



Health

Understanding

Education



The Ohio Commission on Minority Health

Special Edition

John Kasich,
Governor

Gregory L. Hall, MD, Chairman

Angela C. Dawson, Executive Director

A Word from the Chairman



Gregory L. Hall, MD

Chairman, Ohio Commission on Minority Health

Smoking Isn't a Habit, it's an Addiction

As I encounter tobacco smokers in my practice, my family and in the community, one supreme issue comes through: smoking for these "hold-outs" despite smoke-free practices, taxes, and in-your-face campaigns is not a habit, smoking, for them, is an addiction, and we need to start fully appreciating this problem more effectively in order to have an even greater impact. National campaigns have made great strides in decreasing the smoking rate over the last 50 years . . . from almost half of all Americans in 1965 to a new low of 15% in our most recent report. Unfortunately, that 15% still represents 47 million people, who still need help to stop.

Think about it . . . if someone said "let's take a leaf from a plant, dry it, wrap it up, set fire to it, and then inhale its smoke repeatedly" many would think the idea is crazy. People who have never smoked struggle to understand because many still believe smoking is a 'habit' like spitting in public or chewing gum. Many believe we can effect change by repeatedly saying "just say no" or by make logical associa-

tions between smoking and premature death.

While these approaches will (and have) worked with some, the many others who have continued to smoke in the face of these campaigns need better, more effective information that truly addresses why they don't stop.

Unfortunately, a disproportional number of smokers come from underprivileged minorities. Consider these smoking numbers from the CDC's most recent data (2014):

- More than 29 of every 100 American Indians/Alaska Natives (29.2%)
- Nearly 28 of every 100 multiple race individuals (27.9%)
- More than 18 of every 100 Whites (18.2%)
- More than 17 of every 100 Blacks (17.5%)
- About 11 of every 100 Hispanics (11.2%)
- More than 9 of every 100 Asians (9.5%)

A Word from the Chairman,

Continued

And these numbers are after many heroic and largely successful campaigns. What remains are still 70% of smokers who actively want to stop, and 40% who have actually tried in the last year. If smoking was truly a 'habit', most if not all of these people would have stopped already. What percentage of people who actually want to stop spitting in public, or stop chewing gum, are successful? I bet the number is in the high 90's. True "habits" while aggravating to handle, aren't that hard to break.

Unfortunately, many of the 47 million people who still smoke also believe smoking is a habit. They actually believe they are 'choosing' to smoke. Many think they 'want' to smoke. But the evidence to the contrary is overwhelming. With economic strains, unemployment, low pay, and decreasing wages, why would someone choose to pay \$8 for a pack of cigarettes (here in Cleveland, Ohio) which totals 40 cents per cigarette! Based on the time to smoke a cigarette . . . 6 minutes, they pay 40 cents for 6 minutes of satisfaction. People with financial hardships are not willingly choosing to spend that kind of money for a "habit".

Add the overwhelming horrible health data associated with smoking which essentially says that whatever time a smoker spends smoking is lost on the back end. To put it differently, every minute spent smoking takes a minute off of your life. These are hard truths that almost everyone knows, but remains ignored by many. To then call smoking a "habit" in the face of all of these truths, is missing an overly obvious point. Many believed that raising the cost of cigarettes would simply 'price-out' its wide-spread use, and to a limited extent, it has, but unfortunately the hardened addicts will simply 'find' the money to buy 'what they need' at almost any cost. Former Surgeon General C. Everett Koop, the first to assert that smoking was an addiction, initially faced strong opposition from the general public. His mandate to place warning labels on the cigarette packs was revolutionary and one warning simply states: "Smoking causes a strong addiction, do not start it".

My overriding point to the smokers reading this article is to recognize the evidence staring you in the face. Recognize that a "nicotine fit" is evidence of withdrawal from an addictive substance. Recognize that planning your day around smoking breaks, deciding your travel options based on smoking availability, and spending an outlandish amount of money on tobacco . . . are ALL signs of severe addiction. Smokers cannot take steps to address an addiction unless they first recognize its presence. The non-smokers (including many of my doctor colleagues) also need to stop having the smug "I'm not that stupid" and "why don't you just stop" attitude about the smokers in their life and practice. Addictions are not stupid, they are real, strong, and difficult to overcome, and need to be addressed in a sensitive and effective way. Addiction is merely a diagnosis to be addressed. It is not a sign of personality weakness or inferiority. Like cancer, migraines, and the flu, addictions need to be treated with the proper approach. Let's start recognizing and treating nicotine addiction with proven and multi-pronged approaches. And let's take the taxes we collect from current tobacco users and help them stop.

This issue of HUE is dedicated to the widespread lung health problems seen in minority populations. Commissioner Dr. Timothy J. Barreiro's article on lung health disparities nicely outlines the barriers and obstacles we face in our ongoing quest for health equity. Please read it, and think about how we can make a stronger impact on this almost ubiquitous problem. And always remember "Good health begins with you."



Executive Director's Corner

According to the National Thoracic Society (NTS) policy statement, "Health disparities, defined as a significant difference in health between populations, are more common for diseases of the respiratory system than for those of other organ systems, because of the environmental influence on breathing and the variation of the environment among different segments of the population".



The NTS 2013 comparison document identified that the lowest social groups are up to 14 times more likely to have respiratory diseases than are the highest. Contributing factors such as tobacco smoke, air pollution, environmental exposures, and occupational hazards affect the lungs more than other organs, and occur disproportionately in ethnic minorities and those with lower socioeconomic status.

In order to reduce respiratory health disparities influenced by race, ethnicity, and economics, health systems must develop priorities that require awareness and understanding of the disparities, the vulnerable groups, and which disparities can be corrected most easily. The research continues to demonstrate that a major part of chronic diseases can be prevented by reducing common risk factors, such as tobacco use, hazardous or unhealthy environments, physical inactivity, and poor nutrition. These risk factors are often associated with health inequalities.

It is important that we work to raise the awareness of policy makers so that lung health interventions can be targeted at individuals in the most disadvantaged communities. Specific interventions to reduce the effects of respiratory health inequalities should include policies that prioritize the prevention of disease and promotion of respiratory health within all communities while targeting those populations most severely impacted.



Source: http://www.michigan.gov/mdhhs/0,5885,7-339-71550_2955_2985---,00.html

Respiratory Health Equality in the United States



Written by,
Timothy J. Barreiro, DO, MPH, FCCP, FACOI, FACP
Associate Professor of Medicine

Health Disparities are real and have many serious consequences. While unfortunate we know that care is different depending on race, income, gender, and sexual orientation. The bigger challenge is to pinpoint how a positive impact on health disparities can be made.

In the past decade, racial-ethnic disparities in lung health have worsened. Lung-related death secondary to asthma, cancer, and infections, particularly tuberculosis, has tripled for minorities. Access, medical literacy, and the lack of a sensitive, diverse workforce has contributed to poor minority outcomes.

Potential causes of disparities happen at various levels - individual/patient level, the provider level, and system or institutional level. At the patient level, age, education, culture, environment, and personal preferences all influence health-related behaviors. For example, although there are societal influences, the ultimate decision to begin tobacco use is a personal choice, and this one seemingly small decision can lead to long-term smoking and the numerous associated consequences. While the highest rate of smoking among adolescents is among Indian and Alaskan Natives (39.7%), African-American and Hispanic smoking rates have plateaued, but the disease associated with smoking in the later races has worsened. Disparities in smoking rates are also affected by education impacting up to 44% of adults not graduating from high school.

Cultural values, religious or spiritual beliefs, and poor education may lead individuals to reject surgery or other interventions that may be otherwise curative. As a consequence, disparities in resected lung cancer rates and corresponding survival deficits grow, and have been documented for both African-American and Hispanic populations. Chronic obstructive pulmonary disease (COPD) is the fourth-leading cause of death in the United States. When compared over the past 20 years, the mortality rate for COPD has increased by 74% among African Americans compared with 65% in non-Hispanic whites. Also, African Americans and Latinos have almost a twofold increase rate of emergency room visits for COPD and are more likely to be hospitalized for this disease.

People affected by health disparities more frequently live in environments with:

- Toxic conditions
- Inadequate access to affordable nutritious food, places to play and exercise, effective transportation systems, and accurate, relevant health information
- Violence
- Joblessness, poverty
- Targeted marketing and excessive outlets for unhealthy products
- Community norms that do not support protective environments

Health for All Campaign (2003)

Recent data suggest that hormonal changes affecting immune function combined with smoking-related toxin exposure are different in some racial, gender, and ethnic groups. For example, these changes have woman requiring more oxygen and dying sooner than men with the same lung function. African Americans with COPD are younger, smoked less, have worse health-related quality of life. In addition, Latino and African American have four times the lung complication rates than other ethnic groups.

Asthma is the most common chronic disease of childhood and affects 26 million people in the US. Asthma is more prevalent among the poor, Puerto Ricans, and African Americans and the disease severity is worse with higher mortality.

ASTHMA AND ALLERGY AWARENESS

Asthma's Ethnic Gap

Recently the greatest rise in asthma was among African American children - it now affects **#1in6**.



aafa.org  Asthma and Allergy Foundation of America

Physician and other provider characteristics including language proficiency and lack of cultural competence are also associated with growing disparities. The ability to diagnose and treat specific lung diseases effectively in a multicultural, multilingual society is compromised when an inadequate number of cultures are represented among providers. Providers also have unconscious biases. Stereotype-based assumptions and individual racial and cultural variabilities can and have resulted in different interventions based purely on race. Furthermore, medical decision-making between patients and physicians without mutual respect and trust can only lead to inadequate treatments. For example, among patients with advanced lung cancer, Hispanic and African Americans are nearly three times as likely as non-Hispanic whites to have false expectations about cure from chemotherapy, and are less likely to ask or be offered surgery or alternatives treatment options.



Health disparities can also result from system or institutional characteristics. Although only 1 in 10 white Americans are uninsured, 1 in 5 African-Americans and 1 in 3 Latino Americans are uninsured. Even among patients with identifiable Medicaid benefits, racial disparities by outcomes are driven by structural inequalities. For example, private practice or subspecialty Medicaid providers may be less available in low-income neighborhoods. Minority patients as less likely to receive care in a doctor's office, and more likely to receive hospital-based care, typically in an emergency room.

African-Americans and Hispanic patients are also much less likely to find physicians of the same color or culture. Only 2.3% of doctors in the US are African Americans, and only 3.2% of doctors are Hispanic. Also, there are systemic barriers to effective care for chronic conditions. One study looked at the racial difference in waiting list outcomes in chronic obstructive lung disease (COPD) patients needing lung transplantation and found that regardless of age, lung function, or insurance that black patients with COPD were less likely to undergo transplantation and more likely to die or be removed from the transplant list (the main reason reporting “too sick”) than the non-Hispanic white patients. Unequal access to care may have contributed to these difference.

Another study looked at emergency room visits for acute exacerbation of COPD and found that care provided in a standardized way (by protocols) did not differ based on race, gender or ethnicity. However, they noted that compared with white patients, African American and Hispanics patients were more likely to be uninsured or with Medicaid, were less likely to have primary care providers, and

have more frequent ED visits in the past years. While the care was considered "equal", meaning they received bronchodilators and systemic corticosteroids, minorities were less likely to receive diagnostic procedures, such as a CT scan and radiographs.

Ethnic disparities and healthcare outcomes are resistant to simple one-dimensional interventions. Given the complex nature of health disparities and their resistance to simple interventions, many approaches have missed the mark. Surveillance, continued epidemiological assessment and monitoring are a critical aspect of improving outcomes. Improved techniques that track the incidence, prevalence, morbidity, disability, and mortality related to specific risk factors and diseases commonly affecting minorities is desperately needed. Interventions that implement social and economic reform surrounding these factors on a local, state and federal health policy level is critical.



Resources for Lung Health Disparities

Health Disparities/ Race/Ethnic Disparities

<http://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities>

Explains Definition of Health Disparities

Pulmonary Function Testing (Spirometry Test)

Test for asthma, bronchitis, and other lung problems. It measures how much air you breathe out, and how quickly

Common Signs or Symptoms of Lung Disease:

Chronic Cough, Shortness of Breath, Chronic Mucus Production, Wheezing, coughing up blood, chronic Chest Pain, decreased ability to exercise (<http://womenshealth.gov/publications/our-publications/fact-sheet/lung-disease.html>; <http://www.lung.org/lung-health-and-diseases/warning-signs-of-lung-disease/>)

Asthma

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3920741/>

6.8 million children and adolescents in the United States

More common among low SES/ poor

Most common among Puerto Ricans (19%)

Severity worst in Puerto Ricans and African Americans

African Americans have the most ER visits, hospitalizations and higher mortality rates from Asthma

Lung Cancer

<http://www.lung.org/assets/documents/research/ala-lung-cancer-in-african.pdf>

Lung cancer among African Americans

African Americans with lung cancer:

Get treated later

Wait longer after diagnosis to get treatment

More likely to refuse treatment

More likely to die in the hospital after surgery

Great general article that touches on Lung cancer, health disparities, unequal treatment of Lung Cancer, unequal access to care

Physician workforce a good graphic figure 10

75% of physicians are white, 4% African American, 13% Asian, 8% other

Lung Infections

Tuberculosis

<http://www.who.int/bulletin/volumes/86/9/06-038737/en/>

Resources for Lung Health Disparities

TB remains an issue in industrialized countries, especially among minority populations. “Economically poor and vulnerable populations, cultural/ethnic minorities, migrant populations, gypsies and travelers, homeless people and substance users are all at greater risk of TB infection and disease and are likely to have worse treatment outcomes than the general population.”

Migrant workers with frequent movement across country borders increase chances of TB being transmitted due to lack of screening services

In wealthy cities, TB among the homeless can be 20% higher than the general population

COPD

<http://www.nhlbi.nih.gov/health/educational/copd/>

Website to get general information about COPD including:

Get the facts

Get diagnosed

Get involved

Access to Care

<https://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services>

importance of access to health

Lack of diverse workforce in the Medical field

<http://www.ncsl.org/documents/health/Workforcediversity814.pdf>

Current workforce is not reflective of the United States diversity. People of color represent 25% of the United but only represent 10% of health professions

Individual Behaviors

Smoking Disparities

<http://www.cdc.gov/tobacco/campaign/tips/resources/data/cigarette-smoking-in-united-states.html>

cigarette smoking among minority populations (American Indian/ Alaskan Natives 29.2% highest Race)

Provider Influence on Health Disparities

<http://www.yale.edu/intergroup/Burgess.vanRyan.Dovidio.2007.pdf>

reducing racial bias among health care providers

Healthcare providers hold stereotypes based off of patient race, class, sex, ect. This influences their interpretation of behaviors and symptoms and their clinical decisions.

Although this usually occurs outside of their conscious awareness

Providers interact less effectively with minority than white patients

Resources for Lung Health Disparities

Societal Influences

Accessibility to healthcare providers

<http://www.rwjf.org/en/library/research/2009/12/spatial-accessibility-to-providers-and-vaccination-compliance-am.html>

Children living in low-income neighborhoods were less likely to receive vaccinations due to lack of transportation and less healthcare

Uninsured

<http://kff.org/health-reform/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid-an-update/>

Health insurance coverage gaps among poor

<http://kff.org/disparities-policy/issue-brief/the-impact-of-the-coverage-gap-in-states-not-expanding-medicaid-by-race-and-ethnicity/>

Health insurance racial gap

People of color are twice as likely to be uninsured as whites

Lung Health Resources for People in Ohio:

Central Ohio (Columbus)

The Breathing Association <http://www.breathingassociation.org/> (Franklinton County Residents)

Lung Health Clinic

For people who meet the income guidelines, have or do not have health insurance, cannot afford to pay for healthcare, have asthma, COPD, and other lung needs

COPD Information and Services

Asthma Information and Services

HEAP, payment assistance for air conditioner or utility payments to low-income residents of Franklin County who have a diagnosed lung disease. Application process and face to face interview required to determine eligibility and Summer Crisis Program, Winter Crisis Program

Northeastern Ohio (Cleveland, Akron, Canton, Youngstown)

The Cleveland Clinic Respiratory Institute <http://my.clevelandclinic.org/services/lungs-breathing-allergy/diseases-conditions>

Northwestern Ohio (Toledo, Sandusky)

American Lung Association Northwest Ohio <http://www.lung.org/local-content/ohio/support-and-community/northwest-ohio-asthma.html?referrer=https://www.google.com/>

Southwestern Ohio (Cincinnati, Dayton)

Southwest Ohio Air Quality Agency <http://www.southwestohioair.org/>

Resources for Lung Health Disparities

Southwestern Ohio (Cincinnati, Dayton) Continued

University of Cincinnati Pulmonary Medicine <http://uchealth.com/services/pulmonary-critical-care/>

Southeastern Ohio (Athens)

Black Lung Clinic- Ohio Department of Health

For Miners and Former Miners

http://www.odh.ohio.gov/odhPrograms/chss/PCRH_Programs/rural_health/blklung.aspx

East Ohio Regional Hospital

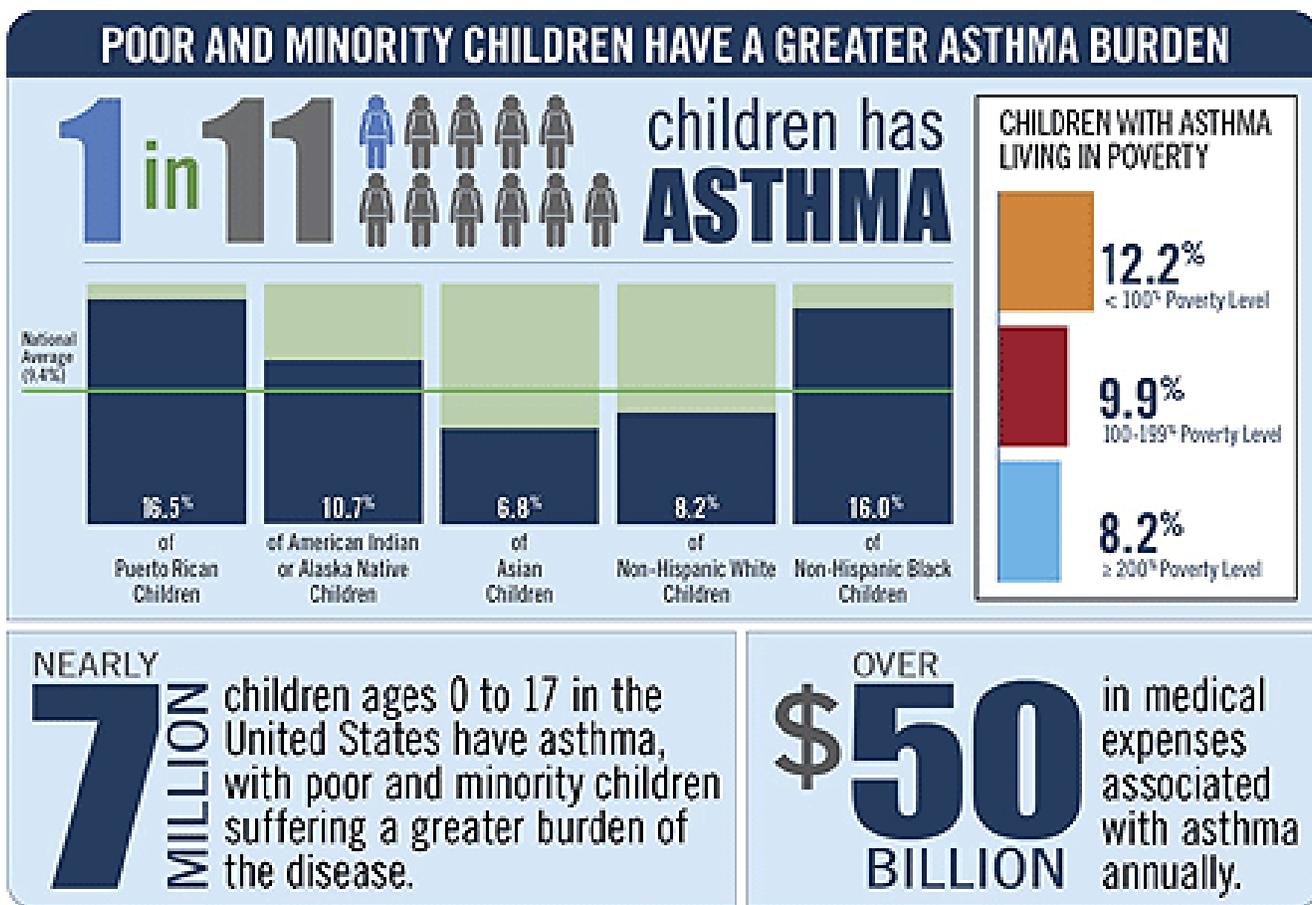
Martins Ferry, Ohio

(877) 633-4715

Genesis HealthCare Systems

Zanesville, Ohio

(800) 322- 4762 ext. 4063



• Source: Coordinated Federal Action Plan to Reduce Racial and Ethnic Asthma Disparities, www.epa.gov/children/taskforce/federal_asthma_disparities_action_plan.pdf



Source: <https://blog.epa.gov/blog/author/janetmccabe/page/2/>

The Ohio Commission on Minority Health Board Members



Barreiro, Timothy J., DO, Chisolm, Deena J. PhD, Dungey, Cynthia, Director, (Designee: Jamie Carmichael), Hall, Gregory L., M.D. (Chair), Hicks, William, M.D., Hodges, Richard, Director, (Designee: Chip Allen), Law, Mark Stephen, M.D., Ross, Richard A., Superintendent (Designee: Jill Jackson), The Honorable Barbara Sears, The Honorable Cecil Thomas, Martin, John, Director (Designee: Tamara Hairston), McCarthy, John, Director (Designee: Traci Bell-Thomas), Modlin, Charles, M.D., Munoz, Cora, PhD, RN (Secretary), Plouck, Tracy, Director (Designee: Jamoya Cox), Richey, Cherie, A., M.D. FACOG Satiani, Bhagwan, MD, and Commission Attorney General, Emily Pelphrey, Assistant Attorney General. Also pictured Executive Director Emeritus, Cheryl Boyce and the first Commission Chair, former Senator Ray Miller, State Representative Herschel Craig, and former Board Member and former State Representative, Roland Winburn.

Not pictured Dr. Cora Munoz, Dr. William Hicks, Director Richard Hodges, Director John Martin, Director John McCarthy, Director Tracy Plouck, Superintendent Richard Ross, State Representative Barbara Sears



Ohio Commission on Minority Health
77 South High Street
18th Floor
Columbus, Ohio 43215
614.466.4000
www.mih.ohio.gov
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