National Medical Association

Consensus Report of the National Medical Association:

Smoking Cessation in the African American Community

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THE NMA SMOKING CESSATION CONSENSUS PANEL

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EXECUTIVE SUMMARY

Key Words: ■ ***African American*** ■ ***Consensus Panel*** ■ ***Cigarettes,*** ■ ***Smoking Cessation*** ■ ***Tobacco*** ■ ***Outcomes*** ■ ***Physicians*** ■ ***Recommendations***

INTRODUCTION

In 2006, the National Medical Association (NMA) revisited the subject of tobacco use and its disproportionate effects on the health of African Americans. The NMA National Programs staff invited experts to join the Smoking Cessation Consensus Panel to examine the effects of smoking and tobacco control initiatives, especially how each relates to the African American community. A briefing paper prepared by the staff for the panel updating the 2004 NMA study on tobacco control summarized recent research on the topic of smoking cessation and African Americans.

About the NMA

The National Medical Association, a 501(c)(3) organization, is the largest and oldest national organization, representing 30,000 African American physicians and health professionals in the United States, Puerto Rico, and the Caribbean and the millions of patients they serve. While throughout its history the NMA (established in 1895) has focused primarily on health issues related to African Americans and medically underserved populations, its principles, goals, initiatives and philosophy encompass all sectors of the population. In accordance with its purpose, the National Medical Association has upheld its priority of developing strategies to facilitate improvements in health care for African Americans through policy initiatives, special programming, training and research opportunities, and collaborative partnerships. The NMA's focus on the elimination of health disparities reflects its mission and continued historical commitment to improve health outcomes for people of color through its ongoing health policy, research, and programmatic thrusts to achieve parity in health care.

Methodology

The NMA staff invited experts to join the Smoking Cessation Consensus Panel in 2006 to examine the effects of smoking and tobacco control initiatives, especially how each relates to the African American community.

A preliminary briefing paper was generated by the staff of National Programs of the NMA and made available to members of the Smoking Cessation Consensus Panel. This paper summarized recent research on the topic of smoking cessation and African Americans.

Members of the Smoking Cessation Consensus Panel reviewed the briefing paper and convened in Sonoma, California, December 7-10, 2006. The panel's purpose at this meeting was to:

- consider the findings of the briefing paper
- discuss current research on the topic

- develop specific recommendations to improve the rate of smoking cessation among African Americans
- ultimately decrease the negative effects of smoking on this population

Key elements to be incorporated in the consensus paper included:

- negative health consequences of smoking
- efforts to curb smoking under certain smoking cessation programs
- related issues to smoking and smoking cessation specific to the African American population
- educational, legislative, and research-related recommendations to support smoking cessation efforts among African American physicians and patients

The research conducted for panel deliberations included data from large-scale studies conducted by the Centers for Disease Control and the U.S. Department of Health and Human Services and other related sources. After reviewing available data, the panel members established the categories of Epidemiological Considerations, Smoking and African Americans, and Pertinent Legislative History.

DISCUSSION

The Surgeon General's report *The Health Consequences of Smoking* states: "No single factor determines patterns of tobacco use among racial/ethnic minority groups." These patterns are the result of complex interactions of multiple factors, such as:

- socioeconomic status
- cultural characteristics
- acculturation, stress
- biological elements
- targeted advertising
- price of tobacco products
- varying capacities of communities to mount effective tobacco control initiatives

Rigorous surveillance and prevention research are needed on the changing cultural, psychosocial, and environmental factors that influence tobacco use to improve our understanding of racial/ethnic smoking patterns and identify strategic tobacco control opportunities.

The capacity of tobacco control efforts to keep pace with patterns of tobacco use and cessation depends on timely recognition of emerging prevalence. Cessation patterns and the resulting development of culturally competent and helath literate appropriate community-based programs is needed to address the factors involved.

The consensus panel has recommended that the NMA, as a leader in both research and action on issues affecting the health of African Americans should continue its work on addressing tobacco related health problems through a program of education, advocacy, policy formation, and research. Mobilization of its membership to greater participation in smoking prevention and cessation activities will also assist in decreasing the disparities in care now found between minority communities and the general public.

FINDINGS

Although the smoking rate for African Americans is at 21.5%, slightly less than for whites at 21.9%, [1] African Americans bear a greater health burden from smoking-related disease and death. African Americans suffer disproportionately from chronic and preventable diseases, to which smoking is a major contributor.

For chronic diseases such as asthma, for which African Americans have a higher prevalence and a higher hospitalization rate, smoking exacerbates the already high incidence of asthma. Tobacco smoke is a leading environmental asthma trigger and has been linked to development of asthma in children and adults.

Smoking is one of the most common triggers for asthma symptoms, and children with asthma can suffer when exposed to secondhand smoke. While the percentages of African Americans who smoke have declined, the numbers are still unacceptable. Controlling exposure to cigarette smoke is often easier in public places than in private homes. According to the American Lung Association, as smoking declines among white, non-Hispanic populations, tobacco companies have targeted both African Americans and Hispanics with intensive merchandising in the media.[12] Additional campaigns oriented toward the African-American community in-

volve sponsorship of civic groups and athletic, cultural and entertainment events. There is a need for state and community-based health initiatives, which include educating the public about potential adverse effects of exposure to secondhand cigarette smoke and other irritants that affect patients with asthma.

Another risk factor specific to African Americans is the fact that three out of four African American smokers smoke menthol cigarettes, as compared to one fourth of white smokers. There is some evidence that menthol cigarettes may facilitate absorption of harmful constituents of cigarette smoke.[6] One study found that people who smoke menthol cigarettes may have a more difficult time quitting smoking. [10]

Other important factors are associated with the promotion of tobacco use among African Americans. Tobacco companies have specifically targeted tobacco advertising toward African Americans, placing ads in stores, magazines, and at special events.[8] Advertising targeted to African Americans often does not describe the harmful effects of tobacco.

Commenting on a study reported in the July 24, *Journal of the American Medical Association (JAMA) (*Vol. 288, No. 4: 468-474) in which researchers looked at accepted treatments for smoking cessation and how they worked in the African American community, an online article included the following points: The authors concluded that one way to improve the "quit rates" for African Americans would be through increased access to medications as part of health insurance programs, especially Medicare and Medicaid. This step would make an investment in reducing the differences in access to health care that exist in the United States, they said. Just as important, the study noted, is to reach the goals of Healthy People 2010 set by the U.S. government. Significant decreases in smoking among "special populations" such as African Americans must occur.[3]

INTRODUCTION

Cigarette smoking is a major contributor to the three most prevalent causes of death in African Americans--heart disease, cancer, and stroke. All people, regardless of race and ethnicity, can become addicted to tobacco and damaged by the harmful effects of smoking. However, health-related factors specific to African Americans must be addressed in any smoking cessation program.

In 2006, the NMA examined current tobacco control initiatives, especially in regard to its own work, which has paid particular attention to the needs of the African American community and other underserved populations. A briefing paper covering the topic was prepared by staff for a consensus panel of experts, who convened in December to examine research and issue recommendations.

HISTORY: THE NMA AND SMOKING CESSATION

Since 1975, the Association has participated in a wide variety of externally funded projects. Some of these programs, funded by federal, state, and local governments, private foundations, pharmaceutical companies, and private corporations, range from topics such as AIDS, bioterrorism, and cultural competence to health literacy, immunization, lupus, clinical trials and prostate cancer. The NMA has historically taken an active role in promoting smoking cessation among African Americans, participating in programs to support tobacco control such as the Stop Active Smoking and Take Charge project (SASATAC) funded by the CDC.

In addition, the NMA has worked with research institutes at the National Institutes of Health, including the National Cancer Institute, the National Eye Institute, the National Institute on Deafness and Other Communication Disorders, and the National Heart, Lung and Blood Institute. The NMA has also collaborated with the Centers for Disease Control and Prevention, the Public Health Service, the Department of Health and Human Services, and the Healthcare Research and Services Administration.

In 1994, the Centers for Disease Control and Prevention (CDC) funded the NMA to develop tobacco control leadership initiatives in the African American community. From 1994 to 1998, the SASATAC project was the NMA's only tobacco prevention and control project and was designed to facilitate coalition building and media advocacy for the promotion of tobacco control policies and initiatives for African Americans.

The principal goal of the three-year NMA project was to develop and publicize a national african american agenda for tobacco control. With the intent to create capacity within the NMA, the program included a component for conducting research and developing national and local resources based on the tobacco control campaign findings.

SASATAC also created and mobilized a national community-based African American leadership network that would participate in developing and promoting the tobacco control agenda.

That African American control agenda was publicized through national and local media advocacy campaigns, tobacco control initiatives, and policies and programs within the African American community nationwide.

While the project primarily focused on building capacity within the NMA to support tobacco control and prevention activities, project staff identified a critical need to increase provider participation in the their patients' efforts to quit smoking. The NMA also chose to address tobacco control by spearheading an agenda that would involve more African American physicians and leaders in designing and promoting health intervention strategies that encourage individuals to change "high risk" behaviors and engage their active participation in the policy and decision making processes.

The NMA's SASATAC project was one of nine organizations funded through the National Tobacco Prevention and Control Program of the CDC Office of Smoking and Health. A primary goal of this program was to

implement strategies of the *Initiatives to Mobilize for the Prevention and Control of Tobacco Use* (IMPACT) to develop a tobacco control capacity within the NMA.

Additionally, in 1997, the NMA launched a dissemination initiative through the SASATAC project, beginning with a series of strategic planning sessions held at NMA headquarters and other locations in Washington, DC and Rockville, MD. Staff of the NMA/SASATAC Project met with Agency for Healthcare Research and Quality (AHRQ) and NMA leaders to finalize plans for additional project activities, which included the following actions:

- Modification of existing AHRQ point of sale and provider information to insure ethnic/cultural relevance and appropriateness
- Recommendations for modifying and customizing the guideline supplemental materials (a quick-reference physician pocket guide and posters)
- Video production and on-site training.
- Massive dissemination of clinical practice guidelines and associated materials.
- Establishing a tentative regional training schedule for NMA state and local organizations.
- Continuing strategic planning meetings with AHRQ staff, NMA leadership, and administrative staff.

More recently, the NMA has undertaken the following additional tobacco program:

In 2002, the NMA collaborated with the CDC on a guide for African Americans that included community-based youth education programs.

STATEMENT OF THE PROBLEM

Cigarette smoking remains the leading preventable cause of death in the United States, accounting for approximately 1 of every 5 deaths (438,000 people) each year. Approximately 20.9% of all American adults (45.1 million people) smoke cigarettes. [1]

After years of progress in reducing adult smoking rates, a recent study issued by the CDC indicates that among adult smokers the cessation effort has stalled, with no observed change between 2004 and 2005.[2] Factors possibly responsible for the lack of decline in smoking may include smaller increases in the price of cigarettes, a reduction in funding for state programs of tobacco control and prevention, and a doubling of tobacco-industry advertising and promotional expenditures.

In addition, although secondhand smoke exposure has declined, more than 126 million nonsmoking Americans continue to be exposed to secondhand smoke.[2] Although progress has been made in recent years to reduce the level of secondhand tobacco smoke exposure, the decline has been greater among adults than among children.[5]

Along with the significant health risks due to smoking, the financial costs of tobacco-related deaths and diseases are enormous. Related costs are an estimated $100 billion dollars per year.[3]

Although the number of high school seniors who smoke has reduced (from 36.5 percent in 1997 to 24.4 percent in 2003), the rate of decline has slowed in recent years.[5]

Recently, the Public Health Service targeted reductions in youth and adult smoking rates in its Healthy People 2010 objectives. Its goals were to reduce current smoking rates from 35% (1999) to 16% among high school youth 14-17 years of age and to reduce current smoking rates from 24% (1998) to 12% among adults aged 18 years and older. [5]

EPIDEMIOLOGICAL CONSIDERATIONS

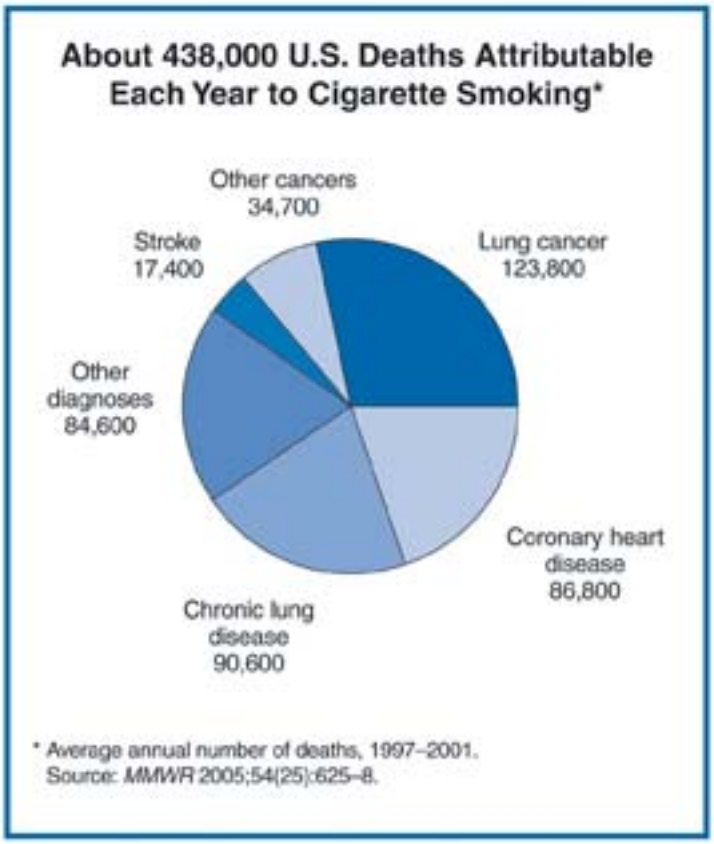
Smoking harms nearly every organ of the body, causing many diseases, including cancer, cardiovascular disease, and respiratory diseases, as well as harmful adverse reproductive effects. Quitting smoking has immediate as well as long-term benefits.[5]

According to a recent report of the Surgeon General on the health effects of smoking:

> Smoking caused an estimated total of 263,600 deaths in males and 176,500 deaths in females (total 440,100) in the United States each year from 1995 to1999. For men aged 35 years and older, annual smoking-attributable deaths were 105,700 for cancers, 87,600 for cardiovascular diseases (CVDs), and 53,700 for respiratory diseases. For women aged 35 years and older, the annual SAM was 53,900 for cancers, 55,000 for CVDs, and 44,300 for respiratory diseases. Among adults, the most smoking attributable deaths were from lung cancer (124,800), ischemic heart disease (IHD) (82,000), and chronic airway obstruction (64,700). Smoking during pregnancy was estimated to result in 560 deaths in infant boys and 410 deaths in infant girls annually. Excluding adult deaths from secondhand smoke, the estimated SAM (Smoking Attributable Mortality) was responsible for a total annual YPLL (Years of Potential Life Lost) of 3,319,000 for males and 2,152,600 for females.[5]

Smoking can be blamed for many forms of cancer, including lung, laryngeal, oral cavity and pharyngeal, pancreatic, bladder and kidney, cervical, endometrial, stomach, and acute leukemia cancers. Smoking has also been linked to cardiovascular diseases, including subclinical atherosclerosis, coronary heart disease, cerebrovascular disease, and abdominal aortic aneurysm.

Cigarette smoking decreases lung functioning, which increases the risk for asthma-related hospital admissions, asthma-related health care use, and the risk of death from asthma. Cigarette smoking has also been associated with an impaired therapeutic response to corticosteroids among people with chronic asthma. Smoking cessation and reduced exposure to secondhand tobacco smoke are key components of asthma management.[9]



SMOKING AND WOMEN

Although the percentage of women who smoke is 21%, slightly less than for men at 26%, smoking has a devastating effect on women's health.[14] In 1997, 165,000 women died of smoking-related deaths. Smoking causes heart disease, the number-one killer of women in the United States. Lung cancer surpassed breast cancer as the leading cause of cancer death among women in 1987. [13]

The tobacco industry spent more than $8.24 billion in 1999 to advertise and promote cigarettes. Women in particular are targeted by tobacco advertising associating social desirability, independence, and weight control, featuring attractive models with smoking messages. [13]

Smoking affects the reproductive process, including causing reduced fertility in women. While smoking is detrimental to women's health, pregnant women who smoke also place their unborn children at risk. It is estimated that between 12% and 20% of pregnant women and girls smoke cigarettes. Carbon monoxide from cigarette smoke reduces the amount of oxygen to the fetus and nicotine reduces blood flow to the uterus. Ten percent of all infant deaths are linked to smoking. Pregnant women who smoke increase the risk of stillbirth, low infant birth weight, premature birth, and sudden infant death syndrome. [14]

Women who smoke during pregnancy leads to a reduction of lung function in infants, to smoking and impaired lung growth during childhood and adolescence, and to asthma. [9]

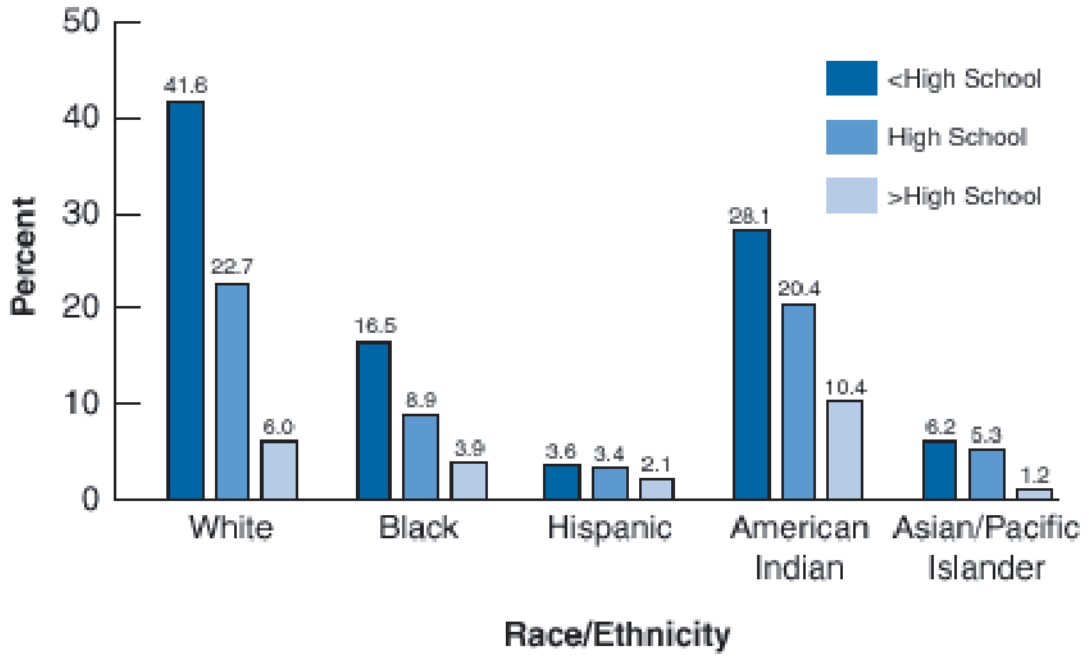
Postmenopausal women who smoke have lower bone density than women who never smoked. Women who smoke also have a higher risk for hip fracture than nonsmokers. Cigarette smoking also causes wrinkles that could make smokers appear less attractive and prematurely old.[13]

SMOKING AND AFRICAN AMERICANS

In the United States, approximately 45,000 African Americans die each year from smoking-related diseases. If this public health crisis is not immediately remedied, approximately 1
million African Americans now under the age of 18 will become regular smokers, and about 500,000 of those smokers will die of a smoking-related disease.[7]

Smoking rates within the African American community vary according to gender and age. In 1997, African American men (32.1%) smoked at a higher rate than white men (27.4%), while African American women (22.4%) and white women (23.3%) smoked at a similar rate.[3] Although the *National Youth Tobacco Survey* found that the smoking prevalence rate was higher among white high school students (32.8%) than among African American high school students (15.8%), recent surveys have shown that smoking rates among Afri-

Pregnant Women Who Smoke, by Education and Race/Ethnicity, United States, 2001



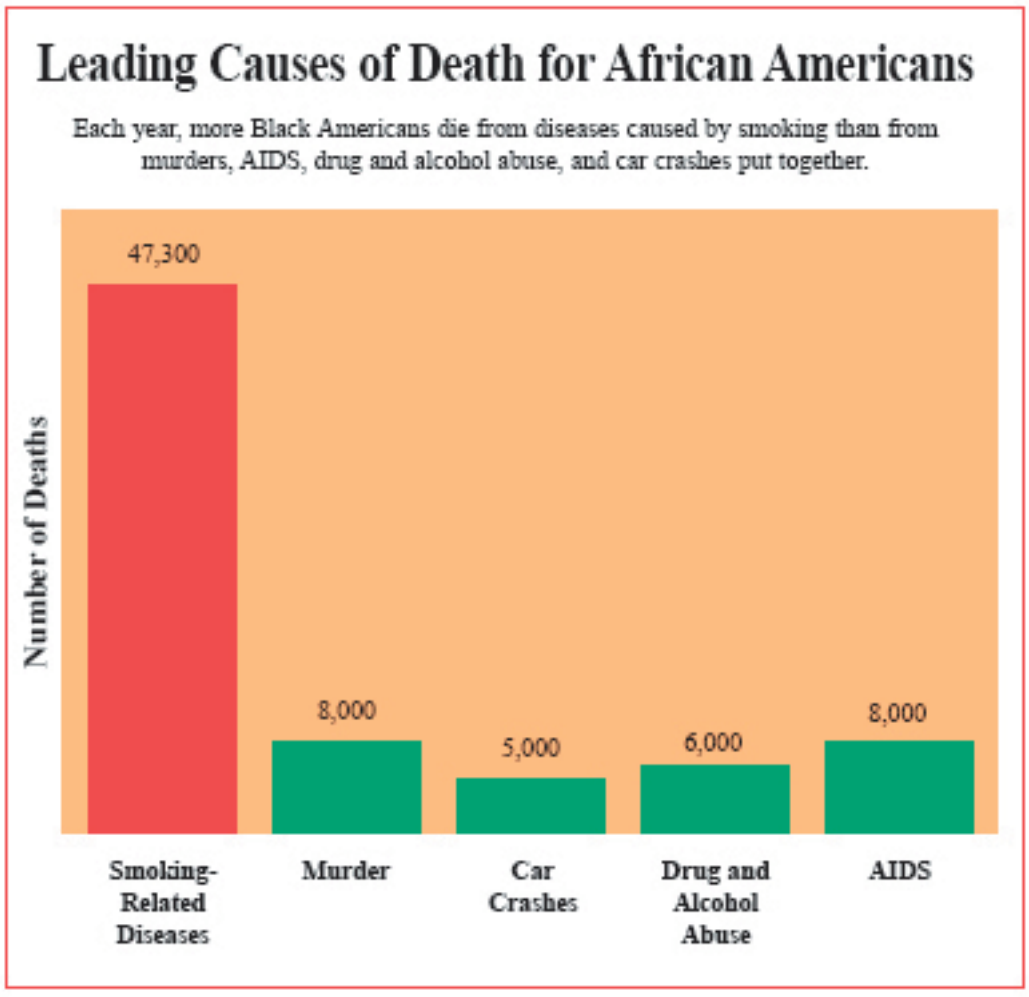
Source: *National Center for Health Statistics*, CDC, 2001.

can American high school students are increasing. [7] As with white men, African American men who were high school graduates showed a greater decline in smoking prevalence than did those with less formal education. Generally, rates of illness have differed across racial ethnic groups. Although some genetic factors may be involved, culture, degree of acculturation, and socioeconomic factors are considered more significant in explaining differences in health between groups. Socioeconomic characteristics in particular often affect health-care access and quality, and minority groups are less likely than whites to be insured and to receive adequate health care.[6]

In an editorial, Neal Benowitz, M.D., from the University of California in San Francisco, commented, "The adverse health effects of smoking are even greater in African Americans, who have a higher risk of lung cancer compared with whites, and also are increased among the poor, who are much more likely to be smokers and to have other risk factors, such as hypertension, diabetes, and obesity, that interact with cigarette smoking to promote cardiovascular disease."[10]

Smoking is the most common cause of lung cancers (87%). African American men are at least 50% more likely to develop lung cancer than white men and have a higher mortality rate of cancer of the lung and bronchus (100.8 per 100,000) than do white men (70.1 per 100,000). The risk of cerebrovascular disease, associated with stroke, is elevated by smoking. Cerebrovascular disease is double among African American women (40.6 per 100,000) as among white women (22.6 per 100,000).[7]

Findings of a 1998 study in *JAMA* seem to indicate that black smokers and white smokers differ in their metabolism of cotinine, as well as in the intake of nicotine per cigarette. These differences may help explain disparities in smoking-related disease risks between black and white smokers. [17]



Pathways to Freedom: CDC, 2007

Levels of serum cotinine (metabolized nicotine) are higher among African American smokers than among white or Mexican American smokers for the same number of cigarettes, possibly because of differing patterns of smoking behavior, rates of nicotine metabolism, and brand mentholation. [6]

A recent study in the Archives of Internal Medicine suggests that smoking menthol cigarettes may make cessation more difficult for the smoker. As menthol cigarettes were found to be preferred by African American smokers (89% versus 29% among other smokers), this finding may indicate why smoking cessation rates are lower among African Americans. [16]

A study found that African American publications *Ebony, Jet,* and *Essence* received higher profits from cigarette advertising than did other magazines. It has been found that cigarette companies also support cultural events and donate to minority higher education institutions, elected officials, civic and community organizations, and scholarship programs. [6]

A 2002 study found "The tobacco industry established relationships with virtually every African American leadership organization and built longstanding social connections with the community, for three specific business reasons: to increase African American tobacco use, to use African Americans as a frontline force to defend industry policy positions, and to defuse tobacco control efforts." It concluded, "As the tobacco industry expands its global reach, public health advocates should anticipate similar industry efforts to exploit the vulnerabilities of marginalized groups…. Helping groups anticipate such efforts, confront industry co-optation, and understand the hidden costs of accepting tobacco industry largesse should be part of worldwide tobacco control efforts."[11]

Data on major population categories might mask differences in tobacco-use prevalence among subpopulations. A study in 2002-2004 exploring the prevalence of cigarette smoking among youths aged 12-17 years in six major racial/ethnic populations and nine Asian or Hispanic subpopulations in the United States indicated that the estimated prevalence of cigarette smoking in this age group ranged from 23.1% for American Indians/Alaska Natives to 2.2% for Vietnamese. Implementing tobacco-control programs that include culturally appropriate interventions may assist in reducing cigarette smoking in racial/ethnic subpopulations.

Sustained, culturally appropriate interventions to prevent youths from starting to smoke or help them to quit might be effective in racial/ethnic populations and subpopulations with a high prevalence of cigarette smoking. Effective tobacco-control initiatives might result from comprehensive behavior-based approaches enhanced by using culturally targeted media and education campaigns and increasing the capacities of specific populations to address tobacco use within their communities.

Relevant Legislation & Legislative History

Three important developments in the 1990's began to influence the way in which tobacco was regulated and used in the United States. The FDA issued final regulations in 1996 to restrict the sale, distribution, advertising, and promotion of cigarettes and smokeless tobacco. In 1997 a group of state attorneys general presented a tobacco settlement proposal, representing 41 of the 50 states.

This initial proposal eventually led to an agreement in 1998 between U.S. tobacco companies to settle pending and prospective lawsuits by states to recover Medicaid expenditures from tobacco use. These national settlements also led to provisions similar to public health regulations. These important regulatory measures included state-wide restrictions on tobacco-related activities, such as a ban on outdoor advertising and advertising to minors, and a call for statewide restrictions on vending machines. [5]

CONSENSUS PANEL RECOMMENDATIONS

After reviewing pertinent literature and recent research, the NMA Consensus Panel made several recommendations to improve the smoking cessation rate and reduce the harmful effects of smoking on the African American population. These recommendations can be categorized under five topics:

- Public Education
- Provider Education
- Advocacy
- Policy
- Research

In its deliberations, the panel worked with the overarching goal to create a comprehensive, culturally appropriate anti-tobacco campaign to convey the serious effects of smoking and to discourage smoking among African American adults and youth.

The recommendations also call for supporting NMA physicians by providing them with the appropriate tools and information to encourage smoking cessation among their patients. At the same time, the consensus panel encourages NMA physicians to take leadership roles to advocate for tobacco control nationally and internationally.

Recognizing the paucity of current research on tobacco and African Americans, the consensus panel also proposes that additional resources be devoted to tobacco control research, clinical trials, and dissemination of research.

Education

Public Education

1. The NMA will continue to develop a culturally competent, comprehensive smoking cessation campaign and will advocate for complementary messages, using a variety of external media (i.e., film, TV, radio, print, medical journals) and internal media (e.g., the *Journal of the National Medical Association, NMA Healthy Living* magazine, and the NMA website). To disseminate this campaign throughout the community, it will form alliances with groups experienced in marketing to African Americans that also have expertise in carrying health messages to grassroots organizations (e.g., the American Legacy Foundation, Priority Populations Initiatives, the National Association of African Americans for Positive Imagery, the National Association for the Advancement of Colored People, the Urban League and other community-based organizations).

2. The NMA will support effective school-based primary prevention programs aimed at youth, particularly African American youth, forming alliances with organizations aimed at youth, such as the Campaign for Tobacco-Free Kids, the YMCA, the YWCA, the Boys and Girls Clubs, alternative and vocational schools and HBCU's.

3. Various media outlets or celebrities may be engaged, as part of a multitude of approaches. The NMA will publicize an annual event centered on tobacco control, which would center on the risks of smoking for pregnant women, (i.e., birth weight, infant mortality, and postnatal physical and mental health), including the effects of environmental tobacco smoke (ETS) on pediatric diseases such as asthma, middle ear infection, and sudden infant death syndrome.

Provider Education

1. The NMA will develop a distribution plan to disseminate the campaign materials to NMA members. Use of the NMA website and links to other websites to provide more comprehensive information on tobacco control issues to members as well as to consumers will be developed.

2. The NMA will develop a provider toolkit (modular format) for members to use in educational efforts as well as for advocacy of tobacco control issues pertinent to African American

communities (i.e., smoking cessation, prevention, disparities). The provider tookit will use the Public Health Service guidelines, modified to be culturally appropriate. These efforts can be expanded through alliances with the National Tobacco Control Program, American Cancer Society, and the like.

Advocacy

1. The NMA must re-establish a leadership position in setting the tobacco control agenda, in order to decrease the impact of tobacco-related diseases in African American communities. To this end, it should educate African American physicians to advocate and provide leadership for tobacco control. Physicians with expertise in tobacco control should be encouraged to become members of organizations such as the Campaign for Tobacco Free Kids that advocate for smoking cessation among African Americans and become a part of government commissions and committees at federal and state levels. Physicians could also partner with other organizations to advocate for vountary policies to create smoke-free venues, such as smoke free college campuses.

2. Niche markets should be identified that the NMA address to relay the message of smoking cessation to African Americans. Possible targets include:

- cigars and "blunts"
- smokeless tobacco
- promotion of smoke-free environments in institutions such as prisons, mental hospitals, and substance abuse treatment centers
- encouragement of smoking cessation in African Americans, particularly in men and pregnant women

3. The NMA should advocate and organize around international tobacco control efforts, especially as they relate to the people of the international African Diaspora. Partnerships with the World Health Organization (WHO) and the Tobacco Control Commission on Africa as well as with international members of NMA and their respective embassies should be considered.

4. The NMA should review current class-action suits involving tobacco control in African Americans.

Policy

1. Key members should organize around tobacco settlement issues to ensure that funding is equally allocated to all segments of the African American community, according to the impact of tobacco use on morbidity and mortality.

2. The NMA should identify "best practices" or models of information distribution from the state level to the membership, in order to mobilize NMA members around the tobacco settlement funding process.

3. A survey of the NMA membership should be implemented to determine their baseline knowledge. The survey will provide an opportunity to educate members about the laws and regulations governing smoking in work sites, public settings, and homes.

4. The NMA should continue to support all legislation that requires regulation of tobacco and its products by the Food and Drug Administration, with preference given to efforts that op pose the marketing of high-nicotine and menthol products to African Americans.

5. The NMA should assist in the development and support legislation that increases reimbursement for treatment of tobacco dependence in African Americans, by such methods as nicotine replacement therapies, other medications, and counseling.

6. The NMA should encourage an ongoing assessment by federal and state agencies of their cultural capacity and infrastructure to support the African American community in this work.

RESEARCH

1. The NMA recognizes the paucity of evidence-based outcomes relate to tobacco control in African Americans and supports the following lines of research:

a. Review of and new research on smoking patterns and the metabolism of nicotine and cotinine in African American versus other ethnicities (i.e., menthol cigarette use in African Americans, cotinine levels and other tobacco metabolites in African Americans, family history and patterns of smoking, etc.).

b. Dissemination of research information to African American physicians about smoking cessation counseling and treatment patterns as well as resource patterns.

c. Review of tobacco industry documents targeted at African Americans.

d. Review and conduct new research in the area of smoking cessation among African Americans (i.e., cultural differences in approaches, what works and why, counseling outcomes, nicotine replacement therapies).

e. Asses or conduct market research in African American communities.

f. The effectiveness of federal/state efforts in regards to the elimination of population disparities.

g. Development, training, and dissemination of tobacco control protocols that are relevant and culturally competent for use in African American communities (e.g., the publication, "Pathways to Freedom").

2. The NMA strongly endorses the use of more African American physicians as well as other minority researchers in the development, design, implementation, and evaluation of clinical trials and will serve as a clearinghouse for such cooperative activities. In particular, it should partner with historically black colleges and universities (HBCUs) as well as with minority researchers (as principal investigators).

3. Panelists urged continued research on relevent topics, including the following:

a. What are the attributes of individuals who quit smoking without the aid of pharmaceuticals? What are the attributes of individuals who quit with pharmaceuticals? What are the attributes of individuals who fail to quit?

b. How do we bring about a shift in the treatment of tobacco addiction? The message should be one of "Let me (the physician) help you quit" versus "You should quit and do it by yourself."

c. The economic impact of smoking cessation on neonatal units and other facets of the health delivery system?

d. Other research categories that the NMA and its W. Montague Cobb Institute might want to pursue include neurobiological, behavioral/attitudinal, model prevention/treatment, environmental, and economic.

Data collection

Data indicating increased tobacco-related morbidity and mortality in African Americans are abundant. However, despite the numerous studies documenting the negative outcomes suffered by African Americans and the general disparity in disease outcomes, the panel stated that data collection efforts regarding African-American patients and physicians including responses to medications need to be refined. The panel discussed the following:

- Culturally specific data
- Clinical trials data
- Patient data

Culturally specific data

There is a need for improved understanding of how race and cultural practices, independent of socioeconomic variables, may influence care for tobacco-related diseases and smoking cessation counseling and the use of

health services in all African American patient populations. To achieve this goal, there is a need to expand current and design future studies to include adequate sampling of both inner-city and non-inner-city African American patients.

Clinical Trials Data

The panel supports federal initiatives led by the U.S. Food and Drug Administration to increase minority representation in clinical trials. Clinical trials ensure the safety and effectiveness of medications and other cessation therapies in targeted patient populations. Research indicates that race and cultural behaviors may influence a patient's response to these medications.

The NMA encourages, through its research institute (W. Montague Cobb) and the clinical trials program IMPACT, the increase of minority physician and consumer participation in clinical trials involving tobacco-related disease and smoking cessation therapies.

Factors such as patient perception of experimental therapies and physician access to research resources, which may influence minority patient and physician participation in clinical trials, should be identified.

Data on the true prevalence of tobacco-related disparities and perceptions of disease severity as well as on expectation of outcomes among African Americans should be aggressively collected.

Patient Data

To fully understand the relationships among race, culture, and adherence to smoking cessation medication and other aspects of tobacco-related illness, support is needed for the expansion of such qualitative studies to include African American patient populations of all socioeconomic backgrounds.

Conclusion

While many of the panel recommendations for the improved care of patients with smoking-related disease suggested by experts will improve care in the African American community, the panel has focused on those issues that will produce the most immediate impact on this public health issue. Conversely, the recommendations target the African American community; however, they will also assist other communities in improving smoking prevention and cessation outcomes.

Organizations with established infrastructures in minority communities, such as the National Medical Association, must partner with foundations such as Legacy, Robert Wood Johnson to lead this effort and marshall member physicians, healthcare professionals, and patients. Smoking prevention and cessation initiatives must contain components to ensure that those affected most disproportionately by tobacco-related illnesses experience improved outcomes. Such initiatives must significantly improve the quality of care and eliminate disparities among underserved communities.

Appendix A

Smoking Cessation in Minority Populations Logic Model

Theory of Change

Smoking cessation in minority populations can be enhanced by providing support to minimize risk factors through education, policy change and advocacy activities, increasing research and evaluation activities, and developing an effective treatment model.

Risk Factors

Lack of public education on health. Problematic family structure. Exposure to crime, substance abuse (Alcohol, tobacco, or other drugs [ATOD]). Lack of access to health care for children with special needs.

Inputs/Resources Interventions

Historical NMA Programs such as Stop Active Smoking and Take Charge (SASA-TAC)

NMA Dissemination Initiative that included: modification of AHRQ POS materials; strategic planning meetings; recommendations for modifying and updating guideline supplemental materials; video production and on-site training; massive dissemination of clinical practice and associated materials; and establishment of a training schedule.

Endorsement of CDC's "Pathways to Freedom: Winning the Fight Against Tobacco" culturally specific cessation program

Collaboration with Glaxo SmithKline on NMA physician education program

Coalition and partnering with tobacco education and advocacy groups including Tobacco Free Kids.

Strategies identified from the expert resources of the 2006 Consensus Panel that include the implementation of evidence-based approaches within the NMA membership.

Outputs

Develop a document that delineates steps to address the issue of smoking cessation in the African American community.

Update on prior consensus recommendations and activities, specifically updating guidelines; strategic meetings; dissemination success; and training effectiveness.

Identify those NMA members who are implementing smoking cessation programs, and smoking cessation interventions (brief screening, intervention, referral, and treatment) and determine which models are effective.

Develop treatment model based on NMA membership successes.

Develop predictive model to assist NMA providers in determining best practices.

Train interested members in effective smoking cessation models.

Identify partners to promote smoking cessation programs, models, and research within the African American community.

Identify targeted research and evaluation areas for exploration and implementation.

Outcomes

Upon presentation and acceptance of consensus recommendations:

Short Term

Disseminate cessation models and predictive models to interested NMA members.

Train interested members in effective cessation models.

Develop and identify toolkits and NMA website models for training and utilization purposes.

Increase collaborations and partnerships specific to research and funding on smoking cessation.

Increase funding level for cessation efforts.

Develop a policy panel of members to utilize information gathered from membership to present smoking cessation agenda to legislators and lawmakers.

Long term

Increase number of NMA members who are implementing some type of smoking assessment and treatment.

Increase number of members utilizing tools and materials developed by NMA.

Increase education of African American communities about effects of smoking and utilization of smoking cessation programs.

Increase number of smoking cessation experts affiliated with the NMA.

NMA becomes a smoking cessation resource portal for members of the African American community, funding community, and advocates.

NMA effects a decrease in smoking in the African American community.

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