

Health Equity
Community-Clinical Linkages



Strategic Planning (State/Local)
Communications (Tailored)

Health Equity: Exploring Opportunities to Reduce Tobacco-Related Cancers Across Settings, Environments and Communities in Missouri

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SelfMade Health Network (SMHN)-CDC National Disparity Network
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Question #1

Which option best describes *your experience* with CDC National Disparity Networks?

- Attended a conference (virtual, face-to-face) sponsored by a CDC National Disparity Network
- Attendee in a webinar sponsored by a CDC National Disparity Network
- Collaborated with a CDC National Disparity Network on a project, initiative or funding opportunity
- Participated in a workshop or training sponsored by a CDC National Disparity Network
- Participated in a strategic planning/action planning meeting that included a CDC National Disparity Network
- Partnered with a CDC National Disparity Network to develop or co-brand a resource, report or document
- Participated in an orientation/introductory call involving a CDC National Disparity Network presentation
- Participated on a committee or workgroup that included a CDC National Disparity Network
- Utilized a resource developed by a CDC National Network
- This is my first introduction to CDC National Disparity Networks, I'm excited



Question #2

To advance or improve health equity in Missouri by November 2022 requires:

What?

Where? *Live, Work, Play, Learn or Worship*

That disproportionately affects **Whom** and **How?**

And **Why** is this important?

Tobacco-related Health Disparities (TRHD)

Tobacco-related Health Disparities (TRHD)

“Differences in patterns, prevention, and treatment of tobacco use; the risk, incidence, morbidity, mortality, and burden of tobacco-related illness that exist among specific population groups in the United States; and related differences in *capacity and infrastructure*, access to resources, and environmental tobacco smoke exposure.”

- differences in capacity, infrastructure, and access to resources include: significant variations in access to care, healthcare quality, socioeconomic indicators that impact healthcare, and psychosocial and environmental resources.
- differences in the tobacco use continuum include: exposure to tobacco, tobacco use initiation, current use (including dual tobacco product use), number of cigarettes smoked per day, quitting/treatment, relapse, and health consequences.

Reference: U.S. National Cancer Institute. A Socioecological Approach to Addressing Tobacco Related Health Disparities. National Cancer Institute Tobacco Control Monograph 22. NIH Publication No. 17-CA-8035A. Bethesda, MD: U.S. Department of Health and Human Services, National Institutes of Health, National Cancer Institute; 2017.

Question #3

What population with low socioeconomic status (SES) characteristics are you most passionate about?

- 1) Populations residing in *medically underserved areas (MUAs) or health professional shortage areas (HPSAs)
- 2) Medicaid enrollees or Dual eligible beneficiaries (Medicaid and Medicare)
- 3) Uninsured or Underinsured: Lack comprehensive health insurance coverage
- 4) Minimum wage or other low-income employees
- 5) Unemployed populations
- 6) Low-income pregnant/postpartum women: Recipients of Supplemental Nutrition Assistance Programs (SNAP) or Women, Infants and Children (WIC) Program
- 7) Populations with disabilities (physical, cognitive)
- 8) Populations (adults or adolescents) residing in communities with high rates of persistent poverty, food deserts or lack internet/broadband access
- 9) Low-income students (universities, colleges, or technical/vocational schools)
- 10) Low-income employees working at universities, colleges, or technical/vocational schools

**Please note:* Medically Underserved Areas (MUAs) are located in rural and metropolitan areas.



Health Equity and Low Socioeconomic Status (SES)

“The state in which everyone has the chance to attain their full health potential and no one is disadvantaged from achieving this potential because of *social position* or any other defined circumstance.”
-National Academies of Sciences, Engineering, and Medicine 2017

“Achieving health equity entails reducing *significant* differences or inequalities in health status and ensuring equal opportunities and resources to enable all people to achieve their fullest health potential.”
-World Health Organization (WHO)

“Health equity is defined as the absence of unfair and avoidable or remediable differences in health among population groups defined socially, economically, demographically or geographically. Achieving health equity in the United States requires that all Americans have access to opportunities to attain their highest level of health and not be disadvantaged because of *significantly* avoidable, unequal or treatable differences in their communities.”
-World Health Organization (WHO)

References:

National Academies of Sciences, Engineering, and Medicine 2017. Communities in Action: Pathways to Health Equity. Washington, DC: The National Academies Press. <https://doi.org/10.17226/24624>

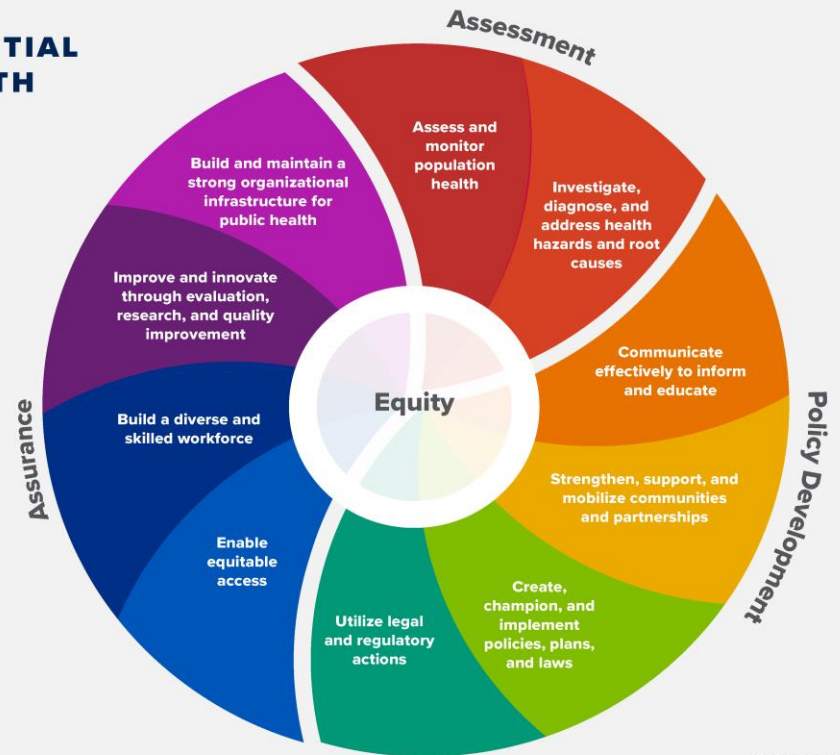
World Health Organization (WHO)-Social Determinants of Health, https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1

Health Equity (1)

THE 10 ESSENTIAL PUBLIC HEALTH SERVICES

To protect and promote the health of all people in all communities

The 10 Essential Public Health Services provide a framework for public health to protect and promote the health of all people in all communities. To achieve optimal health for all, the Essential Public Health Services actively promote policies, systems, and services that enable good health and seek to remove obstacles and systemic and structural barriers, such as poverty, racism, gender discrimination, and other forms of oppression, that have resulted in health inequities. Everyone should have a fair and just opportunity to achieve good health and well-being.

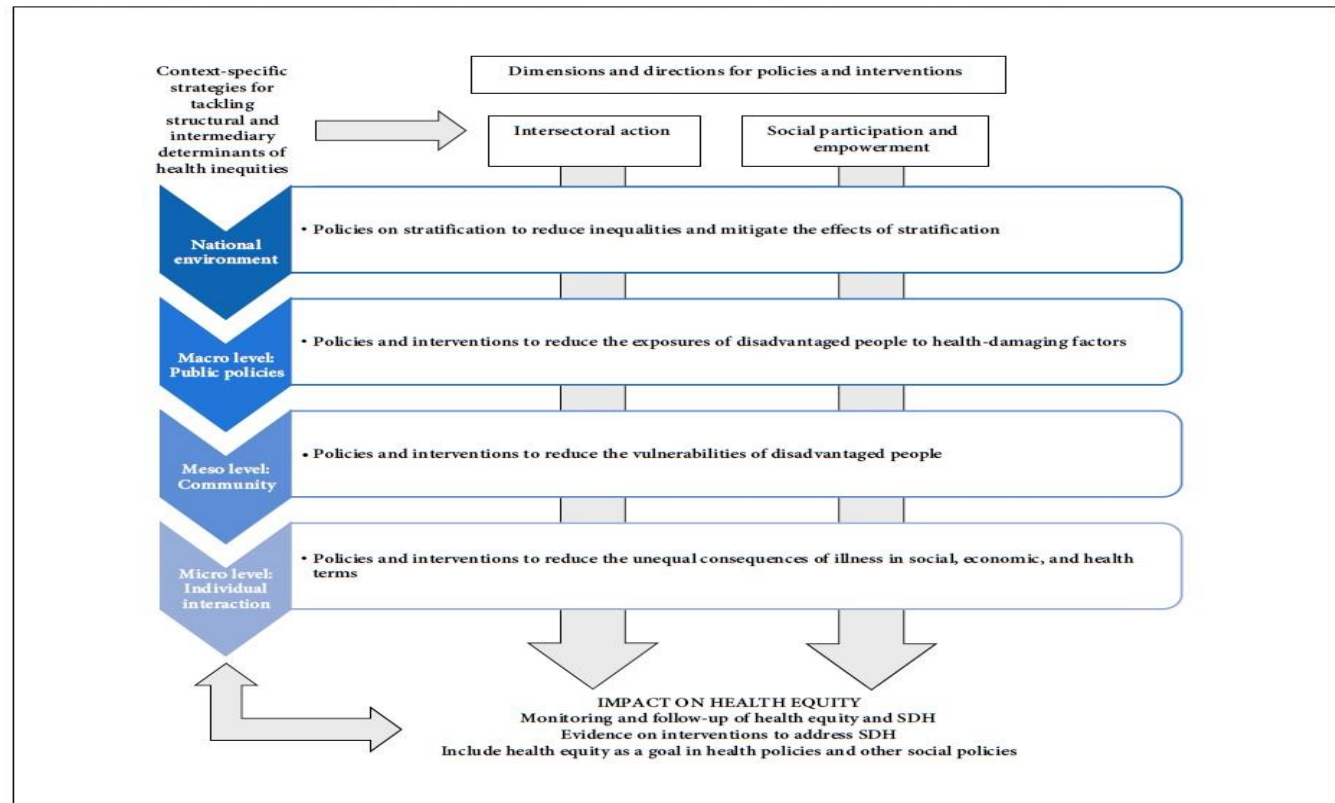


Created 2020

Reference: Centers for Disease Control and Prevention (CDC) 10 Essential Public Health Services
<https://www.cdc.gov/publichealthgateway/publichealthservices/essentialhealthservices.html>

Health Equity (2)

FIGURE 1. Framework for tackling structural and intermediary determinants of health inequities



Source: O. Solar and A. Irwin, A conceptual framework for action on the social determinants of health, Social Determinants of Health Discussion Paper 2 (Policy and Practice) 2010, World Health Organization, Geneva, Switzerland.

Health Equity: Social Determinants of Health (1)

Figure 1

Social Determinants of Health

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment	Housing	Literacy	Hunger	Social integration	Health coverage
Income	Transportation	Language	Access to healthy options	Support systems	Provider availability
Expenses	Safety	Early childhood education		Community engagement	Provider linguistic and cultural competency
Debt	Parks	Vocational training		Discrimination	Quality of care
Medical bills	Playgrounds	Higher education		Stress	
Support	Walkability				
	Zip code / geography				
Health Outcomes Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations					



Question #4

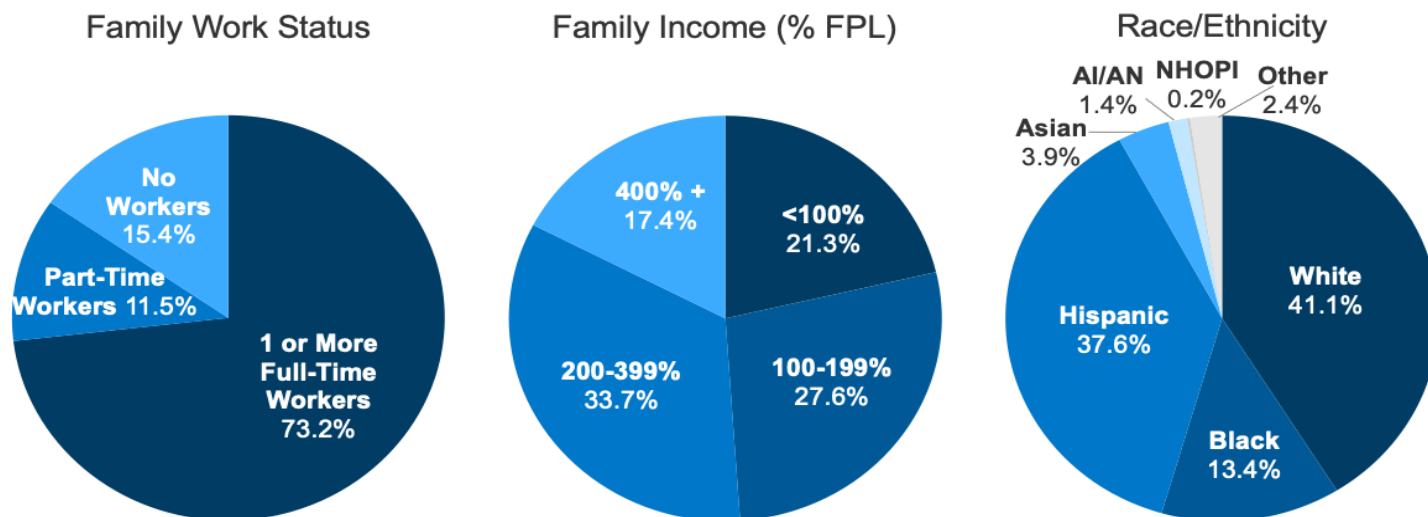
Most uninsured (no healthcare insurance) populations have at least one worker in the family. For example, more than 7 out of 10 uninsured populations (73.2%) have at least one full-time worker in their family.

True or False

Low Socioeconomic Status (SES)-1

Figure 4

Characteristics of the Nonelderly Uninsured, 2019



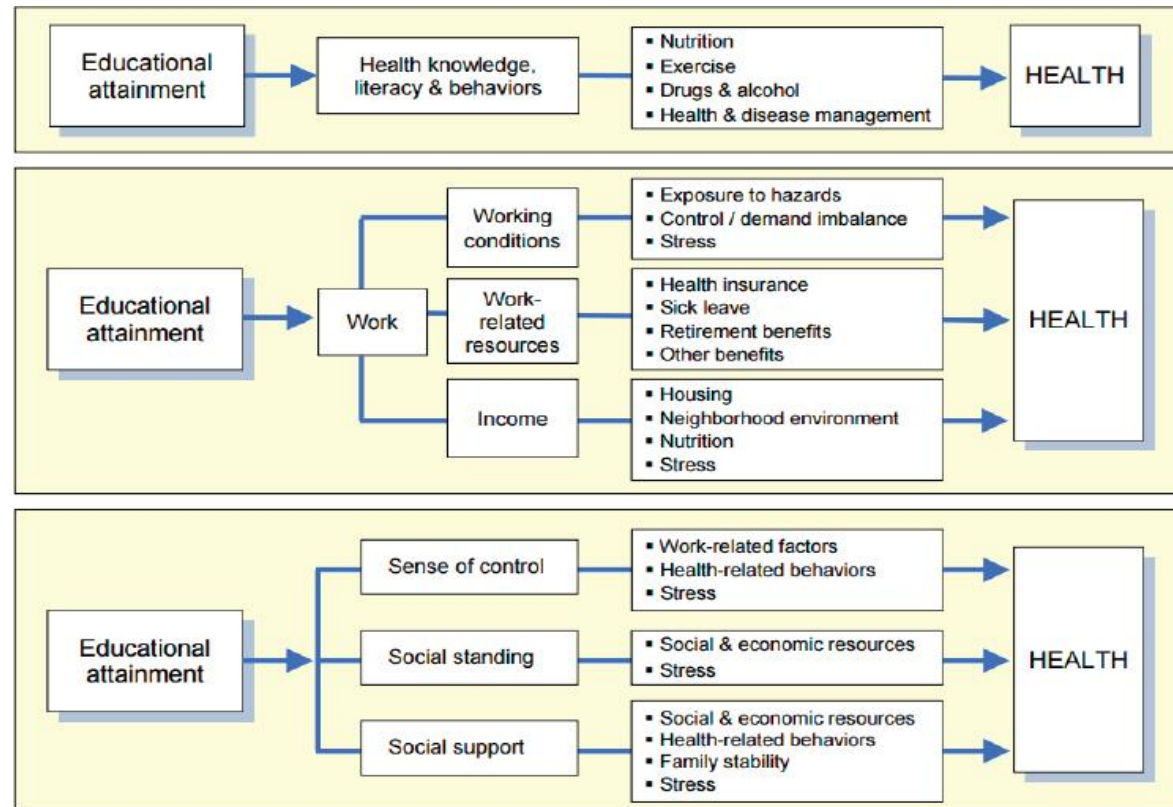
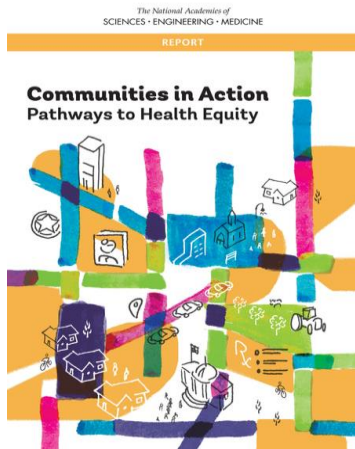
NOTE: Includes nonelderly individuals ages 0 to 64. AI/AN refers to American Indian/Alaska Native. NHOPI refers to Native Hawaiians and Other Pacific Islanders. Hispanic people may be of any race but are categorized as Hispanic; other groups are all non-Hispanic. The 2019 Census Bureau poverty threshold for a family of three was \$20,578. SOURCE: KFF analysis of 2019 American Community Survey, 1-Year Estimates.

KFF

Reference: Key Facts About the Uninsured Population.

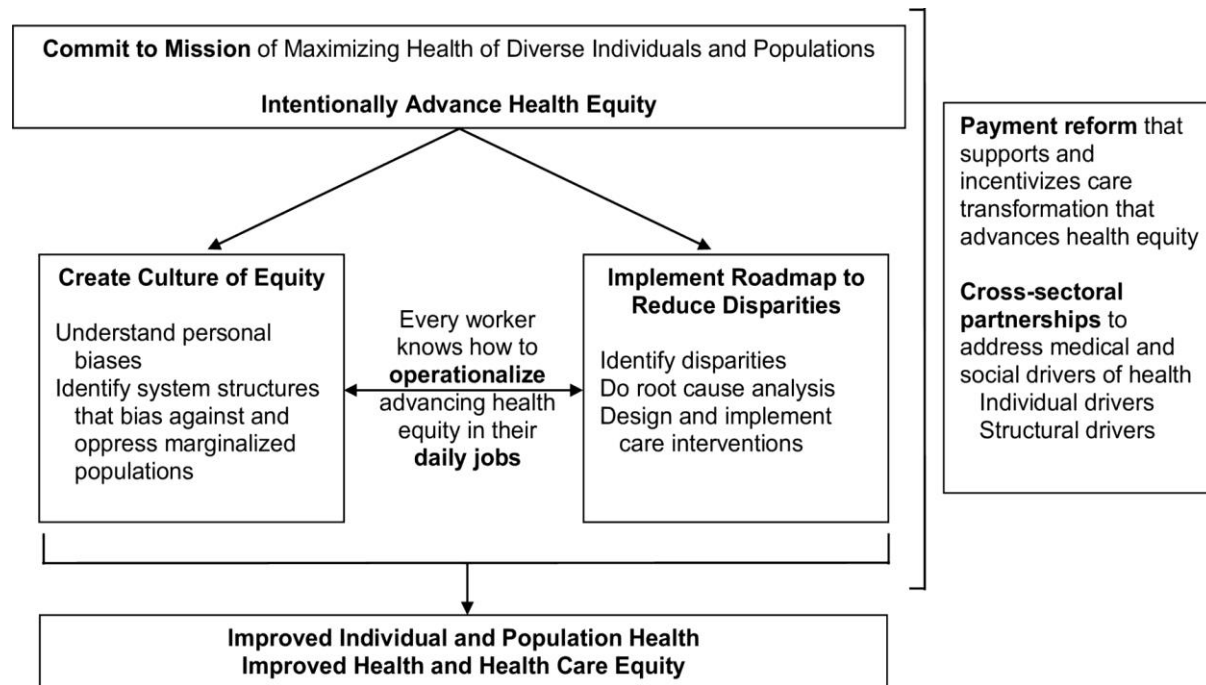
<https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/>

Low Socioeconomic Status (SES)-2



Reference: National Academies of Sciences, Engineering, and Medicine. 2017. *Communities in Action: Pathways to Health Equity*. Washington, DC: The National Academies Press. <https://doi.org/10.17226/24624>.

Health Equity (3)



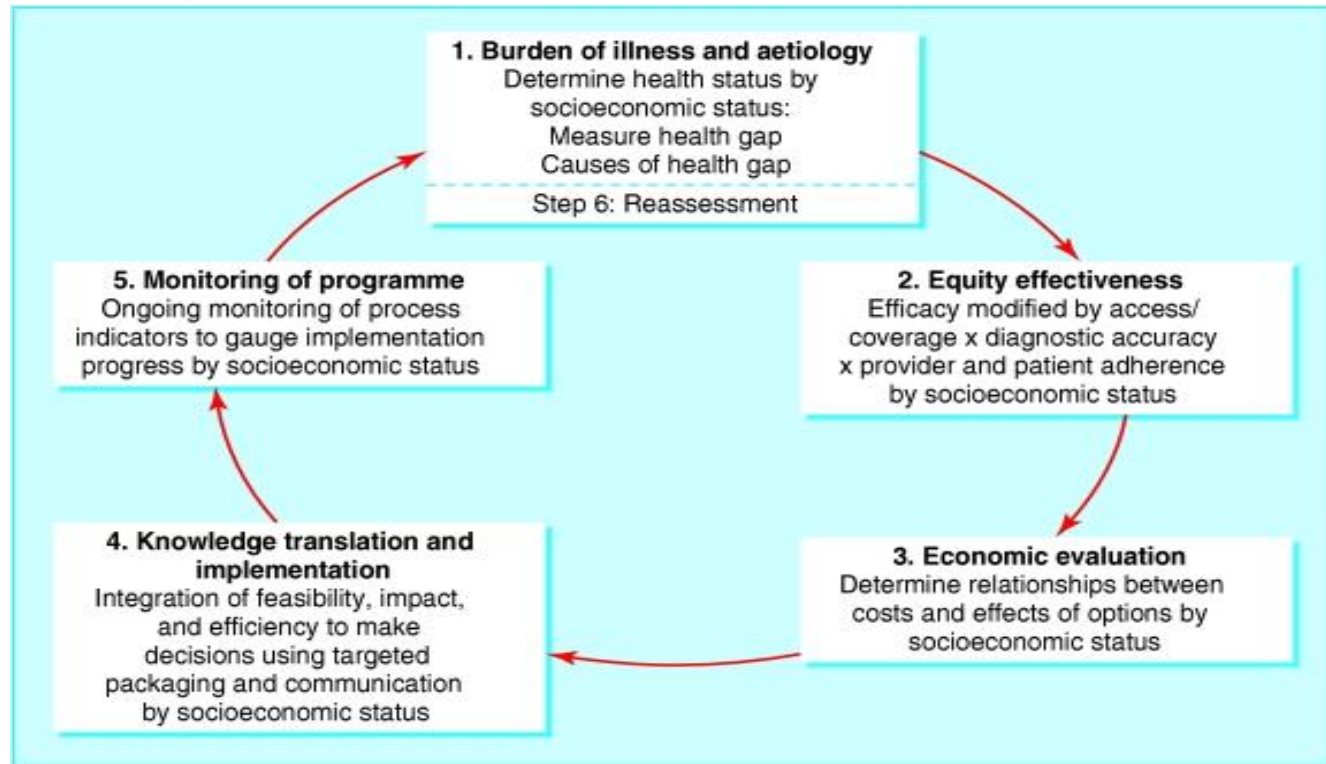
Reference: Chin MH. Advancing health equity in patient safety: a reckoning, challenge and opportunity *BMJ Quality & Safety* 2021;**30**:356-361.



Question #5

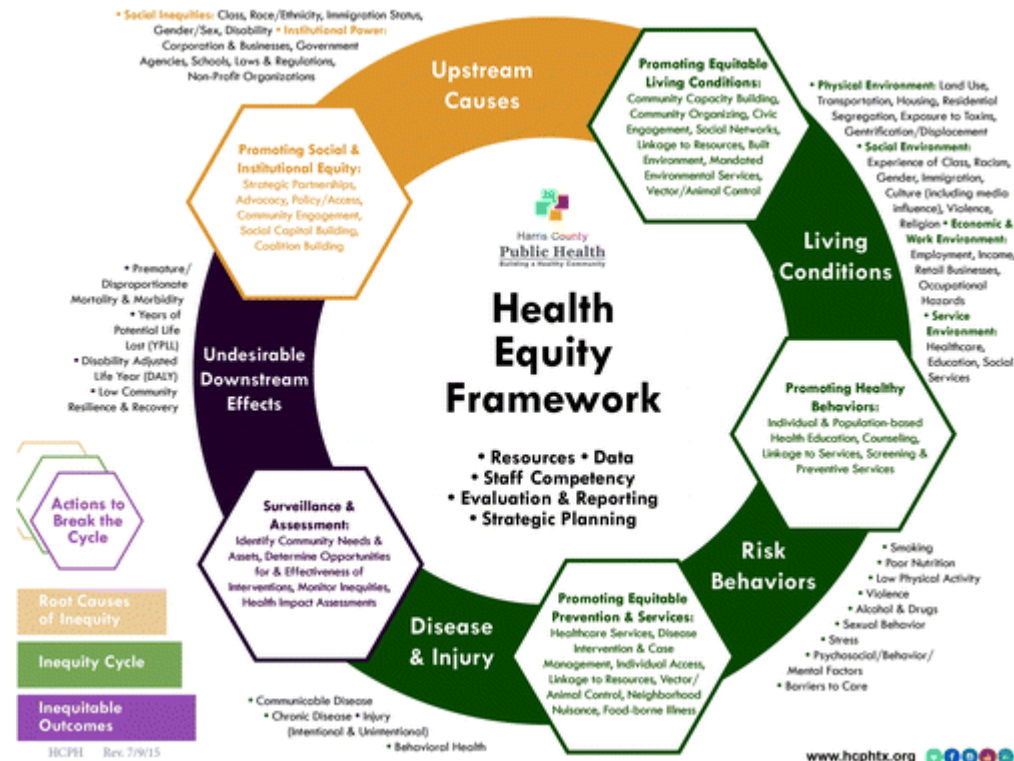
What do you want me (policymaker) to know about health equity and low socioeconomic status (SES) populations that would make me *care more* about this topic, population, community, setting (blue-collar worksite, healthcare system) or geographic area (rural, metropolitan, suburban) and *take action*?

Health Equity (4)



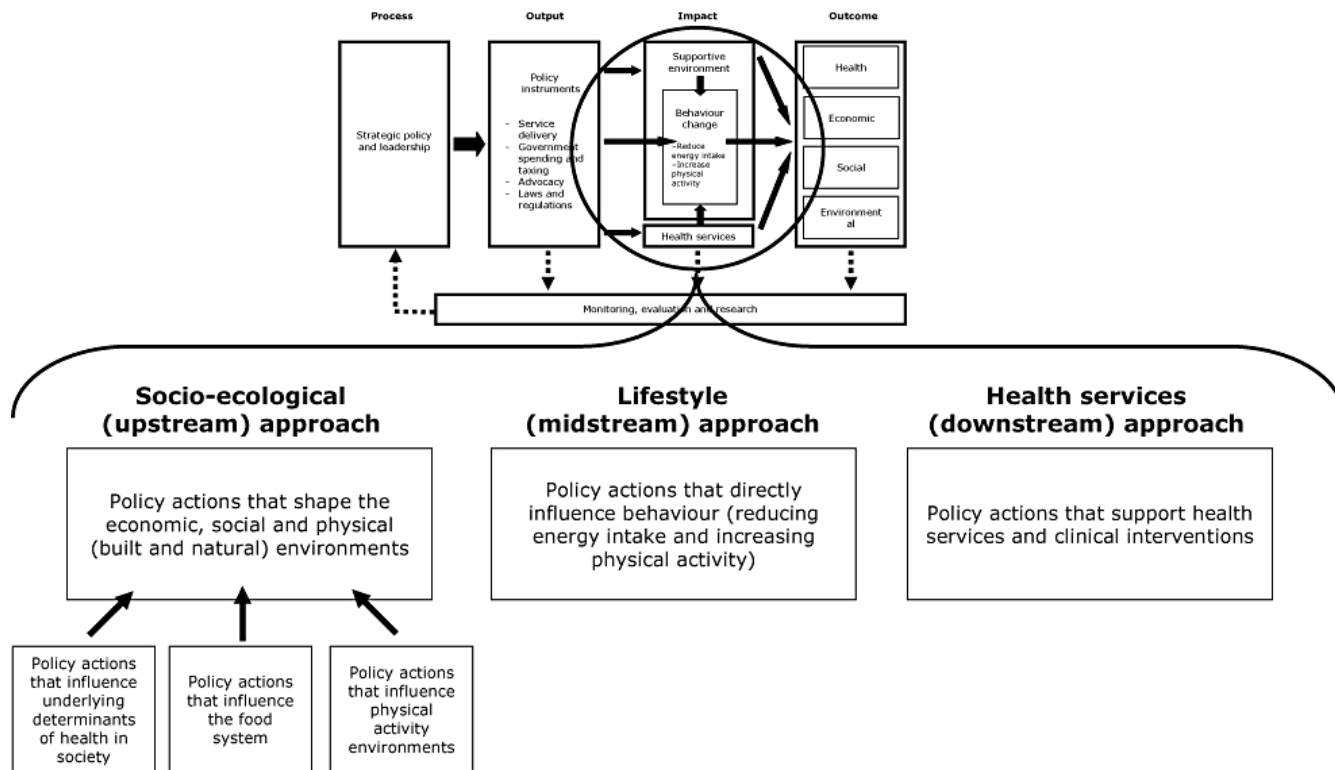
Reference: Tugwell P, de Savigny D, Hawker G, Robinson V. Applying clinical epidemiological methods to health equity: the equity effectiveness loop. *BMJ*. 2006;332(7537):358-361.

Health Equity (5)



Reference: Shah UA, Hadayia JM, Forsys LE. From Principles to Practice: One Local Health Department's Journey Toward Health Equity. *Health Equity*. 2017;1(1):23-27. Published 2017 Jan 1. doi:10.1089/heq.2016.0004

Policy-related Considerations: Health Equity, Low SES Populations and Reducing Modifiable Risks



Reference: Sacks G, Swinburn B, Lawrence M. Obesity Policy Action framework and analysis grids for a comprehensive policy approach to reducing obesity. *Obes Rev.* 2009 Jan;10(1):76-86. doi: 10.1111/j.1467-789X.2008.00524.x. Epub 2008 Aug 26. PMID: 18761640.

Question #6

What do you want me (blue-collar industry employer) to know about health equity and low socioeconomic status (SES) populations that would make me *care more* about this topic, population, community, setting (blue-collar worksite, healthcare system) or geographic area (rural, metropolitan, suburban) and *take action*?



Addressing Healthy People 2030 Objectives: Multi-faceted Approaches (Low SES Perspective)

Reduce the overall cancer death rate — C-01 (**including tobacco-related cancers)

Reduce the lung cancer death rate — C-02

Reduce current tobacco use in adults — TU-01

Reduce current cigarette smoking in adults — TU-02

Reduce current cigarette, cigar, and pipe smoking in adults — TU-03

Increase the proportion of adults who get advice to quit smoking from a health care provider — TU-12

Increase use of smoking cessation counseling and medication in adults who smoke — TU-13

Increase abstinence from cigarette smoking among pregnant women — MICH-10

Increase successful quit attempts in pregnant women who smoke — TU-15

Reference: Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion.
Retrieved [November 3, 2021], from <https://health.gov/healthypeople/objectives-and-data/social-determinants-health>



Addressing Healthy People 2030 Objectives: Multi-faceted Approaches (Low SES Perspective)-1

State/Region/ Multi-county Level:

Increase the number of medical academic institutions and/or health systems that become National Accreditation for Tobacco Treatment Specialist Training Programs (Council Tobacco Treatment Training Programs)

- creates an opportunity to expand the delivery of evidence-based tobacco cessation counseling (on-site) by multi-disciplinary professionals statewide, on regional level and/or counties characterized by high rates to tobacco-related incidence, morbidity (including illnesses, hospitalizations) and morbidity
- creates an opportunity to establish financial sustainability (evidence-based tobacco cessation counseling) while enhancing professional development skills across specialties and settings
- creates an opportunity to increase access to the delivery of evidence-based tobacco cessation counseling (on-site) delivered to:
 - ❑ “hard core” smokers or tobacco users or dual/multiple tobacco users
 - ❑ low-income tobacco product users diagnosed with chronic diseases (tobacco-related cancers, heart disease, Type 2 diabetes, hypertension, kidney disease, chronic obstructive pulmonary disease-COPD)
 - ❑ low-income tobacco product users: pregnant and postpartum women
 - ❑ low-income tobacco product users: women of childbearing age (including technical schools, community colleges and some university students)
 - ❑ low-income tobacco product users: employees (maintenance, custodians/housekeeping, cafeteria/food services, electricians, plumbers, transportation) at technical schools, community colleges, and universities
- creates an opportunity to provide vulnerable populations disproportionately affected by tobacco addiction with additional support by providing both telephonic counseling (state tobacco quitline) combined with on-site tobacco cessation counseling to assist with reducing relapse rates.



Addressing Healthy People 2030 Objectives: Multi-faceted Approaches (Low SES Perspective)-2

State/Region/ Multi-county Level:

A variety of models to consider replicating, depending on your organization's infrastructure, capacity and goals:

- University of Kansas Tobacco Treatment Specialist Training
- Mayo Clinic Nicotine Dependence Center
- University of Massachusetts (UMass) Medical School Tobacco Treatment Specialist (TTS) Training Program
- Memorial Sloan Kettering Cancer Center Tobacco Treatment Specialist Training Program
- West Virginia University School of Dentistry Certified Tobacco Treatment Training Program
- Duquesne University School of Pharmacy (Pittsburgh, Pennsylvania)
- Duke-UNC Tobacco Treatment Specialist Program
- University of Texas MD Anderson Cancer Center Certified Tobacco Treatment Training Program
- Tobacco Treatment Specialist Course at Florida State University College of Medicine
- Maine Tobacco Treatment Education and Training Program
- University of Pennsylvania Comprehensive Smoking Treatment Program
- Rocky Mountain Tobacco Treatment Specialist (RMTTS) Training Program in Colorado
- Roswell Park Tobacco Treatment Training Program
- University of Mississippi Medical Center/ACT Center
- University of Pennsylvania Comprehensive Smoking Treatment Program

[Reference: Accredited Programs – Council for Tobacco Treatment Training Programs \(ctttp.org\)](http://ctttp.org)



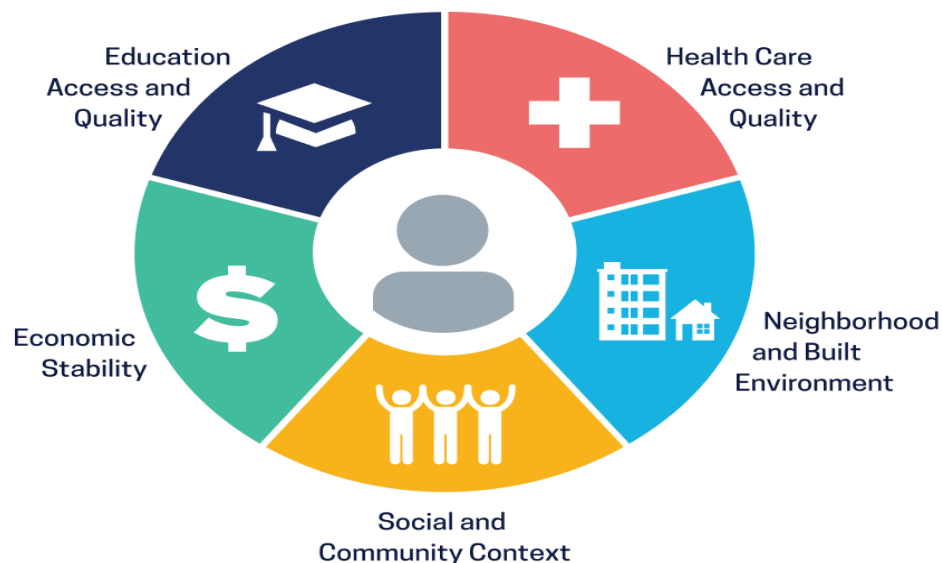
Addressing Healthy People 2030 Objectives: Multi-faceted Approaches (Low SES Perspective)-3

State/Region/ Multi-county/Local Level:

- Increase the number of multi-disciplinary professionals that become Certified Tobacco Treatment Specialists (CTTS) statewide, on regional level and/or counties characterized by high rates to tobacco-related incidence, morbidity (including illnesses, hospitalizations) and morbidity
- Increase the number of Certified Tobacco Treatment Specialists (CTTS) among Medicaid providers (rural, metropolitan areas)
- Increase the number of Certified Tobacco Treatment Specialists (CTTS) in Federally Qualified Health Centers (FQHCs) and rural health clinics (RHCs)
- Increase the number of Certified Tobacco Treatment Specialists (CTTS) in Emergency Room (ER) Departments (including those in Critical Access Hospitals)
- Increase the number of Certified Tobacco Treatment Specialists (CTTS) that partner with and deliver evidence-based tobacco cessation counseling (on-site) services “blue-collar” industry worksites consisting of low-income employees or workers (full time, part-time, seasonal, contractual)

Addressing Healthy People 2030 Objectives: Multi-faceted Approaches (Low SES Perspective)

Social Determinants of Health



Social Determinants of Health
Copyright-free

 Healthy People 2030

Reference: Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Retrieved [date graphic was accessed], from <https://health.gov/healthypeople/objectives-and-data/social-determinants-health>



Addressing Healthy People 2030 Objectives: Multi-faceted Approaches (Low SES Perspective)-4

State/Region/ Multi-county/Local Level:

- Increase the number of organizations on university and college campuses educated about the availability of state tobacco quitline services (free/no-cost)
 - ❖ Military, Medical/Health Sciences, Music, Arts, Agriculture, Engineering, Business, Accounting, Architecture, Criminal Justice, Psychology, Fashion, etc.
- Increase the number of multi-cultural organizations and councils on university and college campuses educated about the availability of state tobacco quitline services (free/no-cost)
- Increase the number of partnerships established with university newspaper staff to increase awareness about state tobacco quitline services (free/no-cost) available to employees, students, and their families.
- Increase the number of partnerships established with university radio station/media staff to increase awareness about state tobacco quitline services (free/no-cost) available to employees, students, and their families.

Addressing Social Determinants of Health (SDoH)



Reference: Brennan Ramirez LK, Baker EA, Metzler M. Promoting Health Equity: A Resource to Help Communities Address Social Determinants of Health. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention; 2008.



Health In All Policies: Introduction

“Health in All Policies is a collaborative approach to improving the health of all people by incorporating health considerations into decision-making across sectors and policy areas.”

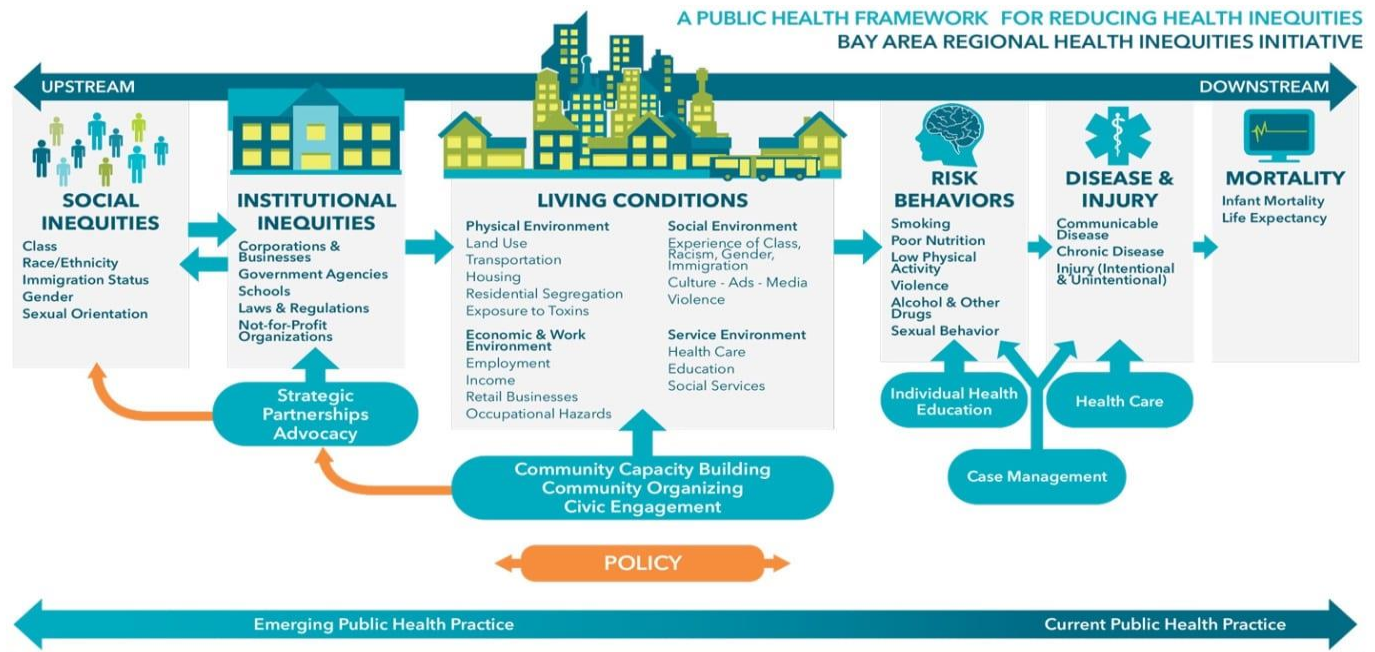
“Health in All Policies, at its core, is an approach to addressing the social determinants of health that are the key drivers of health outcomes and health inequities. Health in All Policies supports improved health outcomes and health equity through collaboration between public health practitioners and those nontraditional partners who have influence over the social determinants of health.”

“Health in All Policies approaches include 5 key elements: promoting health and equity, supporting intersectoral collaboration, creating cobenefits for multiple partners, engaging stakeholders, and creating structural or process change.”

“Many factors, such as the context, authority, participation, resources, politics, community concerns, key leader interests, and any formal legislation or administrative action will play a role in determining the focus and scope of a Health in All Policies initiative.”

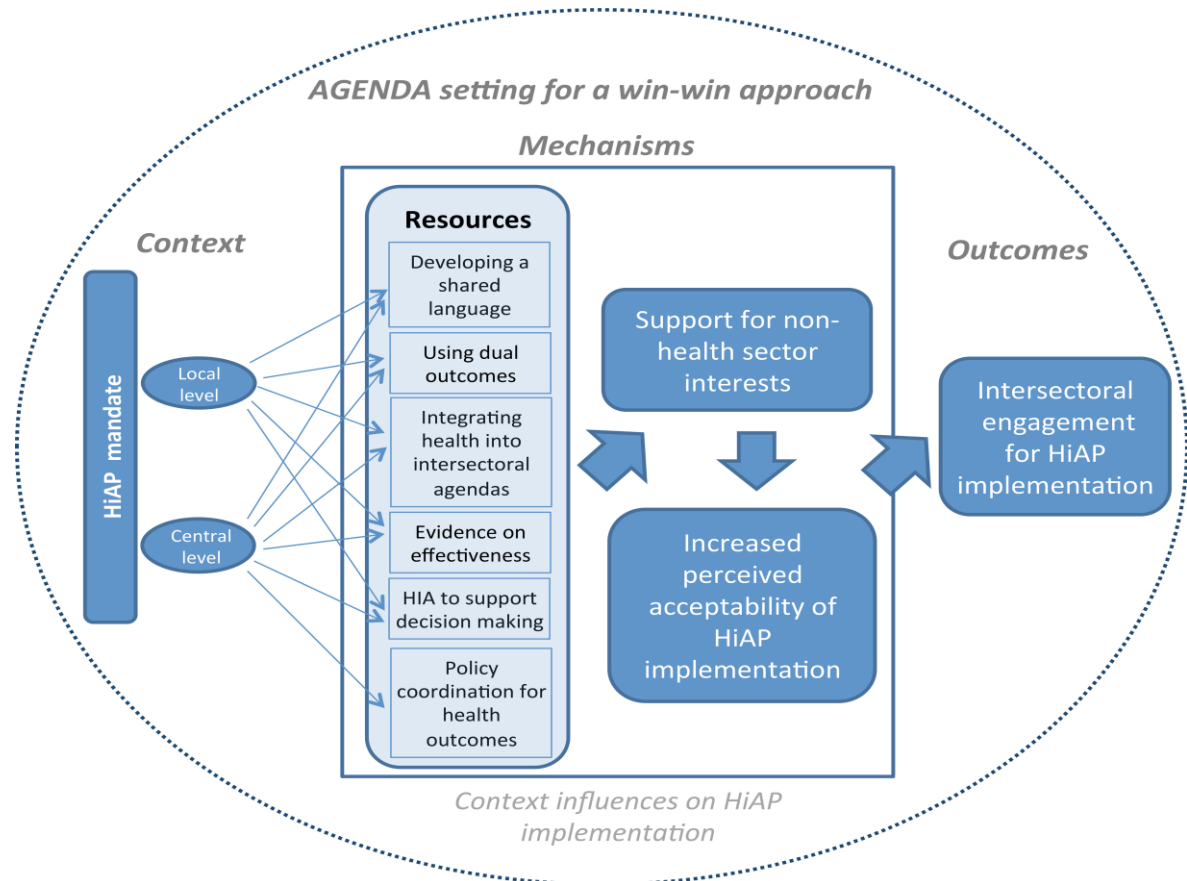
Reference: Rudolph, L., Caplan, J., Ben-Moshe, K., & Dillon, L. (2013). Health in All Policies: A Guide for State and Local Governments. Washington, DC and Oakland, CA: American Public Health Association and Public Health Institute.

Health In All Policies: Bridging sectors (from a health equity perspective)-1



Reference: Committee on Educating Health Professionals to Address the Social Determinants of Health; Board on Global Health; Institute of Medicine; National Academies of Sciences, Engineering, and Medicine. A Framework for Educating Health Professionals to Address the Social Determinants of Health. Washington (DC): National Academies Press (US); 2016 Oct 14. 3, Frameworks for Addressing the Social Determinants of Health. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK395979/>

Health In All Policies (HiAP): Bridging sectors (from a health equity perspective)-2



Reference: Molnar A, Renahy E, O'Campo P, Muntaner C, Freiler A, Shankardass K (2016) Using Win-Win Strategies to Implement Health in All Policies: A Cross-Case Analysis. PLoS ONE 11(2): e0147003. <https://doi.org/10.1371/journal.pone.0147003>

Community Engagement: Framework for Public Health Interventions



Reference: Brunton, G., Thomas, J., O'Mara-Eves, A. *et al.* Narratives of community engagement: a systematic review-derived conceptual framework for public health interventions. *BMC Public Health* **17**, 944 (2017).

Community Engagement Spectrum

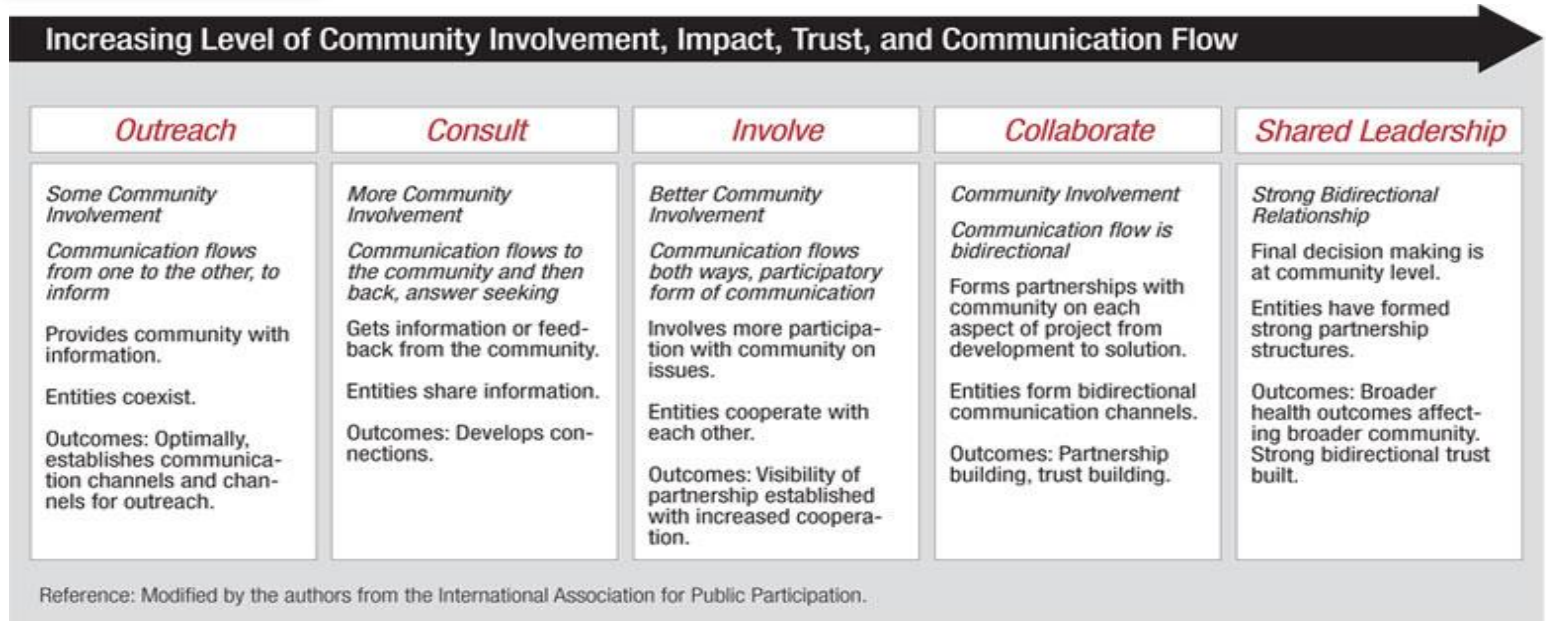


Figure 1.1. Community Engagement Continuum

Reference: Principles of Community Engagement (Second Edition)
https://www.atsdr.cdc.gov/communityengagement/pce_what.html



Health Equity Lens: Unintended Consequences (1)

Are any of the current strategies, activities and/or policies intended to be implemented in communities, healthcare systems, worksites or other types of settings that located in areas with any of these low SES related characteristics: medically underserved areas (MUAs), health professional shortage areas, food deserts, high rates of poverty, worksites with minimum wage employees, counties with low graduation rates (high school), or lack internet/broadband access?

- If not, what steps or solutions should we consider to ensure that at least one strategy, activity or policy does address these low SES related characteristics to ensure that we improve or advance health equity by September 2022?
- What policies or policy implications should we consider, that may significantly *negatively* impact low-income populations or environments where they live, work, learn or receive healthcare services?
- Who is missing “from the decision-making table” that we may want to consider inviting to learn more about potential unintended consequences?



Health Equity Lens: Unintended Consequences (2)

How might the policy change have different effects along the tobacco use continuum and lifespan of vulnerable populations?

- Will any populations or communities disproportionately or unfairly benefit from this decision, directly or indirectly?

What are some ways that the proposed policy or changes may negatively affect tobacco use patterns across a range of economically disadvantaged communities (rural/frontier, metropolitan, geographically isolated areas, health professional shortage areas, medically underserved areas)?

- Will any populations, communities, sectors or geographic areas experience unintended impacts or greater burden, or be left out by this decision?

Does the proposed policy or policy change directly or indirectly affect healthcare costs for small physician practices or health systems? Does it lead to greater equity or inequity affecting small volume healthcare providers?

Does the proposed policy or policy change directly or indirectly affect healthcare costs for rural or low-income metropolitan residents? Does it lead to greater equity or inequity among residents or their healthcare providers?

Does the proposed policy or policy change affect community capacity available to low-income populations, directly or indirectly; including populations residing in areas with food deserts, pharmacy deserts or lacking broadband access?



Health Equity Lens: Unintended Consequences (3)

Does the proposed policy or policy change affect community capacity available to low-income populations, directly or indirectly? This includes populations residing in areas with food deserts, pharmacy deserts or lacking broadband access?

Does the proposed policy or policy change significantly affect access to and affordability to prevention or cessation a within-sector collaboration, or multi-sector collaboration?

Does the proposed policy or policy change create barriers (*actual or perceived*) associated with affordability or affect access to evidence-based interventions or services for low-income employees? Or unemployed populations?

Does the proposed policy or policy change create barriers (*actual or perceived*) associated with affordability or affect access to evidence-based interventions or promising practices delivered in low-income communities? Or small worksites or businesses?

Does the proposed policy or policy change create barriers associated with affordability or affect access to evidence-based interventions or services among small businesses with employee health benefits? Or uninsured employees?

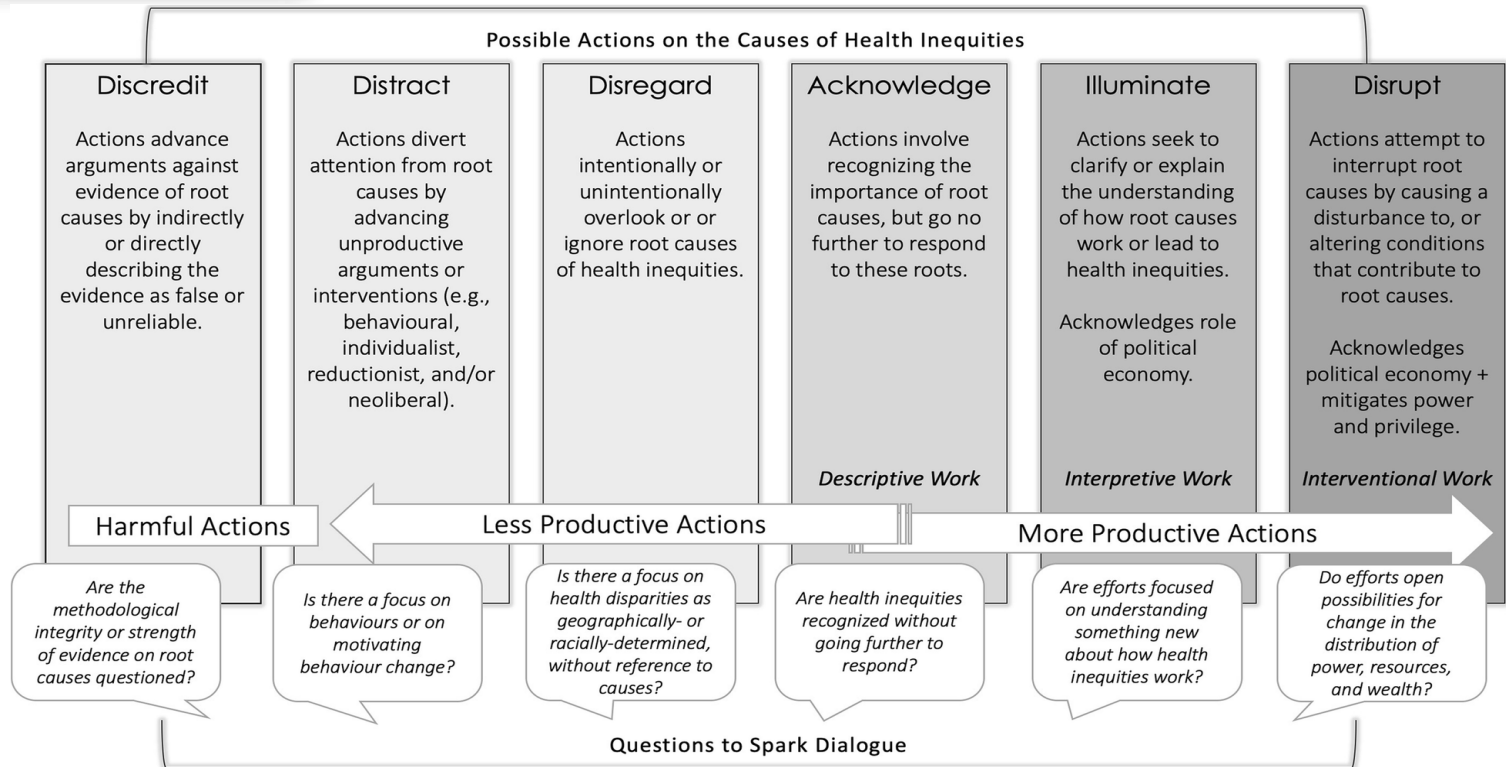
References: Understanding the unintended consequences of public health policies: the views of policymakers and evaluators "Equity Metrics: Toward A More Effective And Inclusive Pandemic Response, " Health Affairs Blog, February 3, 2021. DOI: 10.1377/hblog20210202.251805



Question #7

If I am a policymaker (Federal, State, County) and my loved one (grandfather, uncle, spouse or best friend) recently lost their life due to a tobacco-related cancer (lung cancer), where on the Missouri Department of Health and Senior Services website would you like me to go to find general information about *proposed solutions or recommendations*?

Health Equity (6)



Reference: Plamondon, K.M. A tool to assess alignment between knowledge and action for health equity. *BMC Public Health* **20**, 224 (2020).



Action Steps:

State Level:

- Decision-makers and other major stakeholders need to describe health inequities and the high personal, social, policy-related, and economic costs associated with them in ways that appeal to people's heads and hearts.
- Generate short-term wins: Wins are the molecules of results. They must be collected, categorized, and communicated—early and often—to track progress and energize volunteers to drive change.
- Prioritize health equity and equity in the social determinants of health (SDoH) through investments in low-income and minority communities while building upon community assets.
- Define “Measures of Success” indicators for successful partnerships or collaborations.

Community-Level:

- Incorporate Community Resiliency factors into planning and implementation phases.
- Include community priorities (related to health equity or equity) as part of policy development or change processes that will lead to improved health outcomes.
- Develop and allocate resources to ensure sustainability and community resilience.



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Website: <http://www.selfmadehealth.org/>

Membership Information: Sign-up to become a national network member

Quarterly Newsletter: Available to member organizations and state programs

Send questions or contact us at anytime via shared

SMHN mailbox: info@selfmadehealth.org