

Black Versus White Differences in Rates of Addressing Parental Tobacco Use in the Pediatric Setting

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The authors declare that they have no conflict of interest.

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ABSTRACT

OBJECTIVE: To examine racial differences in rates of screening parents for cigarette smoking during pediatric outpatient visits and to determine if a parental tobacco control intervention mitigates racial variation in whether cigarette smoking is addressed.

METHODS: As part of the Clinical Effort Against Secondhand Smoke Exposure (CEASE) randomized controlled trial, exit interviews were conducted with parents at 10 control and 10 intervention pediatric practices nationally. Parents were asked to report if during the visit did anyone ask if they smoke cigarettes. A generalized linear mixed model was used to estimate the effect of black vs white race on asking parents about cigarette smoking.

RESULTS: Among 17,692 parents screened at the exit interview, the proportion of black parents who were current smokers (16%) was lower than the proportion of white parents who smoked (20%) ($P < .001$). In control group practices, black parents were more

likely to be asked (adjusted risk ratio 1.23; 95% confidence interval 1.08, 1.40) about cigarette smoking by pediatricians than whites. In intervention group practices both black and white parents were more likely to be asked about smoking than those in control practices and there was no significant difference between black and white parents in the likelihood of being asked (adjusted risk ratio 1.01; 95% confidence interval 0.93, 1.09).

CONCLUSIONS: Although a smaller proportion of black parents in control practices smoked than white, black parents were more likely to be asked by pediatricians about smoking. The CEASE intervention was associated with higher levels of screening for smoking for both black and white parents.

KEYWORDS: pediatrics; racial differences; smoking cessation; tobacco control; tobacco smoke

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WHAT'S NEW

Although black parents had a lower prevalence of smoking than white parents, they were more likely to be asked about smoking in control practices. Black and white parents had an equal likelihood of being asked about smoking in intervention practices.

THE SERIOUS HEALTH risks associated with cigarette smoking are well documented. Every day, over 1200 people in the United States die as a result of smoking.¹ In 2010, the United States surgeon general reported that annually, 1 in every 5 deaths is caused by cigarettes and reaffirmed that there is no safe level of tobacco smoke exposure.² In addition to causing numerous cardiovascular and respiratory diseases, smoking cigarettes has been linked to increased risks of several cancers, including those of lung, cervix, pancreas, and kidney, as well as leu-

kemia.³ Smoking during pregnancy is associated with prenatal mortality, preterm delivery, low birth weight, sudden infant death syndrome, and stunted lung development,³ as well as several birth defects, including cardiovascular, musculoskeletal, limb reduction, and facial defects.⁴ Persons who smoke are recommended to quit smoking to improve both their health and the health of their family.

Nonsmokers experience serious health risks and premature death due to exposure to tobacco smoke that is emitted from a burning cigarette or exhaled by a smoker.^{5,6} Between 2007 and 2008, 88 million nonsmokers, were subjected to tobacco smoke exposure.⁷ Children are at an even greater risk of exposure to tobacco smoke than adults; almost 22 million, or nearly 60% of children aged 3 to 11 years, are exposed to tobacco smoke annually.⁸ Childhood tobacco smoke exposure is associated with ear infections, asthma

exacerbations, and acute respiratory infections.⁸ Nonsmoking pregnant women who are exposed to tobacco smoke face increased risk of stillbirth and offspring with congenital malformations.⁹ To minimize smoking-related health issues in children and adults, pediatricians should consistently address smoking with all patients, by identifying smokers and documenting tobacco use status.^{10–12} Previous studies show that parent-targeted cessation intervention can increase quit rates,^{13,14} as the pediatric office visit serves as a unique teachable moment to reduce or even eliminate childhood exposure to tobacco smoke.¹⁵ Parents usually see their child's pediatrician more regularly than their own adult primary care physician,¹⁶ and parents may be more accepting of tobacco cessation assistance when offered within the context of their child's health care visit.¹⁷

In 2011, 19.4% (95% confidence interval [CI] 18.1–20.8) of black adults smoked and 20.6% (95% CI 19.8–21.4) of white adults smoked,¹⁸ but blacks carry a higher health burden from tobacco-related diseases compared to whites.¹⁹ The higher tobacco-related health burden experienced by blacks may be related to fewer home smoking bans,²⁰ higher rates of smoking mentholated cigarettes,²¹ which research shows increases addiction and makes it more difficult to quit, and less access to medical care compared to whites.²² Fewer home smoking bans among black families may be due to lower rates of black parents receiving anticipatory guidance related to reducing environmental asthma triggers.²³ Although tobacco use is associated with higher health risks among black smokers than white smokers, previous research has demonstrated that ethnic and racial minorities are less likely to receive cessation services from their own clinicians.^{24,25}

At least one study has examined racial and ethnic disparities in parental tobacco control in the pediatric setting and found that pediatricians are more likely to ask minority parents about tobacco use.²⁶ This report was based on data collected in 2000 from a national telephone survey with parents or guardians about services received in the last 12 months. Immediate exit survey data collection is considerably more accurate than telephone surveys, as delayed measurement of services can cause an overestimation of the actual services received.^{27,28} Additionally, the validity and accuracy of exit interviews in the context of smoking cessation interventions has been established.²⁹

The aim of this study was to examine the difference in the proportion of black versus white parents being asked about their cigarette smoking. Further, we wanted to determine if a parental tobacco control intervention mitigates racial differences in screening parents for cigarette smoking.

PATIENTS AND METHODS

We analyzed data collected at twenty pediatric practices recruited from Pediatric Research in Office Settings (PROS), the practice-based research network of the American Academy of Pediatrics (AAP). PROS practices that 1) had at least 3 practitioners, 2) were not housed within a medical school or parent university, 3) saw at least 50 pa-

tients per day, and 4) saw at least 10 patients per day that had 1 or more parent smokers were eligible for the study.³⁰ The first eligible practices that responded were randomized to either the intervention or control arms (10 practices each) of a cluster randomized control trial, Clinical Effort Against Secondhand Smoke Exposure (CEASE). Clinicians in practices that were assigned to the intervention group were trained to implement a pediatric office-based intervention to address parental tobacco use.^{14,16,31} The 10 intervention practices were located in 8 states (IL, MA, MD, OH, OK, OR, SD, and WV) as were the 10 control practices (AK, CT, MO, NM, PA, SC, TN, and VA). The study protocol was approved by the institutional review boards (IRBs) of the AAP and Massachusetts General Hospital. The protocol was also approved by individual practice IRBs when required (Clinical Trial Registration NCT00664261).

After practices in the intervention group were trained to conduct routine screening for parental tobacco use, a research assistant approached all adults (smoking and nonsmoking) as they exited their child's health care visit at each intervention and control practice. The research assistant administered a screening questionnaire to the adults (hereafter referred to as parents) that collected demographic information such as parent's age, gender, race, ethnicity, level of education, age of the youngest child present at the visit, and how the visit was paid for (private insurance, Medicaid, self-pay, or some other way). To determine a parent's race, each parent was given the option to choose 1 or more of the following answers: white, black or African American, Asian, Native Hawaiian or other Pacific Islander, or American Indian or Alaska Native. Smoking status was established with the question: "Have you smoked a cigarette, even a puff, within the past 7 days?" To determine whether or not parents were asked about smoking during their child's visit, parents were asked the question: "At any time in your visit today did anyone ask if you smoke cigarettes?" Parents who indicated on the Screening Questionnaire that they have smoked a cigarette, even a puff, within the past 7 days were offered the opportunity to complete a consent form and enroll in the research study. The data used for this analysis came from the screening questionnaire and was collected from 2009 to 2011.

We excluded respondents who did not report being the parents or legal guardian of the children they accompanied. Using chi-square tests, we compared characteristics of parents in intervention and control practices. Multivariate analyses were conducted to examine the effect of parent race on the likelihood of parents being asked about smoking. We used a generalized linear mixed model to estimate the adjusted risk ratio (ARR) that included practice site as a random effect. In the model we assessed if parents were asked about smoking, and included indicator variables for parent race and ethnicity (Hispanic, non-Hispanic black, non-Hispanic Asian, and non-Hispanic Native American/Pacific Islander with non-Hispanic white as the referent), parent type (mother vs father/legal guardian), insurance type (Medicaid vs private insurance/self-pay), visit type (well-child vs sick visit), child age (<1

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