Tobacco Cessation in Public Housing ECHO: Early Experiences

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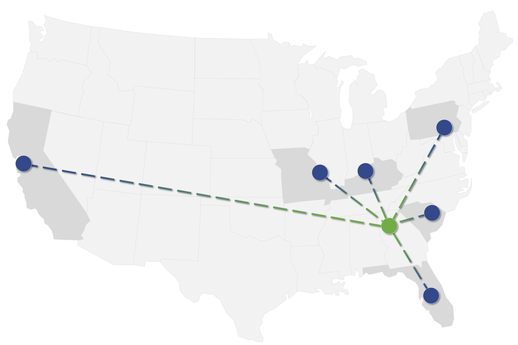
INTRODUCTION

A U.S. Department of Housing and Urban Development (HUD) rule required all public housing agencies (PHAs) to implement a smoke-free policy by July 30, 2018, prohibiting the use of tobacco products in all residential units, indoor common areas, administrative offices, and all outdoor areas within 25 feet of these areas. Each PHA enforces the rule at their own discretion, but residents could be evicted if they don't comply. Since approximately 34% of adults living in public housing smoke cigarettes, the rule provides an opportunity to increase access to tobacco cessation services and help smokers quit for good.

With generous funding from the Robert Wood Johnson Foundation, the American Cancer Society (ACS), Smoking Cessation Leadership Center (SCLC) at UCSF, and the North American Quitline Consortium (NAQC) are collaborating with PHAs, state quitlines, and community health centers (CHCs) to help residents in public housing who are ready to quit smoking. This project is being piloted in 6 sites, one each in California, Florida, Kentucky, Missouri, Pennsylvania, and South Carolina. By strengthening partnerships among community health centers, public housing authorities and residents, quitlines, and other related organizations, this pilot program will help smokers quit and reduce the risk of smoking-related diseases, including cancer. This project will also strengthen local partnerships across sectors including behavioral health and legal aid groups to increase health equity.

To support the goals of this project, we have created a Smoke-free Public Housing ECHO that meets every 2 weeks from January 2019-January 2020.

HUB AND SPOKE STRUCTURE



The **ECHO Hub** is physically located at the American Cancer Society Global Headquarters in Atlanta and includes the ECHO coordinator and facilitator. Other expert hub faculty are located across the U.S. and join ECHO sessions virtually.

The **spokes** represent community health centers, state quitlines, public housing agencies, and quitline service providers from California, Florida, Kentucky, Missouri, New York, Pennsylvania, and South Carolina.

The six pilot states were chosen based on a variety of factors including:

- % of smokers in the state
- % of public housing residents in the state
- Quitline capacity for increased calls and reporting
- Range of available resources, e.g., Medicaid expansion

RECRUITMENT CHALLENGES

We had a short timeline for spoke recruitment and were embarking on developing new relationships in the housing and quitline sectors, so we anticipated some challenges — but were surprised by others.

1. To meet our timeline, we needed to sign on participants linearly *and* simultaneously. We had to identify CHCs and nearby PHAs, and secure participation from state health departments concurrently.
2. State health departments contract with quitline providers each year, so adding additional work or new priorities within a contract cycle was difficult. This challenge forced us to select new states from those originally selected to ensure that the important role of the state quitline would be represented during the project.
3. The CHCs and PHAs were offered grant funding as part of their participation, so there were additional processes to follow for those entities.

Once we signed on state quitlines, we quickly moved to formal recruitment of CHCs and PHAs. ACS regional staff provided important local insight, especially when identifying interested CHCs. In some states, CHCs and PHAs were excited to participate since they'd already wanted to do more work in this space. In other states, we approached several different CHCs before one signed on. In a couple of states, the PHAs and/or quitlines declined to participate citing other pressing priorities.

DISCUSSION

Community Health Centers

ACS has nationwide staff who work directly with CHCs. We relied on their expertise to recruit participating CHCs. In some states, we quickly signed on a CHC; in other states, we had to approach multiple CHCs.

- All CHCs recognized the need for this work, but several did not have the capacity for a project outside their already-determined strategic plans.
- In certain states, we made the decision to move ahead with key CHCs even without sign-on from the state health department or PHA.
- Most CHCs did not have relationships with their nearby PHAs but wanted to work more closely with them. All CHCs felt that outreach to residents on the PHA site is essential to increase access to cessation services.
- Most CHCs did not have relationships with their state quitline beyond referring patients and handing out quitline literature.
- Many CHCs do not have nimble Electronic Health Records, which hinders their ability to track helpful metrics and examine long-term trends.
- Funding was attractive as it allowed resident outreach at the PHA site and to incentivize patients to learn more about tobacco cessation.
- CHCs are participating in all states.

Initial Conclusions: Time spent to identify and recruit the CHCs will result in more local cross-sector relationship building, and the project will possibly serve as a template for additional work with PHAs in the future.

Public Housing Trends and Enforcement

More families than ever are in need of federally subsidized housing as housing costs increase significantly and the number of people in poverty grows. There is a widening housing assistance gap as housing voucher programs increase, new public housing isn't available, and more people are in need. HUD continues to look for cost-neutral options like the Rental Assistance Demonstration (RAD) program.

- RAD privatizes management of public housing buildings, which have been updated or rebuilt by commercial builders. The smoke-free policy does not apply to RAD housing, so residents don't have the urgency to quit tobacco. In San Francisco, all properties converted to RAD after years of substandard housing, so the PHA didn't focus on cessation programs.
- HUD left policy enforcement to each PHA, resulting in inconsistency. Our PHA spokes' enforcement varies from fines to increased rent to potential eviction.
- Residents' reactions to the smoke-free rule varied. Anecdotally, residents who were older and had been smoking longer were most resistant. PHAs that started implementation and communication early, addressed resident feedback, worked with resident councils, and clearly outlined enforcement have had cleaner implementation and fewer enforcement incidents.
- Many PHAs have long-term issues with housing quality, crime, and illegal drug use. One potential spoke has an ongoing rodent infestation. Therefore, enforcement of the smoke-free policy appears to be low on the list of staff priorities.
- Only the PHAs that already wanted to work with CHCs agreed to participate in the project. These PHAs also prioritized the smoke-free rule.
- PHAs are increasingly housing the elderly and people who are disabled -- populations that have been smoking longer, feel the benefit of quitting is minimal, and are generally more resistant to the smoke-free rule.
- Many families in public housing suffer from greater financial, health-related, and environmental stress than the general population. Stress is commonly cited as a reason for smoking in the first place , and also for smokers' lack of interest in quitting tobacco and/or failed quit attempts.
- PHAs are formally participating in KY, SC, and PA. However, the CHC is located on-site in CA, most of the work in MO will be taking place on the campus of the local PHA. FL recruitment is ongoing.

Initial Conclusions: Participating PHAs had prioritized implementation and compliance of the smoke-free policy and used the grant opportunity to get support from and form relationships with their nearby CHC. As the need for housing grows but HUD-owned and -managed public housing declines in favor of privately owned subsidized housing and RAD properties, fewer people receiving government housing assistance will be subject to the smoke-free policy. Residents won't have as much exigency to quit.

Quitlines

State quitlines were largely established by the Master Settlement Agreement from cigarette manufacturers' decades-long misleading claims about the safety of tobacco products. They are part of the state's public health department and are managed by service providers who staff them with trained cessation counselors. Funding and resources vary state by state, and which resources they can offer callers, including nicotine replacement therapy, also varies by state. Quitlines do recognize the importance of being available to this high-tobacco-use population.

- Many states were already preparing for the HUD smoke-free rule, and several quitlines had begun collecting data on callers living in public housing to be able to better support them. Many health departments had provided resources directly to PHAs.
- Because of this preparation, many states were far enough along in their work that they felt this project was redundant.
- The participating state health departments cite wanting to better help their public housing callers and improve workflow.
- Resource limitations and administrative challenges are concerns. Staff turnover resulted in the need to reestablish relationships, which pushed back the timeline. We also had to ensure the quitline's level of participation was not overly burdensome.
- We moved forward in one state without formal sign-on by the state health department's quitline because we felt we'd have replicable learnings.
- Quitlines are spoke participants in CA, KY, MO, PA, and SC. In all states, they will be a cessation resource as normal. The service providers for the participating state quitlines are also spoke participants.

Initial Conclusions: Flexibility and long timelines are required when government agencies are involved as often there are barriers beyond any individual's control. At this time, there are no further conclusions, although we look forward to offering best practices both for working with quitlines and without their formal involvement.

NEXT STEPS

ECHO sessions will take place every 2 weeks until Jan. 21, 2020. Spoke participants are strongly encouraged to have the same individuals or teams attend for consistency, with additional staff joining as the didactics or case discussions pertain to them. Each ECHO session is designed to appeal to the three varied audiences of our project participants, who are both clinical and non-clinical. Case presentations consist of both individual and systems-based cases to spur discussion among the subject experts and other project participants to help patients, uncover and develop solutions to challenges, and share best practices and increased efficiencies.

FACTS ABOUT PUBLIC HOUSING RESIDENTS

As of March 2018, there are

1,871,260 Residents of public housing, including

600,000 children

For 1/3 of households, **wages from working** is the main source of income

$14,578 Average annual household income

$16,460 Federal poverty level for a household of 2

Public housing residents

- Are **more likely** to be in fair or poor health
- Have **higher rates** of tobacco-related illnesses
- Are **more likely** to be facing behavioral health disorders; those with behavioral health disorders are more likely to smoke

Sources: U.S. Department of Housing and Urban Development; the National Center for Health in Public Housing; and the U.S. Department of Health and Human Services

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