

Background

Tobacco use is easy to start but hard to quit. According to the 2014, Surgeon General Report, *The Health Consequences of Smoking—50 Years of Progress*, nearly all tobacco use begins before 18 years of ageⁱ. Trying smoking or electronic nicotine delivery systems (also known as “vaping”) for the first time introduces nicotine to the brain that can quickly change a risk-taking behavior into an addiction. The addiction develops as a result of the chemical nicotine because nicotine induces pleasure and reduces stress and anxiety.ⁱⁱ

What is Health Equity in Tobacco Prevention and Control?

In public health, health equity is the opportunity for everyone to reach their “full health potential.” Health equity in tobacco prevention, control and treatment means there is opportunity for all people to live a healthy, tobacco-free life, regardless of their race, level of education, gender identity, sexual orientation, the job they have, the neighborhood they live in, or whether or not they have a disability. Tobacco control programs can work toward health equity by focusing efforts on decreasing the prevalence of tobacco use and secondhand smoke exposure and improving access to tobacco control resources among populations experiencing greater tobacco-related health and economic burdens.ⁱⁱⁱ

Health disparities or inequities are types of unfair health differences closely linked with social, economic or environmental disadvantages that adversely affect populations. The following populations have been identified as experiencing tobacco-related disparities.

- Age (25-34 year olds)
- Education Attainment (no post high school education)
- Ethnicity (Multiracial/Non-Hispanic)
- Geographic location*
- Homeless*
- Health Insurance Status (Medicaid & Medicare)
- Incarcerated*
- Income (less than \$50K)
- Mental Illness Diagnosis (depressive disorder)
- Military*
- Occupation
- People with Disabilities
- Pregnant Women
- Substance Use Disorders*
- Sexual Orientation/Gender Identity (lesbian, gay, bisexual, and transgender)*

*Nationally, these subpopulations have been identified as disparate groups for tobacco use. New Hampshire specific data is not available.

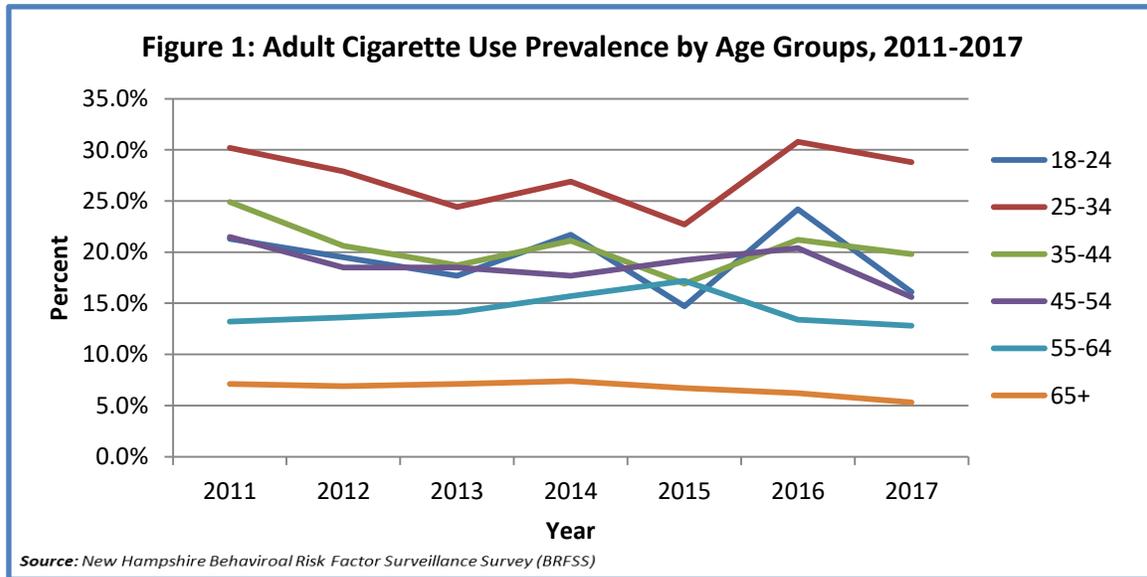
While, New Hampshire saw a decrease in adult smoking prevalence between 2011 and 2017, according to the NH Behavioral Risk Factor Surveillance Survey (BRFSS), when comparing the data across different population groups, details of tobacco use and dependence between adults emerge. This issue brief defines the adult tobacco-related disparities, presents data about these populations, and explains why the New Hampshire Tobacco Prevention and Cessation Program (TCP) are focusing on these certain populations.

For more information on the goals and activities of TPCP and its partners please review the [NH Tobacco Prevention and Cessation Program Strategic Plan](#). This plan serves as a principal guide to promote a tobacco-free NH to reduce the health and economic burdens of tobacco.

New Hampshire Adult Tobacco-Related Disparities Data

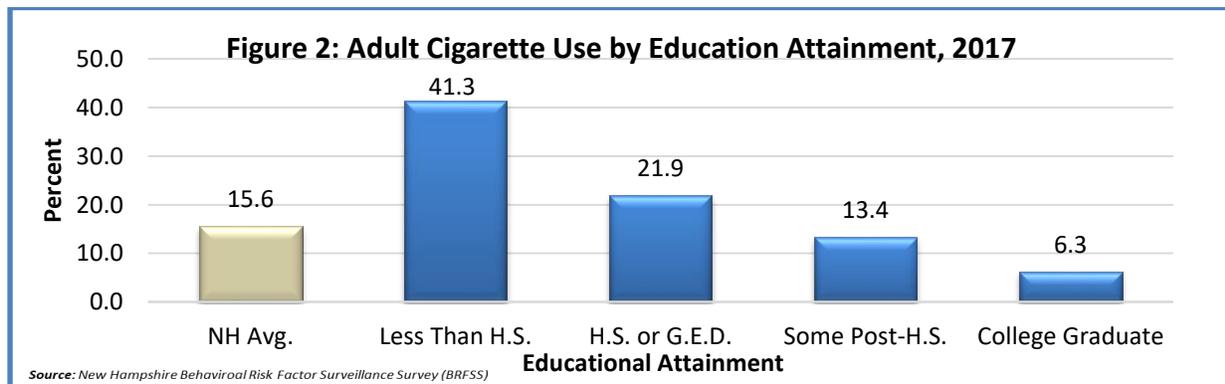
Age

The data in Figure 1 shows that smoking prevalence is highest across 3 age categories: 18-24, 25-34, and 35-44. Implementing system interventions to address tobacco use and dependence in these age groups is critical to improving health and decreasing costs.



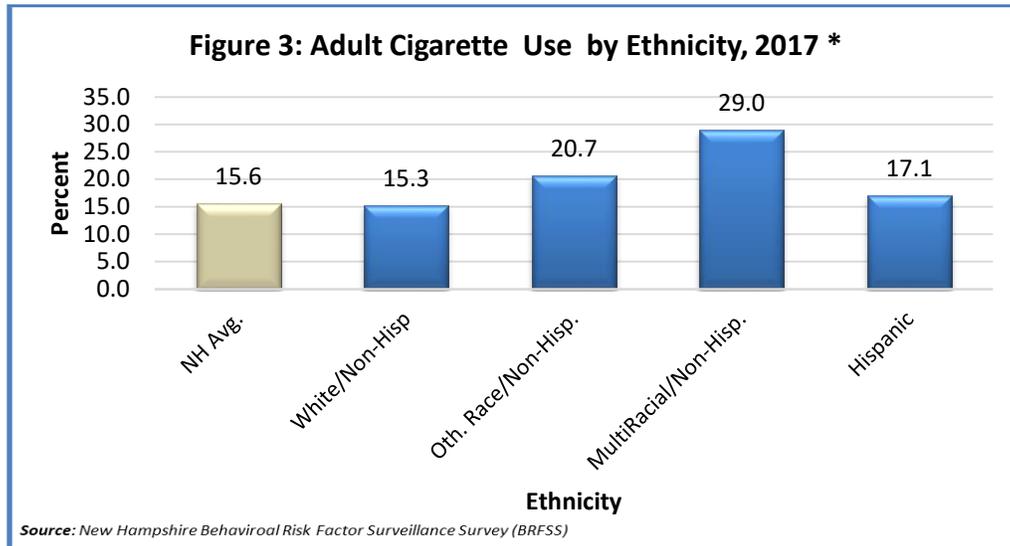
Education Attainment

Data from the 2017 NH Behavioral Risk Factor Surveillance Survey (see Figure 2 below) shows that adults with less than a high school diploma and those with a General Education Diploma (GED) or high school diploma smoke at a higher rate than those who have attended some post high school education. This data is consistent with national findings.



Ethnicity

According to the 2017 BRFSS (see Figure 3), there are differences in smoking prevalence between ethnicities. Respondents that selected multiple races (not including Hispanic) have the highest smoking prevalence at 29%. Next are the respondents that selected a race other than White or Hispanic (including Latino/a, or Spanish) at 20.7%. The number of Blacks or African Americans is suppressed due to the low response rate for the survey.



*The number of NH respondents who say their race is Black or African American has been suppressed as a result of low response rate.

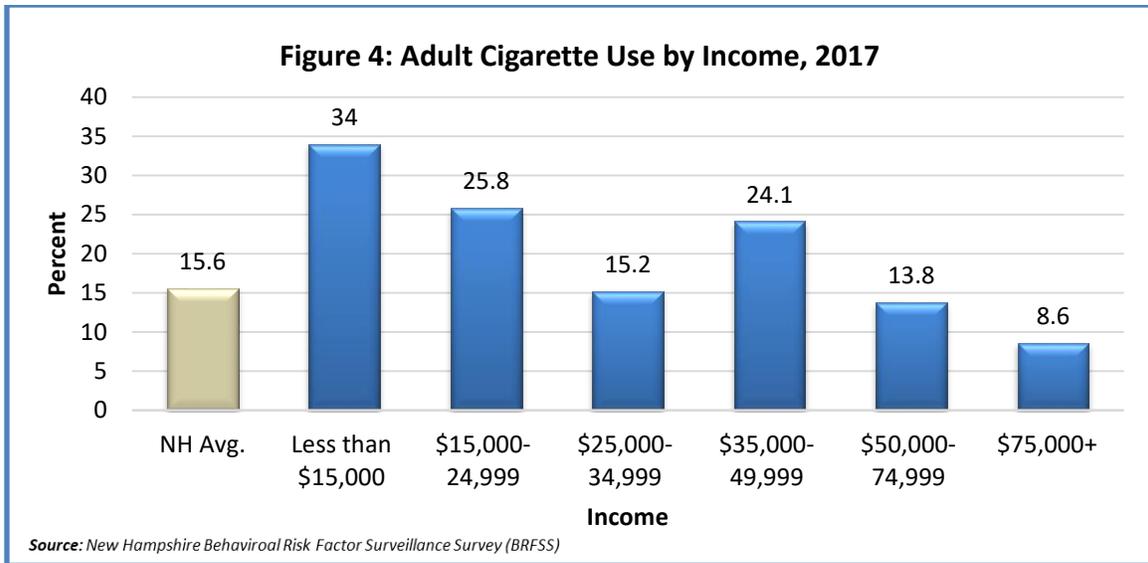
Health Insurance Status

NH DHHS, Division of Public Health Services (DPHS), TPCP is reliant on national data from the Centers for Medicare and Medicaid Services (CMS) to estimate smoking status by those receiving CMS benefits. Currently CMS estimates that 27% of adult Medicaid beneficiaries reported using tobacco products as compared to the national average of 18.1%.^{iv}

In August 2018, DHHS included language in the Managed Medicaid Request For Proposals that will necessitate that clinicians and providers identify smoking status of Medicaid Beneficiaries during encounters. This is critical to begin given the role that tobacco use plays in initiating, complicating, and exacerbating chronic diseases.

Income

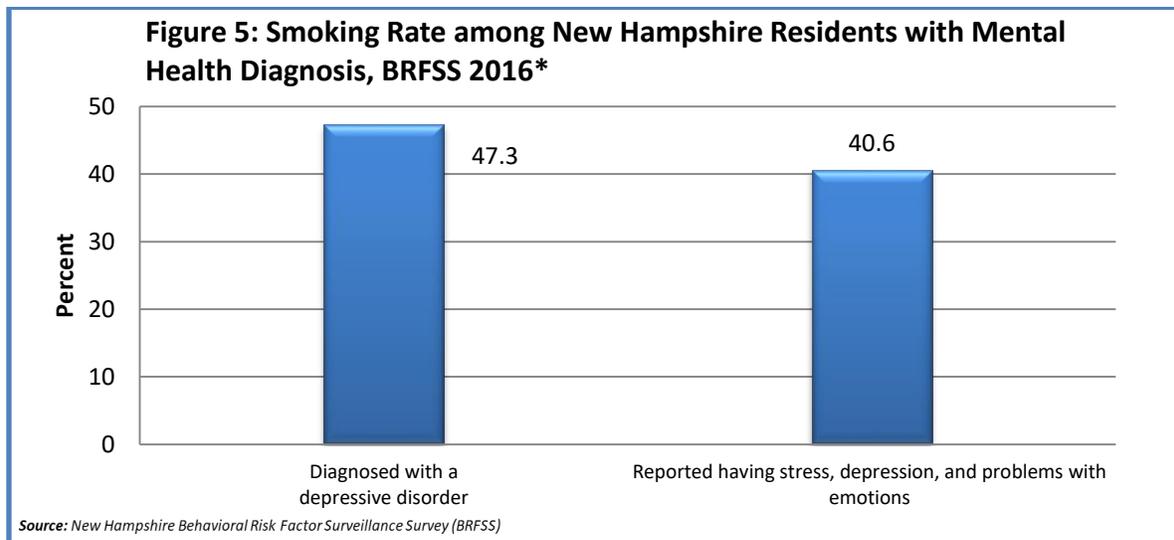
State data (see Figure 4) demonstrates those who earn less than \$50,000 per year smoke at a higher rate than the state average of 15.6%.



Mental Health Diagnosis

Per the Substance Abuse Mental Health Services Administration (SAMHSA) report, *Smoking and Mental Illness among Adults in the United States*,^v adults that experienced a mental illness in the past year were more likely to smoke cigarettes than adults who did not experience a mental illness. This also includes the amount and frequency of cigarettes used by the population experiencing a mental illness. Additionally, according to SAMSHA, the number of persons in the behavioral workforce that smoke is approximately 30-35% as compared to the number of primary care physicians (1.7%).

DHHS does not require tobacco use and dependence be reported by behavioral health clinicians who use the DHHS Phoenix electronic medical record. As such, the Department does not have a population estimate about smoking status. TPCP has analyzed data from the NH BRFSS to provide an estimate of smoking prevalence for this population.

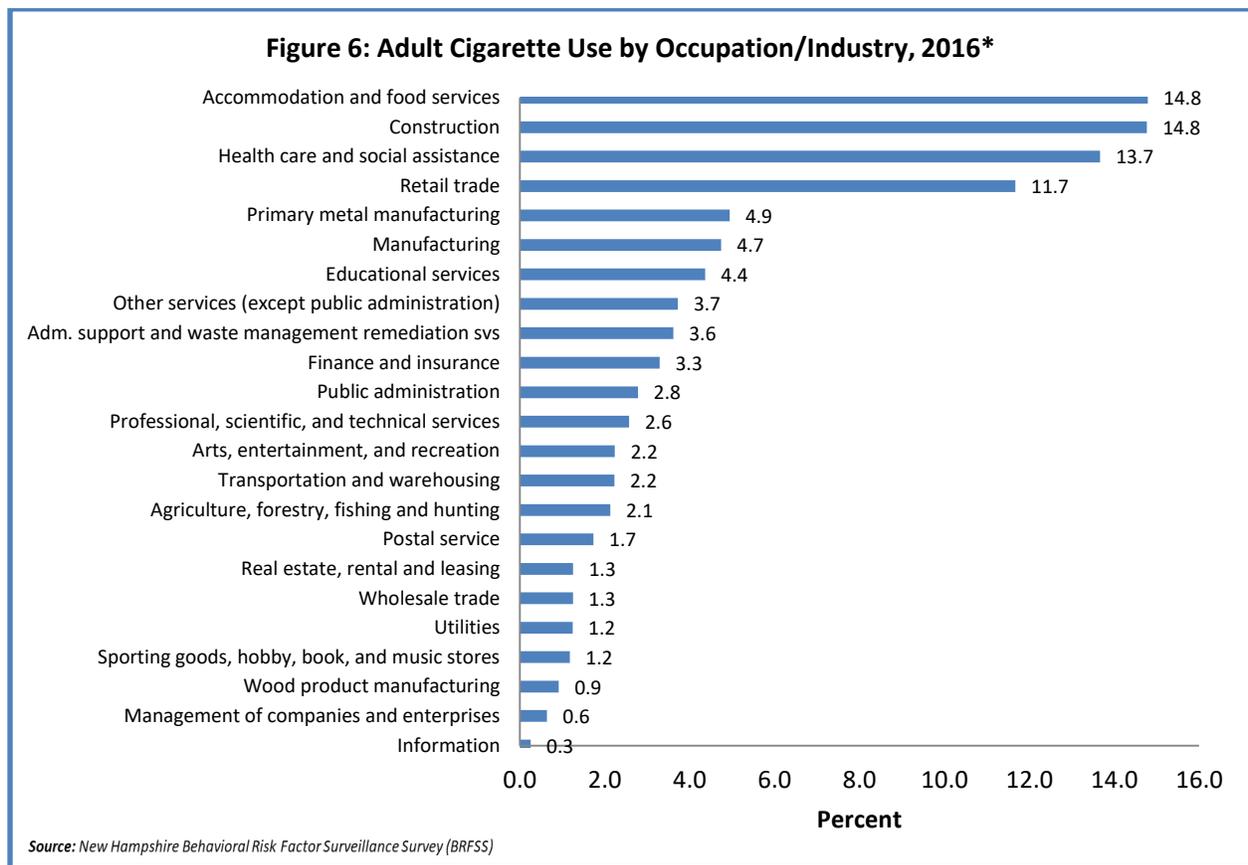


*The 2017 BRFSS data looking at mental health diagnosis had not been analyzed at the time of this report.

In September 2018, DHHS received a SAMHSA funded grant [SAMHSA (FOA) No. SM-17-008] intended to fund person-centered home-model for 16-35 year olds diagnosed with severe/persistent mental illness (SMI) and/or sever emotional disturbance (SED). The primary focus of the grant is to improve health and wellness by integrating primary care into three Community Mental Health Centers. Over the next 5 years, DHHS anticipates the implementation of health behavior change interventions that include incentives, smoke-free campuses, and peer-led tobacco intervention programs.

Occupation

National and state data (see Figure 6) indicates that smoking prevalence can also be dependent on occupation or industry. The NH Behavioral Risk Fact Surveillance Survey (BRFSS) 2016 data consistently demonstrates that food service, construction, health care, social services industries, and retail trade have higher percentages of smoking as compared to other industry sectors.



*The 2017 BRFSS data looking at occupation/industry had not been analyzed at the time of this report.

People with Disabilities

In collaboration with TPCP, the NH Disability and Public Health Project (DPH), University of New Hampshire, contracted for services with QuitNow-NH for a 6-month period in order to better understand the impact on smoking on those with disabilities. QuitNow-NH is the NH Department of Health and Human Services evidence-based tobacco helpline known, which provides tobacco treatment services and medication to those who enroll in counseling.

From August 2017 through January 2018, QuitNow-NH received 1,058 call; 68% of the callers reported having a mental health condition, 32% reported a mobility limitation, 16% had a learning difficulty, and 3% reported a developmental disability. These findings suggest that people with disabilities who use tobacco are enrolling with QuitNow-NH for tobacco treatment resources.

During the six months the following findings were discovered: 95% of QuitNow-NH users were first-time callers; people with learning difficulties were slightly more likely than others to be first-time callers; and people with learning difficulties reported that they had started smoking at a younger age (15.5 years old compared to 17 years old among other callers).

TCPC and DPH will continue to include disability screening questions on the QuitNow-NH intake survey for the next three years to increase understanding of program use among people with disabilities. Lastly, both programs will work to ensure inclusiveness and accessibility for QuitNow-NH.

Pregnant Women

Smoking can pose challenges for women seeking pregnancy as it can affect a woman’s ability to get pregnant. For women of reproductive age, smoking can be particularly insidious because of smoking’s impact on reproductive health including: infertility, conception delay, menstrual irregularity, and early menopausal onset.

Preconception care, which includes a woman’s reproductive life plan, personal health, and lifestyle habits, is an important aspect of women’s well visits. Preconception care improves birth outcomes and reduces infant mortality. Encouraging positive health changes through preconception care not only influences a woman’s overall health, but also the health of her future babies. Addressing concerns such as smoking/tobacco use habits can positively impact a woman’s overall health prior to pregnancy. Smoking can pose challenges for women seeking pregnancy as it can affect a woman’s ability to get pregnant.

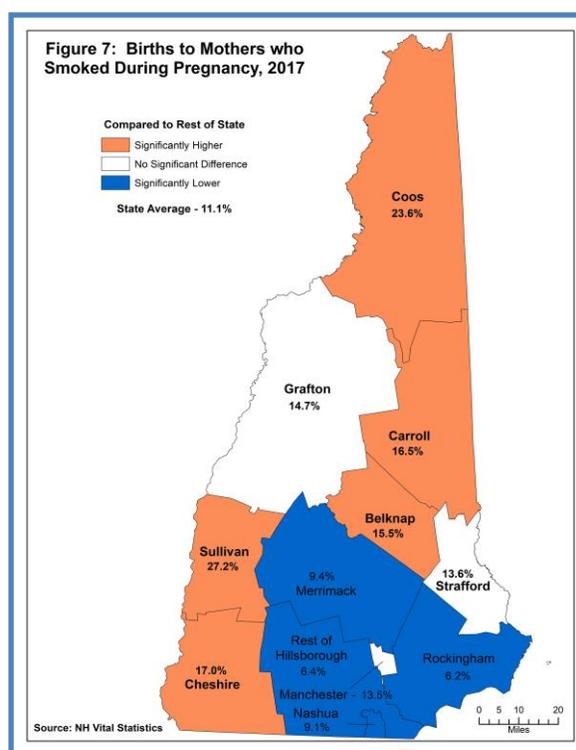


Figure 7 shows vital statistics data from 2017 related to women of child-bearing age who smoke. Coös, Sullivan, Carroll, Belknap, and Cheshire counties all had a significantly higher rate than the rest of the state. Merrimack, Rockingham, and Hillsborough County (not included Manchester) had a significantly lower rate than the rest of the state.

Identifying substance use disorder, which includes tobacco use, is critical for this population. Evidence shows that systematized brief interventions conducted by a medical professional make a difference on a

women’s reproductive health. Brief interventions consist of (1) screening at every visit, (2) assisting with education and medications, and (3) referral to treatment resources such as 1-800-QUIT-NOW.

Sexual Orientation/Gender

The State of New Hampshire has been reliant on national data relative to people who identify as lesbian, gay, bisexual and transgender (LGBT). Smoking rates of the LGBT community are typically higher than heterosexual adults. The LGBT population is often overlooked as a result of stigma and disparities associated with the population. We know that this population typically smokes cigarettes higher than the state average of 15.6%.

- 20.6 % of lesbian, gay and bisexual adults nationally smoke cigarettes^{vi}
- 35.5% of transgender adults nationally smoke cigarettes^{vii}

Substance Use Disorders

DHHS, Division for Behavioral Health (DBH), Bureau of Drug and Alcohol Services (BDAS) uses the Web Information Technology System (WITS) as its electronic medical record. DHHS has not required reporting and submission of individual level tobacco use status via WITS. DPHS and DBH are collaborating to address data collection in order to target finite resources. Figure 8 is a snapshot of the tobacco use and dependence data fields embedded in WITS.

Figure 8: WITS EMR Tobacco/Nicotine

The screenshot shows a form titled "Tobacco / Nicotine" with the following fields:

- Have you ever used Tobacco/Nicotine products? (dropdown menu)
- Smoker Status (text input)
- At what age did you first use tobacco/nicotine product(s)? (text input)
- In the past 30 days, what tobacco/nicotine product did you use most frequently? (text input)
- Other (Please Describe) (text input)
- In the past 30 days, how often did you use tobacco/nicotine product(s)? (text input)
- In the past 30 days, how many cigarettes did you smoke per week? (text input)

At the bottom of the form, there are four buttons: "Cancel" (red), "Save" (green), "Finish" (blue), and two circular navigation arrows (left and right).

Recommendations

- The U.S. Department of Health & Human Services’ (DHHS) *U.S. Public Health Service Clinical Practice Guideline to Treating Tobacco Use and Dependence* can serve as a cornerstone for healthcare systems to support clinician interventions.^{viii} The NH Tobacco Prevention and Cessation Program (TPCP) can provide technical assistance to healthcare systems in New Hampshire that are ready to prioritize treating tobacco use and dependence.
- Any NH resident who uses tobacco, regardless of condition or ability to pay, should be asked, assisted, and referred to tobacco treatment.
- QuitNow-NH (1-800-QUIT-NOW) will continue to provide tobacco treatment services and medication to any NH resident who enrolls in counseling through QuitNow-NH.
 - In 2019, there may be eligibility requirements.

- TPCP will target disparate populations during mass media communications.
- Community Mental Health Centers in New Hampshire should consider adopting tobacco-free policies.
 - Three NH Community Health Centers are positioned to improve tobacco use policies over the next three years.
- TPCP will continue to collaborate with partners to reach disparate populations.

Conclusions

As outlined in this brief, New Hampshire data reflects national data and trends. Health equity in tobacco prevention, control and treatment means there is opportunity for all people to live a healthy, tobacco-free life, regardless of their race, level of education, gender identity, sexual orientation, the job they have, the neighborhood they live in, or whether or not they have a disability. Tobacco control programs can work toward health equity by focusing efforts on decreasing the prevalence of tobacco use and secondhand smoke exposure and improving access to tobacco control resources among populations experiencing greater tobacco-related health and economic burdens.^{ix}

In summary, TPCP has identified the following disparate populations based on the NH data:

Age (25-34 year olds)	Mental Health Diagnosis (depressive disorder)
Education Attainment (no post high school education)	Occupation (food service, construction, health care, and retail trades)
Ethnicity (Multiracial/NonHispanic)	People with Disabilities
Health Insurance Status (Medicaid & Medicare)	Pregnant Women
Income (less than \$50K)	Substance Use Disorder

These findings highlight the importance of evidence-based, population-level strategies to accelerate progress toward reducing tobacco-related death and disease in the United States. Over the next five years TPCP will be focusing their activities on these disparate populations. A few strategies that maybe taken to reach these populations are:

- Collaborate with the NH Medicaid Managed Care Health Plans and Providers to ensure Medicaid patients have access to nicotine replacement therapies (NRT) when enrolled in tobacco treatment counseling
- Implement high-impact mass-media campaigns, social media campaigns, and/or develop a geo-fence location where these populations visit or live to increase call volume to [QuitNow-NH](#) and tobacco quit attempts.
- Continue to offer barrier-free access to tobacco-cessation counseling and approved medications.

Additional strategies that maybe considered are: tobacco price increases, comprehensive smoke-free laws, and FDA regulation of tobacco products at a state level.

For more information or technical assistance:

New Hampshire Department of Health and Human Services
Division of Public Health Services
Tobacco Prevention & Cessation Program
Telephone: (603) 271-6891 Email: TPCP@dhhs.nh.gov
www.dhhs.nh.gov/dphs/tobacco/index.htm

ⁱ U.S. Department of Health and Human Services. The Health Consequences of Smoking—50 Years of Progress. A Report of the Surgeon General. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014.

ⁱⁱ Benowitz N. L. (2010). Nicotine addiction. *The New England journal of medicine*, 362(24), 2295-303. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2928221/> (accessed January 17, 2019)

ⁱⁱⁱ Centers for Disease Control and Prevention. *Best Practices User Guide: Health Equity in Tobacco Prevention and Control*. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2015. <https://www.cdc.gov/tobacco/stateandcommunity/best-practices-health-equity/pdfs/bp-health-equity.pdf> (accessed January 17, 2019)

^{iv} U.S. Centers for Medicare & Medicaid Services. Medical Assistance with Smoking and Tobacco Cessation: Findings from a Nationwide Survey of Adult Medicaid Beneficiaries, 2014-2015. Retrieved 10/10/2018, from <https://www.medicare.gov/medicaid/quality-of-care/downloads/performance-measurement/infographic-tobacco-cessation.pdf>.

^{vi} Lipari, R.N. and Van Horn, S.L. *Smoking and mental illness among adults in the United States*. The CBHSQ Report: March 30, 2017. Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Rockville, MD. Retrieved, 10/5/2018 https://www.samhsa.gov/data/sites/default/files/report_2738/ShortReport-2738.html

^{vii} Centers for Disease Control and Prevention. Current Cigarette Smoking Among Adults- United States, 2005-2015. Morbidity and Mortality Weekly Report. 2016;65(44):1205-1211.

^{viii} Buchting FO, Emory KT, Scout, et al. Transgender Use of Cigarettes, Cigars, and E-Cigarettes in a National Study. *Am J Prev Med*. 2017;53(1):e1.

^{viii} Fiore MC, Jaén CR, Baker TB, et al. *Treating Tobacco Use and Dependence: 2008 Update*. Clinical Practice Guideline. Rockville, MD: U.S. Department of Health and Human Services. Public Health Service. May 2008.

^{ix} Centers for Disease Control and Prevention. *Best Practices User Guide: Health Equity in Tobacco Prevention and Control*. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2015. <https://www.cdc.gov/tobacco/stateandcommunity/best-practices-health-equity/pdfs/bp-health-equity.pdf> (accessed January 17, 2019)