Rural Geographic Areas/Amish and Mennonite

American Lung Association. Pennsylvania

Rural Geographic Areas

Why it Matters

- Residents in rural and nonmetropolitan are twice as likely to smoke as their counterparts residing in urban areas (22.5% versus 11.4%).[1]
- Adult use of smokeless tobacco (current) is higher in non-metropolitan statistical areas (MSAs) than large MSAs (6.6% versus 1.9%).[2]
- Many of the populations prioritized in other sections of this document (e.g., people who are Hispanic, youths, or veterans; women who are pregnant; people who have low incomes; and people who are LGBTQ) also use tobacco at higher rates if they reside in a rural setting rather than in an urban setting.[3]
- People living in rural areas have 18%-20% higher lung cancer mortality than people living in urban areas.[4]
- Residents of rural areas face greater barriers to education, prevention, and cessation treatments.[5]
- Many sociodemographic variables associated with higher tobacco use are more prevalent in among people living in rural areas (e.g. low educational attainment, lower income, lower employment, higher uninsured status). However, in longitudinal studies post-2104, the higher prevalence in rural tobacco use persists after adjusting for these variables.[6]
    - Exceptions to this include: People who are Black Non-Hispanic, Asian, or American Indian.[7]
- Rural areas compound socioeconomic impacts with higher cancer mortality among people with low incomes living in rural areas than those living in metropolitan areas.[8]
- Rural health stakeholders responding to a nationally disseminated web survey, established ten priorities for Rural Healthy People 2020. Tobacco use was ranked number 10 (from among 38 included in Healthy People 2020). This speaks to the need to integrate tobacco into other higher ranked initiatives such as diabetes (3), mental health (4), substance abuse (5), heart disease and stroke (6).[9]
- Health care providers in rural areas report diverse multiple practice settings, the need for a generalist perspective, estimate that more of their patients smoke, and are less likely to assess smoking practices and initiate cessation interventions.[10]

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What We Know About What Works

- In general, the evidence-based programs recommended for people living in urban areas also work for people living in rural areas, including both prevention and cessation efforts. This includes:
  - Mass media counter-marketing and T-21 campaigns to prevent youth initiation
  - Promotion of electronic access to cessation resources, including quitlines
  - Promoting better insurance coverage to remove cost barriers
  - Building health system capacity to support provider engagement
  - Tailored messaging to priority subpopulations
- Policies such as smoke-free air interventions are also effective, but Pennsylvania has preemption laws that limit what local jurisdictions can do.
- The creation of broad-based coalitions can appeal to rural communities' close-knit social networks, overlapping professional and personal connections, and value of mutual aid, reciprocity, and civic engagement (e.g. Mississippi Delta Health Collaborative and Franklin (Maine) Cardiovascular Health Program).
- Among medically underserved worksite participants living in rural areas, educational interventions can increase knowledge regarding the dangers of tobacco use and secondhand smoke exposure. Among current tobacco users, these interventions also increased family rules regarding secondhand smoke exposure in their homes and vehicles.[11]
- The use of remote monitoring and reinforcement of smoking abstinence may enhance the accessibility and acceptability of cigarette smoking abstinence reinforcement programs, particularly in rural areas where transportation can be unreliable and treatment providers are distant.[12]
- For providers in rural areas, consistent, strong curricula education at all health provider levels and continuing education for new and more effective strategies are essential to empower health care providers to address smoking cessation interventions consistently and effectively.[13]
- Qualitative studies of women living in rural areas and who have low incomes identify social support and the individual's social network as significant factors in the decision to stop smoking and individual success with long-term smoking cessation.[14,15]
- A review of the research, however, finds that most cessation intervention research that incorporates social support for tobacco users living in rural areas offers it through distant resources such as telephone, internet, etc. Outcomes using this strategy are inconclusive.[16]

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- The EPIC electronic health record (EHR)-enabled point-of-care treatment model for tobacco use assessment and cessation treatment developed for a large cancer center was adapted for use in a rural setting to validate, by direct medical assessment, the differences in rural healthcare related to smoking and cessation treatment. The study confirmed higher smoking prevalence, lower engagement in smoking cessation treatment, and less likely to receive smoking treatment in rural versus urban cancer clinics. Further, people who currently smoke and who visited the clinics with the ELEVATE module were significantly more likely to receive care and engage in cessation treatment than in clinics without the module. The authors conclude that embedding screening and treatment support in the EHR offers the potential to extend the reach of cessation treatment across rural settings.[17]
    - Note: Other research also indicates that electronic health records can improve documentation of tobacco use and increased counseling assistance. However, the EPIC ELEVATE initiative is focused specifically on rural clinics.
- Youth living in rural areas respond more strongly than their peers in urban areas to national tobacco counter-marketing campaigns. Response increases as the level of exposure to campaign messages increase.

What's Relevant in Pennsylvania

- In 2018, about 26% of Pennsylvania's population lived in rural counties. This is higher than the national average of 17.5%.
- A Rural Tele-Cessation Pilot is currently being developed as the result of the efforts of the American Lung Association, the Erie Department of Health, PA Department of Health, and Pennsylvania Office of Rural Health to provide a resource to rural patients wishing to quit smoking. The pilot will be a combination of the Lung Association's Freedom From Smoking® program and the Quitline initiative. This pilot will provide support via telephone, in addition to resources to quit smoking, such as nicotine patches and nicotine gum. Once patients are identified as interested participants, a weekly support line, with free access will be utilized at an agreed upon convenient time to participate in a tobacco cessation group clinic. Many of the hospitals participating in the Model have cited smoking as being a major contributing factor to symptoms of chronic diseases seen often in their emergency departments such as Chronic Obstructive Pulmonary Disease (COPD) and Chronic Heart Failure (CHF).
- The tele-class will provide patients living in rural areas a resource to assist with quitting smoking that they may not have otherwise had access to. Historically, transportation and broadband access have been barriers for those living in rural areas to participate in support groups, which have been shown to have successes in assisting people in their efforts to quit smoking. The use of a telephone conference support line will eliminate any transportation barriers or WIFI access concerns and will allow patients to access the support from the comfort and convenience of their own homes. This best of breed combination of the Freedom From Smoking program and the Quitline is especially relevant to those living rurally and struggling with access to support services available to those living in more urban environments. This patient-centric pilot will not only provide support via the conference line but will also assist with resources related to nicotine replacement therapy such as gum and patches.

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What Other States are Doing

- The Rural Oklahoma Network is part of AHRQ's Practice-Based Research Networks initiative. As part of that network the Oklahoma State University Center for Health Systems Innovation is doing some groundbreaking work with ways to use technology to support and streamline provider practices' ability to enable provider-assisted quit attempts. As of August 2020, they are still evaluating the data from a preliminary trial, one observation has been the patients living in rural areas opened messages sent from their health systems and physicians at a significantly higher rate than those living in urban areas. This is a promising signal regarding the ability to reach rural populations through messaging. They believe this supports that people living in rural areas make very rational decisions about adopting technology and that the approach they have developed will provide an innovative way to support physician-assisted quit attempts. https://business.okstate.edu/chsi/
- Franklin County Cardiovascular Health Program in Maine used an integrated cardiovascular risk reduction program to target hypertension, cholesterol, and smoking.[18]
- Mississippi Delta Health Collaborative partners with community health workers, pharmacists, community organizations, local leaders and business, and faith-based groups to improve screening and care for heart disease and stroke, including tobacco use. https://msdh.ms.gov/msdhsite/index.cfm/44,4964,372,pdf/WorkingTogetherForHealthyHearts.pdf.
- Mt. Ascutney Preventive Partnership, in rural Vermont is a coalition that works with the Mt. Ascutney Hospital and Health Center to protect youth from the dangers of tobacco smoke. http://www.mappvt.org/
- Somerset Public Health in rural Maine has a community health initiative called the Micros Wellness Project for Small Business. It helps small businesses offer workplace wellness services, including tobacco cessation treatment. https://www.mcdph.org/micro-worksite-wellness

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- ELEVATE EPIC Tobacco Screening and Cessation Module.[19]
- The Rural Health Initiative Rural Tobacco Control and Prevention Toolkit, published in 2017, is an invaluable resource for rural strategies, activities and resources.
    - All of the programs in this toolkit are rural implementations of models recommended by the U.S. Preventive Services Task Force and the Substance Abuse and Mental Health Services Administration (SAMHSA) National Registry of Evidence-Based Programs and Practices.
- Advancing Tobacco Cessation in Rural America. National Network of Public Health Institutes. 2019 is a comprehensive compendium that examines rates and patterns of commercial tobacco use across subpopulations of people living in rural areas; explores aspects of the rural context that may affect tobacco prevention and control efforts; and presents challenges and opportunities for improving health of people living in rural areas through tobacco prevention and control. The report highlights a variety of examples of tobacco prevention and control efforts underway in rural communities across America that can be replicated and scaled to reduce the prevalence of commercial tobacco use and improve public health. It also cross-references the Rural Health Initiative Tobacco Control and Prevention Toolkit. https://nnphi.org/resource/ruraltobacco/
- The Regional Pennsylvania Tobacco-Free Coalitions have specific resources available rural communities. Visit rptfc.org to find all of the current resources. The Regional Pennsylvania Tobacco-Free Coalitions have a Rural Health: Ask, Advise, Refer to Quit Don't Switch Brief Intervention Training that can assist community partners that work in rural communities.

Tags:
Smokeless Tobacco, Low Income, Hispanic, Youth and Young Adults, Veterans, Pregnant Women, LGBTQ, Lung Cancer

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Amish and Mennonite

Why it Matters

- Pennsylvania is home to several communities known as the Amish, that isolate themselves from the larger society and that are descended from Anabaptist sects that migrated to America to avoid religious persecution in Europe.[1] Amish communities do not have their own health care providers due to limitations on schooling, but many utilize modern medical services outside their communities. Many Amish people turn to alternative forms of treatment and do not seek medical attention for minor ailments.[2]
- In Pennsylvania there is a significant Amish population, with an estimated 81,500 individuals across the state of Pennsylvania, which consists of 59 settlements and 550 districts.[3]

What's Relevant in Pennsylvania

- The Harrisburg Area YMCA Tobacco Control Program were able to serve the Amish community in Dauphin County and offer tobacco control programing. Initial programs focused on tobacco use prevention for a group of Amish youth that would meet on a regular basis. These prevention programs hosted approximately 50 youth and 20 adults. The elders of this community always attended with the youth to observe and ensure that the content of the program was appropriate. After these initial prevention programs, a few of the adults participated in the free cessation programs offered by the Harrisburg Area YMCA. The Harrisburg Area YMCA Tobacco Control Program created a document called Programs and Services for Amish Communities, that highlights best practices, successes, and challenges from their experience with working with the Amish Community.
- The University of Pittsburgh, School of Social Work created 'Guidelines for Professionals When Working with the Amish Community'. While these guidelines are a part of The Pennsylvania Child Welfare Training Program and not specific to tobacco interventions, this resource provides helpful suggestions on how to interact with the Amish community.

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What Other States are Doing

- In 2003 in Homes County, Ohio an in-person version of the Behavioral Risk Factor Surveillance System (BRFSS) survey was conducted among Amish adults. The estimated prevalence of tobacco use was low: 13% (95% confidence interval 7%-19%) among males and 0% among females.[4] The published article "Tobacco Use Among the Amish in Holmes County, Ohio" examined this data further and pulled out specific statistics within in this community. It is important to note that the article stated there was no current assessments of biochemically confirmed tobacco use among the Amish, which is important to keep in mind it is not known if they could profit from prevention and cessation programs.[5]

References and Resources

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