Serving Disparate Populations

in Pennsylvania

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2020 has been called a year of uncertainty, year of disruption, and a year for change. These descriptions have been brought to us by a pandemic, Black Lives Matter and climate change, among other challenges. A common thread among these issues has been a focus on racial equity and social justice, which have spotlighted health disparities across many areas of American life.

Heightened awareness and a new sensitivity around an old problem have engendered a new focus on why we have had disparities at the systems level and new frameworks for talking about them. The public health community has recognized tobacco product related disparities for at least 20 years. The 1998 Surgeon General's Report, Tobacco Use Among U.S. Racial/Ethnic Minority Groups, was the first report to focus exclusively on tobacco use among members of African Americans, American Indians and Alaska Natives, Asian Americans and Pacific Islanders and Hispanics[1]. Many studies have evaluated how to address tobacco product related disparities over the years, but 2020 has brought us to new recognition, understanding and preferences for framing this and other health equity issues.

This document brings together some of the old "tried and true" advice on tobacco product related disparities in addition to some of the new guidance on mapping, describing, and solving them. We recognize the value of both kinds of information. As yet, many of public health's most current data and analyses are not yet framed or described using newer or more sensitive terms, but they are included to broaden the understanding of the audience.

This project was funded by a grant from the Pennsylvania Department of Health.

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The Pennsylvania Tobacco Prevention and Control Strategic Plan 2018-2022 includes a goal to identify and eliminate tobacco products disparities.[2] This is consistent with the Centers for Disease Control (CDC) recommendation that "identifying and eliminating tobacco-related disparities among population groups" should be a primary goal of every state tobacco control program.[3] Despite decades of efforts to reduce and eliminate health disparities, they persist—and in some cases, they are widening. Such disparities do not have a single cause. They are created and maintained through multiple, interconnected, and complex pathways. There is no single solution.

As such, this compendium of material goes from broad to specific and addresses both policy and direct service interventions. This Overview and Framework Section provides a plan and information that is helpful across all U.S. populations experiencing tobacco-related disparities. It includes an overview of drivers of health disparities in general, as well as specific to tobacco use. It includes a Quick Reference Checklist that synthesizes the literature's suggestions on how to partner effectively with most populations affected by tobacco-related disparities and the organizations that serve them. It then builds on the Quick Reference Checklist by sharing additional insight into entities with whom to partner, tools and techniques to address cultural competency, and resources available that might be useful across disparate populations.

Following this section is a Data Prevalence Section that compiles national and Pennsylvania-specific (where available) prevalence information for each of sixteen unique populations that have been identified as those with higher incidence of tobacco use or those who encounter barriers to treatment or cessation in Pennsylvania. Disparities and health inequity are not caused by higher prevalence, rather prevalence can be a symptom of systemic inequities. As such, this data can be an important source of information and a way to measure progress.

Finally, for each of the populations with tobacco products related disparities included in the Data Prevalence Section, there is a unique Priority Populations stand-alone section that details five categories of information:

1. **Why it Matters** describes the tobacco product-related disparity in terms of prevalence, cessation, secondhand smoke, and other factors
2. **What We Know About What Works** provides evidence-based or best and promising practices
3. **What's Relevant in Pennsylvania** gives state specific statistics and program descriptions
4. **What Other States are Doing** offers descriptions of other state programs
5. **References and Resources** gives information on national efforts, tools and information

At the end of each section, "tags" identify other populations that are mentioned. For example, the section on low socioeconomic populations includes primary information for that group, but other sections with the tag "Low SES" will include additional information.

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Health Disparities: Definitions and Influences

In public health, health equity is the opportunity for everyone to reach their full health potential, regardless of any socially determined circumstance. Despite decades of efforts to reduce and eliminate health disparities, they persist—and in some cases, they are widening. Such disparities do not have a single cause. They are created and maintained through multiple, interconnected, and complex pathways.[4] There are many different ways to frame the drivers of health disparities. The CDC identifies the following factors:

- Root causes or social determinants of health such as poverty, lack of education, racism, discrimination, and stigma
- Environment and community conditions such as how a community looks (e.g., property neglect), what residents are exposed to (e.g., advertising, violence), and what resources are available (e.g., transportation, grocery stores)
- Behavioral factors such as diet, tobacco use, and engagement in physical activity
- Availability and quality of medical services[5]

Addressing Tobacco Product Disparities

The US has steadily expanded tobacco protections since 1964, with less smoke in the air and fewer advertisements for harmful products as a result. But these protections, which most Americans now take for granted, are less likely to cover the places where people of color live, learn, work, and play and they are less likely to cover rural areas. The FrameWorks Institute, in partnership with a Working Group that included a wide variety of organizations such as California LGBT Tobacco Education Partnership, National African American Tobacco Control Leadership Council, National Behavioral Health Council, Nuestras Voces/Alliance for Hispanic Health, and the Walsh Center for Rural Analysis, identified the following drivers of tobacco product disparities:

- The tobacco industry pressures some groups with tailored marketing tactics
- Some Americans are protected from secondhand smoke while others are not
- Corporate marketers use flavors to entice specific groups to try tobacco products
- Access to treatment for tobacco-related health issues varies widely by population, geography and other variables
- Discrimination increases stress, driving higher rates of tobacco use for some groups[6]

The CDC says **Health Equity** is when everyone has the opportunity to be as healthy as possible and **Health Disparities** are differences in health outcomes and their causes among groups of people.

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Health Disparities: Definitions and Influences

There are many commonalities to the drivers of health disparities in general and tobacco disparities in particular. This reinforces the importance of considering the greater social forces that may be driving tobacco-product disparities among populations you wish to serve. Leading voices in tobacco control recognize that equity issues must be elevated, but with sensitivity. If not carefully worded, communications could inadvertently reinforce unproductive misconceptions and biases about the communities who are most affected by tobacco-related diseases.[7]

Although addressing these broader societal drivers is beyond the scope of this compendium, references will be made throughout to ways those drivers may be impacting tobacco disparities. The research and options presented in this compendium include both policies and direct-service interventions. Each play a role in addressing tobacco disparities.

1. Public health interventions which focus on tobacco control policies can drive large-scale, population-level changes. These policies have the potential to influence and change social norms related to tobacco initiation, use, and secondhand smoke exposure.[8] Examples include tobacco taxes, smoke-free laws, and comprehensive cessation service availability.

2. Direct-service interventions focus on individual behaviors. Examples include cessation programs that focus on target populations such as pregnant women, or different ethnic groups.

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Quick Reference Checklist

To partner effectively with people affected by tobacco-related disparities and the organizations that serve them, incorporate the needs, values and culture of the population you wish to engage. Table 1 is a brief checklist that includes items to be considered for any program aiming to reduce tobacco-related disparities. More comprehensive material follows this checklist.

Table 1: Quick Checklist

Outreach Considerations	Message Effectiveness
Internal Awareness	• Use an organizational self-assessment to ensure your organization has the ability to be responsive to the communication and language needs of the disparate population(s) you would like to serve
Appropriate Language	• Use of untrained individuals or minors to provide translation is discouraged • Clearly communicate language assistance services
Low Health Literacy/ Readability	• According to the National Assessment of Adult Literacy, 30 million adults struggle with basic reading tasks • Only 12% of consumers have proficient health literacy skills[9] • Some experts suggest that a 3rd to 5th grade level is often appropriate for low-literacy readers[10]
Communications Barriers	• Deaf/hearing-impaired • Blind • Limited English language proficiency
Cultural Competence	• Partner with the community to design, implement and evaluate policies, practices, and services. This ensures programs consider needs, values, and cultures. • Remain sensitive to individual differences and spiritual and health beliefs • Use culturally relevant channels to promote/communicate • Use trusted sources within a community to deliver messages about tobacco control and evidence-based cessation • Support organizations that can effectively reach, involve, and mobilize disparate populations
Media and Communications	• Feature testimonials from persons with a variety of backgrounds, including those from the disparate populations you wish to reach • Use thoughtful media placement and tailored media buys to reach identified populations

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General Guidelines

Expanding on the Quick Checklist, some guidelines to follow for any population include:

- The basic treatment recommendations and methodology should follow, at a minimum, the guidelines outlined in the Agency for Healthcare Research and Quality Treating Tobacco Use and Dependence 2008 Update and the Final Recommendation of the United States Preventive Services Task Force in 2015 on Tobacco Smoking Cessation in Adults, Including Pregnant Women: Behavioral and Pharmacotherapy Interventions.[11,12] However, it is likely that certain populations will require increased counseling or medication, in addition to other modifications necessary to effectively reach a population of disparate burden.
- Identify and partner (see section below on **Partnerships**) with representative groups and community-based organizations who work with or serve the populations identified:
    - Use trusted leaders or sources within a community to deliver messages about tobacco control and evidence-based cessation
    - Support organizations that can effectively reach, involve, and mobilize disparate populations
    - Consider creating work groups or ways to connect organizations serving the population to learn from each other's experiences and provide input on program design

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- Be attuned to the possibility that tobacco cessation is not the highest priority for the population. Poverty, violence, housing, cardiovascular disease, asthma, and substance abuse may all legitimately take precedence over tobacco use and secondhand smoke exposure. Highlighting tobacco use as a key risk factor for other conditions and as a component of policies to address housing, poverty and other social issues is a way to collaborate across a broader spectrum of interests and organizations serving your target population.
    - The American Lung Association offers a similar strategy in the "How to Make the Case for Tobacco" section of Hospital Community Benefit and Tobacco Cessation which provides talking points linking tobacco control to other priority community health needs.
- Remember the Tobacco Quitline in your state. Quitlines use the telephone to provide evidence-based behavioral counseling and support to help tobacco users who want to quit. Counseling is provided by trained cessation specialists who follow standardized protocols that may include several sessions delivered over one or more months. Quitline counseling is widely accessible, convenient to use, and generally provided at no cost to users. Content may be adapted for specific populations and tailored for individual clients.[13] The following tailored programs are available through the Pennsylvania Free Quitline:
    - Pregnancy and Postpartum Program
    - Youth Tobacco and Vaping Cessation Program
    - Native American Protocol
    - Asian Smokers Quitline
    - Spanish Quitline (855-DEJELO-YA)
    - Behavioral health protocol
- In addition, material from the Pennsylvania Free Quitline can be ordered in the following languages:
    - Arabic
    - Burmese
    - Dari
    - Farsi
    - French
    - Kinyarwanda
    - Nepali
    - Spanish
    - Swahili
- Health delivery organizations should consider tailoring programs already offered in places and by providers serving the medical needs of targeted population.
    - Promote the integration of cessation services in health care services to which the population already has access (i.e., behavioral health treatment)
    - Work with health systems and providers who serve the population (e.g. federally qualified health center, Medicaid managed care organization, mental health clinics, Women's Infants Children's programs)

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Partnerships

Promoting cessation in partnership with organizations that serve populations experiencing tobacco-related health disparities can be a helpful way to leverage existing infrastructure and experience. Potential partners include:[14]

- Behavioral health providers
- Community and tribal health clinics
- Community based organizations
- Community health workers
- Dentists
- Faith-based organizations
- Free clinics
- Federally qualified health centers
- Homeless shelters
- Lesbian, gay, bisexual, transgender, and queer/questioning (LGBTQ+) organizations
- Local public housing authorities
- Primary care providers
- Pharmacists
- Workforce development organizations

According to the CDC Best Practices User Guide Health Equity in Tobacco Prevention and Control, when developing, implementing, and enforcing tobacco control policies, coalitions can create the sustainable **partnerships** that are needed to reduce tobacco use and secondhand smoke exposure in these communities.

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Cultural Competency

Among the many contributors to health inequities, the lack of culturally and linguistically appropriate services in health settings has been recognized as one of the more modifiable factors. Improving the availability of such services will not only improve the quality of care provided, but it may also reduce disparities experienced by racial and ethnic minorities and other underserved populations who face language, literacy, or other cultural barriers.[15]

Cultural competency should be assessed at three levels:

1. The internal cultural competency of the organization considering making a policy, developing a program, or providing a service
2. The cultural competency of the policy or program being developed
3. The cultural competency of the practitioners offering services to diverse populations

Internal Capability and Cultural Competency

Before launching any new programs to promote health equity, assess your own organization's commitment. If you have already been serving disparate populations, this is likely unnecessary. However, if this is a new initiative for your organization, items to consider include:

- Is health equity included in the organization's mission statement and strategic goals?
- Does the organization have staff with experience and a commitment to the target population(s)?
- Have staff received training in cultural competency and is it offered on an ongoing basis?
- Have leadership, partners and stakeholders been educated about the importance of cultural competency to ensure buy-in to proposed programs?

The Office of Minority Health (DHHS) defines cultural competency as: patterns of human behavior that includes the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups.

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Programmatic Cultural Competency

This includes making sure that the proposed program has been developed with full knowledge and awareness of the unique cultural needs of the target population and that this is reflected in:

- Partnerships that have been developed with the target community to design, implement and evaluate policies, practices, and services to ensure programs fully consider needs, values, and culture
- The channels being used to promote and communicate about the program are culturally relevant
- The program is using trusted sources within the community to deliver messages about tobacco control and evidence-based cessation
- The program provides adequate support to organizations that can effectively reach, involve, and mobilize disparate populations

Healthcare Service Delivery Cultural Competency

From a service delivery perspective, evidence shows that when patients receive respect and appreciation of cultural differences by their healthcare team, health outcomes can improve. When patients do not feel respected and honored for who they are, multiple barriers impact the quality of a healthcare interaction.

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Additional Resources Helpful in Addressing Tobacco Product Related Disparities

Tobacco product-related disparities have been recognized for decades and highlighted as critical to comprehensive tobacco control services for nearly as long. Many experts from clinical, public health and social justice disciplines have provided education, preferred language and tools to assist providers and community members in tackling root causes and solutions. Several of these are listed, described, and linked below for your consideration. Depending on your type of organization, the policy or intervention you are considering and your goals, different resources will be more important.

1. One simple framework is the ETHNIC Model[16] of culturally competent medical interventions:

Explanation	• What do you think may be the reason you have these symptoms? • What do friends, family, or others say about these symptoms? • Do you know anyone else who has had or has this kind of problem? • Have you heard about/read/seen it on TV/radio/social media/newspaper? • What concerns you most about your symptoms?
Treatment	• What kinds of medicine, home remedies or other treatments have you tried for this condition? • Is there anything you eat, drink, or do (or avoid) on a regular basis to stay healthy? Tell me about it. • What kind of treatment are you seeking from me?
Healers	Have you sought any advice from alternative healers, friends, or other people (non-doctors) for help with your problem? Tell me about it.
Negotiate	• Negotiate options that will be mutually acceptable to you and your patient and that do not contradict, but rather incorporate your patient's beliefs. • Ask what the most important results are your patient hopes to achieve from this intervention.
Intervention	Determine an intervention with your patient. It may include incorporation of alternative treatments, spirituality, and healers as well as other cultural practices (e.g. food eaten or avoided in general and when sick).
Collaboration	Collaborate with patient, family members, other healthcare team members, healers, and community resources.

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2. Think Cultural Health: The Guide to Providing Effective Communication and Language Assistance Services is a resource that provides information and support for both direct service interventions and organizations (including public health entities) that are developing a program or new service.
    - Direct Service Delivery: This track is tailored to healthcare providers (or those providing direct care and services), with information on cross-cultural communication skills, working with an interpreter and more.
    - Organizational: This track is tailored to healthcare administrators, with information on planning, implementing, and evaluating effective communication and language assistance services.
    - Internal and external assessment tools
3. Included on the Think Cultural Health website is access to National CLAS Standards to implement culturally and linguistically appropriate services. To provide meaningful and practical guidance on delivering culturally and linguistically appropriate services, the U.S. Department of Health and Human Services (HHS) Office of Minority Health (OMH), in collaboration with federal and nonfederal partners across the country, developed the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care. The National CLAS Standards aim to improve health care quality and advance health equity by establishing a framework for organizations to serve the nation's increasingly diverse communities.

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4. Justice in the Air is a strategic brief from the FrameWorks Institute, a think tank that advances the capacity of the mission-driven sector to lead productive public conversations on social change. Their Tobacco Disparities Messaging Project outlined effective ways to shift thinking and build support for solutions, illustrated how these frames can be applied to communications and highlighted the research that underpins its recommendations. Recommendations include:

   A. Talk about tobacco control as an issue of fairness and justice.

   B. Expand the public's mental model of "tobacco."

   C. Give contemporary examples of industry tactics that are driving disparities.

   D. Don't just point to prevalence—explain the drivers of disparities.

   E. Frame and explain data—don't expect it to tell a story by itself.

   F. Avoid framing disparities as an economic issue, a crisis or the "last mile" for tobacco control.

   G. Don't avoid talking about disparities—but take care to avoid cultural deficit framing.

   FrameWorks Institute's Julie Sweetland, a sociolinguist, also participated in a Roundtable on Population Health Improvement in 2016, sharing that frames matter: people's understanding of issues are frame-dependent and communication needs to be selective about what to say, what to leave unsaid, and what to emphasize. How issues are framed has a large impact on the way that people hear, interpret and act on different policy proposals that are put forth on racial equity in health outcomes or on any other issue.[17]

5. Talking about Tobacco-Related Disparities is another guide published by the FrameWorks Institute. It includes sections on children and youth advocates, racial and ethnic justice advocates, health equity advocates and public health professionals, and offers recommended language to replace several commonly used ideas. For example, they recommend using "harmful tobacco products, like cigarettes, chewing tobacco, cigars and e-cigarettes" instead of "cigarettes and other tobacco products."

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