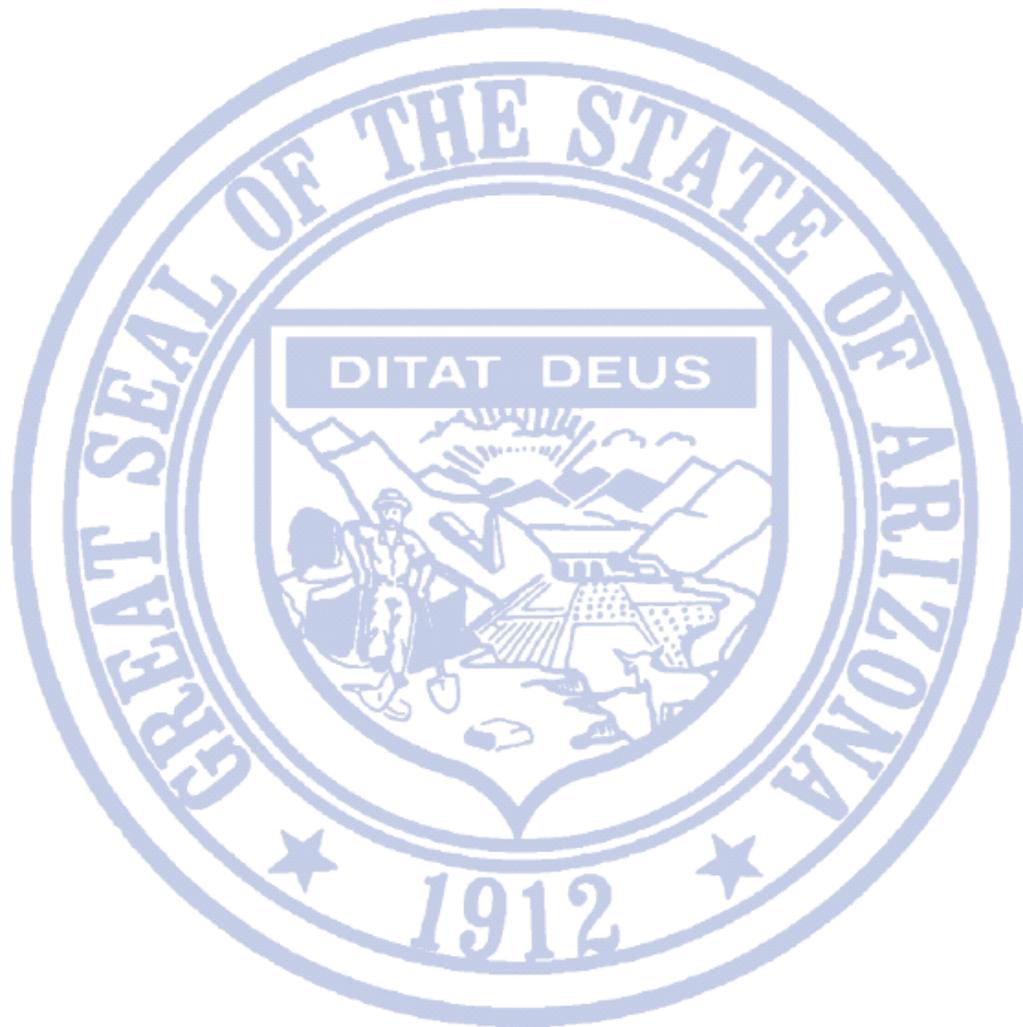


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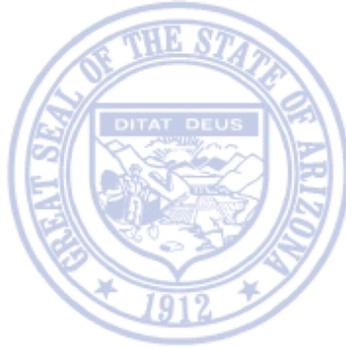
2010 BIENNIAL EVALUATION REPORT

Fiscal Years 2009 – 2010

ARIZONA DEPARTMENT OF HEALTH SERVICES

A REPORT ON TOBACCO CONTROL PROGRAMS AND SERVICES

BUREAU OF TOBACCO AND CHRONIC DISEASE



2010 BIENNIAL EVALUATION REPORT

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DIVISION OF PUBLIC HEALTH SERVICES
Bureau of Tobacco and Chronic Disease

**THANKS AND APPRECIATION
FOR HER CONTRIBUTIONS ARE ALSO EXTENDED TO**

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EXECUTIVE SUMMARY

OVERVIEW

This report contains a description of the tobacco related activities within the state of Arizona for Fiscal Years 2009 and 2010 (FY09 and FY10, respectively). The primary responsibility for its content rests on the Arizona Department of Health Services (ADHS) Bureau of Tobacco Chronic Disease (BTCD) with supplemental information from Smoke-Free Arizona and BTCD partners. Key outcome indicators for youth and adult tobacco-related behavior and attitudes are presented.

BIENNIAL EVALUATION REPORT HIGHLIGHTS: YOUTH

Prevalence of Youth Tobacco Use

Data shows a downward trend for tobacco use among all youth groups from 2000-2009. However, there is a dramatic increase in the use of hookah and smokeless tobacco, especially among high school students.

Youth Susceptibility to Initiating Smoking

Middle school student rates of current and lifetime tobacco use have dropped by 50 percent since 2000; the lowest percentage of middle school tobacco use was measured in 2009. However, current use of all tobacco products among high school students has not significantly changed since 2003.

Youth Access to Tobacco Products

From 2000-2009, the most common location for purchasing cigarettes for middle school students was a gas station. The percentage of middle school students who were asked for proof of age when trying to purchase a tobacco product continues an upward trend. High school students, however, reported acquiring tobacco products through social networks—from friends.

Youth Exposure to Secondhand Smoke

In 2009, the majority of Arizona's middle school students lived in homes with a complete smoking ban. Accordingly, the percentage of middle school students' self-reported exposure to secondhand smoke in a car or room is decreasing, for students living both with and without a smoker; however, this trend is stronger for students not living with a smoker.

Youth Counter-Marketing

In 2009, BTCD launched a new marketing campaign, *Venomocity: Brought to You by Addiction*, aimed at a target audience of 12-17 years old. Using focus groups from the target age group, BTCD formed the "I Know" (IK) Council to help develop the television, Internet and social media campaign.

2009 also saw a shift in focus from school-based curriculum prevention efforts to the formation of youth coalitions. The Arizona Youth Coalition Premiere Event, held in June 2010, introduced 300 students from across the state to the idea that active policy engagement is a more effective tool to

both increase youth awareness of how tobacco affects their communities and decrease youth tobacco prevalence.

BIENNIAL EVALUATION REPORT HIGHLIGHTS: ADULT

Prevalence of Adult Tobacco Use

Smoking prevalence in Arizona continued its downward trend in 2009, still falling below the national average of 17.9 percent. 2009 BRFSS demographics indicated that current smokers are more likely to be male (18.0 percent) than female (14.3 percent). Employment is not shown to be a significant indicator of smoking, with 30.4 percent of smokers unemployed and 30.1 percent either employed for wages or self-employed, but more than one in four smokers make less than \$25,000 a year (26.2 percent).

Adult Cessation: ASHLine

The Arizona Smokers' Helpline (ASHLine) launched a media campaign in January 2010; previous to the campaign, the primary way that clients heard about ASHLine was through their healthcare providers. Post-campaign, call volume to the ASHLine drastically increased, posting a 327 percent increase in call volume, month for month, compared to the previous year.

IDENTIFYING AND ELIMINATING TOBACCO-RELATED DISPARITIES

In 2009, BTCDD sought grant proposals from community organizations to conduct community assessments that would assist with capacity building and program planning for the development of sustainable commercial tobacco prevention programs. The Community Health Initiative to Reduce Disparities (CHIRD), will be conducting community and health systems assessments with the end goal of increasing utilization of services among African American, American Indian, Asian-Pacific Islander, Hispanic (youth and families), as well as migrant farm workers and formerly incarcerated persons.

REDUCING THE BURDEN OF CHRONIC DISEASE

ADHS also awarded a research grant to Mayo Clinic, to develop the Stroke Telemedicine for Arizona's Rural Residents (STARR), which offers 24/7 emergency support to hospitals in rural and underserved areas of the state. The grant included six original hospitals, with a subscription fee model for expansion.

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INTRODUCTION

This report contains a description of the tobacco related activities within the state of Arizona for Fiscal Years 2009 and 2010 (FY09 and FY10, respectively). The primary responsibility for its content rests on the Arizona Department of Health Services (ADHS) Bureau of Tobacco Chronic Disease (BTCD) with supplemental information from Smoke-Free Arizona and BTCD partners. Key outcome indicators for youth and adult tobacco-related behavior and attitudes are presented.

BACKGROUND

In 1994, Arizona voters passed the Tobacco Tax and Health Care Act (Proposition 200) which increased the state sales tax on tobacco products to fund several programs: health care for the medically needy, medically indigent, and low income children; tobacco education and prevention; and tobacco-related research. This marked the beginning of Arizona's tobacco taxation, which was increased with the 2006 vote to raise the excise tobacco tax to \$2.00. Proposition 303, passed in 2002, voter protected the tobacco tax monies and these funds were required to be spent on tobacco prevention. Administered by ADHS BTCD, two percent of the tax was dedicated to a chronic disease fund.

In November 2006, Arizona voters approved the Smoke-Free Arizona Act, which took effect May 1, 2007. The act bans smoking in all indoor public buildings with the exception of retail tobacco stores, veteran and fraternal clubs, designated smoking hotel rooms, and outdoor patios. The ADHS Office of Environmental Health is responsible for monitoring compliance with the law.

Fiscal years 07-08 (FY07, F08) were an era of change for the ADHS BTCD, which led to a new staff, a new direction, and a new strategic plan generated by intensive research and community involvement. To better illustrate the changes, the following pages include: the current organizational chart for ADHS BTCD, a table containing a list of the contracts and expenditures, a timeline of the events, and finally, information about the strategic plan and a copy of a stakeholder chart.

CHRONIC DISEASE PARTNERSHIPS

When Arizona voters passed Proposition 303 in 2002, which increased the state tax on cigarettes by 60 cents per pack and taxed other tobacco products, two percent of this tax was set aside for a chronic disease fund which is administered by the ADHS BTCD.

During FY09, ADHS BTCD funded nine community outreach programs and two statewide outreach programs for chronic disease prevention; however, these projects were phased out and replaced by services provided by county programs in FY10. Shown below are lists of the programs which were funded under this provision.

Community Outreach Vendors, FY09

- American Lung*
- APCA*
- Coconino County*
- Maricopa County*

* Projects were phased out and replaced by the local partners for FY10

- Mountain Park CHC*
- Native American Comm. *
- Wingspan*
- TGen*
- Wesley Community Center

Community Outreach Vendors, FY10

- APCA[†]
- Mountain Park CHC[†]
- Phoenix Fire
- Wesley Community Center

Statewide Projects Vendors, FY09

- American Cancer Society
- AIA

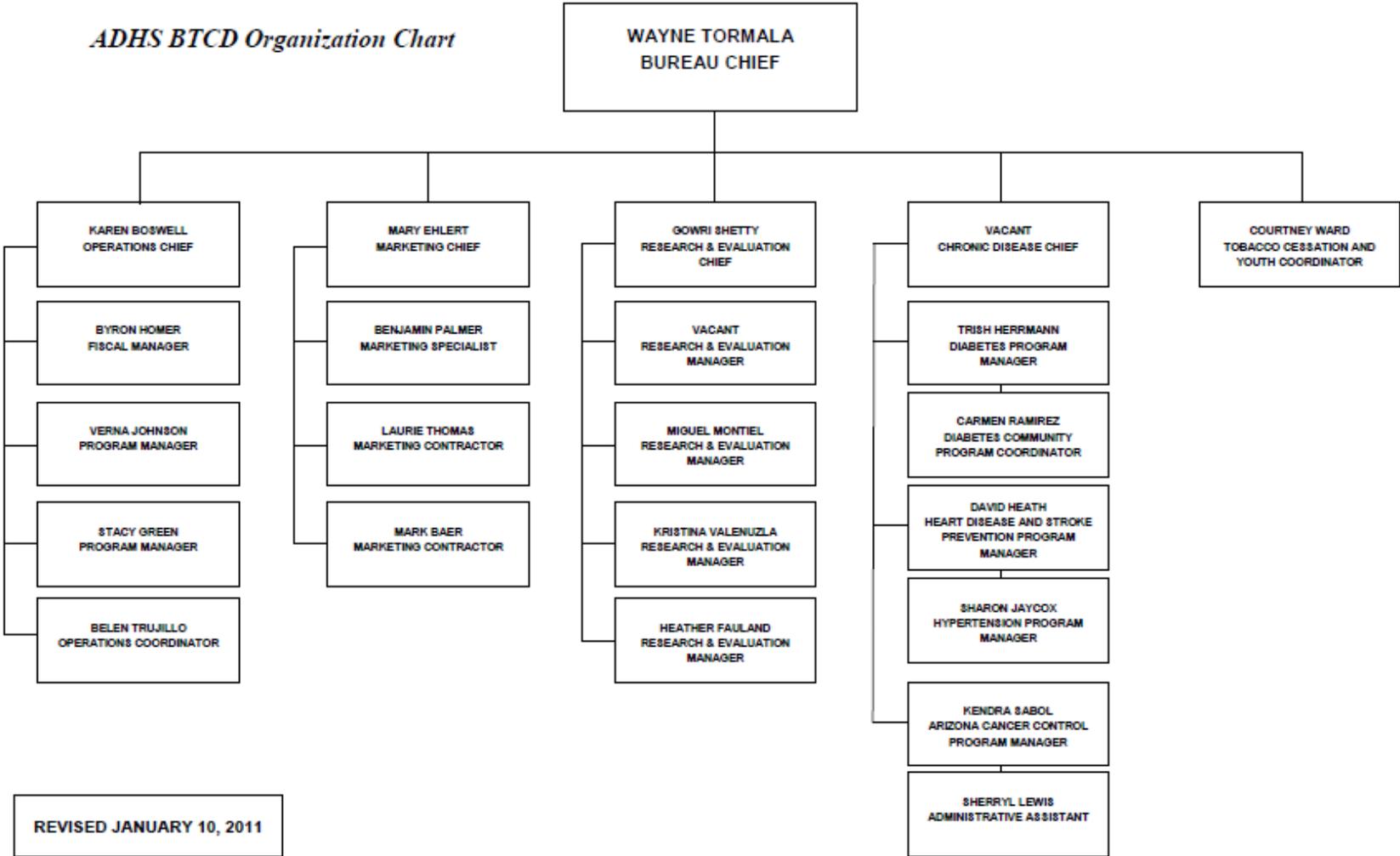
Statewide Projects Vendors, FY10

- American Cancer Society
- AIA (Phased out in FY10)

[†] Contracts listed here are different than those listed in FY09

ARIZONA DEPARTMENT OF HEALTH SERVICES
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ADHS BTCD Organization Chart



REVISED JANUARY 10, 2011

Figure 1: ADHS BTCD organizational chart

ADHS BTCD – EXPENDITURES AND CONTRACTS

Following are the FY09 and FY10 Budgets for both of the tobacco Propositions (200 and 303), as well as federal monies from the CDC.

ADHS Tobacco - Prop. 200

Table 1: PROP 200 expenditures and contracts for FY09-FY10

Projects	Expenditures	
	FY09	FY10
Local Partners		
Apache County	142,156	143,479
Cochise County	154,522	177,863
Coconino County	285,888	285,456
Gila County	128,942	132,495
Graham County	110,814	121,210
Greenlee County	77,770	51,057
La Paz County	262,163	190,165
Maricopa County	2,479,801	2,188,863
Mariposa Community Hlth Cntr	0	121,927
Mohave County	349,010	352,878
Navajo County	133,223	130,822
Pima County	1,293,236	1,093,132
Pinal County	327,647	314,454
Santa Cruz County	134,120	0
Yavapai County	286,555	260,947
Yuma County	291,127	257,368
Total Local Partners	6,456,974	5,822,116
Administrative	1,349,094	899,898
Community Outreach	625,604	430,072
Evaluation	1,363,830	653,511
Licensing – Empower	0	422,562
Marketing and Communication	3,504,867	4,556,559
Native American Outreach	600,219	648,666
Statewide Projects	3,872,352	2,916,193
Total Tobacco Expenditures	17,772,940	16,349,577

ADHS Chronic Disease - Prop. 303

Table 2: PROP 303 expenditures and contracts FY09-FY10

Projects	Expenditures	
	FY09	FY10
Local Partners		
Apache County	15,009	42,087
Breast Cancer Screening	219,497	138,854
Colorectal Cancer Screening	573,388	465,400
Cochise County	0	49,954
Coconino County	39,002	71,027
Hepatitis B	92,908	204,668
Lung – COPD	641,375	654,024
Navajo County	24,100	46,103
Stroke Awareness	640,417	366,848
Total Local Partners	2,245,696	2,038,965
Administrative	378,734	439,506
Community Outreach	51,825	3,043
Evaluation	122,957	137,250
Marketing and Communication	12,953	4,968
Native American Outreach	0	39,502
Statewide Projects	336,419	0
Total Chronic Disease Expenditures	3,148,584	2,663,234

ADHS CDC – Federal

Table 3: CDC expenditure and contracts FY09-FY10

Projects	Expenditures	
	FY09	FY10
Administrative	763,556	990,023
Community Outreach	0	177,591
Evaluation	117,691	74,604
Marketing and Communication	154,555	11,157
Native American Outreach	0	172,662
Statewide Projects	32,993	468,859
Total Federal Expenditures	1,068,795	1,894,896

YOUTH PROGRAM ACTIVITIES AND SERVICES

This section contains data relevant to the outcomes of the Arizona tobacco control program. The data have been assembled to correspond with the outcome indicators for evaluating comprehensive tobacco control programs developed by the CDC. Results for all identified CDC outcome indicators are not presented here. Rather, a selection of outcome measures with the highest relevance to Arizona tobacco control activities is provided. The behavioral and attitude-related results are reported separately for youth and adults.

For every outcome measure reported, the respective CDC indicator number and label are presented; this is to ensure consistency of reported results with CDC recommended and approved standard outcome measures.

PREVALENCE OF YOUTH TOBACCO USE³

CDC Outcome Indicator 1.14.1 Prevalence of tobacco use among young people

According to the Arizona Youth Tobacco Survey (YTS), 2009, 23 percent of middle school students reported ever using any tobacco product. The Youth Risk Behavioral Surveillance System (YRBSS), although it did not provide data for ever-use among high school students, did show that 28 percent are currently using some form of tobacco. Cigarettes were the most popular tobacco product ever tried across both groups. (Refer to Figure 2 and Figure 3). Fewer than 1 in 10 middle school students and 1 in 3 high school students reported current use of any tobacco product.

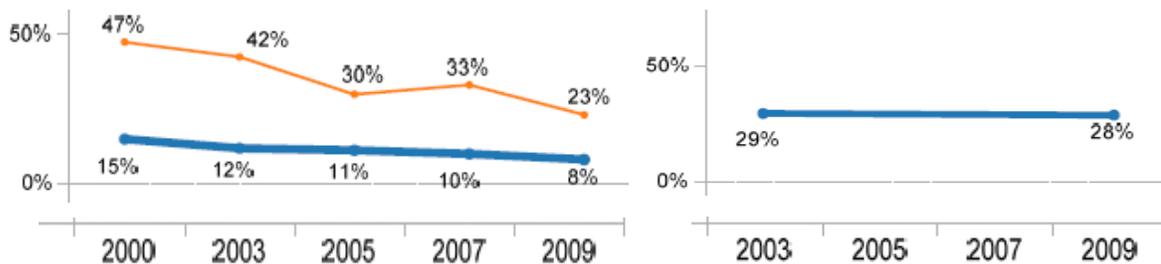


Figure 2: Trends in the use of any tobacco product by Arizona middle school students, 2000-2009 (left), and high school students, 2003-2009 (right)

³ In previous years, the AZ Youth Tobacco Survey (YTS) reported on both middle and high school populations; however, the high school portion of the survey was discontinued in FY 2008-2009. For the purposes of this report, the represented high school data was collected through the Youth Risk Behavioral Surveillance System (YRBSS).

It is also important to note that the data in these school-based surveys are representative of the public school student population; private schools, parochial schools, juvenile detention centers and other special schools are not included in the surveys. Existing evidence demonstrates that adolescents who are not in school (and those with high numbers of absences) have higher rates of tobacco use.

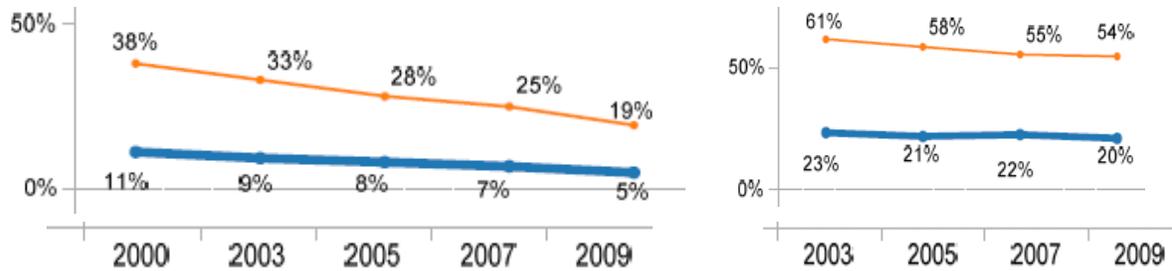


Figure 3: Trends in the use of cigarettes by Arizona middle school students, 2000-2009 (left), and high school students, 2003-2009 (right)

American Indian/Alaskan Native students reported the highest rates of *current tobacco use*, in both middle and high school. They also report the highest rates of *ever tobacco use* among middle school students. In 2009, White students reported the lowest rates of both *ever* and *current use* in middle school, whereas Hispanic/Latino students showed the lowest rates for *current use* in high school. Black/African American high school students report 25 percent *current use* of any tobacco product in 2009, as well as the lowest percentage of current cigarette smokers—49 percent. Hispanic/Latino students who have ever smoked cigarettes have seen the steepest drop in the six-year period recorded, falling from a high of 70 percent in 2003 to 59 percent in 2009; however, prevalence rates among all groups, for *any tobacco products* and *cigarettes*, are downward trending. (See Figure 4.)

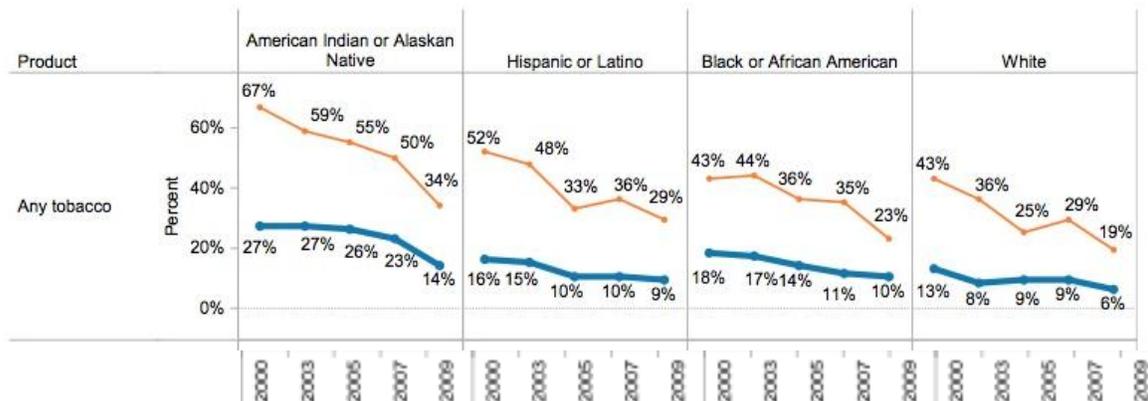


Figure 4: Any tobacco use among middle school students, by race, 2003-2009

Hookah use, contrary to the general downward trend of tobacco use among middle school students, has demonstrated marked popularity since 2005. This increase is much more dramatic for high school students. Whereas current use among middle school students in 2009 was measured at 3 percent, it was five times that for high school, with more than one in four admitting to lifetime use. When broken down by grade, the increase in use among high school students is even more pronounced. (See Figure 5.) Thirty-five percent of high school seniors admitted to ever using hookah.

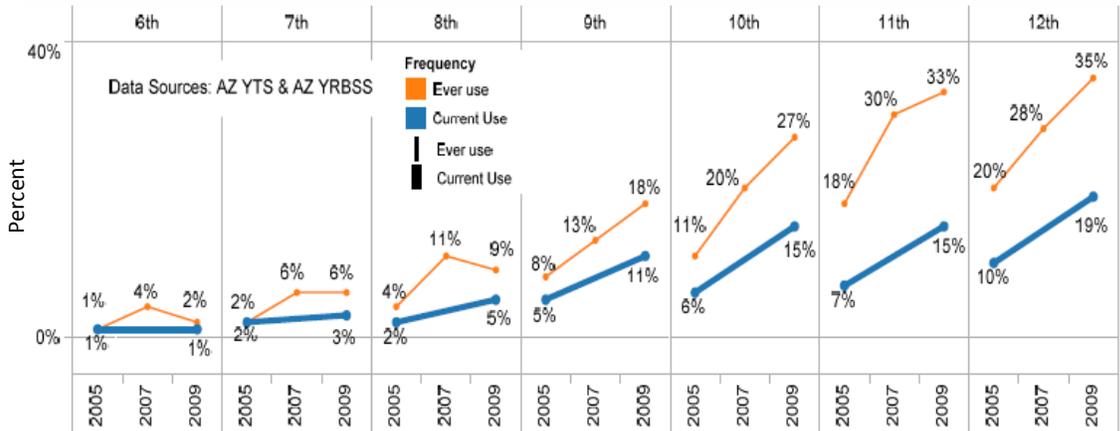


Figure 5: Current and any use of hookah by middle and high school grades, 2005-2009

The Arizona Youth Survey (AYS), conducted biennially by the Arizona Criminal Justice Coalition, shows a dramatic increase in the popularity of smokeless tobacco since 2004, particularly among high school students. (See Figure 6.) The percentage of 8th graders who admitted to using smokeless tobacco—chew, snuff, plug, dipping tobacco or chewing tobacco—remained relatively steady, gaining less than half a percent since 2004. However, the number of current users in the 10th and 12th grades has risen rapidly. The percentage of 12th graders using smokeless tobacco has risen 50 percent since 2004; for 10th graders, it has risen 68 percent in the same period.

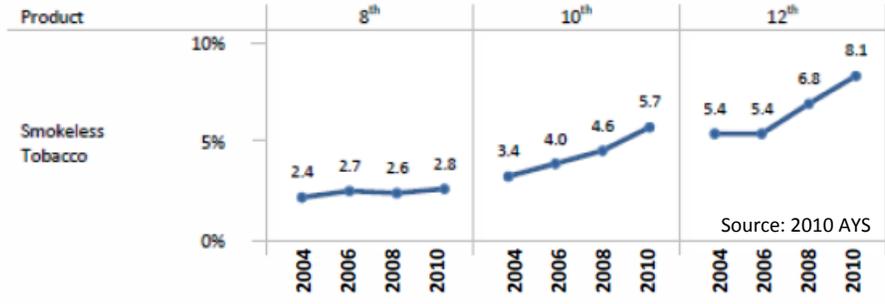


Figure 6: Current use of smokeless tobacco by middle and high school students, 2004-2010

PREVENTING YOUTH INITIATION

Susceptibility to Initiating Smoking

CDC Outcome Indicator 1.13.2 Prevalence of young people who report never having tried a cigarette

According to the YTS, 3 out of 4 middle school students reported having never used any tobacco product in 2009. Most middle school rates of tobacco use have dropped by 50 percent since 2000; when broken down by grade (6th-8th), 2009 showed middle school tobacco use at an all-time low. (See Figure 7.)

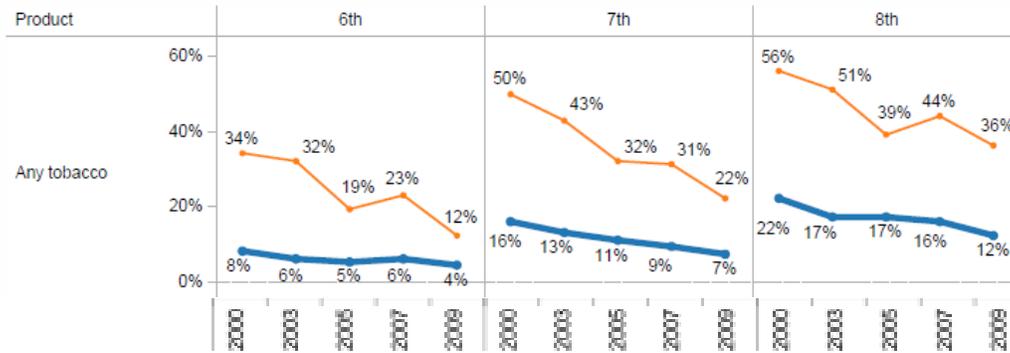


Figure 7: Trends in the use of tobacco products by Arizona middle school students, 2000-2009

Current use of all tobacco products among high school students has not significantly changed since 2003. However, an increase in the popularity of smokeless tobacco and cigars/cigarillos was noted in 2009; use of cigars and cigarillos among the high school population (18 percent) is now nearly as popular as that of cigarettes (20 percent). When broken down by grade, current use of *any tobacco* has risen slightly for younger high school students (9th-10th grades), and fallen slightly for older students (11th-12th grades). (Refer to Figure 8.)

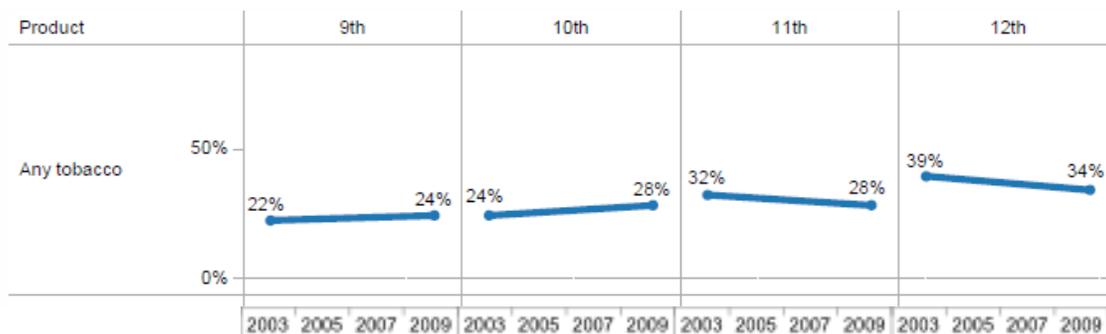


Figure 8: Trends in the use of tobacco products by Arizona high school students, 2003-2009

Access to Tobacco Products

CDC Outcome Indicator 1.11.2 Proportion of young people reporting that they have been sold tobacco products by a retailer

Students under 18 years of age often acquire tobacco products through social networks, borrowing or bumming cigarettes from friends. However, data reveals middle and high school students have different acquisition patterns.

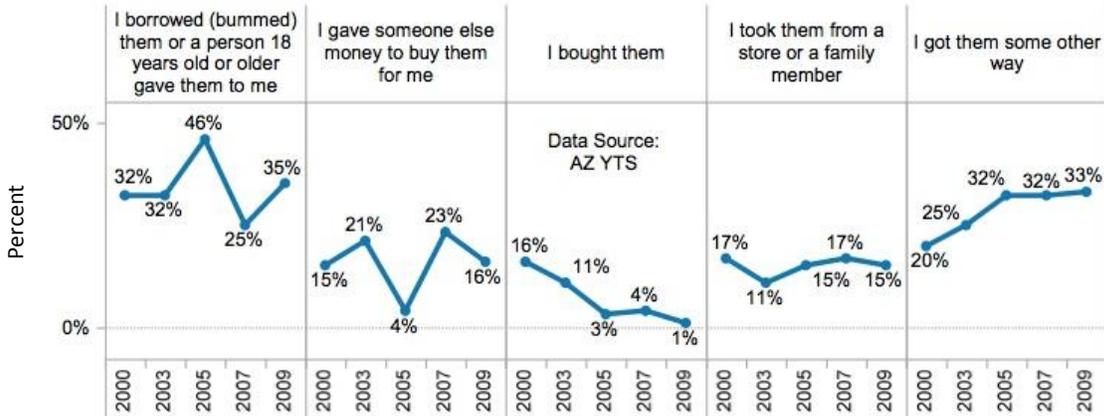


Figure 9: Self-reported access to cigarettes among middle school students, 2000-2009

Middle school students reported gas stations as the most common location for purchasing cigarettes. Fewer students reported buying cigarettes from convenience stores, smoke shops and over the Internet (See Figure 9); however, questions regarding smoke shops and the Internet as purchasing sources were not asked every year.

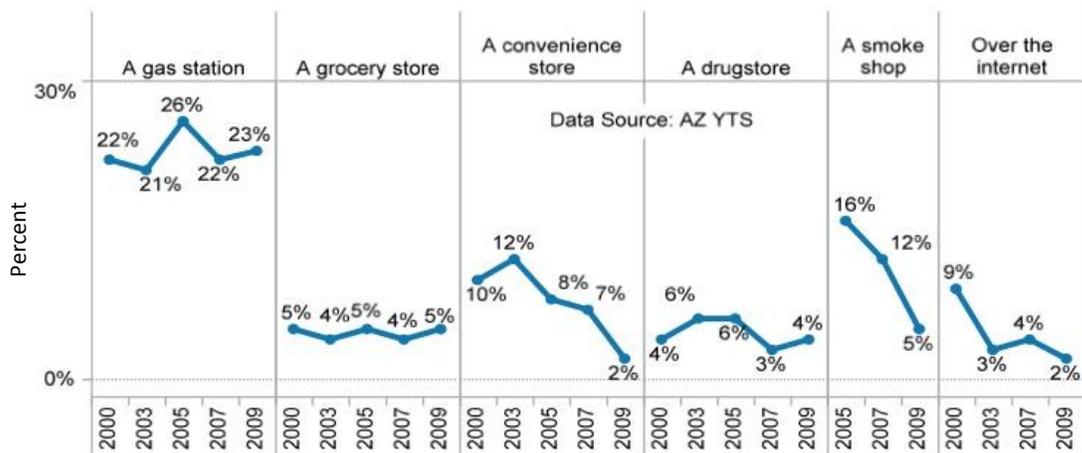


Figure 10: Store type where smokers in middle school bought their cigarettes, 2000-2009

The percentage of middle school students who were asked for proof of age when trying to purchase a tobacco product held a strong upward trend from 2000-2005, peaking at 30 percent. In 2007, however, the percentage of carded middle school students dropped 7 percent. While the numbers from 2009 indicate a slight gain to 25 percent, it is still short of the 2005 high (See Figure 11.)

The percentages for sale refusals to middle school students show a similar pattern; following a 2003 high of nearly 40 percent, 2005 began an upward trend. In 2009, about 1 in 3 students indicated that they had been refused a tobacco purchase.

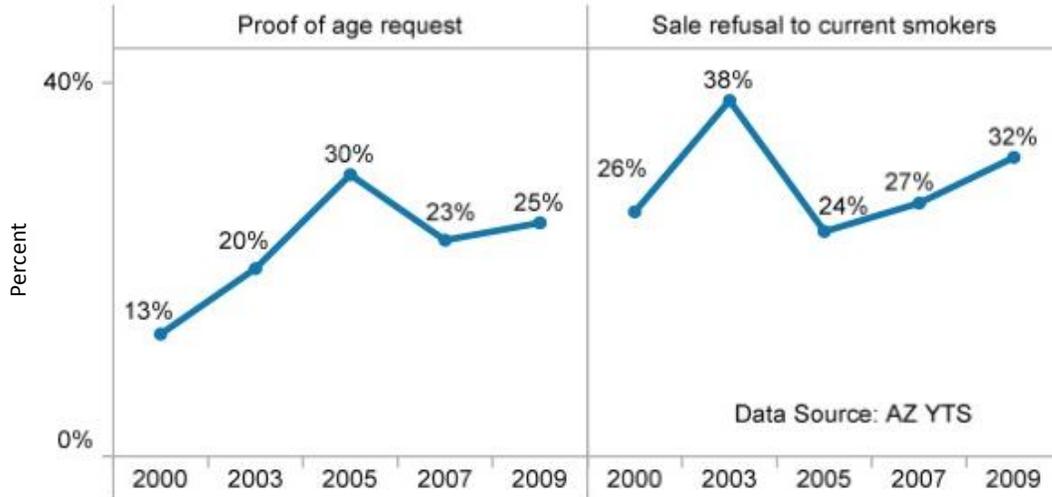


Figure 11: Self-report of middle school students who have been asked for proof of age and sale refusal, 2000-2009

Over time, fewer high school students have reported getting cigarettes through social means— from friends, for example—and more have reported buying them directly at retailers such as gas stations (See Figure 12). An increasing proportion of high school students also list “some other way” of obtaining tobacco products, but these means are not reported in any more specific detail.

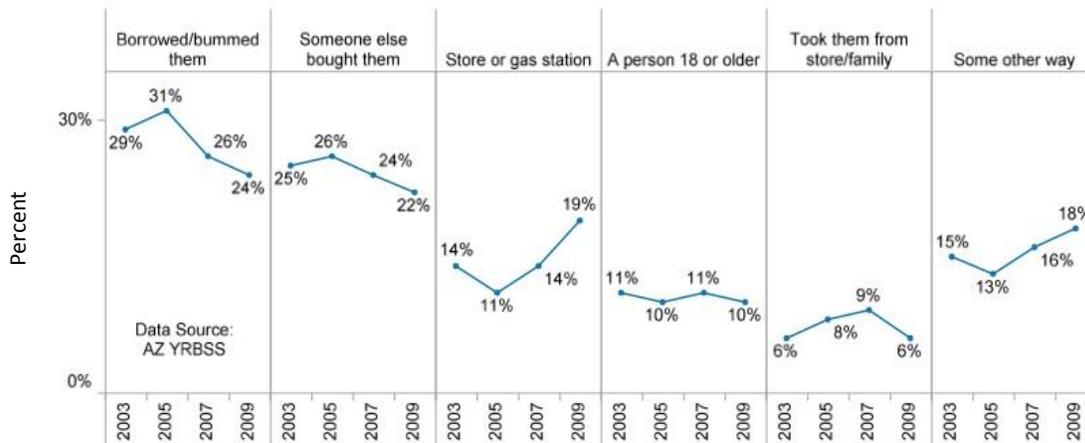


Figure 12: Self-reported access to cigarettes among high school students, 2003-2009

RESTRICTING YOUTH EXPOSURE TO TOBACCO

A.R.S. §13-3622, the “Youth Access Statute,” reads that

A person who knowingly sells, gives or furnished cigars, cigarettes or cigarette papers, smoking or chewing tobacco to a minor, and a minor who buys, or has in his possession or knowingly accepts or received from any person, cigars, cigarettes or cigarette papers, smoking or chewing tobacco of any kind, is guilty of a petty offense.

During FY09-10, BTCD was involved in several projects aimed at restricting youth access and exposure to tobacco products.

Youth Access to Tobacco Products: Attorney General's Youth Tobacco Program

The Attorney General’s Office (AGO) monitors compliance with and enforces the tobacco Master Settlement Agreement (MSA), laws restricting the availability and sale of tobacco products to minors, and Arizona’s non-participating manufacturer legislation, A.R.S. §44-7101 and §44-7111. AGO also operates and maintains the Arizona Youth Tobacco Program. The program seeks to:

- Reduce youth access to tobacco products
- Facilitate the efforts of local law enforcement agencies seeking to enforce Arizona’s youth tobacco laws
- Monitor the rate at which Arizona tobacco retailers comply with laws that prohibit the sale of tobacco to minors

The AGO systematically performs undercover investigations of tobacco retailers throughout the state. In order to assess compliance with the law, AGO agents and officers recruit, train and coordinate youth volunteers who visit tobacco retail outlets and attempt to buy tobacco products.

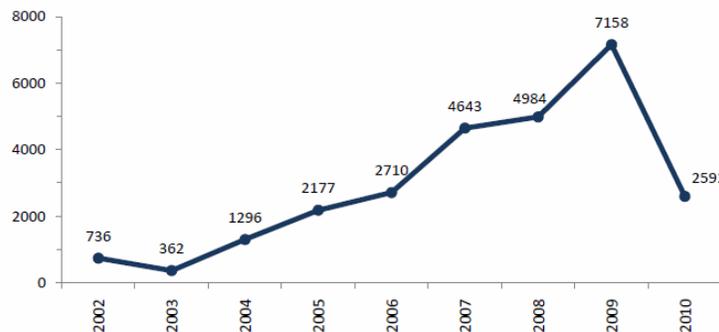


Figure 13: Total AGO inspections, 2002-2010

AGO conducts inspections, which are generally not announced, in every county in Arizona; compliance data from these inspections is then shared with local law enforcement, who also receive funding to conduct inspections within their communities, and ADHS. Since the program’s inception in 2001, it has conducted over 20,000 inspections and issued over 2000 citations. Since 2003, AGO has steadily increased the annual number of inspections (with the

exception of 2010; see Figure 13); this increase will naturally follow to the total number of failed inspections and citations. The percentage of failed inspections has been slowly trending downward, from a peak of 26.5 percent in 2004 (see Figure 14). In 2009, the program measured its highest rate of compliance, with only 309 out of 1758 inspections failing (4.3 percent). While 2010 posted a significantly higher fail rate than FY09 (14.9 percent), it still represented a drop from 2006-2008, where the fail rate held steady around 19 percent.

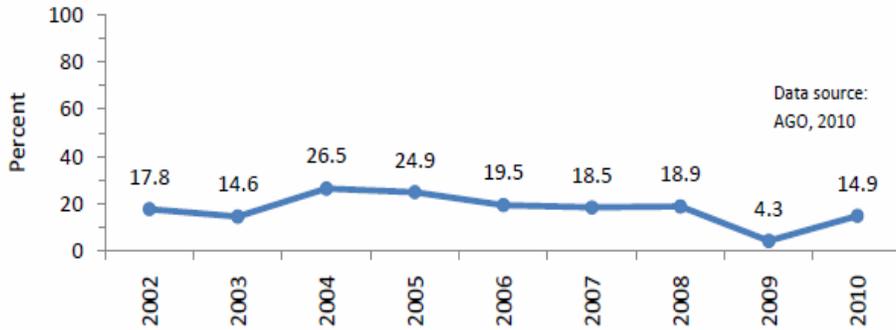


Figure 14: Percent of inspections that failed, 2002-2010

In contrast to the slow trend seen with failing inspections, the number of failed inspections that result in a citation has been steadily increasing. In its first year, citations were issued at 95.4 percent of failed inspections, followed by a steep drop in 2003 (to under 2 percent). However, since 2003, citations have been steadily rising; 2010 posted a citation rate of nearly 80 percent (see Figure 15).

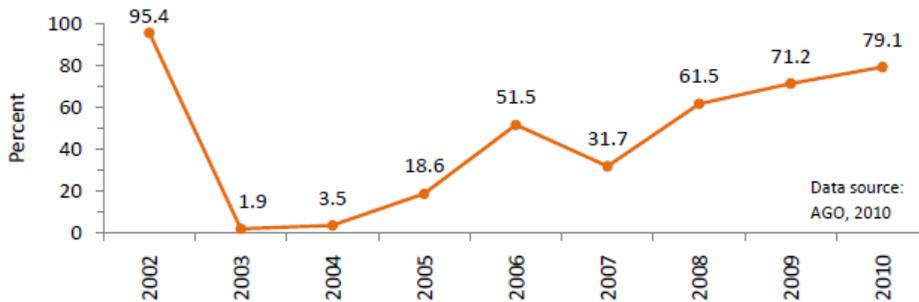


Figure 15: Percent of failed inspections that resulted in citations, 2002-2010

AGO faces many difficulties in translating failed inspections into policy change; citations are issued to the offending clerk, not his or her employer, making it difficult to establish corporate liability. However, the Family Smoking Prevention and Tobacco Control Act, signed into law in June 2009, seeks to diminish these hurdles; it requires federal inspections of tobacco retailers, under the purview of the FDA, and enforces stricter penalties for noncompliance.

Youth Exposure to Secondhand Smoke

Secondhand smoke contains cancer-causing chemicals and contributes to numerous diseases in both adults and children⁴. The impact of secondhand smoke on young people's health is heightened due to their ongoing physiological development. Young people are particularly vulnerable to exposure to secondhand smoke at home and in cars, where concentrations of toxic chemicals from tobacco smoke can reach excessively high levels.

Secondhand Smoke Exposure in Rooms and Cars

Figure 16 shows that among middle school self-reported exposure to second-hand smoke in a car or room at least once during the seven days prior to the survey has continued its decreasing trend in 2009. Overall, exposure in a room was still considerably higher than self-reported exposure in a car.

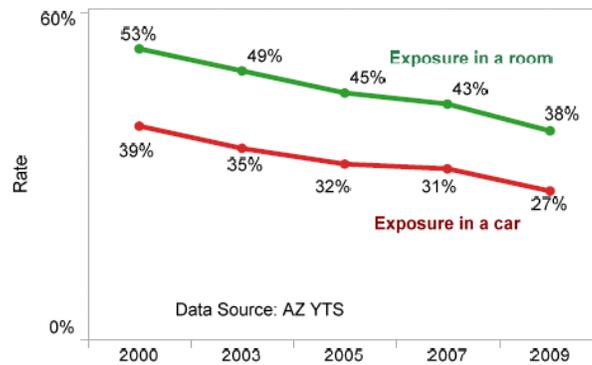


Figure 16: Self-reported exposure to second-hand smoke among middle school students during the past 7 days, 2000-2009

Figure 17 shows that among middle school students exposure rates declined for students living with a smoker and students not living with a smoker. However, strong differences emerged in the slope of the trend depending on the absence or presence of a smoker in the home. That is, reported exposure of students not living with a smoker decreased much more than exposure reported by students living with a smoker. This was true for both rooms and cars. Among those not living with a smoker, rates have dropped by about 50 percent for both rooms and cars. In contrast, those living with a smoker reported reductions of only about 10 percent over the same period.

⁴ U.S. Department of Health and Human Services (2006). The health consequences of involuntary exposure to tobacco smoke: a report of the Surgeon General U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, Coordinating Center for Health Promotion, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health.

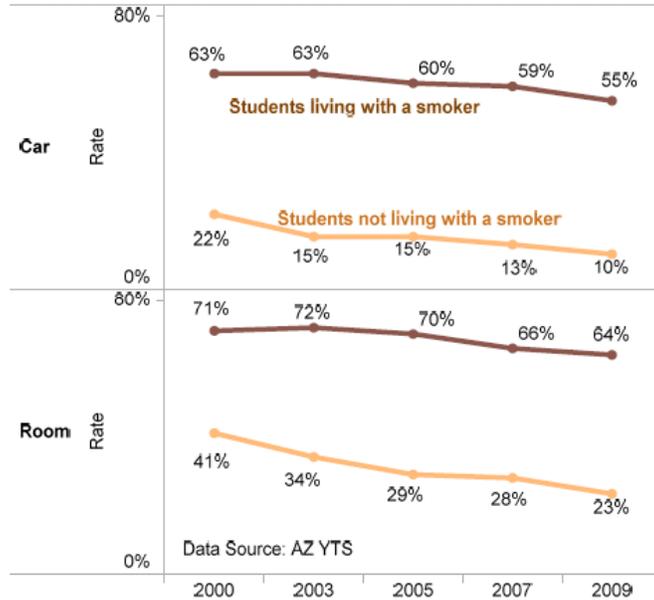


Figure 17: Self-reported exposure to second-hand smoke among middle school students, by presence of smoker in household, 2000-2009

Rules about Smoking in the Home

Figure 18 shows that middle school students reported steady increases in complete smoking bans at their homes, with a complementary decrease in partial bans and homes with no bans. The vast majority of middle school students now live in homes with a complete smoking ban.

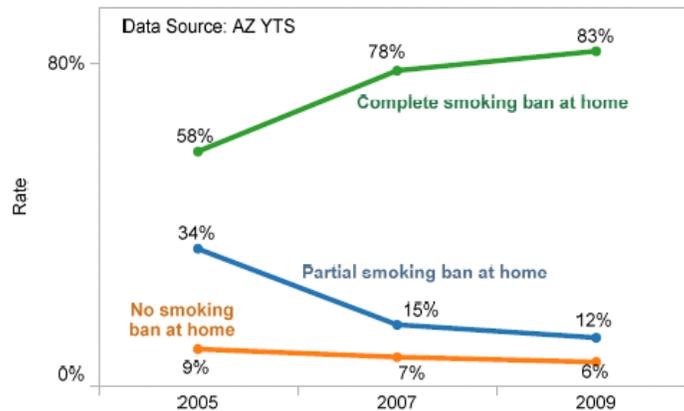


Figure 18: Smoking ban at home, 2005-2009

Overall, students living with a smoker were much more likely to report a partial or no smoking ban at their home than those not living with a smoker. (Refer to Figure 19.). However, those living with a smoker were much more likely to report a complete ban in 2009 than in 2005. The rate of complete bans at homes with smokers has almost doubled, whereas reported rates of no ban in those homes stayed roughly the same. Among those not living with a smoker, nearly all students reported a complete smoking ban at their home, up from roughly three out of four students in 2005.

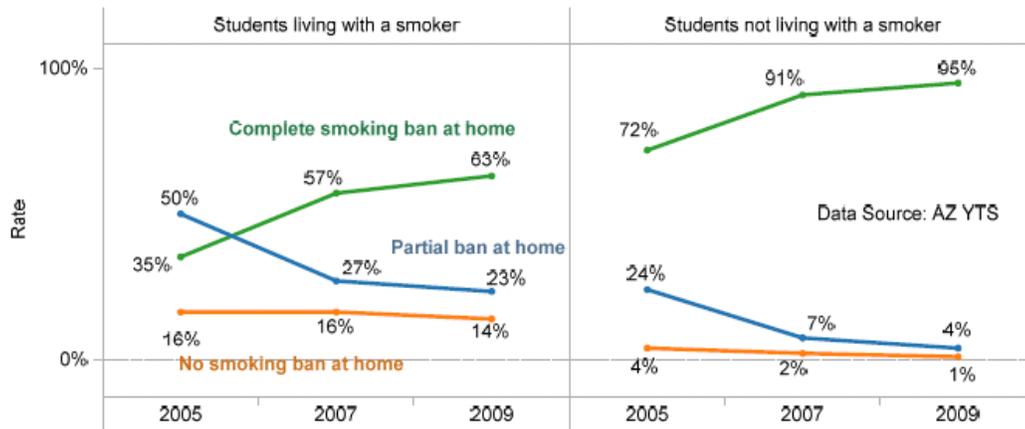


Figure 19: Smoking ban at home, by presence of a smoker, 2005-2009

YOUTH COUNTER-MARKETING

State tobacco control programs often lack the flexibility and authority to directly influence or advance tobacco policies that change social norms within a community. Thus, tobacco control programs cannot be considered truly comprehensive unless there are coalitions in place to actively advocate for policy change and foster a message of awareness around the issue of tobacco control (See CDC, *2007 Best Practices for Comprehensive Tobacco Control Programs*).

Youth play an intricate and unique role in advocating for tobacco control policy change because the age of initiation is lower—12 years old in Arizona—than the legal age to purchase tobacco products. Tobacco companies know that since adults report 19 as the average age for becoming a regular smoker, the 12-17 year-old target age group is extremely important. It is also extremely impressionable, and tobacco companies use specific marketing tactics to target this demographic.

From the release of the 1964 Surgeon General's report through the early 1990s, health education was primarily focused upon youth tobacco control intervention, based on the assumption that young people simply needed the right information to make the right choices. Interventions consisted of adults talking at youth, usually within a classroom setting and using scare tactics to demonstrate the negative health effects of tobacco. However, in the early 1990s, programs begin to notice that youth were not primarily influenced by statistics, but rather by their social environment—their peers, their family and the media. It is imperative that youth become more directly involved in addressing tobacco control policies, instead of being indirectly involved through health education; they are important strengtheners in developing future tobacco control policy.

BTCDC has set out to implement a counter-marketing campaign aimed at youth, to increase their knowledge and reduce the initiation of tobacco use. This campaign utilizes both traditional means (e.g., television, radio) and innovative media favored by youth (e.g., text messaging, music and social networking sites like Facebook, MySpace and Twitter). Additionally, an integral part of this campaign is the incorporation of grassroots outreach, to engage and empower youth to directly attach the manipulative efforts of tobacco companies, as well as

- improve policies around tobacco control
- change social norms
- reduce smoking consumption and the age of initiation in Arizona

This grassroots outreach will be achieved through a comprehensive statewide network of community youth coalitions, which will work within their own communities to counter-market anti-tobacco messages to youth in and out of school, making tobacco less desirable, acceptable and accessible.

Background: The Social Normative of Tobacco

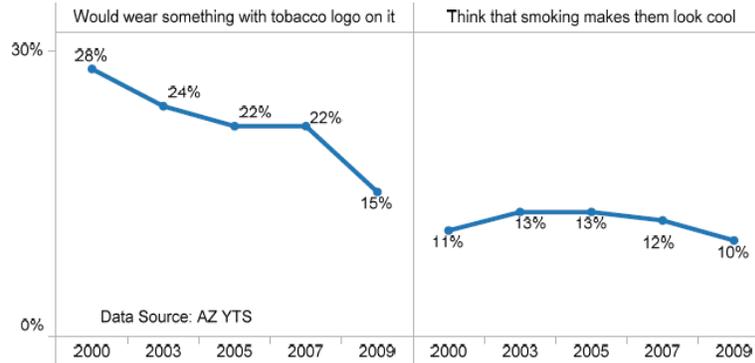


Figure 20: Arizona middle school students who would wear something with a tobacco logo on it (left) or think that smoking makes them cool (right), 2000-2009

CDC Outcome Indicator 1.6.2. Level of receptivity to anti-tobacco media messages

The AZ YTS asks middle school students whether they think smoking makes them look cool. This measure has historically been low, and its trend over the past decade has been stable (moving from 11 percent in 2000 to 10 percent in 2009).

The YTS also asks middle school students if they would wear something with a tobacco logo on it, and the trend here has been more significant. In 2000, 28 percent of students agreed that they would wear a tobacco logo; in 2009, this number was 15 percent, represented a roughly 50 percent decrease. (See Figure 20.)

The percentage of middle schools students whose parents talk to them about the dangers of smoking has remained stable since 2000, measuring 73 percent in 2009 (from 71 percent in 2000, and a peak of 75 percent in 2005).

Venomocity: Brought to you by addiciton

In 2007, BTCDD embarked on a statewide strategic planning process to address rising smoking prevalence rate among youth, 12-17 years old. It was determined the Bureau needed to raise awareness about tobacco among teens and to develop advertising to prevent youth from starting to smoke, reversing the trend of high youth prevalence and low age of initiation.

BTCDD formed focus groups and conducted input sessions targeting this age group; the "IK Council," or "I Know Council," evolved from these meetings. In an effort to incorporate youth into the policy process, this group of 12-17 year-olds then worked with BTCDD to develop an effective youth campaign.

The formative research with the target audience was telling. While the 12-17 year-olds reported knowing the negative health effects of smoking, and even described smokers as "gross, hairy-tongued and stupid," they still did not see that smoking today as teens would lead them into becoming "a smoker" later in life. Almost 90 percent of present-day adult smokers report starting in their teens, and two out of three teens that start younger will still be smoking when

they are 19 years old. While youth understood the harmful health effects of tobacco and all the “gross” factors, they did not ‘see’ tobacco's addictive qualities.

Using input from these focus groups, it was determined that this campaign was an opportunity to focus on addiction; by providing addiction with an identity, giving it dimensions and making it real, youth can better understand how it grows inside of them and takes control after just a few cigarettes.

Program Goals and Development

BTCDC worked with the IK Council, helped to help teens guide the creative process toward what they considered realistic and “not cheesy.” The IK Council helped create storyboards for the television and radio advertisements, Internet banner ads, social media elements such as Facebook and MySpace pages and the entire website “lair” at venomocity.com. Working in tandem with the youth, the creative team developed an identity for addiction. “Venomocity” evolved as the personality of addiction. Addiction became an entity that is never fully seen—appendages and flashes of imagery are visible, but never the whole “beast.”

Addiction/Venomocity wants you to smoke. It is a smooth talker, here to take control; it lurks within you when you take even the first puff of a cigarette. It has a lair—venomocity.com—which it invites kids to visit. On the website, youth can

- play tobacco themed games
- explore the “Hall of Fumes” to see tobacco addiction's greatest achievements throughout history
- play with an electro larynx to hear what the voice of a person who has lost their voice box to smoking sounds like.

Three commercials were also developed to suggest that addiction, through tobacco use, could take over after just a few cigarettes.

- “First Time” tells the story of a young girl trying her first cigarette, which she does not like, but is forced to resume smoking when the appendage of addiction pushes it back into her mouth.
- “Cravings” illustrates a young man fighting the desire to have a cigarette and the force of addiction driving him to smoke, with the appendage of addiction dragging him down a hallway to a lit cigarette.
- “Surrender” illustrates the control addiction has over a young man who is awakened from sleep by the appendage of addiction and forced to go outside for a cigarette.

The commercials were placed in targeted media—cable and broadcast television shows with an audience more than 50 percent 12-17 years old—in early 2009. They were also placed in theaters statewide, 10 minutes prior to PG-13 and R- rated movies. The commercials, and all media elements, have the call to visit www.venomocity.com.

The campaign’s kick-off coincided with President's Day 2009, when schools were closed and the majority of the target audience would be at Arizona malls. Four simultaneous kick-off events were scheduled at four different malls throughout the Phoenix metropolitan area; venomocity.com launched that day as well.

Venomocity Evaluation

The primary goal of *Venomocity: Brought to You by Addiction* is to increase awareness of addiction among youth. Campaign evaluation focused upon

- assessment of reach and frequency numbers
- analytics from Internet engagement, such as the number of visitors to venomocity.com
- an assessment of community/grassroots event engagement
- qualitative assessment by the IK Council
- eight focus groups with the target audience, which were conducted six months into the campaign
- an Internet-based survey emailed directly to the target audience, conducted at nine months

According to the measures, the program exceeded its initial goals. The focus groups and Internet survey indicated that the message is received and well understood by teens. “The ads made me think that after you smoke for the first time you can’t stop. It made me feel surprised,” was one focus group quote. Another teen said, “It scared me. It’s creepy to see how much hold your body/brain (even addiction) can have over you. The addiction or whatever the black thing was, it was a symbol of how controlling it is.”

Seventy percent of participants reported they had seen or heard the advertising on television, in a theater or on the Internet; the most common medium was television (80 percent); 76 percent of respondents also indicated that these commercials were “better” than other anti-drug commercials. Venomocity.com measured more than 350,000 page views; the average visitor stayed on the site close to six minutes, indicating that visitors were engaged with the site. Through statewide community events, including those held in both rural and urban areas, close to 10,000 youth email addresses were collected; this also addresses engagement as youth interact with [Venomocity](http://Venomocity.com) at an event, and then receive emails informing them of new features on venomocity.com and additional events happening near them.

The majority of respondents agreed or strongly agreed that the campaign helped them understand the harmful effects of tobacco (77 percent); helped them understand that tobacco is addictive (89 percent); and made them less likely to try tobacco (79 percent).

Youth Coalitions

In addition to the *Venomocity: Brought to You by Addiction* campaign, BTCD is working to develop a statewide network of local youth coalitions by FY2012, to directly involve youth in changing both the social norms surrounding smoking and current tobacco policy. To achieve this goal, the following objectives will be implemented:

- Review best practices and establish a Youth Coalition Development Plan
- Engage qualified partners to assist BTCD in engaging youth in development and extension of the Plan
- Engage youth statewide in local and statewide coalition activities for tobacco use prevention
- Create a youth coalition leadership council and youth communication hub at the statewide level that establishes the youth-led coalition efforts

- Provide on-going technical assistance and training on leadership, including peer-to-peer leadership, advocacy and community education.

Coalitions are one of the most cost-effective and efficient strategies for achieving social norm change; they also provide a healthy learning environment for youth to obtain skills in leadership and engage peer-to-peer communication.

Create the Movement: Be a Star

At the end of FY2010, BTCD launched an introduction to the youth coalition program with the 2010 Youth Tobacco Coalition Premiere Event. The event, held June 18-19 at NAU, hosted more than 200 students with the red carpet theme, “Create the Movement: Be a Star!” Attendees were largely chosen through current county-level anti-tobacco programs, and ranged in age from late elementary school to early college. Students participated in two of four concurrent sessions focused on coalition-building and tobacco policy:

- “All about the Benjamins” explained how corporate tobacco targets youth, particularly through social networking sites.
- “Freedom Writers” focused on the importance of public speaking in coalition building; it helped participants develop their abilities to answer questions on the fly and state their opinions clearly and powerfully.
- “Harold and Kumar” talked about new tobacco products on the market, making the point that alternative tobacco products like hookah, e-cigarettes and nicotine water just as dangerous as cigarettes.
- “Take the Lead” discussed the importance of understanding cultural backgrounds, that youth come from different cultures and ethnicities, have different tastes in food and music, and that because of this, tobacco affects youth in different ways.

The event was designed to introduce youth to the coalition campaign, as well as amp up excitement about more direct youth involvement in anti-tobacco policy efforts.

Join the Movement: Current Youth Coalition Activities

Efforts to build a sustainable network of youth coalitions are ongoing. There are currently several strong county-level youth coalition programs in Arizona. Current efforts are organized through BTCD's *Join the Movement* campaign, which hosts both a Twitter and Facebook page, and utilizes elements from the *Venomocity: Brought to You by Addiction* campaign.

For example, Pima County has a youth coalition of 600 students between 4th and 12th grades; outside of strictly focusing upon anti-tobacco efforts, the coalition promotes healthy lifestyles among youth. The coalition is comprised of over 60 charters, each of which is responsible for holding five events per year. Past events have included participating in the Tucson Rodeo Parade and national Kick Butts Day. See the Pima County Health Department's Tobacco website⁵ or the Pima County twitter page⁶ for more information.

Mohave County also has a strong youth coalition. The Kingman Youth Coalition: Beating up Teen Tobacco (KYC Butt) is comprised of students from Kingman High School (since 1998) and Kingman Academy High School (since 2006), and is an active participant at both the school and community level; activities include Adopt-a-Block clean-ups of cigarette butts, school presentations and assemblies, as well as BTCD's *Join the Movement* events. See the KYC Butt Facebook page⁷ for more information.

YOUTH CESSATION: HELPING TOBACCO USERS QUIT

CDC Outcome Indicator 3.11.2. Proportion of young smokers who have made a quit attempt

In 2009, roughly half of all current cigarette smokers in high school reported attempting to quit in the past twelve months; considering data from 2003-2009, this trend appears relatively stable. Likewise, 50 percent of middle school students reported a quit attempt; this represents a reversal in what was a downward trend, 2000-2007. (See Figure 21.)

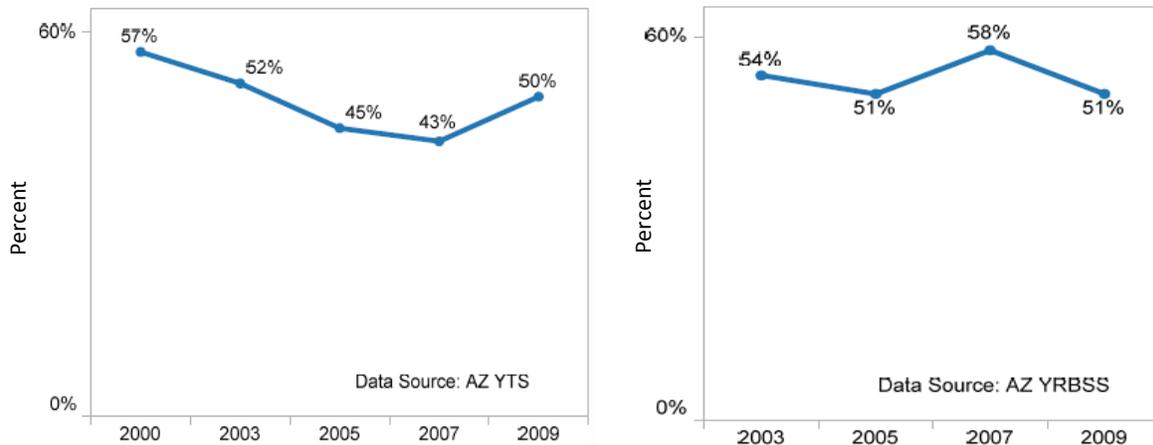


Figure 21: Self-reported quit attempts among current smokers in middle school, 2000-2009 (left), and high school, 2003-2009 (right)

⁵ <http://www.pimahealth.org/tobacco/>

⁶ <http://twitter.com/PCHDSwat>

⁷ <http://www.facebook.com/?ref=logo#!/profile.php?id=100000798506315&sk=wall>

ADULT PROGRAMS ACTIVITIES AND SERVICES

PREVALENCE OF ADULT TOBACCO USE

CDC Outcome Indicator 3.14.1 Smoking Prevalence

According to the 2009 Arizona Behavioral Risk Factor Surveillance Survey (BRFSS), 16.1 percent of respondents identified themselves as current smokers. Additionally, the Arizona prevalence of current tobacco use is less than the national prevalence. (See Figure 22.) Table 4 lists demographic information about respondents who reported they are current smokers.

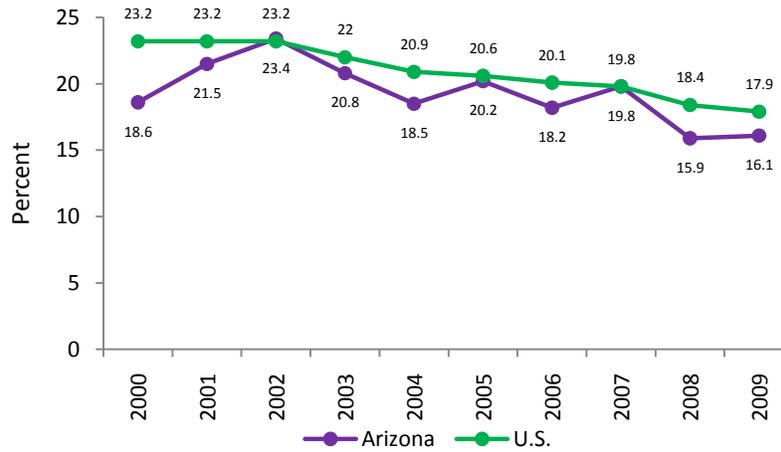


Figure 22: 2009 BRFSS, Prevalence of current tobacco use, Arizona and U.S.

Table 4: 2009 Arizona BRFSS, demographics of respondents who are current smokers

Sex			
Female	14.3	Male	18.0
Age		Employment	
18 – 24	15.0	Employed for Wages	16.5
25 – 34	18.5	Self-employed	13.6
35 – 44	16.4	Out of work	30.4
45 – 54	23.7	Homemaker	10.6
55 – 64	14.8	Student	11.2
65 or more	7.5	Retired	9.6
		Unable to work	36.4
Marital Status		Income	
Married	12.9	< \$25,000	26.2
Divorced	27.2	\$25,000 – \$34,999	20.1
Widowed	14.2	\$35,000 – \$49,999	22.6
Separated	30.6	\$50,000 – \$74,999	12.8
Never Married	19.5	> \$75,000	7.9
Unmarried Couple	26.2		
Education		Race/Ethnicity	
Less than High School	25.7	White, Non-Hispanic	16.0
High School Graduate/GED	24.9	Black, Non-Hispanic	14.1
Some College/Tech School	16.9	Other race, Non-Hispanic	16.6
College Graduate	6.6	Hispanic	15.7

CDC Outcome Indicator 3.14.2. Prevalence of tobacco use during pregnancy

According to the Arizona Department of Health Services Bureau of Public Health Statistics (ADHS BPHS), Health Status and Vital Statistics Section the prevalence rate of women who report tobacco use during pregnancy is 4.8 per 100 births in 2009, which is lower than 2005 (5.4 per 100 births).

ADULT PREVENTION: RESTRICTING EXPOSURE TO TOBACCO

Smoke-Free Arizona

Arizona went Smoke-Free in FY07. In November 2006, Arizona voters approved a statewide smoking ban (Smoke-Free Arizona Act A.R.S. §36-601.01), which essentially prohibits smoking in most enclosed public places, as well as worksites. The establishments are required to follow the 20 foot rule: smoking within 20 feet of an entrance is prohibited. According the Smoke Free Arizona website (www.smokefreearizona.com), the following establishments were required to implement the ban:

- Restaurants, bars, grocery stores, or any establishment that serves food
- Office buildings and work areas such as meeting rooms, employee lounges, classrooms, and private offices
- Healthcare facilities, hospitals, health care clinics, and doctor's offices
- Company-owned or employer-owned vehicles during working hours if the vehicle is occupied by more than one person
- Enclosed common areas in hotels and motels
- Lobbies, elevators, restrooms, reception areas, halls, stairways, and any other enclosed common-use areas in public and private buildings including condominiums and other multiple-unit residential facilities
- Any place of employment not exempted

There are some exempt public places, defined by A.R.S. § 36-601.01 (B), where smoking is allowed. The following is a list of exempt places:

- Private residences (except when used as a licensed child care, adult day care, or health care facility)
- Hotel and motel rooms designated as smoking rooms (no more than fifty percent of rooms rented to guests in a hotel or motel are so designated)
- Retail tobacco store (physically separated and independently ventilated so that smoke from retail tobacco stores does not infiltrate non-smoking areas)
- Veterans and fraternal clubs when they are not open to the general public
- Smoking when associated with religious ceremony practiced pursuant to the American Indian Religious Freedom Act of 1978
- Outdoor patios so long as tobacco smoke does not enter areas where smoking is prohibited through entrances, windows, ventilation systems, or other means
- Theatrical performance upon a stage or in the course of a film production or television production if the smoking is part of the performance of production

- Tribes are Sovereign Nations. The Smoke-Free Arizona Act has no application on Indian reservations as defined in A.R.S. §42-3301 (2).

The ADHS Office of Environmental Health is responsible for monitoring compliance with the law.

ADULT CESSATION: ARIZONA SMOKERS' HELPLINE (ASHLine)

ADHS BTCDC funds the Arizona Smokers' Helpline (ASHLine), which offers free telephone coaching, free on-line quit coaching through WebQuit on www.ashline.org and free or reduced cost nicotine replacement therapies and other medications for smoking cessation. In FY09, BTCDC no longer funded community-based cessation classes, and placed the statewide focus on ASHLine for cessation services.

The goal of ASHLine is to provide access to effective, research-based tobacco use cessation services for all Arizona residents. In order to achieve this goal, ASHLine offers the following services:

- Individual/personalized telephone counseling in English and Spanish
- Web-based information/online WebQuit
- Printed materials
- Access to free nicotine replacement therapies (NRT) and medications

Since its inception, ASHLine has received more than 10,000 calls each year. ASHLine utilizes various approaches to maximize the accessibility of tobacco cessation, including:

- Individualized quit planning design
- Client anonymity and confidentiality
- Proactive counseling
- Structured protocol counseling
- Culturally competent and sensitive counseling
- Multilingual services, including English, Spanish, Korean, Arabic

ASHLine has greater quit rate (nearly 40 percent) after six months compared to most national quitlines' quit rates (20 percent). When accompanied by medications ASHLine's quit rate is nearly 60 percent.

Medication to Assist Clients in Quitting

Current research indicates that one of the most effective tobacco cessation methods is a combination of quitline and nicotine replacement therapy, including prescription medications (NRT+). ADHS BTCDC, during FY09 and FY10, offered a medication benefit to ASHLine clients older than age 18 who were enrolled in services. The distribution services ADHS BTCDC contracted with for this service is beBetter Inc. The benefit included over-the-counter nicotine replacement therapy (NRT), specifically nicotine patches, gum, or lozenge. Each client could receive the benefit for two weeks. Unlike the voucher program, this program ships two weeks of products to the callers' homes.

In April 2008, the Arizona state legislature passed a bill which mandated that tobacco tax funds be transferred from ADHS BTCD to AHCCCS annually to pay for quit tobacco medications. These dollars are matched two to one by federal money. This benefit only applies to Title XIX medical beneficiaries. Beneficiaries under the age of 18 will need their health care provider's consent. Pregnant and breastfeeding women do not need special consent. The benefit covers all seven first-line tobacco cessation medications (nicotine patch, gum, lozenge, nicotine inhaler, nasal spray, bupropion, and varenicline) to be used for up to 12 weeks. An AHCCCS eligible participant can use this benefit once every six months.

Users’ Satisfaction with Tobacco Cessation Services

During FY09, the North American Quitline Consortium (NAQC) adopted an official formula for calculating the success of tobacco quitlines. ASHLine adopted the same formula to calculate its quit rate. For FY09, the ASHLine quit rate was 35.8 percent. In addition, ASHLine began assessing its own services and began calling 100 percent of clients, instead of a sample of clients. The follow-up survey found that 82.7 percent of clients were satisfied with ASHLine services.

ASHLine Counter-Marketing

In 2010, ADHS BTCD launched a multi-faceted statewide media campaign titled “You Can Quit. We Can Help.” to generate a greater call volume to the ASHLine and enrollment into ASHLine services. To achieve these goals, the primary objective was to generate between 525 and 720 calls per week. The second objective was to increase enrollment by at least 50 percent to approximately 830 enrollments per month. This campaign ran for eight months from May 2010 to November 2010.

Initially, ADHS BTCD utilized a campaign, titled “Dear Me,” which was received free of cost from the State of Washington at the end of 2009. It was launched in the beginning of 2010, but it did not have a strong enough call to action to achieve ASHLine's goals; consequently, the "You Can Quit. We Can Help." Campaign was created to promote cessation services of ASHLine.

Prior to the media campaign initiated in January 2010, the primary way that clients heard about the ASHLine was through their healthcare providers. Fifty-eight percent of ASHLine clients indicated hearing about services through their doctor or at a healthcare facility. A description of the proactive Quitfax Referral program is detailed in the Healthcare Provider Services section.

Table 5: How ASHLine clients heard about services

	Pre-Campaign (%)	Campaign (%)
TV	2.0	42.5
Radio	0.8	2.0
Billboards/Other media	7.9	4.3
Friends and Family	9.0	5.8
Doctor/Healthcare Facility	58.1	32.3
All Other	22.1	13.1

The new media campaign was based on the results of focus groups and various data sources (e.g. ATS, BRFSS, and reviews of cessation advertising best practices). Qualitative research

showed that an average smoker knew smoking was bad for their health and had a strong desire to quit, but needed help. The data also indicated that a smoker on average makes about eight quit attempts before succeeding. The call to action was to get smokers to call ASHLine. The success of the campaigns is apparent in the change in the percent of clients who responded that they heard about ASHLine services on television. The proportion of clients indicating seeing ads on television rose from two percent prior to the media campaigns to more than 42 percent. See Table 5 for details.

Four commercials were created, and debuted in conjunction with an earned media (public relations) effort for the national recognition day– World No Tobacco Day– in May 2010. The campaign included the four new television commercials, existing radio commercials, in-theater commercials and earned media, which included a media “tour” of several counties in the state to visit print and radio stations for interviews. The four commercials ran in all mediums through the end of November 2010. An intense earned media push was done to coincide with a surge in the commercials airing for the Great American Smokeout on November 18, 2010. After the Great American Smokeout, the television commercials were discontinued until December 27, 2010.

Table 6: Budget for cessation marketing

Total Budget for Cessation Marketing	\$1,293,775
Expended for Dear Me media placements (television and radio)	\$700,745
Remaining for You Can Quit Campaign	\$593,030
You Can Quit. We Can Help. Campaign Budget	\$559,592
Television commercial production	\$48,433
Media placements (television)	\$362,561
Media placements (radio)	\$138,091
Media placements (print)	\$9,851
Print developed in-house/no hard cost	\$656

The Campaign reached both goals during the time period it ran in 2010. It helped to generate the greatest average monthly calls to ASHLine compared to all previous years combined. Data showed that ASHLine received more than 24,700 calls during the Campaign. The call volume during the Campaign exceeded the primary objective with 774 calls per week. The total call volume was 327 percent greater month for month over the prior year’s call volume. Lastly, enrollment increased by more than 250 percent to 1400 enrollments per month, which exceeded the Campaign’s second objective.

Who are ASHLine Service Users?

The clientele of ASHLine is diverse, in part due to media reach. The following table (Table 7: ASHLine Client Demographics) is an indication of the clientele for FY09 and FY10. The percentages are based on the number of Client Intake Forms (CIFs) completed for the fiscal year.

Table 7: ASHLine clients demographics

	Fiscal Year 2009 N(%)	Fiscal Year 2010 N(%)
Client Intake Forms Completed	5205 (100)	9806 (100.00)
Gender		
Male	2569 (50.9)	3226 (40.7)
Female	2477 (49.1)	4693 (59.3)
Service Language		
English	4479 (95.7)	6757 (95.0)
Spanish	203 (4.3)	353 (4.9)
Sexual Orientation		
Heterosexual	4557 (95.5)	7129 (96.3)
Gay, Lesbian, Bisexual, or Transgender	213 (4.5)	278 (3.8)
Race		
American Indian/Alaska Native	91 (2.3)	158 (2.5)
Asian	19 (0.5)	29 (0.5)
Black or African American	310 (7.7)	510 (8.2)
Native Hawaiian or Other Pacific Islander	4 (0.1)	1 (0.02)
White/Caucasian	3598 (89.5)	5532 (88.8)
Hispanic		
Yes	889 (18.5)	1264 (17.1)
No	3918 (81.5)	6140 (82.9)
Insurance		
AHCCCS	1705 (44.4)	2436 (46.4)
Other Insurance	2138 (55.6)	2811 (53.6)

Proactive Referral System/QuitFax

Health and human service providers are recommended to ask every client about their tobacco use at every visit. For those clients who are looking for help quitting tobacco, ASHLine has created a fax referral form (QuitFax) making it easier for providers to ensure clients have access to tobacco cessation services. The 2010 Annual report by the North American Quitline Consortium (NAQC) identified Arizona as having the top proactive referral system in North America in FY09.

FY09 saw ASHLine formalize its Referral Development Team which focuses on a health systems change model. The ASHLine Referral Development Teams works with Arizona health systems to implement changes around policies and practice for assessing and treating tobacco use with every patient. During FY09, 46 health systems made more than 5600 referrals to ASHLine; in FY10 47 health systems made more than 6300 referrals (See Table 3.). The efforts of the Referral Development team reach beyond health systems when encouraging people to refer to ASHLine for tobacco cessation services. During FY09, 1,264 individuals at 624 locations made referrals to ASHLine. That number increased to 1,508 individuals at 648 locations.

Table 8: Number of health systems referring to ASHLine

	FY09	FY10
# of Referring Systems	46	47
# of Referrals from the Systems	5691	6371

Table 9: Number of referring agents and locations

	FY09	FY10
# of Referring Agents	1264	1508
# of Referring Locations	624	648

Table 10: Number of referrals by location type

Location Type	FY09 # Referrals (%)	FY10 # Referrals (%)
Behavioral Health	97 (1.1)	114 (1.1)
BTCD Partner	326 (3.8)	667 (6.6)
Community Group	54 (0.6)	178 (1.8)
Community Health Center	1555 (18.0)	1754 (17.5)
Dental Practice	87 (1.0)	86 (0.9)
Health Insurance Group	271 (3.1)	282 (2.8)
Hospital	2232 (25.9)	2680 (26.7)
IHS/Tribal 638	13 (0.2)	11 (0.1)
Medical Practice	2724 (31.6)	3270 (32.6)
Pharmacy	4 (0.0)	85 (0.8)
School/University	19 (0.2)	50 (0.5)
WIC	367 (4.3)	370 (3.7)
Worksite	288 (3.3)	388 (3.9)
Other	596 (6.9)	101 (1.0)
Total	8633 (100.0)	10036 (100.0)

Referrals may be made to ASHLine via a fax using the QuitFax form or online using ASHLine’s online portal known as WebQuit. The form (both QuitFax and online) provides ASHLine with a client’s name and contact information. Within 24 hours of receiving a referral, a referral call team member attempts to contact the client, with a minimum of three attempts to reach them in 10 days. The clients are informed of the telephone cessation coaching available at ASHLine. In order to keep the providers informed, ASHLine sends a fax or email with information on the services a client has accepted to the healthcare provider.

Table 11: QuitFax referral system

	Fiscal Year 2009 N (%)	Fiscal Year 2010 N (%)
Total Referrals	8633	10036
Clients Enrolled	2664 (30.9)	3902 (38.9)
Received Some Level of Service (of the Clients Enrolled)	2162 (81.2)	2482 (63.6)

IDENTIFYING AND ELIMINATING TOBACCO-RELATED DISPARITIES

There are certain groups that exhibit disproportionately high morbidity and mortality rates associated with tobacco use. Factors including, but not limited to an individual's age, race/ethnicity, educational attainment, income, and sexual orientation, greatly contribute to health disparities within a given population. Tobacco-related disparities are demonstrated by increased prevalence of tobacco use, greater exposure to secondhand smoke, and limited access to educational information and prevention/cessation programming, among other considerations.

In 2009, ADHS BTCDC solicited a Request for Grant Application (RFGA) seeking grant proposals from community organizations to conduct community assessments that would assist with capacity building and program planning for the development of sustainable commercial tobacco prevention programs. Additionally, BTCDC secured a five-year grant from the Center for Disease Control (CDC) to develop an integrated project that will engage community partners to achieve sustainable positive change in reducing health disparities relating to diabetes, tobacco-use, and obesity. The Community Health Initiative to Reduce Disparities (CHIRD) is a comprehensive project that will be completed in four major phases:

- Project infrastructure and development
- Community and health system assessment
- Building an infrastructure for services
- Increase utilization of services

With the combined resources of tobacco tax revenue dollars and CDC grant funds, eight community organizations, including eight sub-contracts, six of which were funded to conduct community and health systems assessments with the end goal of increasing utilization of services. The funded organizations will be conducting work in various communities throughout the state in these population groups:

- African American
- American Indian: seven (7) tribal nations and three (3) urban centers
- Asian-Pacific Islanders
- Hispanic youth and families
- Migrant farm workers
- Re-entry jail population

A number of assessment methods were utilized for the community assessments. These methods included: asset mapping, surveys, focus groups, key informant interviews, and best practice reviews. The BTCDC worked with the organizations in the development of the questions used in the surveys, focus groups, and interviews. Throughout the process, the BTCDC assisted with survey data analysis, training on report writing, and facilitation of strategic planning. The following is a summary of the results from each of the community assessments.

Black Hills Center for American Indian Health (BHCAIH): Navajo Nation Project

The high rates of smoking among Navajos, particularly among young adults and adolescents, are accompanied by lenient attitudes toward smoking on the Navajo Nation. Efforts to promote effective health policies have been met with opposition by the tribal leaders who have

exempted the casinos from the no smoking efforts. The issue provides many challenges because of the conflicts between the traditional view of tobacco as a sacred plant to be used in ceremonies and its current casual use; there is an absence of training on this issue by health providers. The strategic plan outlined by BHCAIH calls on hospitals/clinics to:

- ask patients about tobacco use
- refer smokers to quit lines

BHCAIH will institute training, technical assistance, and follow-up to implement a series of strategies, including a tool kit to achieve the objectives.

Asian Pacific Community in Action: Asian Pacific Islanders

This project serves a diverse population of about 125,000 residents in Maricopa County, which is composed of various Asian groups (Chinese, Asian Indian, Filipino, Vietnamese etc.). This population is confronted by significant barriers, including cultural and linguistic, as well as disproportionate high rates of chronic diseases, including diabetes, liver cancer, cardiovascular, respiratory, arthritis, and stroke. Tobacco use varies among the groups, but is highest among the Vietnamese population. The program links the use of tobacco with chronic diseases and thus takes a comprehensive approach that includes self-management, cessation services and linkages to their existing networks.

The assessment strategies, including focus groups and key informant surveys, which were used to establish their goals which are to expand and institutionalize their Chronic Disease Self-Management Program over the next three years by:

- developing a team of trainers
- establishing a Lay Health Advisory Council
- completing an initiative with “hard to reach communities”
- publishing articles on chronic diseases in local newspapers and websites

Worthy Institute: Hispanic Youth

The Youth Tobacco Community Assessment Project’s aim is to strengthen the health infrastructure that address tobacco related issues facing Hispanic youth and their families. While developing a strategic plan, the project identified and developed partnerships and other groups to collect data and identify appropriate resources within the impacted community. It is important to note that the Hispanic community does not view smoking as a high priority problem, as they do education, crime, poverty, and legislation such as SB1070. However, Youth do view smoking as a negative behavior.

Based on the findings of the risk factors as well as the strengths in the Hispanic community (e.g., long history in the community, strong families, cultural pride), the strategic plan includes changing perceptions of the use of tobacco, incorporating dangers of drug use with that of tobacco, developing culturally appropriate strategies, and encouraging community groups to invest greater resources.

Inter Tribal Council of Arizona, Inc. (ITCA): Five Tribal Nations and Three Urban Centers

Tobacco related chronic diseases are a major health concern among Native American communities as they have the highest rate of tobacco abuse, according to ITCA. Among Native American youth, the rate is nearly 70 percent.

The ITCA Community Education and Prevention Program (CTEPP) began developing a strategic Plan in collaboration with five Tribes and three Urban Indian Centers by conducting a Community Needs Resource Assessment in their respective communities. The CTEPP identified health priorities, resource accessibility and availability, attitudes on support of ordinances regarding commercial tobacco use and access, as well as conducted surveys, focus groups, interviewed key informants, and provided training, technical assistance and held meeting. There was consensus among the nearly 2500 respondents:

- 70 percent believed that youth should receive in class tobacco and drug prevention education in the schools
- 60 percent would call a statewide quit line for cessation services
- 75 percent would call for tribes to enforce youth access laws
- 83 percent supported ordinances for smoke-free buildings

Based on these findings, the Tribes and the Urban Centers developed a Strategic Plan that would:

- Integrate tobacco prevention with chronic diseases programs
- Implement a reminder system among health providers of tobacco products
- Build chronic disease self management programs
- Work with youth, coalitions, and existing networks to implement strategic plan

Concilio Latino de Salud: Re-Entry Jail Population (Maricopa County)

The project focuses on incarcerated persons reentering a targeted neighborhood within the city of Phoenix. This project is different from others in that its population is well-defined. Since Maricopa County jails are tobacco-free, the idea is to track individuals who are released to see if they can remain nicotine-free upon their reentry.

The project is a collaboration with the Canyon Corridor Weed and Seed Prevention, Intervention, Treatment Committee and proposes an asset-based community development approach to provide cessation and chronic disease resources to inmates prior to reentry. Its aim is to increase the number of reentry population referrals to ASHLine through a pilot program as part of the AHCCCS application process.

Campeños Sin Fronteras (CSF): Hispanic and Migrant Farmworkers

Staff will integrate tobacco use prevention and cessation in all CSF programs: Chronic Disease Prevention, Youth Programs, Employment and Training Services, and Housing Development. They will also provide training to five local community agencies on the Tobacco Cessation Brief Intervention tool, titled “2 A’s and an R,” and ASHLine. In addition, staff will educate 1,000 farm workers on tobacco prevention and cessation, and chronic disease self-management, as well as

work with Yuma County Health Department to provide education and technical assistance to five agricultural companies on developing and implementing smoke-free workplace policies.

Tanner Community Development Corporation: African American

This program provides technical support to the Anti-Tobacco Community of Practice Coalition regarding the smoke-free multi-tenant housing initiative. They work with other community partners in the development of a statewide network of youth coalitions, by identifying youth to participate. Tanner also collaborates with existing partners to identify methods to integrate tobacco and chronic disease components into the Barber/Beauty Shop Blood Pressure Program. Lastly, they work with partners to identify methods to integrate tobacco and chronic disease components into the First Time Motherhood/New Parents Initiative.

REDUCING THE BURDEN OF CHRONIC DISEASE

MAYO CLINIC STROKE TELEMEDICINE FOR ARIZONA RURAL RESIDENTS

Stroke Telemedicine for Arizona's Rural Residents (STARR) - Effect of Telemedicine Acute Stroke Care in Rural Hospital Emergency Departments, an ADHS research grant⁸ awarded to Mayo Clinic, provides 24/7 emergency telemedicine stroke services to hospitals located in rural and underserved areas throughout the state of Arizona. The original aim of STARR was to address the shortage of stroke specialist care in rural and underserved Arizona communities by utilizing advancements in telemedicine. Based on a hub and spoke design the goal of Mayo Clinic STARR was to develop a six-spoke network in Arizona that would be self sufficient at program maturity. A transition plan from ADHS sponsored funding for spoke sites to a subscription fee based model was implemented for the six original spoke sites. Additional sites would join the network under the fair market value based subscription fee model.

The initial cohort of hospitals (Yuma Regional Medical Center (YRMC), Kingman Regional Medical Center (KRMHC), La Paz Regional Hospital (LPRH), and Copper Queen Community Hospital (CQCH)) received Telestroke services under STARR- Effect of Telemedicine Acute Stroke Care in Rural Hospital Emergency Departments. This research grant is scheduled to expire March 19, 2011, and stipulates that Mayo Clinic STARR provide Telestroke services for six (6) rural hospitals within the state of Arizona. Additional discussions allowed for the target population definition to expand from rural to rural and underserved populations. Thus, the addition of Verde Valley Medical Center (VVMC) and Maricopa Integrated Health System (MIHS) fulfilled the goal of the Mayo Clinic STARR program. In July 2010, Flagstaff Medical Center (FMC) became the first hospital to join the Arizona Campus of Mayo Clinic Telestroke Program under the subscription fee model.

A transition plan has been developed for affiliate spoke hospitals currently funded under the ADHS research grant to continue receiving Telestroke services after the expiry of ADHS funding. Telestroke Service Agreements have been delivered to each ADHS funded spoke hospital. The plan allows for a seamless transition from ADHS funding to a subscription fee model without any interruption in services once ADHS funding ends. All ADHS sponsored spoke hospitals have favorably viewed the Telestroke Service Agreements they have received and have begun internal review of the agreement. Preliminary indications show a unanimous interest in continuing participation in the Mayo Clinic Telestroke Program.

FIT AT FIFTY HEALTH PROGRAM

The goal of this program is to increase colorectal cancer (CRC) screening rates for Arizonans by providing free screens for the uninsured and encouraging screening among the insured. Funding for this program comes from Proposition 303 and CDC. Specifically, Prop 303 funds for the screens of symptomatic patients, whereas the majority of CDC funding is used for activities related to program development and training. iFOBT, immunochemical fecal occult blood test, is used to screen if may be risk for CRC. Individuals that have a positive iFOBT are further screened with a colonoscopy.

⁸Solicitation No: HP961118

When the program was first launched three health facilities were contracted, now, there are seven contracted sites. Challenges that confronted the program are predominately administrative. It was found that programs that had the greatest success were at sites with a strong Well Women Health Program infrastructure.

This program also receives funding from CDC, and sponsored screening began March 10, 2010. In the first CDC evaluation, Arizona surpassed the benchmarks established for all the CDC core quality indicators. (See Table 12.) Almost all new clients, who were at average risk for CRC, were screened, and those that presented abnormal tests had complete diagnostic follow-ups.

Table 12 Core Quality Indicator Summary

INDICATOR TYPE	DESCRIPTION	CDC BENCHMARK	ARIZONA
Screening Priority Population	Percent of new clients screened who are at average risk for CRC	≥ 75%	95.4%
	Percent of average risk new clients screened who are aged 50 years and over	≥ 95%	100%
Completeness of Clinical Follow-up	Percent of abnormal test results with diagnostic follow-up completed	≥ 90%	92.3%
	Percent of diagnosed cancers with treatment initiated	≥ 90%	NA*
Timeliness of Clinical Follow-up	Percent of positive tests (FIT) followed-up with colonoscopy within 90 days	≥ 80%	88.9%
	Percent of cancers diagnosed with treatment initiated within 60 days	≥ 80%	NA*

*Patients diagnosed with colorectal cancer were found early in the program, prior to screening with CDC funds. Therefore, they do not show up in this report. (The report evaluates patients served with CDC funding.) Three colorectal cancers were found in this time period and treatment was provided within two weeks. If they were included in this spreadsheet Arizona's result would be 100%.

WELL WOMEN HEALTH PROGRAM

The goal of the program that is funded by Prop 303 is to increase breast cancer screening rates for rarely or never screened women. Specifically, Prop 303 provides funding for screening mammograms, diagnostic mammograms, consults and office visits, ultrasounds, MRIs, biopsies, and pathology analysis.

Number of screening procedures

Mammogram (initial)	6204
Clinical Breast Exam	7049
Pap Test	4506
Pelvic Exam	4736
Total	22495

Number of women screened across screening procedures

Mammogram (initial)	6170
Clinical Breast Exam	6735
Pap Test	4418

Pelvic Exam	4613
Total	7678

Number of cancer cases

Breast	91
Cervical	6
Total	97

MUCH ACCOMPLISHED...AND MUCH MORE TO DO!

Just two years ago, I reported in the Biennial Report that we had worked with our many partners at the local, state and national levels to launch the beginning of a major change in the prevention and treatment of tobacco use and chronic disease! We had implemented new program directions that were characterized as “evidence-based,” more sustainable at the local and state levels, and able to withstand an era of decreasing revenues. Since then, during the past two years, *Arizona has moved the bar on several important areas of tobacco control, and is ranked in the “Top Ten” of several major categories: lowest exposure to secondhand smoke in the home and workplace, lowest tobacco use among pregnant women, highest drop in overall tobacco use, highest drop in heavy tobacco use among youth, fifth lowest tobacco use among women, and seventh lowest overall tobacco use.*

Through robust efforts in creating a state-of-the-art Quitline, establishing linkages to healthcare systems, increasing public awareness and skills in quitting tobacco, using social media and the internet to reach youth, enforcing laws pertaining to tobacco sales to youth, and building the beginnings of a statewide youth movement, *fewer Arizonans are now using tobacco and the implications for a healthier, less costly Arizona are clearly evident.*

But, while we have accomplished a great deal, we still have more to do. Tobacco use is on the rise among 12th graders in our state, and many of our youth are turning to hookah and smokeless tobacco, and we must continue our vigilance on the dangers of addiction. And while tens of thousands of Arizonans have quit smoking, more than 800,000 continue to smoke and endanger children with second-hand, and even third-hand smoke. Thus, we must continue to ensure high levels of evidence-based strategies such as bold social marketing, data-proven quitlines, and access to medications for those who are uninsured or under-insured.

In the U.S, seven out of ten deaths each year are the result of chronic diseases that could have been prevented or effectively managed. Heart disease, cancer, lung disease and stroke account for more than 50 percent of all deaths each year. Through new and expanded community partnerships, we are identifying and reducing health disparities and helping people living in rural areas gain access to stroke treatment.

By merging the Bureaus of Tobacco and Chronic Disease, we have brought integration and efficiencies that can ease the burden of chronic disease in Arizona, as more people seek annual health checks, know their blood pressure, cholesterol and glucose levels, and acquire the necessary self-management skills that can extend their years of life and productivity.

Working side-by-side with our many partners across Arizona, every day we move closer to our goal of having a state that is free of commercial tobacco abuse; every day we gain ground in the fight to reduce unnecessary suffering and loss due to preventable disease; and every day we increase the financial gain that benefits us all when people choose healthy behaviors.

Wayne Tormala, Bureau Chief
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Arizona Department of Health Services
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