participant did not see smoking as a problem. People smoking did not bother other participants. They noted that they had not seen people smoke inside their building.

Perceptions of Smokers. Men and women and young and older persons were equally likely to be seen as smokers, despite one individual commenting that you can “tell who the smokers are.” One individual lamented that his/her son had started smoking despite smoking related deaths (e.g., lung cancer) in the family. Another noted the connections between smokers and sicknesses like asthma and cancer. Additionally, one person described smokers as contaminated individuals with smelly hands. Furthermore, another individual was concerned that people shared cigarettes and worried about them contracting tuberculosis or hepatitis. Finally, one person noted, “I don’t know exactly what they smoke [when they smoke].”

Perceptions of Smoking Places. It was noted that individuals smoked in the parking lots or outside their apartments on their balconies. Another noted that people ignored smoking policies.

Reasons for Smoking

Multiple participants noted that people continued to smoke out of habit or addiction. Others noted smoking was used for comfort or to calm one’s nerves. Peer pressure, pleasure, and apathy were also mentioned. One individual noted that smoking started when in the army as it came with the food.

Reasons for Quitting Smoking

Participants indicated that individuals might quit because they stop denying the risks, especially once they are more conscious of the risks. Other reasons for quitting were lack of money and the unnecessary stress smoking creates.

Another person noted that serious events might give individuals a wake-up call to quit smoking. One person quit smoking at the same time as quitting drinking. Another person commented, “Just one day I woke up and didn’t want it anymore.” People mentioned they tapered themselves off smoking and the cravings faded. Two individuals never tried to quit and did not want to try to quit.

Difficulties with Quitting

- One individual noted that if people smoke, they have chosen it, and usually started smoking before they knew it was bad.
- Another commented, “I have been here for six years and those that need to smoke, need to smoke.”
- It was noted that smoking can be a coping mechanism to help individuals deal with daily problems, so they often give up on quitting after a few days.

- Smoking was noted as an addiction.
- One person noted that the only time individuals do not think about smoking is when they are asleep.

Resources to Quit

The focus group participants identified a number of resources individuals can use to quit. The following were mentioned:

- Smokers' hotline (e.g., ASHLine)
- Nicotine gum
- Nicotine patch
- E-Cigarettes
- Seek doctor's advice
- One-on-one or group meetings

One individual noted not being able to use nicotine aids because of heart issues. Another individual noted not knowing what resources were available. It was mentioned that individuals need to be provided with resources to understand the harm smoking causes. Finally, one person stated that individuals should try giving up smoking during the Christian season of Lent.

Smoke-Free Policy Comments

Smokers in the group displayed a strong degree of defiance of the policies. One individual commented, "Policies are bullshit." Another commented that it is "too hot to be smoking on a parking lot in 120+ degrees, [and] should be grandfathered in for no smoking policy." Further, one commented that individuals "don't want to be told what to do; we're not hurting anyone but ourselves." One person remarked, "If they start buying my cigarettes then they can tell me to quit." Another person would rather smoke in the car than on the street.

Smokers wanted to be able to smoke on the patio, but did worry about the heat. One elderly person commented regarding the policy, "Enough is taken away at this age." One person stated that you could "even smoke in prison." Another thought the patio would be fine as long as the door is kept closed. Nonsmokers noted concerns that smoke will come in through their vents.

Another person commented that they would not ordinarily smoke in front of a nonsmoker. This person thought the smoke-free policy to be pointless. Another found the current smoke-free policy to be pointless, because no one followed it. Another did not feel it was bad policy commenting that other housing places are smoke-free outside, but individuals could smoke inside. Finally, one individual questioned, "Who initiated the smoke-free policy?"

Potential Smoking Cessation Programs

One individual would not want to be part of a cessation program. Another commented, "If they want to smoke let them smoke, they're over 21- there's nothing else you can do - you can't be around them all the time." A lack of faith for the success of such programs was expressed.

- Participants put the onus of quitting on the individual.
- One commented, "If somebody wants to quit, they will find a way."
- Another commented, "I have 15% of my lungs left and have emphysema, and I still smoke."

- One person stated, “Just give me a cigarette, I am happy.”
- Another person remarked, “I want a cigarette now just talking about it.”
- One more person believed, “You can quit if you want.”
- Furthermore, someone said, “If they want to smoke let them smoke – only hurting themselves.”

In the focus groups, some potential interventions were noted:

- Keep yourself occupied / keep people busy
- Individual and group meetings (~ once a month) for people who want to quit
 - One person suggested a support system like alcoholics anonymous
- Nicotine patches
- An intergenerational program connecting youth and older adults
- Leave information by the door, like a flyer

Additional comments.

Individuals commented that programs and resources needed to be sensitive and nondiscriminatory. They also felt that neighbors gossiped a lot.

Finally, one person felt it was unsafe for people to smoke outside after dark; there was recent crime in the neighborhood.



Discussion of Findings

The purpose of this Whitepaper was to determine how best can the Arizona Department of Health Services, Bureau of Tobacco and Chronic Disease (ADHS/BTCD) capitalize on the opportunity of the HUD final rule to assist disparate populations in Maricopa County quit smoking. In examining that overall issue, these specific questions were answered from the findings:

1. What percentage of Maricopa County public housing residents smoke?

In this survey of 336 public housing residents, 25% of respondents identified as current smokers. This is higher than the U.S. rate of 15%. The finding of age and children in the homes was not significant in our study. However, smokers were from disadvantaged or lower socio-economic groups, which should not be surprising given that they were public housing residents.

While the focus groups represented only a small number of people ($n=13$), 33% of focus group respondents were current smokers, similar to the finding in the Helms, King and Ashley (2017) study. Additionally, the significant link between non-Hispanic white persons and smoking as a finding of the research by Helms, King and Ashley (2017) was consistent with this study's findings.

2. What percentages of public housing properties have started or implemented the smoke-free policy throughout Maricopa County?

The new smoke-free policy went into effect for City of Phoenix as of July 1, 2017. There were 26 properties reviewed for this study, either managed or contracted by the City of Phoenix and the Housing Authority of Maricopa County (HAMC). The City of Phoenix and HAMC had 13 properties each (2,481 units and 452 units respectively) for a total of 2,933 possible households.

The large majority (96%) of the public housing sites (except one, at the time of the interview) were completely smoke-free according to the HUD final rule. All properties had some form of a smoke-free policy implemented despite resistance from clients. The properties that expressed the most challenges with rule enforcement were public housing properties that served seniors and people with disabilities. Regardless of the policy, residents "do what they want to do."

3. What percentage of public housing residents are aware of or use ASHLine services?

ASHLine Awareness. The majority of surveyed individuals had not heard of ASHLine (54.5%), and 45.5% of individuals surveyed had heard of ASHLine.

ASHLine Utilization. Only 5% ($n = 16$) of survey participants had used ASHLine's services in the past.

4. Where do public housing residents routinely get their medical care?

Public housing residents utilize a variety of medical services. Of those surveyed, 78% (n=229 of 292) reported having received routine medical care in the past 12 months. Many residents indicated that they did get regular medical care in the last 12 months, 184 respondents provided some categorization of who provided this care. Some indication that they visited a primary care physician was provided by 82 respondents (45%). Many respondents (48), 26% mentioned that they went to a clinic for medical services and other types of medical centers were mentioned by 54 (29%) of respondents. Table 10 lists many of these health providers by name.

Often, decisions for medical care depend upon factors such as type of insurance, access to transportation to a provider, level of trust and cultural sensitivity. The Arizona Health Care Cost Containment System (AHCCCS) provides insurance for 193 individuals (67% of 288 respondents) with 96 individuals, (33%) reported using Medicare as well. Only 24 respondents reported working either full or part-time, and thus only 12 individuals reported having employer-provided health insurance.

Federally Qualified Health Centers (FQHCs) outreach specifically to public housing residents/communities. FQHCs try to build rapport/networks with other community organizations for referral purposes. However, FQHCs have difficulties reaching their populations of interest. Individuals in need tend to come in for healthcare only when they are very sick and exhausted all other resources. They often do not know what services are available to them. There is a lack of health literacy in general.

5. How many FQHCs (and look-alikes) in Maricopa County currently refer to ASHLine?

FQHCs serve low SES, homeless and clients that live in public housing as one of their populations. Some FQHCs identify smoking behaviors during intakes/screenings, while others have mobile clinics and bus services that go to some public housing sites. Typically, when clients are screened and identified as smokers, FQHCs refer them to services and clinics. Some FQHCs have identified that the process of asking clients about their smoking behavior is uncomfortable for the clinician.

ASHLine is used as a referral but does not receive large volumes of calls from public housing individuals. Some of these may be referrals from the FQHCs; however, neither the FQHCs nor ASHLine capture or follow-up of clients referred. FQHCs are unsure how many clients have been referred and how many are using their services.

6. Research and make recommendations to identify the best ways to reach public housing residents with the intent of providing smoking cessation activities, including ASHLine.

Meeting people where they are was a common theme, as was being culturally sensitive to various needs of individuals and groups. Outreach strategies should target specific places and target groups with individual messages.

There remains a lack of awareness regarding ASHLine and other smoking cessation services available for free to individuals. Reaching the population where they are and when they are interested would require expanding ASHLine to residential housing and places where resource insecure populations tend to go (i.e. food banks) and expanding services to be available 24/7; more workers and funding for staffing to provide those level of services for ASHLine.

Helping people to navigate the healthcare system was a repeated message. Navigating the system is difficult but providing assistance could help public housing residents learn of services available, and would be especially helpful for targeted groups such as non-English speakers, Native Americans, girls and women, LGBTQ persons, and other underserved groups. Since many residents did visit a healthcare facility or provider, assuring that these providers and doctors have materials and the impetus to address cessation with their clients could help reach additional individuals.

7. Survey of HUD residents: Questions should include the following: If residents want to quit, what onsite assistance would they find most helpful - smoking cessation groups, quitline, online course, free patch, gum or text communication?

There is often an assumption that once individuals (public housing or otherwise) are 'educated' about the hazards of smoking, they will want to quit and seek cessation services. This study determined that although that may be the case for some public housing residents, there were many residents who lack a desire to quit smoking and many others who had issues (e.g. mental health problems), including health-related concerns (e.g. medication costs or chronic diseases), that took priority over smoking.

Of the 56 individuals who made attempts at quitting smoking, quitting 'cold turkey' was the most popular strategy for quitting followed by nicotine replacement therapy; similar strategies were the preferred methods of those who made attempts at quitting e-cigarettes and other tobacco. There were 71 participants who responded about influential persons, places, or communities that motivated them to quit; most influential was the doctor/healthcare practitioner followed by housing facility and third most popular was online.

Focus group participants also identified helpful resources and mentioned the smokers' hotline (e.g., ASHLine), nicotine gum, nicotine patch, e-cigarettes, seeking doctor's advice, and one-on-one or group meetings. They also mentioned not knowing what resources were available. However, when asked about potential cessation programs, the most common answer was that it varied by individual and that one must want to quit before any service becomes relevant. Also important was that programs and resources needed to be sensitive and nondiscriminatory.

8. Where are the Maricopa County FQHCs (and look-alikes) located in proximity to public housing?

- Maps are presented in Appendix A.
- Lists of resources including medical clinics are presented in Appendix B.

9. What kind of technical assistance do public housing officials need with smoke-free policy (implementation, compliance, enforcement, eviction)?

Since the smoke-free policy went into effect in the city of Phoenix on July 1, 2017, (with others to follow) it has been implemented at most sites, but enforcement is uneven. All properties had some form of a smoke-free policy implemented despite resistance from clients. Regardless of the policy, residents "do what they want to do."

It was difficult for officials to know to what degree to enforce the policy; some properties placed the smoke-free policy and enforcement at equal priority to other policies. But knowing that enforcement could lead to evictions was difficult for some officials because these residents do not have anywhere else to go and are already one of the most vulnerable populations.

Staff persons still remain unsure how to prove that their residents are smoking inside their apartments; they are particularly concerned about the elderly and disabled. They also are unsure about how many violations must occur before residents are/should be evicted. They wonder if fines are better than evictions, while also feeling that individuals are going to smoke regardless of the smoke-free policy.

Forcing people to stop smoking is impossible and impractical; cessation services would not work for those individuals who blatantly responded that they were not motivated to quit and indeed had the 'right' to continue smoking.

Officials also need to know how to get residents to stop smoking in housing units. While implementing cessation programs on-site is one strategy, resident enrollment in cessation programs off-site was difficult for many due to lack of affordable or consistent transportation, or needing to attend many sessions when other appointments interfered.

Some staff work with residents to agree on a designated smoking area, but this can be challenging when such a space does not already exist. Having a designated smoking area would also seem to help, but these need to be near-by and perceived as safe; safety of being outside after dark was an expressed concern of residents.

Public housing staff noted that they need to have persistent dialogue with their residents, but efforts can be made when individuals move in and during their time in the housing units. New residents could be provided with smoking cessation materials with their move-in packets.

Regarding events, public housing staff persons have noted that advertising the day of or day before sometimes works at attracting residents. Incentives and prizes for attending events have also worked to get residents motivated to come to educational classes.

Public housing staff also emphasized reaching out to community agencies to help provide services to clients.

10. SIRC staff are prepared to present findings of this Whitepaper to a variety of audiences.
11. Recommendations for cessation are provided in the next section.

Recommendations

Findings from this study and Whitepaper guide the proposed recommendations and strategies by which ADHS/BTCD can best capitalize on the opportunity of the HUD final rule smoke-free policy to assist disparate populations in Maricopa County to quit smoking. These recommendations provide possible steps that can be taken at multiple levels – individual, organization, and environmental – to impact smoking among the public housing population, and other underserved groups, in Maricopa County.

Provide direct services to public housing residents

At the individual level, various social, cognitive and behavioral therapies are available, yet two major problems exist: motivating people to want to quit and getting them the services appropriate to their needs.

Many individuals expressed a lack of motivation or desire to quit smoking. Long-term smokers are more stubborn about quitting. Only 25% (n=74) of the public housing population were current smokers; 63 people responded about plans to quit of which 21 people replied “no plans” and 42 people indicated they were planning to quit. Decisions will need to be made about how to target these people spread across multiple properties.

Lack of funds prevents individuals from affording smoking cessation medication and other medical programs. Informing residents about opportunities from ASHLine, or making more information available to them about possible insurance and AHCCCS coverage of medical, behavioral and pharmacotherapies that are affordable may be needed. Health navigators are excellent at helping to provide this type of information, some of their services do cost but there are services such as, Keogh that are free.

Residents often expressed that they wanted to felt respected, welcomed, and supported, but not told how to live in their own homes. Finding messages that can translate the health benefits of smoke-free policies and cessation programs (carrot) without threatening privacy or loss of home (stick) for smoking violations will be an upcoming challenge to be overcome in impacting this population.

The public housing population said they respond well to word of mouth and personalized messages as well as to one-on-one invitations.

Social support systems are important to many aspects of healthy living and could be an important vehicle for providing cessation services and building support for the smoke-free policy. Creating opportunities to bring residents together in formal (educational) or informal (celebrations) can set the stage for delivery of messages on health and smoking topics.

Transportation services are needed for residents that are reliable at low or no cost. Whether it is going to a doctor or medical appointment, cessation program, or grocery store, the provision of these services shows residents that their needs are being addressed.

Providing safe, well-lit places for those who choose to smoke is also recommended. There is no policy that has full enforcement to alleviate smokers from their properties. While

providing a designated smoking area may not be a preferred policy, neither is endangering residents thus an alternative or compromise must be determined.

Helping people to navigate the healthcare system was a repeated message.

Provide support services to housing staff

Like the residents, the officials often lack information about the specifics of services or the services available. For officials to know what services are provided by the ASHLine, including phone and nicotine replacement therapy twice a year, would be helpful.

Staff also need to know what other medical and cessation services are nearby to which they can refer residents. Recruiting local navigators or health clinics to visit on-site or leave brochures door-to-door might begin to spread the word about programs and services available.

Public housing staff should be provided with training in cultural competence and sensitivity to all people and standards for such behaviors should be the expected norm.

Guidelines on policy enforcement should be discussed with all public housing staff including specific procedures. As it was difficult for officials to know to what degree to enforce the policy, staff need to know in what areas they have flexibility.

Provide support services to ASHLine and other health provider staff

Involving primary care providers, other health providers and health insurance coverage information will encourage cessation as many public housing residents do get routine medical care. To encourage the participation of providers, providing incentives, such as the ability to charge/bill for such services, may be necessary.

Additional means to help people navigate the healthcare system was a major theme and this assistance could take many forms including the provision of navigators, cross-training of those already in the systems who are the front-line or secondary liaisons, or the expanded use of media based educational systems.

Support services and health related staff should be provided with training in cultural competency and sensitivity to all people and standards for such behaviors should be the expected norm.

Staff persons need to work a little harder to reach and assist underserved populations. This is especially true Native Americans, girls and women, LGBTQ persons, and other underserved groups as well as for non-English speaking and refugee populations, those with language barriers and work with community partners that provide interpretation services.

ASHLine, if it to be utilized more by the public housing population, needs to better target and distribute its message and make its services better known. A top-down approach was deemed best by the key informants to get buy-in from senior provider leaders. More staffing, and improved messages were key recommendations along with extended hours and enhanced cultural sensitivity.

FQHCs had recommendations for overcoming the barriers mentioned. These included: finding resources to address barriers like transportation; extending hours; offering mobile clinics and offering breakfast have helped to bring clients in to get care; promoting themselves better via word of mouth; developing peer support services; getting staff out in the community to find out why individuals are not engaged; providing a sliding e-scale on which to charge clients for services based on their income; trying to reach individuals where they are at (e.g., churches, community centers); and expediting services once people get in the door.

The FQHCs had other suggestions for improving services and giving their clients more hope. They desired to connect clients and teach them how to take care of themselves to be self-sufficient (e.g., budgeting). Housing needs are the ultimate self-sufficient strategies, but clients need to know and learn how to maintain their housing and pay their rent among other things. FQHCs could also teach clients how to access help in various and creative ways.

FQHCs highlighted the importance of follow-up post treatment. Smoking support groups were seen as helpful. Clients need a support system to change their mentality in order to quit the substance. They also need a better routine.

Providing a variety of pharmacotherapies and cognitive-behavioral therapies is also a necessary part of cessation services. Bringing together the health and housing providers can help to target the public housing residents to assure personalized, affordable services.

Implement new policies or procedures

Comprehensive Tobacco Policies also known as CTPs have managed to decrease significantly the frequency of smoking in certain populations. In several states “demoralization” has been inserted as an element of CTPs. This helps to transform the perception of smoking into a socially unacceptable activity.

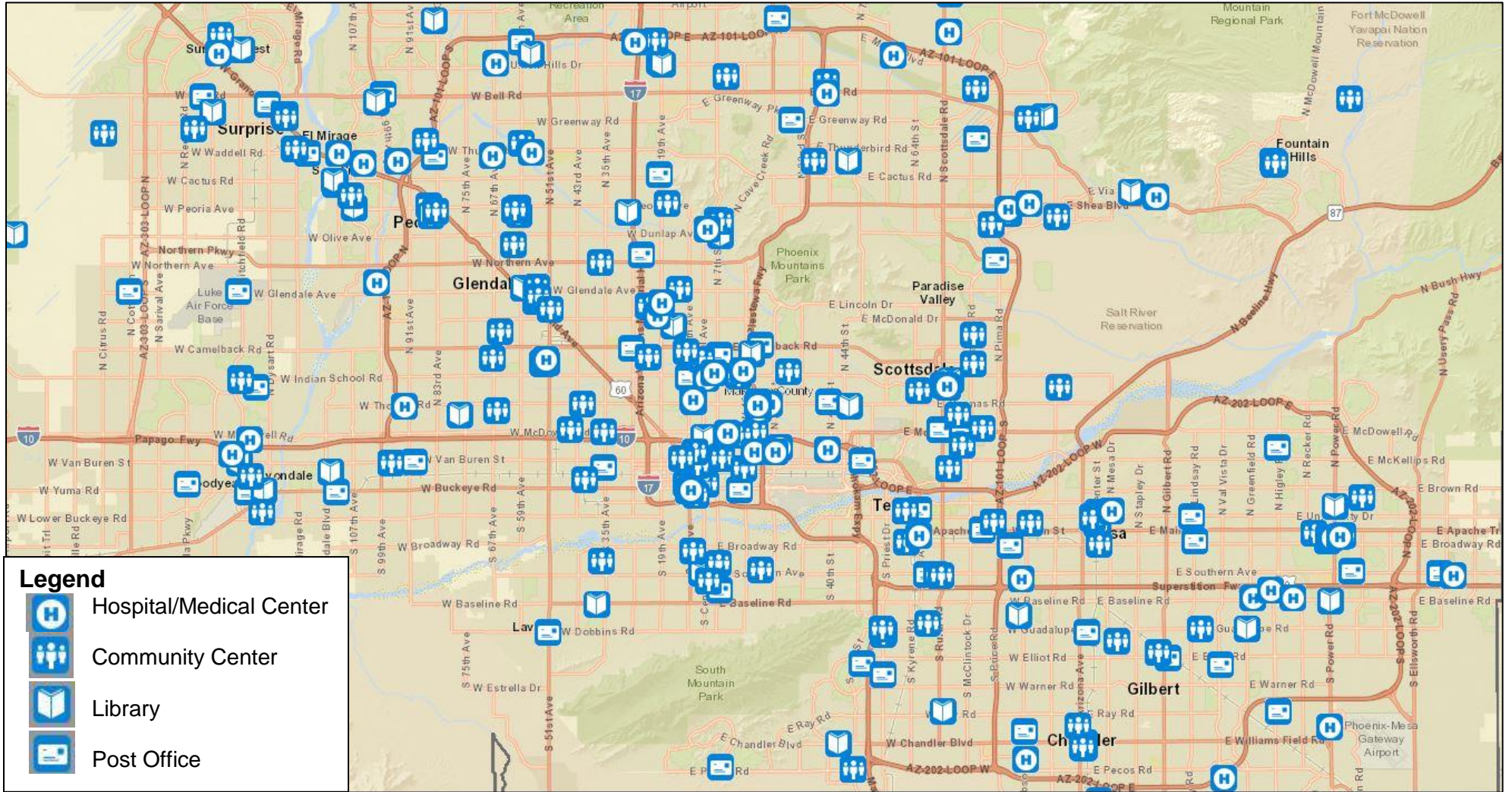
Multiple approaches are needed: advocating for evidence-based interventions, prevention programs, and control measures, such as smoke-free policies will send consistent messages to policy makers about the need for all of these strategies as part of the community and public health approach.

Tax increases and smoking policies would be great, because they educate the public of the harm of smoking and encourage them to quit or seek resources to help them. The likelihood of such strategies lies in the jurisdiction to which it is applied; often municipal, county level approaches can be enacted more easily than state-level policies.

Appendices

Appendix A - Maps

Maricopa County



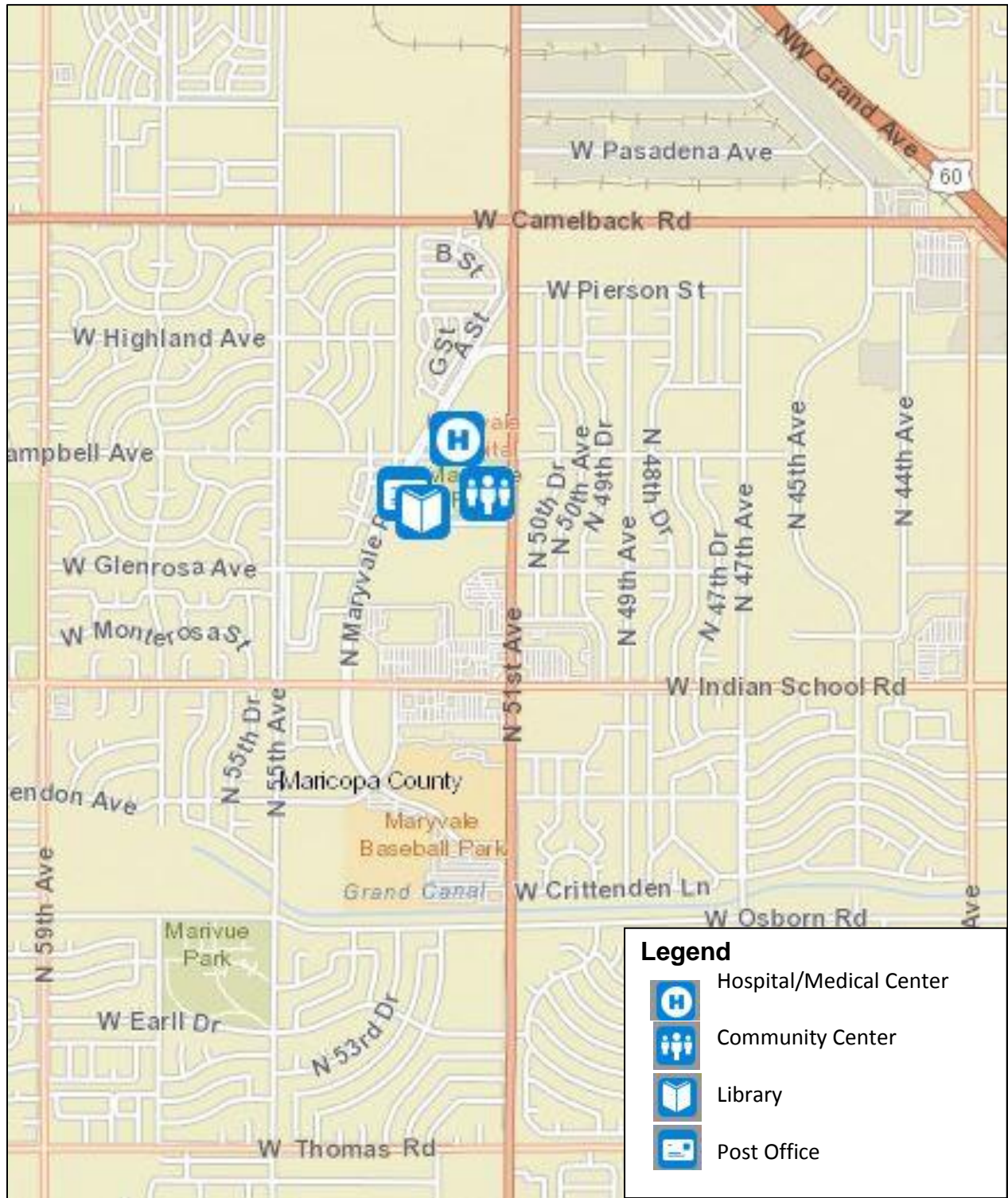
Map by Maricopa Association of Governments, 2016, Maricopa County

West Valley - Avondale, El Mirage, Peoria, Surprise



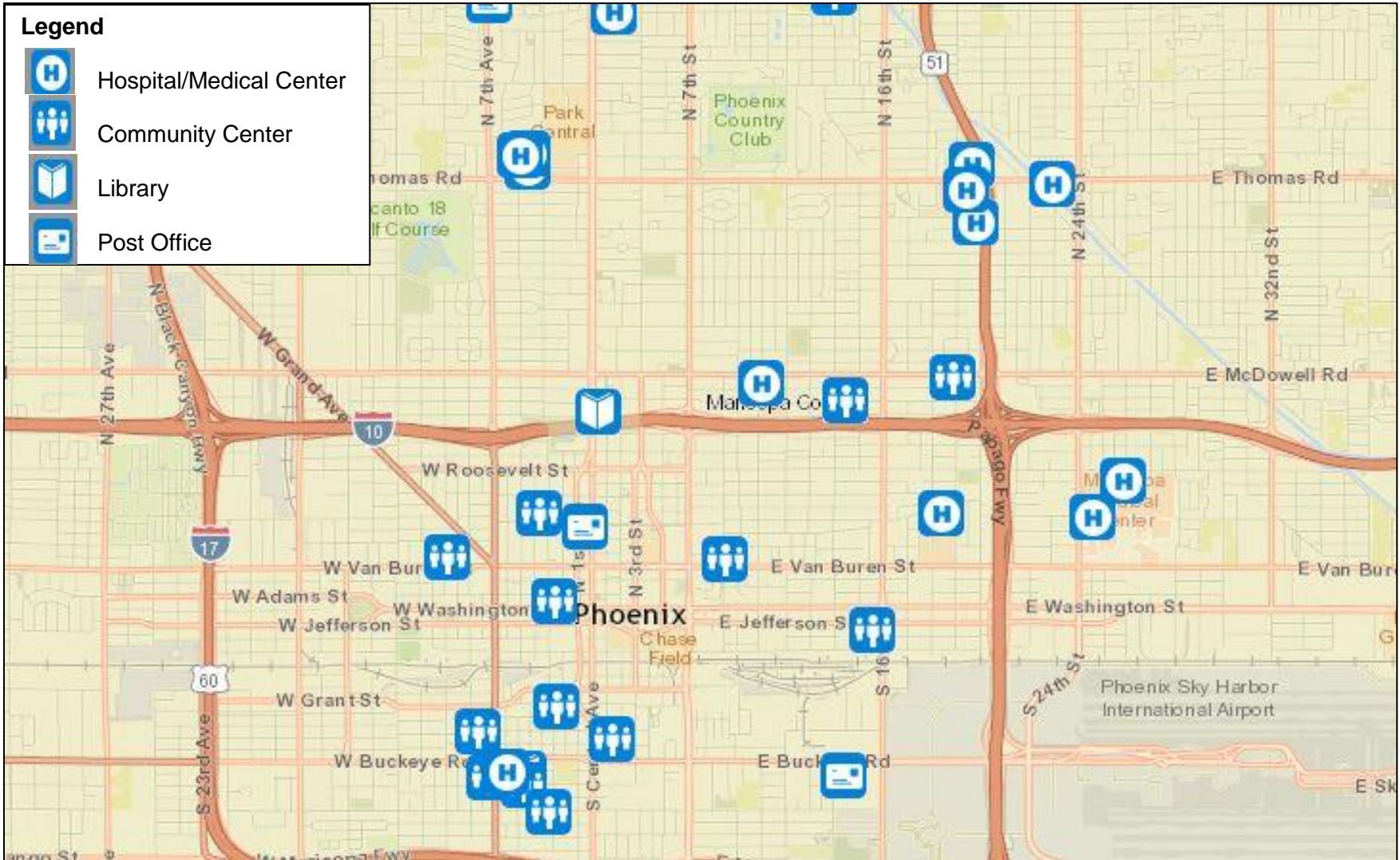
Map by Maricopa Association of Governments, 2016, West Valley (Avondale, Surprise, El Mirage, Peoria)

Maryvale Parkway



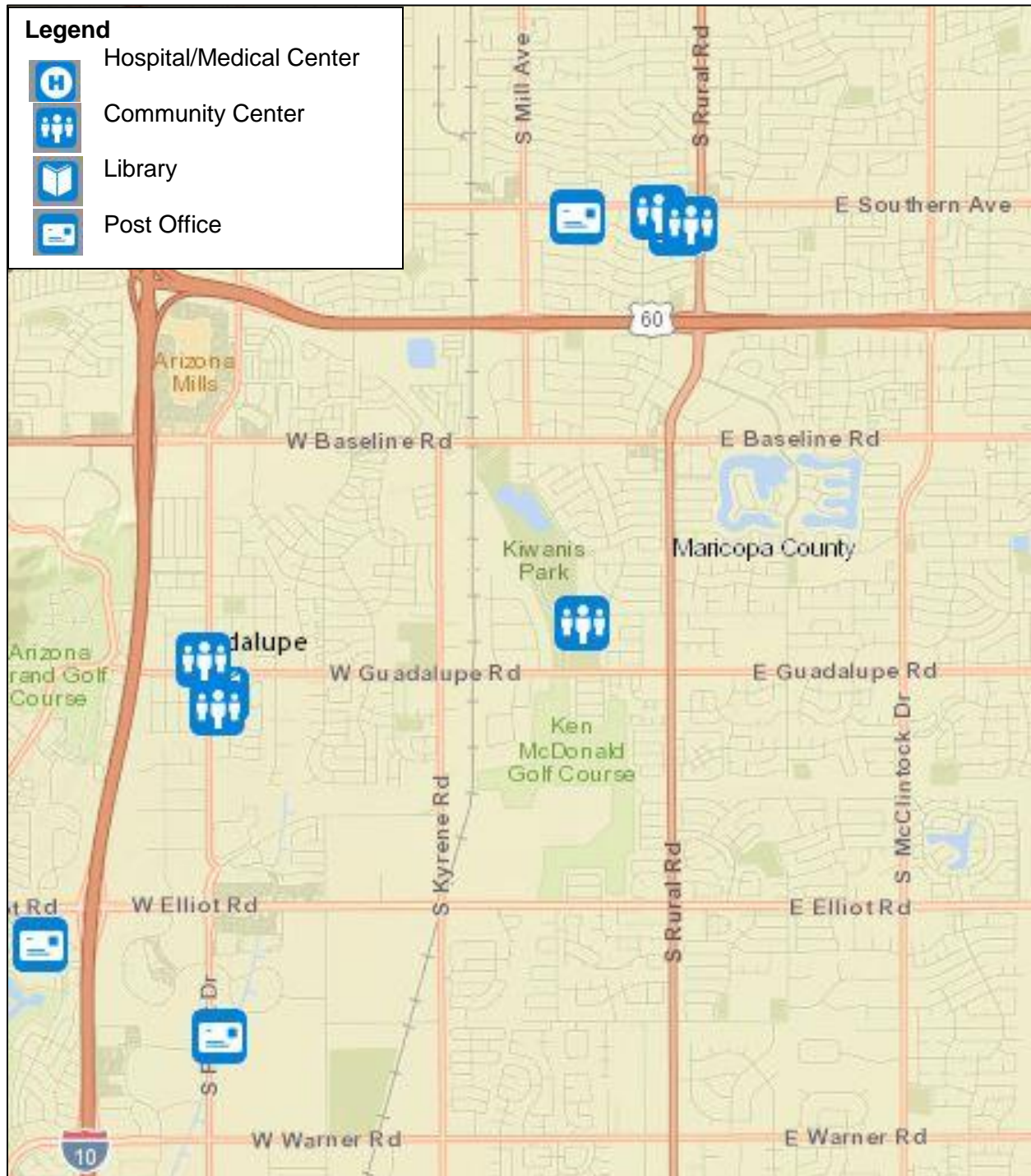
Map by Maricopa Association of Governments, 2016, West Valley (Maryvale Parkway)

Central Phoenix



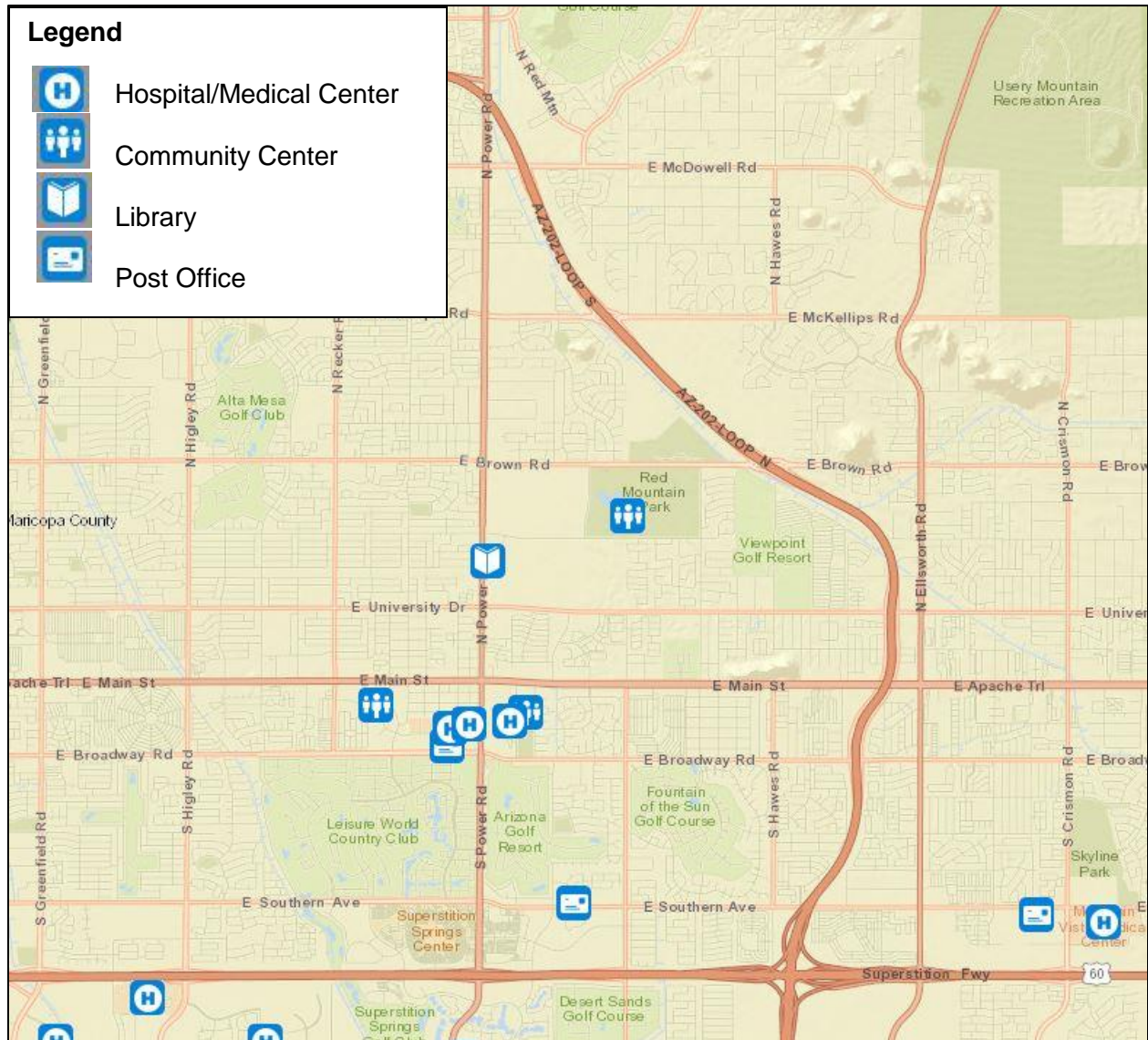
Map by Maricopa Association of Governments, 2016, Central Phoenix

Guadalupe



Map by Maricopa Association of Governments, 2016, Guadalupe

East Mesa



Map by Maricopa Association of Governments, 2016, East Mesa

Appendix B – Resource List

Phoenix		
Community Centers		
Central Park Recreation Center	140 E Tonto St	Phoenix
City of Phoenix Senior Services	200 W Washington	Phoenix
Eastlake Park Community Center	1549 E Jefferson St	Phoenix
Grant Recreation Center	701 S 3rd Ave	Phoenix
Harmon Recreation Center	1425 S 5th Ave	Phoenix
Marcos De Niza Senior Center	305 W Pima St	Phoenix
McDowell Place	1845 E McDowell	Phoenix
Native American Senior Center	1325 N 14th St	Phoenix
Salvation Army Laura Danieli Senior Center	613 N 4th Ave	Phoenix
Senior Opportunity West	1220 S 7th Ave	Phoenix
University Park Recreation Center	1002 W Van Buren St	Phoenix
Verde Park Community Center	916 E Van Buren St	Phoenix
Vernell Coleman Recreation Center	830 W Tonto St	Phoenix
Hospitals/Medical Centers		
Arizona Heart Hospital	1930 E Thomas Rd	Phoenix
Arizona Heart Institute	2632 N 20th St	Phoenix
Arizona State Hospital	2500 E Van Buren St	Phoenix
Banner Good Samaritan Center	1111 E McDowell Rd	Phoenix
Barrow Neurological Institute at St Josephs	350 W Thomas Rd	Phoenix
Kindred Hospital - Phoenix	40 E Indianola Ave	Phoenix
Los Ninos Hospital	2303 E Thomas Rd	Phoenix
Maricopa Medical Center	2601 E Roosevelt St	Phoenix
Phoenix Childrens Hospital	1919 E Thomas Rd	Phoenix
Promise Hospital of Phoenix	1201 S 7th Ave	Phoenix

Smoking Cessation Whitepaper

Select Specialty Hospital - Phoenix	350 W Thomas Rd	Phoenix
St Josephs Hospital and Medical Center	350 W Thomas Rd	Phoenix
St Lukes Medical Center	1800 E Van Buren St	Phoenix
Libraries		
Phoenix Library	1221 N Central Ave	Phoenix
Phoenix Library	1325 S Fifth Ave	Phoenix
Post Offices		
USPS - Phoenix Downtown	522 N Central Ave Lbby	Phoenix
USPS - Phoenix Osborn	3905 N 7th Ave	Phoenix
USPS - Phoenix Rio Salado	1441 E Buckeye Rd Lbby	Phoenix

East Mesa		
Community Centers		
Discovery Point Retirement Community	6210 E Arbor Ave	Mesa
Jefferson Recreation Center	120 S Jefferson St	Mesa
Red Mountain Active Adult Center	7550 E Adobe St	Mesa
Red Mountain Multigenerational Center	7550 E Adobe St	Mesa
Hospitals/Medical Centers		
Arizona Spine and Joint Hospital	4620 E Baseline Rd	Mesa
Banner Baywood Heart Hospital	6750 E Baywood Ave	Mesa
Banner Baywood Medical Center	6644 E Baywood Ave	Mesa
Banner Gateway Medical Center	1900 N Higley Rd	Gilbert
HealthSouth East Valley Rehabilitation Hospital	5652 E Baseline Rd	Mesa
Mountain Vista Medical Center	1301 S Crismon Rd	Mesa
Restora Hospital of Mesa	215 S Power Rd	Mesa
Libraries		
Mesa Library	2055 S Power Rd, Suite 1031	Mesa
Mesa Library	635 N Power Rd	Mesa
Post Offices		
USPS - Mesa Desert	6644 E Broadway Rd	Mesa
USPS - Mesa Falcon Field	5155 E Eagle Dr	Mesa
USPS - Mesa Four Peaks	9855 E Southern Ave	Mesa
USPS - Mesa Superstition Springs	7316 E Southern Ave	Mesa

East Valley - Tempe/Guadalupe		
Community Centers		
Edna Vihel Community Center	3340 S Rural Rd	Tempe
Guadalupe Senior Center	9401 S Avenida del Yaqui	Guadalupe
Guadalupe Youth Center	9050 S Avenida Del Yaqui	Guadalupe
Kiwanis Park Recreation Center	6111 S All America Way	Tempe
Pyle Adult Center	655 E Southern Ave	Tempe
Libraries		
Maricopa County Library	9241 S Avenida Del Yaqui	Guadalupe
Tempe Library	3500 S Rural Rd	Tempe
Post Offices		
USPS - Phoenix Ahwatukee	11010 S 51st St	Phoenix
USPS - Tempe	233 E Southern Ave	Tempe
USPS - Tempe South Station	8205 S Priest Dr	Tempe

West Valley - Avondale, Peoria, Surprise, El Mirage		
Community Centers		
Avondale Community Center	1007 S 3rd St	Avondale
Avondale Community Center - Active Adults	1007 S 3rd St	Avondale
Desert West Community Center	6501 W Virginia Ave	Phoenix
El Mirage Senior Center	14010 N El Mirage Rd	El Mirage
Glendale Adult Center	5970 W Brown St	Glendale
Glendale Adult Center	5970 W Brown St	Glendale
Glendale Community Center	5401 W Ocotillo Rd	Glendale
Goodyear Community Center	420 E Loma Linda Blvd	Goodyear
Holiday Park Recreation Center	4560 N 67th Ave	Phoenix
Japanese Senior Center	5414 W Glenn Dr	Glendale

Litchfield Park Recreation Center	100 Old Litchfield Rd	Litchfield Park
O'Neil Recreation Center	6448 W Missouri Ave	Glendale
Olive Branch Senior Center	11250 N 107th Ave	Sun City
Peoria Community Center	8335 W Jefferson St	Peoria
Peoria Senior Center	8335 W Jefferson St	Peoria
Rose Lane Recreation Center	5003 W Marlette Ave	Glendale
Tolleson Senior Center	9555 W Van Buren St	Tolleson
YWCA Senior Center - Glendale	8561 N 61st Ave	Glendale
Hospitals/Medical Centers		
Banner Boswell Medical Center	10401 W Thunderbird Blvd	Sun City
Banner Estrella Medical Center	9201 W Thomas Rd	Phoenix
Banner Thunderbird Medical Center	5555 W Thunderbird Rd	Glendale
HealthSouth Valley of the Sun Rehabilitation Hospital	13460 N 67th Ave	Glendale
Kindred Hospital - Northwest Phoenix	13216 N Plaza Del Rio Blvd	Peoria
Restora Hospital of Sun City	13818 N Thunderbird Blvd	Sun City
St. Joseph's Westgate Medical Center	7300 N 99th Ave	Glendale
West Valley Hospital Medical Center	13677 W McDowell Rd	Goodyear
Western Regional Medical Center	14200 W Fillmore St	Goodyear
Libraries		
Avondale Library	495 E Western Ave	Avondale
Avondale Library	11350 W Civic Center Dr	Avondale
Glendale Library	7010 N 58th Ave	Glendale
Glendale Library	5959 W Brown St	Glendale

Maricopa County Library	10600 W Peoria Ave, Room 144	Sun City
Maricopa County Library	101 W Wigwam Blvd	Litchfield Park
Maricopa County Library	14011 N 1st Ave	El Mirage
Maricopa County Library	250 N Litchfield Rd, Suite 185	Goodyear
Peoria Library	8463 W Monroe St	Peoria
Phoenix Library	7602 W Encanto Blvd	Phoenix
Tolleson Library	9555 W Van Buren St	Tolleson
Youngtown Library	12035 N Clubhouse Square	Youngtown
Post Offices		
USPS - Avondale	401 W Western Ave	Avondale
USPS - Avondale Goodyear	875 S Estrella Pkwy	Goodyear
USPS - Cashion	1216 S 111th Dr	Cashion
USPS - El Mirage	11925 W Thunderbird	El Mirage
USPS - Glendale	5955 W Peoria Ave	Glendale
USPS - Glendale Downtown	6537 N 55th Ave	Glendale
USPS - Glendale Luke AFB	14032 W Mustang	Glendale
USPS - Litchfield Park	591 E Plaza Cir	Litchfield Park
USPS - Peoria	8380 W Emile Zola Ave	Peoria
USPS - Peoria Downtown	10700 N 85th Ave	Peoria
USPS - Tolleson	8805 W Van Buren St	Tolleson
USPS - Youngtown	11129 W Arizona Ave	Youngtown
Maryvale Parkway		
Community Centers		
Maryvale Community Center	4420 N 51st Ave	Phoenix
Hospitals/Medical Centers		
Maryvale Hospital Medical Center	5102 W Campbell Ave	Phoenix
Libraries		
Phoenix Library	4402 N 51st Ave	Phoenix
Post Offices		
USPS - Phoenix Maryvale	4415 N Maryvale Pkwy	Phoenix

Appendix C – Organizational Contacts

The following individuals contributed to this study either through participant recruitment, information distribution, key informant interviews, or scheduling of focus group venues.

Name, Title	Organization	City
Angela Hogan, Housing Supervisor	City of Phoenix, Housing Department	Phoenix
Anne Maiden, DO, FAAP, Chief Medical Officer and Pediatrician	Valle Del Sol	Phoenix
Ariadna Valentin, Service Coordinator	City of Phoenix, Housing Department	Phoenix
Carolyn Campbell, District Manager	Dunlap & Magee Property Management Inc.	Phoenix
Debra Sebastian, Housing Manager	City of Phoenix, Housing Department	Phoenix
Dennis Huff, Behavioral Health Administrator	Native Health	Phoenix
Diane Kochel, Property Manager	Housing Department of Maricopa County	Mesa
Diane Reifentahl, Housing Management	City of Phoenix, Housing Department	Phoenix
Dina Fernandez, Housing Supervisor	City of Phoenix, Housing Department	Phoenix
Gloria Munoz (previously Donna Ybarra, interviewed) Executive Director	Housing Department of Maricopa County	Phoenix
Doris Hudson, Service Coordinator	City of Phoenix, Housing Department	Phoenix
Francisco Blanco, Caseworker Services Coordinator	City of Phoenix, Housing Department	Phoenix
Gautam Aggarwal, MD	Native Health	Phoenix
Griselda Moreno, Property Manager	Housing Department of Maricopa County	Avondale
Heather Leeper, Property Manager	Housing Department of Maricopa County	Surprise
Janna Hami, MD Medical Director	Circle the City	Phoenix

Jeff Jirak	Maricopa County Healthcare for the Homeless	Phoenix
Jerianne Mackenzie, Housing Management	City of Phoenix, Housing Department	Phoenix
Joe Collins, Assistant Housing Supervisor	City of Phoenix, Housing Department	Phoenix
Karen Akin, MPA, Community Development Specialist	ASHLine	Tucson
Kay Daukei, Service Coordinator	City of Phoenix, Housing Department	Phoenix
Kerry Nickerson, BSN, RN, Clinical Program Manager	Adelante Healthcare	Phoenix
Kimberly Ostroe, Housing Manager	City of Phoenix, Housing Department	Phoenix
Krista Walker, MSW, Community Development Specialist	ASHLine	Maricopa County
Lorena Escalante Community Manager	City of Phoenix, Housing Department	Phoenix
Lydia Grieger, Housing Manager	City of Phoenix, Housing Department	Phoenix
Mary Ellen Williams, Property Manager	Housing Department of Maricopa County	Peoria
Michele Johnson, Resident Services Coordinator	Dunlap & Magee Property Management Inc.	Phoenix
Natalie Rumpff, Service Coordinator	City of Phoenix, Housing Department	Phoenix
Reina Hart, Assistant Property Manager	Housing Department of Maricopa County	Mesa
Ryan Reikowsky, MA, MPH, Manager, Community Development	ASHLine	Tucson
Shelli Ross, Senior Director	Arizona Alliance for Community Health Centers	Phoenix
Sonia Chavez, Service Coordinator	City of Phoenix, Housing Department	Phoenix
Torre Valentine, Prevention Manager	Terros Health	Phoenix
Tristan Villanova, Housing Manager	City of Phoenix, Housing Department	Phoenix
Veronica Grittman, Housing Manager	City of Phoenix, Housing Department	Phoenix

Smoking Cessation Whitepaper

William Emerson, Deputy Housing Director	City of Phoenix, Housing Department	Phoenix
Zona Pacheco, Coordinator Housing Supportive Services	City of Phoenix, Housing Department	Phoenix

Appendix D – Instruments: Surveys, Focus Groups, Key Informants

ADULT SUPPLEMENTAL QUESTIONNAIRE

----- SECTION 1: COMMUNITY/ENVIRONMENT -----

First, we would like to ask you some questions about your neighborhood and its surrounding area. Please mark the one answer that best fits your response.

Thinking about the neighborhood that you live in, please indicate how much you agree or disagree with the following statements. (Circle one answer for each statement)	Strongly Disagree	Disagree	Neither Disagree Nor Agree	Agree	Strongly Agree
It is safe being outside alone during the day and/or evening near our housing unit.	SD	D	N	A	SA
People in this neighborhood share the same values.	SD	D	N	A	SA
People around here are willing to help their neighbors.	SD	D	N	A	SA
This is a close-knit neighborhood.	SD	D	N	A	SA
On an average day, there is usually no tobacco-related litter, such as cigarette butts, empty packs, etc., in my neighborhood.	SD	D	N	A	SA
Secondhand smoke is not a problem in my neighborhood.	SD	D	N	A	SA
Smoking cigarettes is seen as harmful by my neighbors.	SD	D	N	A	SA
Smoking tobacco products other than cigarettes (e.g., cigars, cigarillos, pipes, hookah, smokeless or chewing tobacco, etc.) is seen as harmful by my neighbors.	SD	D	N	A	SA

----- SECTION 2: TOBACCO USE -----

Next are some questions regarding your use of tobacco-related products. Please mark the one answer that best fits your response.

1. **Have you ever in your lifetime used any tobacco products (e.g., cigarettes, cigars, cigarillos, pipes, hookah, smokeless or chewing tobacco, etc.) or e-cigarettes, even if it was just once?**
 - A. Yes
 - B. No (SKIP TO SECTION 6: GENERAL HEALTH)

ADULT SUPPLEMENTAL QUESTIONNAIRE

10. How long has it been since you completely stopped smoking cigarettes?

_____ (days/weeks/months/years)

11. Why did you quit smoking cigarettes? (Check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> To be healthier | <input type="checkbox"/> I was dissatisfied with being dependent on cigarettes |
| <input type="checkbox"/> Because of health related problems | <input type="checkbox"/> It is too expensive |
| <input type="checkbox"/> Because of concern for others' health (family/friends) | <input type="checkbox"/> It is too inconvenient |
| <input type="checkbox"/> Because of concern shown by others (family/friends) | <input type="checkbox"/> Other (please specify) _____ |

----- **SECTION 4: OTHER TOBACCO PRODUCTS** -----

12. When was the last time you used e-cigarettes or any tobacco product other than cigarettes (e.g., cigars, cigarillos, pipes, hookah, smokeless or chewing tobacco, etc.)? (Circle one)

- | | |
|--|--|
| A. In the past 30 days | C. Sometime in my lifetime but not in the past 12 months |
| B. In the past 12 months but not in the past 30 days | D. Never (SKIP TO SECTION 5: CESSATION MOTIVATION) |

13. How old were you when you first started to use e-cigarettes or tobacco products other than cigarettes (e.g., cigars, cigarillos, pipes, hookah, smokeless or chewing tobacco, etc.) regularly? (Circle one)

- | | |
|---------------------|---|
| A. Enter age: _____ | B. Never used e-cigarettes or a tobacco product other than cigarettes regularly |
|---------------------|---|

14. During the past 30 days, on how many days did you use e-cigarettes or any tobacco product other than cigarettes (e.g., cigars, cigarillos, pipes, hookah, smokeless or chewing tobacco, etc.)?

Approximate number of days: _____

15. In the past 30 days, were any of the e-cigarettes or any tobacco product other than cigarettes (e.g., cigars, cigarillos, pipes, hookah, smokeless or chewing tobacco, etc.) that you used flavored to taste like menthol or mint, clove, spice, candy, fruit, chocolate, or other sweets? (Circle one)

- | | | |
|--------|-------|---|
| A. Yes | B. No | C. Did not smoke any cigars in the past 30 days |
|--------|-------|---|

ADULT SUPPLEMENTAL QUESTIONNAIRE

16. Do you now use e-cigarettes or any tobacco product other than cigarettes (e.g., cigars, cigarillos, pipes, hookah, smokeless or chewing tobacco, etc.) every day, some days, or not at all? (Circle one)

A. Every day

b. How long have you been smoking on a daily basis? (Enter in years)

_____ years

B. Some days

C. Not at all

17. Around this time last year, were you using e-cigarettes or any tobacco product other than cigarettes (e.g., cigars, cigarillos, pipes, hookah, smokeless or chewing tobacco, etc.) smoking cigars, cigarillos, or little filtered cigars every day, some days, or not at all? (Circle one)

A. Every day

B. Some days

C. Not at all

18. How old were you when you first tried e-cigarettes or any tobacco product other than cigarettes (e.g., cigars, cigarillos, pipes, hookah, smokeless or chewing tobacco, etc.)? (Enter age)

_____ Years old

IF YOU DID USE E-CIGARETTES OR OTHER TOBACCO RELATED PRODUCTS BUT NO LONGER DO TODAY, PLEASE ANSWER QUESTION 19 AND 20. OTHERWISE SKIP TO SECTION 5.

19. Why did you quit using e-cigarettes or tobacco products other than cigarettes (e.g., cigars, cigarillos, pipes, hookah, smokeless or chewing tobacco, etc.)? (check all that apply)

To be healthier

Because of health related problems

Because of concern for others' health (family/friends)

Because of concern shown by others (family/friends)

I was dissatisfied with being dependent on cigarettes

It is too expensive

It is too inconvenient

Other (please specify)

20. About how long has it been since you completely quit using e-cigarettes or tobacco products other than cigarettes?

_____ (days/weeks/months/years)

ADULT SUPPLEMENTAL QUESTIONNAIRE

----- SECTION 5: CESSATION MOTIVATION/INTENT -----

21. Do you plan to quit smoking cigarettes? (Circle one)

- A. No plans to quit
- B. Yes, within the next month
- C. Yes, within the next 6 months
- D. Yes, within the next year
- E. Yes, at some point but not within the next year
- F. I do not smoke cigarettes

22. During the past 12 months, have you made a serious attempt to stop smoking because you were trying to quit – even if you stopped for less than a day? (Circle one)

- A. Yes
- B. No (SKIP TO SECTION 6: GENERAL HEALTH)

23. Thinking back to the last time you tried to quit smoking in the past 12 months, did you use any of the following: (Check all that apply)

- Telephone helpline/ counseling
- Online programs
- Self-help guides/other materials
- Brief help by a doctor/healthcare professional (such as when a doctor takes 10 mins. or less to give a patient advice)
- Prescription for non-nicotine medication (such as prescription medications like Zyban or Chantix)
- Quit “cold turkey”; without any help
- Nicotine replacement therapy (such as nicotine gum, patches, inhalers, sprays, and lozenges)
- Individual or group in-person counseling
- Behavioral therapy (such as training in problem solving)
- Hypnosis
- Acupuncture
- Laser therapy
- E-cigarettes/Other tobacco products
- Other: _____

24. Have you ever used the electronic cigarette (e-cigarettes) to help you stop smoking? (Circle one)

- A. No, I have never used it
- B. Yes, I have used it in the past but no longer use it
- C. Yes, I occasionally use it but not daily
- D. Yes, I use it everyday

25. Have you ever used any other tobacco products other than e-cigarettes (e.g., cigars, cigarillos, pipes, hookah, smokeless or chewing tobacco, etc.) to help you stop smoking? (Circle one)

- A. No, I have never used it
- B. Yes, I have used it in the past but no longer use it
- C. Yes, I occasionally use it but not daily
- D. Yes, I use it everyday

ADULT SUPPLEMENTAL QUESTIONNAIRE

26. **Do you plan to quit using e-cigarettes or any tobacco product other than cigarettes (e.g., cigars, cigarillos, pipes, hookah, smokeless or chewing tobacco, etc.)?** (Circle one)

- | | |
|----------------------------------|--|
| A. No plans to quit | E. Yes, at some point but not within the next year |
| B. Yes, within the next month | F. I only smokes cigarettes |
| C. Yes, within the next 6 months | |
| D. Yes, within the next year | |

IF YOU PLAN ON QUITTING SMOKING CIGARETTES OR OTHER TOBACCO RELATED PRODUCTS, PLEASE ANSWER THE FOLLOWING QUESTIONS. OTHERWISE, SKIP TO SECTION 6.

27. **Why do you want to quit?** (check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> To be healthier | <input type="checkbox"/> I am dissatisfied with being dependent on cigarettes |
| <input type="checkbox"/> Because of health related problems | <input type="checkbox"/> It is too expensive |
| <input type="checkbox"/> Because of concern for others' health (family/friends) | <input type="checkbox"/> It is too inconvenient |
| <input type="checkbox"/> Because of concern shown by others (family/friends) | <input type="checkbox"/> Other (please specify) _____ |

28. **How confident are you that you will be able to quit?** (Circle one)

- | | |
|-------------------------|-------------------|
| A. Not at all confident | D. Confident |
| B. Slightly confident | E. Very confident |
| C. Moderately confident | |

29. **What smoking cessation programs or services would you use in the future?** (Check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Telephone helpline/ counseling | <input type="checkbox"/> Nicotine replacement therapy (such as nicotine gum, patches, inhalers, sprays, and lozenges) |
| <input type="checkbox"/> Online programs | <input type="checkbox"/> Individual or group in-person counseling |
| <input type="checkbox"/> Self-help guides/other materials | <input type="checkbox"/> Behavioral therapy (such as training in problem solving) |
| <input type="checkbox"/> Brief help by a doctor/healthcare professional (such as when a doctor takes 10 mins. or less to give a patient advice) | <input type="checkbox"/> Hypnosis |
| <input type="checkbox"/> Prescription for non-nicotine medication (such as prescription medications like Zyban or Chantix) | <input type="checkbox"/> Acupuncture |
| <input type="checkbox"/> Quit "cold turkey"; without any help | <input type="checkbox"/> Laser therapy |
| | <input type="checkbox"/> E-cigarettes/Other tobacco products |
| | <input type="checkbox"/> Other: _____ |

ADULT SUPPLEMENTAL QUESTIONNAIRE

30. If you decide to participate in a smoking cessation programs or services in the future, where would you like to be able to go to get information/resources? (Check all that apply)
- | | |
|--|---|
| <input type="checkbox"/> My housing facility | <input type="checkbox"/> Online (website) |
| <input type="checkbox"/> My church | <input type="checkbox"/> Schools |
| <input type="checkbox"/> My doctor/healthcare practitioner | <input type="checkbox"/> Post office |
| <input type="checkbox"/> Local community center | <input type="checkbox"/> Government assistance office (such as WIC, DES, DCS, etc.) |
| <input type="checkbox"/> Library | <input type="checkbox"/> Other: _____ |

----- **SECTION 6: GENERAL HEALTH** -----

31. Would you say that in general your health is excellent, very good, good, fair, or poor? (Circle one)

- A. Excellent B. Very good C. Good D. Fair E. Poor

32. Have you visited a doctor or other health care provider in the past 12 months? (Circle one)

- A. Yes B. No

33. Has a doctor or other health professional ever told you that you had any of the following health issues (check all that apply):

- Asthma Diabetes Gum disease Rheumatoid arthritis Heart disease Stroke
 Obesity Chronic bronchitis, emphysema, COPD or other lung disease (not including cancer)
 Cancer of the lungs; mouth, nose, or throat; larynx; trachea; esophagus; stomach; pancreas; kidneys and ureters; bladder; cervix; or bone marrow and blood.

34. During the past 12 months, did any medical doctor advise you to quit smoking/using tobacco-related products? (Circle one)

- A. Yes B. No C. Don't know/don't remember

35. On how many occasions during the past 12 months have you visited the doctor or hospital for tobacco-related health issues? (Note: tobacco-related health issues include any health issues associated with your personal tobacco use or exposure to secondhand smoke.)

_____ Times

----- **SECTION 7: SECONDHAND SMOKE** -----

36. Over the past 3 months, has anyone smoked anywhere inside your home? (Circle one)

- A. Yes B. No C. I don't know

ADULT SUPPLEMENTAL QUESTIONNAIRE

37. **How often does anyone smoke inside your home? Would you say daily, weekly, monthly, less than monthly, or never?** (Circle one)
- A. Daily B. Weekly C. Monthly D. Less than monthly E. Never F. I don't know
38. **Please tell me which best describes the rules of smoking tobacco in your housing unit.** (Circle one)
- A. No one is allowed to smoke anywhere inside your home
B. Smoking/tobacco use is permitted in some places or at sometimes inside your home
C. Smoking/tobacco use is permitted anywhere inside your home
D. Don't know
39. **In buildings with multiple housing units or living areas, do you think that smoking should be...**(Circle one)
- A. Allowed inside all housing units or living areas
B. Allowed inside some housing units
C. Not allowed at all inside housing units
40. **Now think about indoor public or common areas in buildings with multiple housing units, such as halls, stairs, lobbies, and recreation areas. Do you think that smoking should be...**(Circle one)
- A. Allowed in all indoor common areas
B. Allowed in some indoor common areas
C. Not allowed at all in any indoor common areas
41. **On an average day, how frequently are you exposed to secondhand smoke while in your housing unit?** (Circle one)
- A. Never B. Rarely C. Sometimes D. Often E. All of the time
42. **Would you be in favor of a smoke-free policy within your housing complex?** (Circle one)
- A. Yes B. No C. Not sure
43. **If you responded 'Yes' to Question #42, would you be in favor of a partial ban or a full ban?** (circle one)
- A. Partial ban – Indoor ban only; allowed to smoke anywhere outside
B. Partial ban – Outdoor ban only; allowed to smoke anywhere inside your housing unit
C. Indoor and outdoor ban – not allowed to smoke within so many feet of the housing units and playground areas

Adult Focus Group Agenda & Script

AMERICAN LUNG ASSOCIATION SMOKING CESSATION OPPORTUNITIES FOR RESIDENTS OF PUBLIC HOUSING

*** Notes: Times listed in parentheses are estimates. There is a little additional time included in case participants have a lot to say on a particular piece so do not rush them too much if you are still getting new information from the discussion. If they are stuck on something and you're not learning anything new, move them along. The highlighted questions below are the most important so be sure to get through each of those if you find you are running out of time.***

Food & Paperwork (15 minutes)

- If food is available, have participants eat as soon as they come in and then grab a seat and begin filling out their paperwork. You should collect a signed **Adult Information Letter** from each participant as well as the **Adult Focus Group Questionnaire** (1 page front and back) prior to the beginning of the group if possible. If people need more time to complete the questionnaire, that is fine, but you cannot start the group without a signed Adult Information Letter from each participant. [Put signed info letters in separate folder from questionnaires.]

Introduction (5 minutes):

Welcome. Thank you for participating in this focus group discussion on smoking cessation programs and services. My name is [moderator] and I will facilitate this discussion with [co-moderator]. We are researchers with ASU's Southwest Interdisciplinary Research Center and we are working with the American Lung Association to gather information about the smoking cessation needs of residents living in public housing facilities within Maricopa County.

You were invited here because you are a current resident living in public housing and live in Maricopa County. We want to hear about your perspectives on the health in your neighborhood as it relates to smoking. You will probably have different points of view, but there are no right or wrong answers. Please feel free to share your thoughts even if they may not agree with someone else's.

We will be taking notes during this session because we don't want to forget any of the valuable ideas you share. However, your names will not be included in the reports or notes from this discussion so no one will be able to link the responses to a specific person. Your responses will remain anonymous.

As described in your information letters, the focus group will be audio recorded so that the research team can capture all of the information necessary to thoroughly analyze the themes and ideas that emerge from the focus group, but your responses will not be linked to your name or contact information. The audio will not be shared with anyone outside of the research team.

To get started, if you haven't already, please write whatever name you would like us to call you on the name tents in front of you. This will help me remember your names and will help you if you want to refer to someone's comments.

Please keep in mind that we are here to have a group discussion. I will ask some questions to guide the conversation but you do not always have to respond directly to me. You are encouraged to have a conversation with everyone at the table. We would like to hear from all of you. If you are talking a lot, I may ask you to let others have a chance. If you are quiet, I may call on you. We just want to be sure that everyone is heard. I also ask that you avoid interrupting one another. Please talk slowly, clearly and loudly enough so that your voice can be heard on the audio recording and so that accurate notes can be taken.

Does anyone have any questions before we begin?

Ok, let's get started. [Ask co-facilitator to start the audio recordings. Once they have started them and are out of the way, continue with script.]

Focus Group Questions

For the purpose of this discussion, neighborhood will refer to where you live and its surrounding environment (e.g., nearby parks on property, shared community centers/pools, neighbors within your building and nearby apartment buildings).

Opening Question

1. To begin, why don't we go around the table and introduce ourselves. State your name (or whatever you would like us to call you) and what makes you most proud of your neighborhood.

General Smoking Questions:

Next, I would like to ask you general questions about smoking. When we talk about "smoking" during this discussion, it will refer to tobacco products only. This includes cigarettes, e-cigarettes, cigars, cigarillos, pipes, hookahs, smokeless or chewing tobacco, etc. With that in mind...

2. When I say 'smoking' what is the first thing that comes to mind?

[Prompts – ask about these things if they do not come up naturally]

What about...

- i. Do you think smoking is a problem in your neighborhood? If so, how?
 - ii. Who do you tend to see smoking in your neighborhood?
 - iii. Are they smoking outside in the parking lot, on their balconies?
 - iv. Are they smoking cigarettes, e-cigarettes, pipes, hookahs...?
 - v. Are they older or younger looking?
3. Why do you think people smoke?
 - a. Do you think they are aware of the health risks of smoking and/or secondhand smoke?
 - b. Do you think there are enough advertisements in your neighborhood that share information and resources about smoking?

General Smoking Cessation Questions

Let's now move on to cessation services or programs that are available in your community to help you quit smoking.

4. Why do you think people want to quit smoking?
5. What do you think makes it difficult for people to quit smoking cigarettes or other tobacco products?
6. What would be needed to make it easier for smokers to quit smoking?
7. For those who have quit, attempted to quit, or know someone who tried quitting smoking, what resources were used?

[Prompts – ask about these things if they do not come up naturally]

What about...

- i. Where did you/they go for help?
- ii. Why did you/they choose that resource?

- iii. Which resources did you think were not the best for you?
 - iv. Why did you think they would not be helpful?
8. Have you ever heard of ASHLine?
- a. If so, how did you hear about it?
 - b. What do you know about ASHLine?
 - c. Have you ever tried using ASHLine or helplines like it? Why or why not?
9. If a smoke-free policy were created in your neighborhood, what comments and/or concerns would you have?

Communication Strategies

10. Help us create a program to assist people in your neighborhood quit smoking, Think about the people in your community, their needs and experiences. What would the program look like? Where would it be located? What days and times is it available? What other services does it provide?

[Prompts – ask about these things if they do not come up naturally]

What about...

- i. What tools or resources would you use to advertise it? (e.g., printed materials, online, etc.)
 - ii. Would this be an in-person program? Online? Over the phone?
 - iii. Would it only be tobacco-related services?
 - iv. Who would you target?
 - v. What is the best way for community groups and organizations, schools, and/or the district to communicate with you to ensure that you have up-to-date information about available programs, needs, resources about smoking available in your neighborhood?
11. Now that we have designed this program, how do we let people know about it?

[Prompt – Where do you get most of your information about services available in your community?]

Final question

12. Is there anything else that you would like to share on this topic that we did not yet cover?

KEY INFORMANT QUESTIONNAIRE

AMERICAN LUNG ASSOCIATION SMOKING CESSATION OPPORTUNITIES FOR RESIDENTS OF PUBLIC HOUSING

Hello, my name is [NAME] with the Southwest Interdisciplinary Research Center at Arizona State University. Thank you for agreeing to participate in this interview. We are conducting this study in partnership with the American Lung Association for the purpose of learning more about smoking cessation programs and services available to public housing residents in Maricopa County. The study will help increase our knowledge about available resources and programs for this population as well as barriers or obstacles that might prevent residents from taking advantage of these resources /programs. It will also help us to identify potential strategies to help residents overcome these barriers, with the ultimate goal of decreasing smoking cessation rates specifically.

If you have any questions concerning the research study, please contact the Principal Investigator of the study: Wendy Wolfersteig, PhD, wendy.wolfersteig@asu.edu, 602-496-1086.

The interview will take approximately 30 minutes. I will ask questions mainly about your program/services, the populations that you serve, challenges and successes you have had engaging clients in services, and the networks of individuals and organizations working to better your community.

Do you have any questions before we begin?

- 1) Tell me about your organization and the programs/services you offer.
 - a. What populations does your program or organization serve?
 - b. What are the geographic boundaries of the area your programs serve?
 - c. Does your organization conduct any outreach for programs or services in the community and/or to public housing residents?

- 2) Now I would like to ask you a few questions about participation barriers and strategies.
 - a. Of all the people you target within your programs, which groups do you have the most challenges engaging? (e.g., families? children? adults with or without children? older adults? younger adults? etc.)
 - b. Why do you think these particular groups participate less than others?
 - c. What strategies have you found to be successful at reaching or engaging the harder to reach populations/clients?
 - d. What do you think are the biggest barriers your clients experience to accessing the services and programs they need?
 - e. If cost or feasibility were no object, what strategies, services, or programs do you think would most help them overcome these barriers?

- 3) Let's discuss smoking cessation programs and services specifically (if applicable).
 - a. Do you offer smoking cessation programs or services at your organization?
 - i. If so...,
 1. What kind of smoking cessation programs/services?
 2. What barriers do smokers experience that may limit their participation in smoking cessation programs and services that you offer?
 3. What efforts, if any, is your agency making to encourage more participation in these smoking cessation programs and services?
 4. Do you feel smoking cessation services are a priority in your organization?
 5. On a scale of one to 10 (one being lowest and 10 the highest), how would you rate the degree of importance of smoking cessation programs compared to other programs and services that your organization offers?

KEY INFORMANT QUESTIONNAIRE

6. What other resources are available in your community that smokers might be accessing to address their smoking habits if they are not participating in the programs for which they are eligible?
 - ii. If not....,
 1. Why do you think your organization does not yet offer a smoking cessation program?
 2. Do you think your organization is interested in developing a smoking cessation program or having services/resources available for community members at your organization?
 3. What are the challenges you encounter in trying to establish smoking cessation services?
 4. Do you feel smoking cessation services are a priority in your organization?
 5. On a scale of one to 10 (one being lowest and 10 the highest), how would you rate the degree of importance of smoking cessation programs compared to other programs and services that your organization offers?
- 4) To help me develop a more general understanding of your community, tell me about the broader factors at play in your community that impact your work, even if indirectly. (e.g., substance abuse, homelessness, lack of transportation, crime/safety, etc.)
- 5) Is there anything else you can think of that might be helpful to my understanding of the people, services, or issues affecting public housing residents in your community? (In other words, is there anything that I didn't ask that you think is important?)
- 6) Is there anyone else that you would suggest I talk to about this?

Thank you so much for sharing this information with me. May I contact you again if I have any follow-up questions?