# Promoting Health Equity in Communities: Addressing SDOH

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1

## About the Presenter

- Born in the Midwest (Michigan)
- Raised in the Southeast
  - Family in MS
  - Grew up in GA
- Education
  - BS in Biology from TSU (Nashville, TN)
  - MSPH in Health Promotion, Education, & Behavior from UofSC (Columbia, SC)
  - PhD in Health Services, Policy, & Management from UofSC (Columbia, SC)
- Currently research and provide training in the fields of community health and human services

2

## Presenters Disclosures

- No relationships to disclose.
- My thoughts and ideas communicated are my own and may not represent my employer.
- Efforts have been made to include information that is not meant to offend or bring harm to members of the audience. However, information within "acknowledges" challenges that exist within society with an aim bringing people together for the purpose of problem solving within communities.

The Wilkinson Wellness Lab

www.wilkinsonwellnesslab.com

3

## Health Equity – How do we define?

**What is Health Equity?** CDC

**Health equity** is the state in which everyone has a fair and just opportunity to attain their highest level of health. Achieving this requires focused and ongoing societal efforts to address historical and contemporary injustices; overcome economic, social, and other obstacles to health and healthcare; and eliminate preventable health disparities.

Similar to Healthy People 2020, Healthy People 2030 defines **health equity** as "the attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities." HP 2030

**What is health equity?** HRSA

Health Equity is the absence of disparities or avoidable differences among socioeconomic and demographic groups or geographical areas in health status and health outcomes such as disease, disability, or mortality.

**OHEMH**

The ADPH Office of Health Equity and Minority Health (OHEMH): Establishing and Maintaining a Culture of Health Equity

*"Bringing vision and imagination through a multisector frame to achieve equity in health" is the mission of the Alabama Department of Public Health's Office of Health Equity and Minority Health—an established priority area for the ADPH.*

OHEMH OFFICE OF HEALTH EQUITY AND MINORITY HEALTH

The Alabama Department of Public Health, like the Centers for Disease Control and Prevention, recognizes that health equity is achieved when every person has the opportunity to "attain his or her full health potential" and no one is "disadvantaged from achieving this potential because of social position or other socially determined circumstances." Health inequities are reflected in differences in length of life; quality of life; rates of disease, disability, and death; severity of disease; and access to treatment.

4

## Health Equity – Commonalities


5

## Key Terms

- Health disparity (HP 2030) is a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage.
- Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their:
  - Racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.
- Health disparities are referred to as health inequities when they are the result of the systematic and unjust distribution of critical resources.

6

Healthy People 2030


7

## Achieving Understanding on Health Equity

- Towards better health…attaining their health potential.
- Act! Addresses myriad of SDOH factors contributing to poorer health outcomes.
- Targeting health disparities/inequities.
  - Focused effort where evidence of concentrated negative outcomes guide us.
- Focused efforts on health disparities/inequities.
  - Socially > working through human relationships and groups of individuals
  - Societally > working through systems, policies, and institutions within society

8

## Our Country's DestiNation



**Healthy People 2000**, the second iteration of the initiative, was guided by 3 broad goals.

- Increase the span of healthy life
- Reduce health disparities
- Achieve access to preventive services for all


**Goal 2: Eliminate Health Disparities**

The second goal of Healthy People 2010 is to eliminate health disparities among different segments of the population.

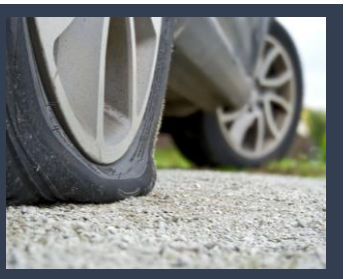

**Overarching Goals**

- Attain high-quality, longer lives free of preventable disease, disability, injury, and premature death.
- Achieve health equity, eliminate disparities, and improve the health of all groups.
- Create social and physical environments that promote good health for all.
- Promote quality of life, healthy development, and healthy behaviors across all life stages.

9

## Hard to reach DESTINATION with a flat tire!

1) Age of your tires
2) Road debris
3) Temperature ?
4) Vandalism
5) Valve damage
6) Overinflated tires

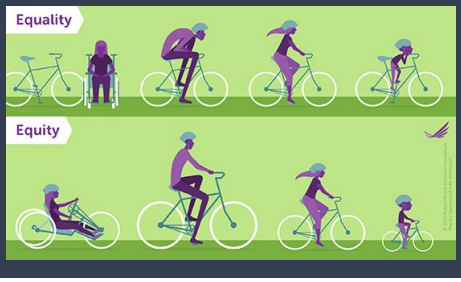


Healthy People 2030 | OASH

- Eliminate health disparities, achieve health equity, and attain health literacy to improve the health and well-being of all.

10

## Health Equity is "Not" Health Equality




11

## Reflections

What are your thoughts about some of the information shared?

12

## Health & Quality of Life Outcomes – Alabama – Madison Co.

| Additional Health Outcomes (not included in overall ranking) | Madison (MD) County | Alabama | United States |
|---|---|---|---|
| Life Expectancy | 77.4 | 74.8 | 78.5 |
| Premature Age-Adjusted Mortality | 400 | 500 | 360 |
| Child Mortality | 50 | 70 | 50 |
| Infant Mortality | 7 | 8 | 6 |
| Frequent Physical Distress | 9% | 11% | 9% |
| Frequent Mental Distress | 15% | 16% | 14% |
| Diabetes Prevalence | 11% | 13% | 9% |
| HIV Prevalence | 260 | 342 | 380 |

County Health Rankings & Roadmaps, 2023
www.countyhealthrankings.org

13

## Health Factors – Alabama – Madison Co.

| Health Behaviors | Madison (MD) County | Alabama | United States |
|---|---|---|---|
| Adult Smoking | 16% | 20% | 16% |
| Adult Obesity | 35% | 39% | 32% |
| Food Environment Index | 7.4 | 5.3 | 7.0 |
| Physical Inactivity | 23% | 28% | 22% |
| Access to Exercise Opportunities | 74% | 61% | 84% |
| Excessive Drinking | 16% | 16% | 19% |
| Alcohol-Impaired Driving Deaths | 33% | 26% | 27% |
| Sexually Transmitted Infections | 675.8 | 552.2 | 481.3 |
| Teen Births | 18 | 28 | 19 |

County Health Rankings & Roadmaps, 2023
www.countyhealthrankings.org

14

## Clinical Care Factors – Alabama – Madison Co.

| Clinical Care | Madison (MD) County | Alabama | United States |
|---|---|---|---|
| Uninsured | 10% | 12% | 10% |
| Primary Care Physicians | 1,150:1 | 1,520:1 | 1,310:1 |
| Dentists | 1,940:1 | 2,050:1 | 1,380:1 |
| Mental Health Providers | 590:1 | 800:1 | 340:1 |
| Preventable Hospital Stays | 3,094 | 3,599 | 2,809 |
| Mammography Screening | 44% | 36% | 37% |
| Flu Vaccinations | 47% | 44% | 51% |

County Health Rankings & Roadmaps, 2023
www.countyhealthrankings.org

15

## Social & Economic Factors – Alabama – Madison Co.

| Social & Economic Factors | Madison (MD) County | Alabama | United States |
|---|---|---|---|
| High School Completion | 92% | 87% | 89% |
| Some College | 76% | 62% | 67% |
| Unemployment | 2.7% | 3.4% | 5.4% |
| Children in Poverty | 14% | 23% | 17% |
| Income Inequality | 5.0 | 5.2 | 4.9 |
| Children in Single-Parent Households | 26% | 31% | 25% |
| Social Associations | 10.6 | 11.9 | 9.1 |
| Injury Deaths | 74 | 87 | 76 |

County Health Rankings & Roadmaps, 2023
www.countyhealthrankings.org

16

## More Social & Economic Factors – Alabama – Madison Co.

| Additional Social & Economic Factors (not included in overall ranking) | Madison (MD) County | Alabama | United States |
|---|---|---|---|
| High School Graduation | 93% | 91% | 87% |
| Disconnected Youth | 5% | 8% | 7% |
| Reading Scores | 3.2 | 2.9 | 3.1 |
| Math Scores | 3.0 | 2.7 | 3.0 |
| School Segregation | 0.15 | 0.28 | 0.25 |
| School Funding Adequacy | -$2,140 | -$3,869 | $1,062 |
| Gender Pay Gap | 0.69 | 0.74 | 0.81 |
| Median Household Income | $78,400 | $54,000 | $69,700 |
| Living Wage | $41.66 | $40.29 | $45.00 |
| Children Eligible for Free or Reduced Price Lunch | 34% | 53% | 53% |
| Residential Segregation - Black/White | 49 | 58 | 63 |

County Health Rankings & Roadmaps, 2023
www.countyhealthrankings.org

17

## More Social & Economic Factors – Alabama – Madison Co.

| | | | |
|---|---|---|---|
| Child Care Cost Burden | 19% | 27% | 27% |
| Child Care Centers | 7 | 6 | 7 |
| Homicides | 8 | 11 | 6 |
| Suicides | 17 | 16 | 14 |
| Firearm Fatalities | 18 | 22 | 12 |
| Motor Vehicle Crash Deaths | 13 | 20 | 12 |
| Juvenile Arrests | 19 | | 24 |
| Voter Turnout | 69.9% | 62.6% | 67.9% |
| Census Participation | 74.1% | | 65.2% |

County Health Rankings & Roadmaps, 2023
www.countyhealthrankings.org

18

## Physical Environment Factors – Alabama – Madison Co.

| Physical Environment | Madison (MD) County | Alabama | United States |
|---|---|---|---|
| Air Pollution - Particulate Matter | 7.4 | 9.3 | 7.4 |
| Drinking Water Violations | No | | |
| Severe Housing Problems | 11% | 13% | 17% |
| Driving Alone to Work | 83% | 84% | 73% |
| Long Commute - Driving Alone | 27% | 35% | 37% |
| **Additional Physical Environment (not included in overall ranking)** | **Madison (MD) County** | **Alabama** | **United States** |
| Traffic Volume | 258 | 214 | 505 |
| Homeownership | 67% | 69% | 65% |
| Severe Housing Cost Burden | 10% | 12% | 14% |
| Broadband Access | 89% | 82% | 87% |

County Health Rankings & Roadmaps, 2023

19

## What about Health Disparities?

Samples from the Alabama Department of Public Health reports.

20

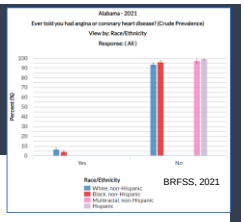
## Years of Potential Life Lost Rate

| Disaggregated by Race | Value | Error Margin |
|---|---|---|
| **Years of Potential Life Lost Rate** | **8,400** | **8,000-8,700** |
| Black | 10,300 | 9,600-11,000 |
| Hispanic | 5,300 | 4,200-6,600 |
| White | 8,100 | 7,700-8,600 |

County Health Rankings & Roadmaps, 2023

21

## Health Trends – Heart Disease




BRFSS, 2021

### Cardiovascular Diseases

### Alabama's #8 Health Indicator

Cardiovascular Diseases (CVDs) are identified as the eighth most prominent health indicator in AL. It refers to a group of serious health conditions which can result in death and disability (CDC Heart Disease). CVD was the leading cause of death in AL for 2019 (America Health Rankings).

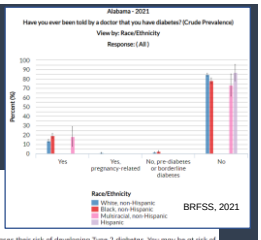
**Disproportionately Affected Populations**

CVDs are considered an aging disease, which means your risk of receiving the diagnosis increases with age. White males have the highest risk of developing CVDs, followed by AA/black males, AA/black females, and Asian males (CDC Heart Disease). Individuals that live in food deserts (i.e., places with limited access to healthy and affordable food choices) and low-income neighborhoods with little green space have higher rates of CVD morbidity (American Heart Association).

ADPH. Cardiovascular Diseases. https://www.alabamapublichealth.gov/healthstrategy/cardiovascular.html

22

## Health Trends – Diabetes




BRFSS, 2021

### Are You At Risk?

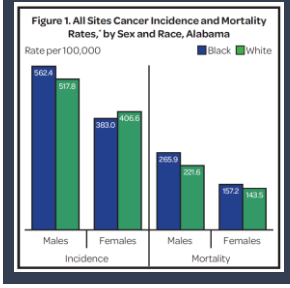
### Diabetes Alert Day, March 28, 2023

In Alabama, more than 550,000 people have diabetes. Even more, Alabamians have prediabetes, which increases their risk of developing Type 2 diabetes. You may be at risk of developing Type 2 diabetes if you:

- Have prediabetes
- Are overweight
- Are 45 years or older
- Have a parent, brother, or sister with type 2 diabetes
- Are physically active less than 3 times a week
- Have ever had gestational diabetes (diabetes during pregnancy) or given birth to a baby who weighed over 9 pounds
- Are an African American, Hispanic or Latino, American Indian, or Alaska Native person. Some Pacific Islanders and Asian American people are also at higher risk.

23

## Health Trends by Gender/Race - Cancer




**Estimated Number* of Cancer Deaths for Selected Cancer Sites, Alabama, 2021**

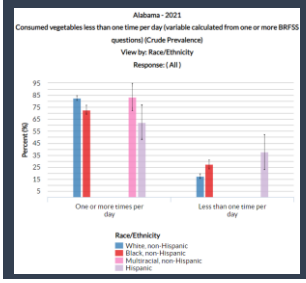
| Site | Deaths |
|---|---|
| All Sites | 10,590 |
| Brain/Nervous System | 310 |
| Female Breast | 720 |
| Colon & Rectum | 920 |
| Leukemia | 350 |
| Liver | 470 |
| Lung & Bronchus | 2,860 |
| Non-Hodgkin Lymphoma | 270 |
| Ovary | 220 |
| Pancreas | 820 |
| Prostate | 480 |

*Rounded to the nearest 10.

**Source:** American Cancer Society. *Cancer Facts & Figures 2021*. Atlanta: American Cancer Society.

24

## Health Trends by Race – Fruit & Vegetables

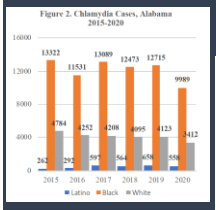


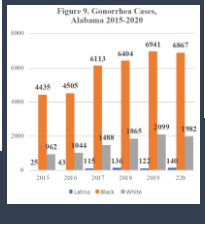


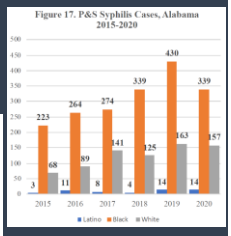
BRFSS, 2021

25

## Health Trends by Race - STDs



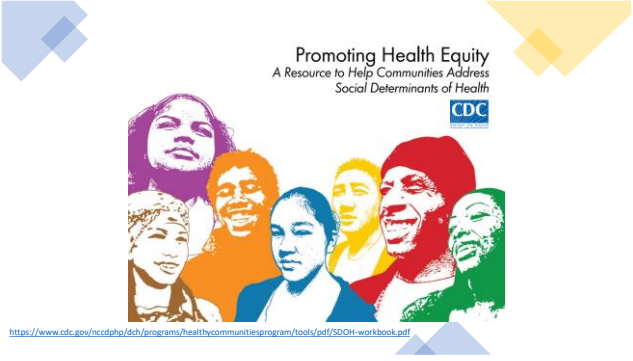

ADPH. Sexually Transmitted Diseases Annual Report 2020. https://www.alabamapublichealth.gov/std/assets/std_annualreport_2020.pdf

26

## Addressing Health Disparities

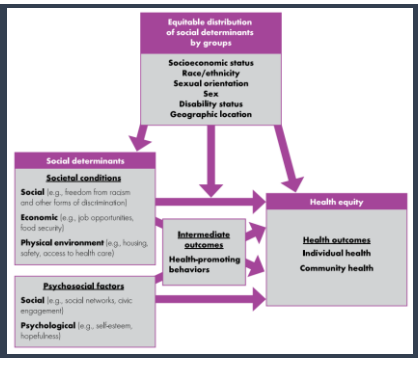
Promoting Health Equity in Communities

27




https://www.cdc.gov/nccdphp/dch/programs/healthycommunitiesprogram/tools/pdf/SDOH-workbook.pdf

28




29

## Create/Strengthen Partnerships to Address SODH

- How many of you are a part of partnerships to address a specific issue?
- Partnerships can:
  - Provide information, understanding of needs/assets, advocate for public policies, advance support for a cause/issue etc.
  - Minimize duplication of effort/services, broaden talent pool to align with community diversity, have increased odds of making meaningful change.
- Let's get started (in practice)!
- Discuss at your table and come to agreement on a particular topic you would like to address.

30

## Focus Partnership Efforts on SDOH

- Get useful information -> Health rankings, other data, & stories!
  - Also, discuss with your partners. Who do they represent?
  - What information is missing that you will still need to collect?
- Conduct community assessments for needs and strengths.
- Collect and organize information to be shared with all partners, community organizations, and community members!
- Now you can prioritize the SDOH factors the partnership wants to address: Education, Health Care, Economic Stability, Social/Community Context, and/or Built Environment.
- What would addressing the SDOH factor "mean" to your community?

31

## Build Capacity to Address SODH

- What are the resources, infrastructures, relationships, and operations that enable a community to create change?
  - Parks, Libraries…
  - Schools, health care facilities…
  - Small businesses, corporations…
  - Faith-based groups, social services, volunteer groups…
  - Local government, law enforcement
- What are the relevant skills, capacities, and experiences of community members and organizations that can help address SDOH for your problems? What is missing?

32

## Select the Approach to Create the Change

- Employ Consciousness raising
  - Discuss and raise the profile of individual and group experiences or concerns and the social/structural factors that influence them.
  - Barrier: Social connectedness and dissimilarity.
- Employ Community development
  - Processes/efforts to create local community change through strengthening social ties, **increasing awareness** of issues affecting the community, and enhancing community member participation in **addressing** these issues.
  - Trust is a must!
- Take Social action!

33

## Select the Approach to Create the Change

- Health promotion
  - Activities designed to help people improve their health or prevent illness through changes in environments, lifestyle, and behavior.
  - Within community settings is best!
- Media Advocacy
  - Strategic use of media coverage to encourage social, economic, or environmental change.
  - Always communicate in consideration of your overall goal(s)/objective(s).
- Policy & Environmental Change
  - May take time and persistence from your partnership. Patience!

34

## Action: Moving towards Progress

- What are your goals (1 – 3)?
- What are your SMART(er) objectives?
  - Specific
  - Measurable
  - Achievable
  - Relevant
  - Time-bound
  - Evaluate
  - Refine (re-adjust)
- Take a few minutes to write down your SMARTER goal/objective.

35

## Assess Partnership Progress

- Evaluate your efforts, impact, and outcomes.
  - How is your partnership working?
  - How well has your action plan worked?
  - Are your partners making progress in sub-goals/objectives?
  - Have you observed changes within the community?
    - Individual Level
    - Interpersonal Level
    - Neighborhood Level
    - Societal Level
  - Have you observed changes in the health/quality of life measures?
    - Look back at your community assessment information.

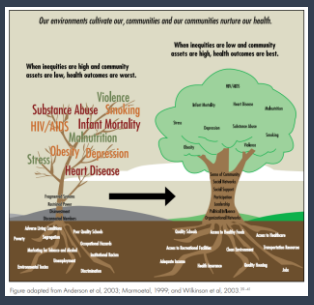
36

## Movement Momentum & Maintenance

- What is the maintenance schedule for the car that you drive?
  - Yes, we are going back to the car analogy….a little.
  - Knowledge, Skill development, Cultural competence, Advocacy!
- Be responsive to changes.
  - Social, economic, political, and environment conditions.
    - Road hazards, seasons, etc.
- Community fatigue is real!
  - Prepare your partnership for the long journey.
    - Change the oil.
    - Enjoy some tune-ups on regular intervals.
    - Play some jams! Celebrate small wins!

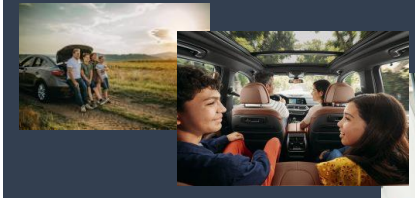
37

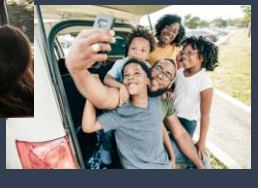
## Closing Thoughts




38

## Embrace and Enjoy the Journey & Outcome!





Questions ?

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39