Tobacco Use Behavior among Race and Ethnic Populations

Eliseo Pérez-Stable, MD
Director of the National Institute on Minority Health and Health Disparities at the National Institutes of Health

February 10, 2022
Moderator

Catherine Saucedo
Deputy Director

Smoking Cessation Leadership Center
University of California, San Francisco
A National Center of Excellence for Tobacco-Free Recovery

Catherine.Saucedo@ucsf.edu
Disclosures

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Anita Browning, Christine Cheng, Brian Clark, Jennifer Matekuare, Ma Krisanta Pamatmat, MPH, Eliseo Pérez-Stable, MD, Jessica Safier, MA, Catherine Saucedo, and Aria Yow, MA.
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- Use the **‘ASK A QUESTION’ box** to send questions at any time to the presenter.
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▪ For our California residents, SCLC offers regional trainings, online education opportunities, and technical assistance for behavioral health agencies, providers, and the clients they serve throughout the state of California.

▪ For technical assistance please contact (877) 509-3786 or [Jessica.Safier@ucsf.edu](mailto:Jessica.Safier@ucsf.edu).

▪ Visit [CABHWI.ucsf.edu](http://CABHWI.ucsf.edu) for more information
I COVID QUIT!

- Launched March 31, 2021

SCLC’s own campaign funded by Robert Wood Johnson Foundation

- Real people sharing their UNSCRIPTED experiences of improved mental health after quitting smoking—and they did it during the COVID-19 pandemic!

- FREE videos, digital images and toolkit for your use at ICOVIDQUIT.org

- We continue to seek and share more stories, particularly from those who represent underserved communities! Please email anita.browning@ucsf.edu if you would like to share a story
Today’s Presenter

Eliseo Pérez-Stable, MD
Director of the National Institute on Minority Health and Health Disparities
National Institutes of Health
Tobacco Use Behavior among Racial and Ethnic Populations

February 10, 2022

UCSF Smoking Cessation Leadership Center Webinar

Eliseo J. Pérez-Stable, M.D.
Director, National Institute on Minority Health and Health Disparities
eliseo.perez-stable@nih.gov
Summary of Presentation

• Minority Health and Health Disparities Science
• Tobacco use epidemiology
• COVID-19 and tobacco use
• Biological markers of tobacco use
• Smoking cessation interventions
• Structural determinants and policy
Populations with Health Disparities

• Racial/ethnic minority populations defined by Census
• Less privileged socio-economic status
• Underserved rural residents
• Sexual and gender minorities
• Social disadvantage that results in part from being subject to discrimination or racism, and being underserved in health care
• A health outcome that is worse in these populations compared to a reference group defines a health disparity
Census Race/Ethnic Classification

- African American or Black
- American Indian and Alaska Native
- Asian American
- Native Hawaiian and Pacific Islander
- Latino or Hispanic
- White
- More than one race
Race/Ethnicity and Socioeconomic Status are Fundamental in Determining Health

- Race/ethnicity and SES predict life expectancy and mortality that are not fully explained
- African Americans have more strokes when compared to Whites for same level of SBP
- Most chronic diseases are more common in persons of less privileged SES
- Among persons with diabetes, all race/ethnic minority populations have less heart disease and more ESRD, compared to Whites
Relative risk of All-Cause Mortality by US Annual Household Income Level

- < $25,000: 3.03
- $33,000: 2.49
- $50,000: 2
- $82,000: 1.45
- $115,000: 1.36
- > $115,000: 1

US Annual Household Income (Converted to 2013 US Dollars)
477,000 Excess Deaths, 74% from COVID, 2 to 4 Times more in AA/B, AI/AN, L/H, 2020

# National Institute on Minority Health and Health Disparities Research Framework

<table>
<thead>
<tr>
<th>Domains of Influence (Over the Lifecourse)</th>
<th>Levels of Influence*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Biological</strong></td>
<td>Individual</td>
</tr>
<tr>
<td>Biological Vulnerability and Mechanisms</td>
<td>Caregiver-Child Interaction</td>
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<tr>
<td></td>
<td>Family Microbiome</td>
</tr>
<tr>
<td><strong>Behavioral</strong></td>
<td>Interpersonal</td>
</tr>
<tr>
<td>Health Behaviors</td>
<td>Family Functioning</td>
</tr>
<tr>
<td>Coping Strategies</td>
<td>School/Work Functioning</td>
</tr>
<tr>
<td><strong>Physical/Built Environment</strong></td>
<td>Community</td>
</tr>
<tr>
<td>Personal Environment</td>
<td>Community Functioning</td>
</tr>
<tr>
<td><strong>Sociocultural Environment</strong></td>
<td>Societal</td>
</tr>
<tr>
<td>Sociodemographics</td>
<td>Community Environment</td>
</tr>
<tr>
<td>Limited English</td>
<td>Community Resources</td>
</tr>
<tr>
<td>Cultural Identity</td>
<td>Societal Structure</td>
</tr>
<tr>
<td>Response to Discrimination</td>
<td></td>
</tr>
<tr>
<td><strong>Health Care System</strong></td>
<td></td>
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<tr>
<td>Insurance Coverage</td>
<td></td>
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<tr>
<td>Health Literacy</td>
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<tr>
<td>Treatment Preferences</td>
<td></td>
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<tr>
<td><strong>Health Outcomes</strong></td>
<td></td>
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<tr>
<td>Individual Health</td>
<td></td>
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<tr>
<td>Family/Organizational Health</td>
<td></td>
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<tr>
<td>Community Health</td>
<td></td>
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<tr>
<td>Population Health</td>
<td></td>
</tr>
</tbody>
</table>

*Health Disparity Populations: Race/Ethnicity, Low SES, Rural, Sexual/Gender Minority Other Fundamental Characteristics: Sex/Gender, Disability, Geographic Region
Tobacco Use Epidemiology
Smoking Prevalence by Interview Quarter, BRFSS, U.S., 2016-2020

The red line demarcates the beginning of the COVID-19 pandemic in the US. Quarter 1=Jan-Mar; Quarter 2=Apr-Jun; Quarter 3=Jul-Sep; Quarter 4=Oct-Dec

# Cigarette Smoking in the U.S., 2019

<table>
<thead>
<tr>
<th>Race/ethnicity</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>AI/AN</td>
<td>20.9%</td>
</tr>
<tr>
<td>White</td>
<td>15.5%</td>
</tr>
<tr>
<td>Black</td>
<td>14.9%</td>
</tr>
<tr>
<td>Latino/a</td>
<td>8.8%</td>
</tr>
<tr>
<td>Asian</td>
<td>7.2%</td>
</tr>
<tr>
<td>Other or More than 1 race</td>
<td>19.7%</td>
</tr>
<tr>
<td>Gen. ed. development</td>
<td>35.3%</td>
</tr>
<tr>
<td>High school graduate</td>
<td>19.6%</td>
</tr>
<tr>
<td>Undergraduate degree</td>
<td>6.9%</td>
</tr>
</tbody>
</table>

*National Health Interview Survey, MMWR-November 20, 2020; 69(46);1736-1742*
## Tobacco Use in the U.S., Age ≥18 y, 2019

<table>
<thead>
<tr>
<th>Race/ethnicity</th>
<th>Combustible</th>
<th>E-Cigs</th>
</tr>
</thead>
<tbody>
<tr>
<td>AI/AN</td>
<td>22.3%</td>
<td>N/A</td>
</tr>
<tr>
<td>Black</td>
<td>18.6%</td>
<td>3.4%</td>
</tr>
<tr>
<td>White</td>
<td>18.3%</td>
<td>5.1%</td>
</tr>
<tr>
<td>Latino</td>
<td>11.2%</td>
<td>2.8%</td>
</tr>
<tr>
<td>Asian</td>
<td>8.6%</td>
<td>2.7%</td>
</tr>
<tr>
<td>Other</td>
<td>22.0%</td>
<td>9.3%</td>
</tr>
<tr>
<td>Lesbian, gay, bisexual</td>
<td>22.7%</td>
<td>11.5%</td>
</tr>
<tr>
<td>High school diploma</td>
<td>21.9%</td>
<td>4.3%</td>
</tr>
<tr>
<td>Undergraduate degree</td>
<td>10.0%</td>
<td>3.2%</td>
</tr>
</tbody>
</table>

National Health Interview Survey, MMWR-November 20, 2020; 69(46);1736-1742
Very Light and Non-Daily Smokers

• New paradigm: No physiological addiction
• 53% Latinos, 44% Asians, 36% Blacks
• Smoke average 11.7 days / month
• Younger, more educated, more women, ethnic minority groups, people with mental health or substance use challenges
• Average 3.7 cigarettes on smoke days
• Cigarettes per month as a new metric?
• Tobacco control paradigm remains stuck
Tobacco Product Use among Middle and High School Students, NYTS, US, 2019-20 (MMWR 2020 69(50);1881-1888)

<table>
<thead>
<tr>
<th>Race/ethnicity</th>
<th>Any tobacco</th>
<th>Cigarettes</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>17.8%</td>
<td>3.7%</td>
</tr>
<tr>
<td>Latino</td>
<td>17.2%</td>
<td>3.6%</td>
</tr>
<tr>
<td>Black</td>
<td>13.2%</td>
<td>2.5%</td>
</tr>
<tr>
<td>Other</td>
<td>10.1%</td>
<td>N/A</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sexual identity</th>
<th>Any tobacco</th>
<th>Cigarettes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lesbian, gay, bisexual</td>
<td>25.5%</td>
<td>7.0%</td>
</tr>
<tr>
<td>Heterosexual</td>
<td>15.1%</td>
<td>2.7%</td>
</tr>
</tbody>
</table>
Estimated Monthly Prevalence of Past-30-Day E-Cigarette Use Among Youths and Young Adults

E-Cig Use Among Youths and Young Adults Before and During the COVID-19 Pandemic by Age Group (n = 5164): United States, January 1–June 29, 2020

SHS Exposure in the U.S., 2013-4
Serum cotinine = 0.05-10 ng/ml in non-smokers

<table>
<thead>
<tr>
<th>Demographic Factor</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>21.4%</td>
</tr>
<tr>
<td>Black</td>
<td>50.3%</td>
</tr>
<tr>
<td>Mexican American</td>
<td>20.0%</td>
</tr>
<tr>
<td>Age 3 to 11 y</td>
<td>37.9%</td>
</tr>
<tr>
<td>Below Poverty Level</td>
<td>47.9%</td>
</tr>
<tr>
<td>Above Poverty Level</td>
<td>21.2%</td>
</tr>
<tr>
<td>Lives with smoker</td>
<td>73.0%</td>
</tr>
<tr>
<td>High school graduate or equivalent</td>
<td>28.8%</td>
</tr>
<tr>
<td>Undergraduate degree or higher</td>
<td>10.8%</td>
</tr>
</tbody>
</table>

NHANES, MMWR, December 7, 2018; 67(48);1342-1346
Exposure to SHS by Race and Ethnicity, Ages 3-11 years, NHANES, 1988-2014

Percentage of nonsmokers aged 3–11 years* with evidence of secondhand smoke exposure (serum cotinine levels 0.05–10 ng/mL), by race and Hispanic origin† — National Health and Nutrition Examination Survey (NHANES), United States, 1988–2014

† Because of sample design, racial and Hispanic origin categories were limited to non-Hispanic whites, non-Hispanic blacks, and Mexican Americans across all survey cycles.
Exposure to SHS by Race and Hispanic Origin, NHANES, 2009-2018

Percentage of nonsmoking adults exposed to secondhand smoke (SHS)

* Secondhand smoke exposure was defined as serum cotinine level of 0.05–10 ng/mL.

† All includes persons reporting other races not shown separately or more than one race. Data are not available for 2009–2010 for non-Hispanic Asian.

NHANES, MMWR, February 12, 2021; 70(6);224
Tobacco Related Disparities

• Gradual progress over past 30 years
• American Indian/Alaska Native higher
• Second-hand smoke exposure affects Blacks and poor disproportionately
• Are Mixed Race persons at higher risk?
• Dynamic of immigration and SES
• E-cigarettes > smoking in White youth
• LGBTQ+ have higher smoking rates
COVID-19 and Tobacco Use
COVID-19 and Smoking

• “Smoker’s paradox” myth

• Risk of smoking history
  o Higher risk of severe disease (OR = 1.53)
  o Higher relative risk of death (OR = 1.25)

• Patterns in smoking cessation
  o 33% of cigarette users and 23% of e-cig users increased use due to stress

• Behavior common among smokers may heighten risk
  o Touching face, sharing e-cig devices
COVID-19 and Youth Tobacco Users

• Preliminary study shows e-cig use is an underlying risk factor for COVID-19
• Youth (aged 13-24) ever e-cig users 5x more likely to test positive
• Prevalence of e-cig use in youth (aged 13-24 y) decreased during stay-at-home orders: accessibility
• Current understanding on e-cig and COVID-19 is mostly based on preclinical studies and theoretical models
Association between COVID-19 and use of inhaled tobacco products, adjusting for sociodemographic factors, weighted

National cross-sectional survey of adolescents and young adults aged 13-24 years (n = 4351): United States, May 6– May 14, 2020

* indicates statistical significance

<table>
<thead>
<tr>
<th>Race/ethnicity</th>
<th>Ever-use of inhaled tobacco + COVID-19 symptoms</th>
<th>Ever-use of inhaled tobacco + COVID-19 diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian/NH or PI</td>
<td>1.92</td>
<td>0.08*</td>
</tr>
<tr>
<td>Black</td>
<td>2.06*</td>
<td>1.18</td>
</tr>
<tr>
<td>Latino</td>
<td>2.01*</td>
<td>2.84*</td>
</tr>
<tr>
<td>White</td>
<td>Ref</td>
<td>Ref</td>
</tr>
<tr>
<td>Other/multi-race</td>
<td>1.89*</td>
<td>3.88*</td>
</tr>
</tbody>
</table>

Biological Markers of Tobacco Use
Optimal Serum Cotinine for Distinguishing Smokers and Nonsmokers

- NHANES: 13,078 nonsmokers and 3,078 smokers; based on ROC curves
- Whites: 5.92 ng/ml
- African Americans: 4.85 ng/ml
- Mexican Americans: 0.84 ng/ml
- Overall cut point is 3.08 ng/ml; 96% sensitivity and 97% specificity
- 14 ng/ml underestimates smokers

Nicotine Metabolism in Blacks, Whites, Chinese and Latinos

- Metabolic clearance of nicotine and cotinine in 40 Latinos was similar to that in 40 Whites, higher among 40 Blacks and lower among 40 Chinese smokers.

- Intake of nicotine (mg) per cigarette:
  - Chinese: 0.73
  - Latinos: 1.05
  - Whites: 1.10
  - Blacks: 1.41

- Nicotine intake = tobacco smoke

Multiethnic Cohort Study Update: Racial/Ethnic Differences in Lung Cancer

- 4993 cases lung cancer ascertained by 2012
- Model Excess RR of smoking 50 y at 10 CPD
- **Native Hawaiians** = 21.9, African Americans = 19.1, Whites = 11.9, Japanese Americans = 10.1, Latinos=8.0
- After adjustment for predicted total nicotine equivalents, AA and JA did not differ from Whites
- Latino and NHOP risks are not explained
Genome-wide Association Study of Smoking in the HCHS/SOL

• Hispanic Community Health Study / Study of Latinos: genetic associations with smoking behavior in 12,741 participants; 5119 ever smokers

• CHRNA5, encodes the α5 cholinergic nicotinic receptor subunit, associated with heavy smoking defined as ≥10 CPD at genome-wide significance (p ≤ 5 x10^{-8})

• Loci on chromosomes 2 and 4 — genome wide significance association with non-daily smoking

• Replication attempts were limited by small Latino samples and lack of items on non-daily use

Saccone NL, et al, Nicotine and Tobacco Research, 2018; 20: 448-457
Smoking Cessation Interventions: Gaps in the Evidence
Receipt of health professional advice to quit smoking among smokers aged ≥18 years, NHIS, US, 2015

<table>
<thead>
<tr>
<th>Demographic Factor</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>60.2%</td>
</tr>
<tr>
<td>Black</td>
<td>55.7%</td>
</tr>
<tr>
<td>Latino</td>
<td>42.2%</td>
</tr>
<tr>
<td>AI/AN</td>
<td>38.1%</td>
</tr>
<tr>
<td>Asian</td>
<td>34.2%</td>
</tr>
<tr>
<td>Multiple race</td>
<td>69.6%</td>
</tr>
</tbody>
</table>

*NHIS, MMWR, January 6, 2017; 65(52);1457-1464*
Smoking Cessation Interventions

- Maximize reach and efficacy: Web, text
- Medication trials needed with minorities
- Implement electronic referrals from EHR to website or telephone help line
- Dependence measure predicts success in Blacks: Time to first cigarette
- Menthol smokers have less success
- We need trials with Non-Daily Smokers!
Cessation Interventions for Minorities

• Motivations to quit vary by race, culture
• Effects on family is a major factor
• Magnified concern with personal health
• Adverse influence on interpersonal relations in Latinos and Asians
• Language specific tailored components needed
• Addiction paradigm may not apply
• Access to pharmacological aids limited

Tomando Control website: Results of RCT of 1000 smokers at one year

<table>
<thead>
<tr>
<th>Intervention</th>
<th>% Quit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guia alone</td>
<td>19.8%</td>
</tr>
<tr>
<td>Guia + ITEM</td>
<td>19.1%</td>
</tr>
<tr>
<td>Guia + ITEM + Mood</td>
<td>20.7%</td>
</tr>
<tr>
<td>Above + Virtual Group</td>
<td>22.7%</td>
</tr>
</tbody>
</table>

Intervention Strategies for Nondaily Smokers

• Less emphasis on pharmacological approaches
• Adapt cessation efforts to fit the needs of non-daily smokers, which differ from daily smokers
• Differ in their motives and personal goals
• Targeting vulnerable subpopulations, where nondaily smoking is prevalent
• Racial/ethnic minorities, people with mental health and substance use challenges

Methods that may Enhance Cessation

- African Americans: menthol smoking bans
- AI/AN: cessation interventions need to differentiate between traditional and recreational tobacco use
- Asians: using family and/or social support in cessation interventions
- Latinos: using text message interventions, adapt interventions to incorporate cultural characteristics (familism)
Structural Determinants and Policy
Targeted by the Tobacco Industry

80% of blacks smoke menthol cigs compared to 30% of whites

Menthol marketing

In 1969 Lorillard increased its “Negro market budget” by 87% over 1968
Trajectories of Cigarette Smoking Behaviors

• Cohort study to examine the effect of tobacco coupons and progression of smoking behaviors
• Current smokers with less education and higher poverty were more likely to have received these coupons
• Receipt of coupons associated with progression of smoking behaviors, lower likelihood of cessation, and higher likelihood of relapse

(Choi et al., Tobacco Control, 2018)
# Home Smoking Bans in US Households with Children and Smokers

*Tobacco Use Supplement, Am J Prev Med 2011; 41: 559-65*

<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>Total</td>
<td>14.1%</td>
<td>50%</td>
</tr>
<tr>
<td>Asian/PI</td>
<td>28.5%</td>
<td>65.9%</td>
</tr>
<tr>
<td>Whites</td>
<td>12.7%</td>
<td>48%</td>
</tr>
<tr>
<td>African Am</td>
<td>9.2%</td>
<td>32.8%</td>
</tr>
<tr>
<td>Latinos</td>
<td>26.7%</td>
<td>72.2%</td>
</tr>
<tr>
<td>HS Grad or &lt;</td>
<td>11.1%</td>
<td>42%</td>
</tr>
</tbody>
</table>
Policies to Limit Tobacco Use

• Implement mobile and web-based technologies to promote quit attempts
• Taper nicotine content of tobacco to prevent addiction and promote cessation
• Ban on flavorings and menthol
• Control the wild west internet market
• Incorporate electronic cigarettes as pharmacological option
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California Behavioral Science Professionals: University of California, San Francisco School of Medicine (UCSF) is approved by the California Association of Marriage and Family Therapists to sponsor continuing education for behavioral health providers. UCSF maintains responsibility for this program/course and its content.

Course meets the qualifications for 1.0 hour of continuing education credit for LMFTs, LCSWs, LPCCs, and/or LEPs as required by the California Board of Behavioral Sciences. Provider # 64239.

Respiratory Therapists: This program has been approved for a maximum of 1.0 contact hour Continuing Respiratory Care Education (CRCE) credit by the American Association for Respiratory Care, 9425 N. MacArthur Blvd. Suite 100 Irving TX 75063, Course # 186986000.

California Addiction Counselors: The UCSF Office of Continuing Medical Education is accredited by the California Consortium of Addiction Professional and Programs (CCAPP) to provide continuing education credit for California Addiction Counselors. UCSF designates this live, virtual activity, for a maximum of 1.0 CCAPP credit. Addiction counselors should claim only the credit commensurate with the extent of their participation in the activity. Provider number: 7-20-322-0722.
Free CME/CEUs will be available for all eligible California providers, who joined this live activity thanks to the support of the California Tobacco Control Program (CTCP).

For our California residents, SCLC offers regional trainings, online education opportunities, and technical assistance for behavioral health agencies, providers, and the clients they serve throughout the state of California.

For technical assistance please contact (877) 509-3786 or Jessica.Safier@ucsf.edu.

Visit CABHWI.ucsf.edu for more information.
SCLC is offering FREE CME/CEUs for our recorded webinar collections for a total of **29.75 units**.

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