Massachusetts Health Policy Forum: Social Determinant of Health Panel

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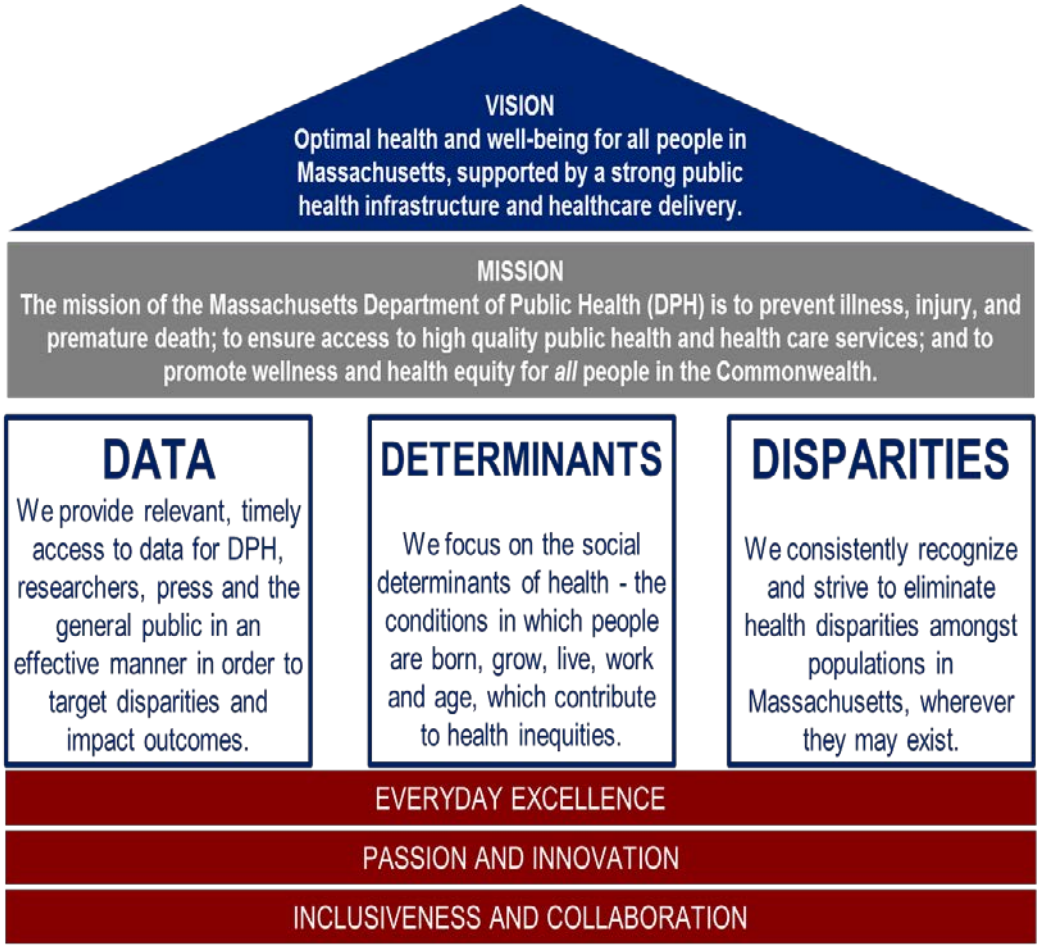
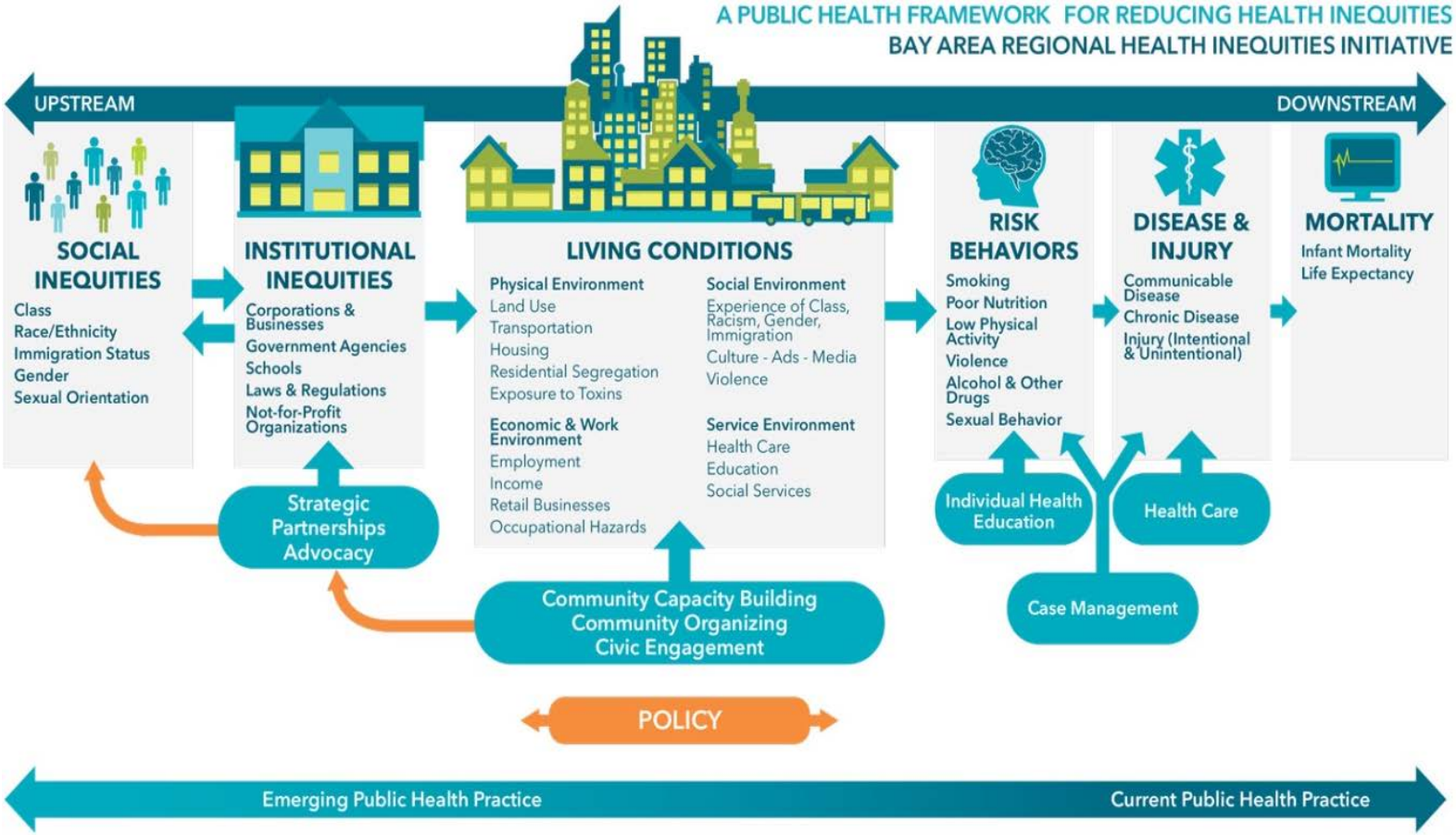
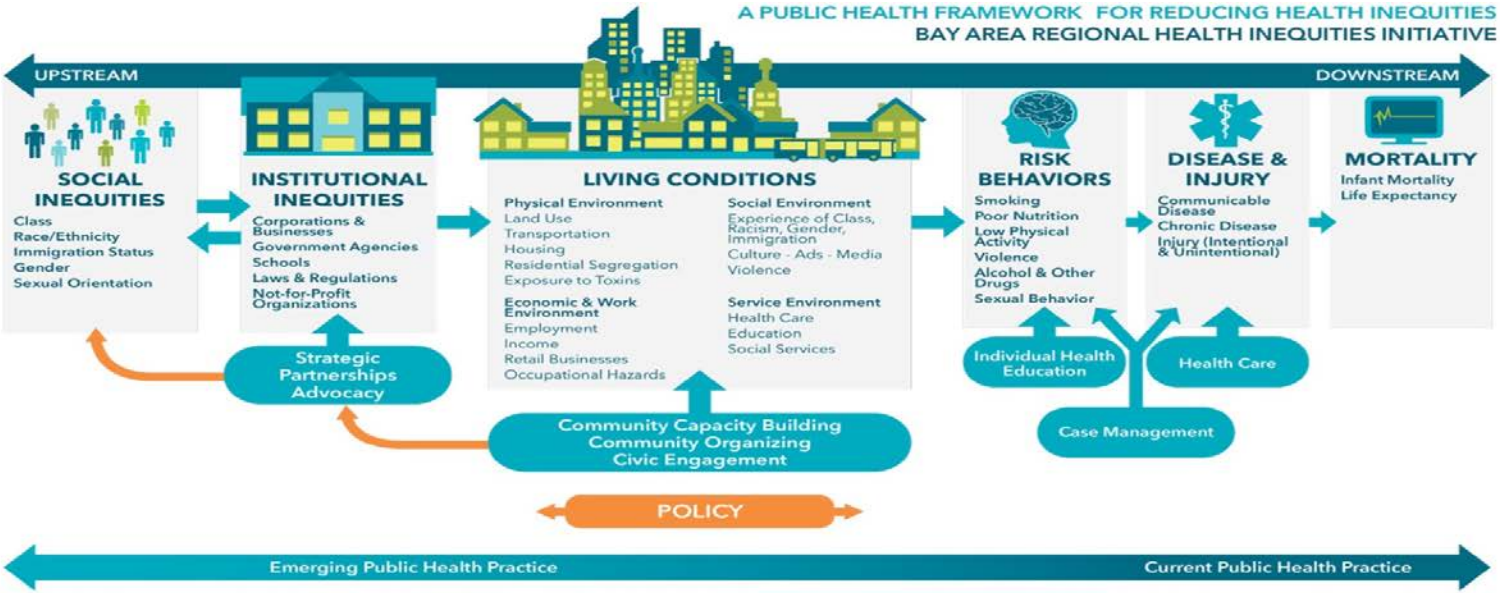
Massachusetts Department of Public Health
Friday, January 11, 2019


VISION
Optimal health and well-being for all people in Massachusetts, supported by a strong public health infrastructure and healthcare delivery.
MISSION
The mission of the Massachusetts Department of Public Health (DPH) is to prevent illness, injury, and premature death; to ensure access to high quality public health and health care services; and to promote wellness and health equity for *all* people in the Commonwealth.
DATA
We provide relevant, timely access to data for DPH, researchers, press and the general public in an effective manner in order to target disparities and impact outcomes.
DETERMINANTS
We focus on the social determinants of health - the conditions in which people are born, grow, live, work and age, which contribute to health inequities.
DISPARITIES
We consistently recognize and strive to eliminate health disparities amongst populations in Massachusetts, wherever they may exist.
EVERYDAY EXCELLENCE
PASSION AND INNOVATION
INCLUSIVENESS AND COLLABORATION



Source: Bay Area Regional Health Inequities Initiative



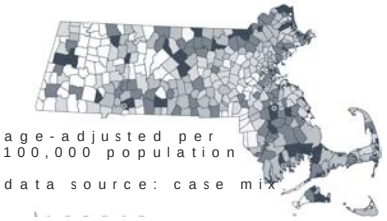
Source: Adapted from the Bay Area Regional Health Inequities Initiative

Innovative State and Local Public Health Strategies to Prevent and Manage Diabetes and Heart Disease and Stroke

- New cooperative agreement with federal funding for statewide chronic disease work
  - CDC money; CDC rules and parameters
  - MA implementation; MA innovation to identify and address social determinants

MA Innovation:
Create geographic composite scores for all communities using health outcome data and social distribution data; In addition to statewide infrastructure, fund health centers serving the populations, and addressing the gaps identified

STROKE HOSPITALIZATIONS

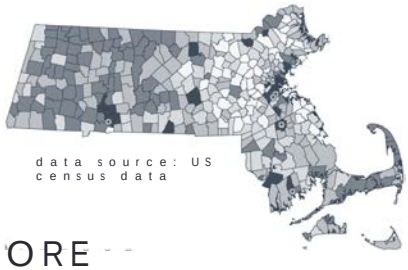


age-adjusted per 100,000 population

data source: case mix

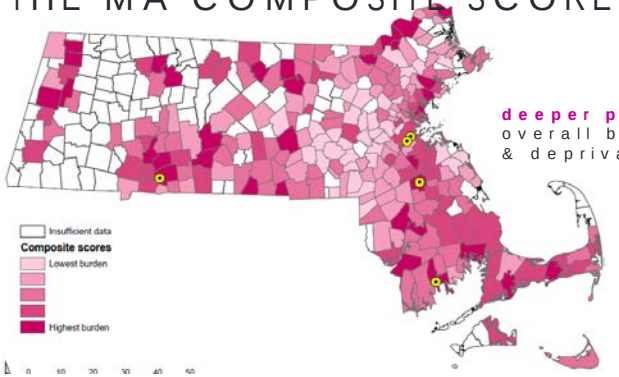
deeper gray = higher rate; higher concentration of deprivation

INDEX OF CONCENTRATION AT THE EXTREMES



data source: US census data

THE MA COMPOSITE SCORE



deeper pink = higher overall burden & deprivation

STATEWIDE DATA INFRASTRUCTURE

(1) **Rigorously Validated Surveys**: pharmacy survey, community health worker survey.
(2) **Health Information Technology (HIT)**: Azara DRVS, MDPHnet.
(3) **Surveillance Data**: case mix, all payers claims database.
(4) **Programmatic Tracking**: total & location of all Diabetes Prevention Programs in the state.

RACIAL JUSTICE LENS

--BURDEN & INEQUITIES COMPOSITE SCORE--

COMMUNITIES OF FOCUS

--ASSESSMENTS & EVIDENCE GATHERING--

BARRIERS & FACILITATORS
- What are the barriers to DPP retention?
- Is existing HIT useful for identifying undiagnosed hypertension?

PROCESS MEASURES
- Total DPP referrals, enrollments, & completions.
- Total providers with protocol to identify cases of undiagnosed hypertension.

OUTCOME MEASURES
- Percent with 5-7% weight loss.
- Reduced prevalence of undiagnosed hypertension.

continuous program quality improvement

Approach

EFFECTIVENESS

IMPACT

Incorporating a racial justice lens

How the Massachusetts Tobacco Cessation and Prevention Program (MTCP) used “re-framing” to shift focus from individual-level behaviors to upstream social determinants of health and societal structures

Re-Frame of Tobacco BRFSS Factsheets

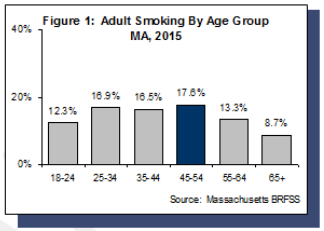
How the Massachusetts Tobacco Cessation and Prevention Program (MTCP) used “re-framing” to shift focus from individual-level behaviors to upstream social determinants of health and societal structures

Updated 08/19/2016

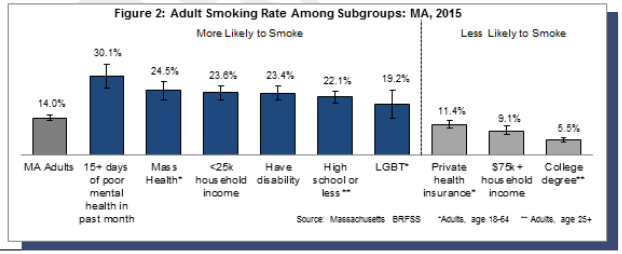
Who Smokes
Massachusetts Fact Sheet

In 2015, 14% of Massachusetts adults (or 708,015 residents) were current smokers, a historic low.

- 16.4% of men smoke; 11.9% of women smoke.
- 14.6% of whites, 15.8% of blacks, and 11.6% of Hispanics smoke.
- 17.6% of adults, age 45-54 smoke, the highest of any age group (Figure 1).
- 12.3% of adults, ages 18-24 smoke. However, this rate does not reflect use of other tobacco products (eg. little cigars, e-cigarettes, etc.), which may be more prevalent among this age group.[1]



Smoking rates are highest among people with mental illness, low socio-economic status, people with disabilities, and the LGBT population (lesbian, gay, bisexual, and transgender) (Figure 2). All subgroup smoking rates other than LGBT were significantly different from the rate for all MA adults (14%).



[1] Hu SS, Neff L, Agaku IT, et al. Tobacco Product Use Among Adults- United States, 2013-2014. Morbidity and Mortality Weekly Report. 2016; 65:685-691. Accessed 8/15/2016 at http://www.cdc.gov/mmwr/volumes/65/wr/mm6527a1.htm.

Massachusetts Department of Public Health
Tobacco Cessation and Prevention Program
(617) 624-5900…www.mass.gov/dph/mtcp

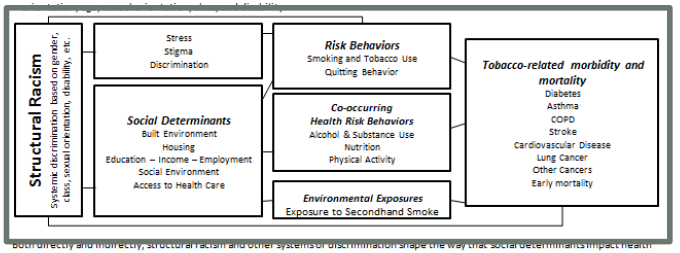
Make smoking history.

Who Smokes
Massachusetts Factsheet: 2016

Smoking remains the leading cause of *preventable* death and disease in Massachusetts. Despite an overall decline in adult smoking rates over the past 20 years, some population subgroups continue to smoke at much higher rates than the general population.

Why do people smoke?

Smoking is often shaped by a broad range of unequal social and environmental factors beyond choice. Social determinants of health such as education, employment, access to health care and quality of care, support from families and peers, the built environment, and societal norms and systems all influence an individual's smoking behavior. However, these determinants do not impact everyone in the same way. Structural racism is a societal system which has historically limited, and continues to limit, the ability of people of color to accumulate resources and power (such as housing and education), and thereby gives white people an advantage over people of color. Structural racism co-occurs with and reinforces other societal systems of disadvantage based on gender, sexual



both directly and indirectly, structural racism and other systems of discrimination shape the way that social determinants impact health risk behaviors and long-term health.

Inequities in Social Determinants Include:

Education, Income, Employment

- Years and quality of education received not only determines knowledge of the health risks of smoking, but also an individual's opportunity to obtain employment, higher income jobs and economic stability.[1]
- Schools in communities of color and low-income communities often receive less funding, thus disadvantaging youth and adults in these communities from having the knowledge and skills needed to improve health behavior.

Access to Health Care

- Access to health insurance is often linked to employment, and barriers to achieving health care are often disproportionately experienced by those who smoke at higher rates than other groups (See: Who Quits).
- Due to unique stressors faced by people of color and disproportionately-affected groups, quitting smoking may be a low priority, and smoking may be used as a coping mechanism.

Social Environment

- Risk factors that contribute to the uptake and continuation of smoking, such as stress and stigma, disproportionately affect those experiencing poverty and people of color experiencing discrimination.
- Social environment, such as peer and family use of tobacco can influence smoking behavior among youth and adults.

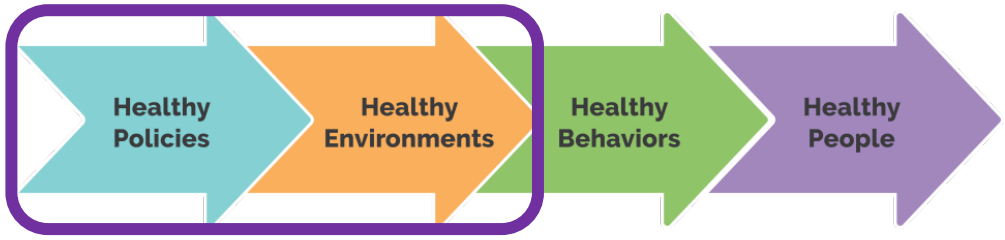
Built Environment and Housing

- Where one lives determines their ability to access tobacco and their exposure to tobacco-related marketing, especially in the point of sale environment.
- Extensive research has shown that the density of tobacco retailers in neighborhoods surrounding schools has been associated with higher youth smoking rates.[2] Greater retail density can support the normalization of tobacco use and increase environmental cues to smoke through constant exposure to tobacco products and advertising.[3]

Mass in Motion

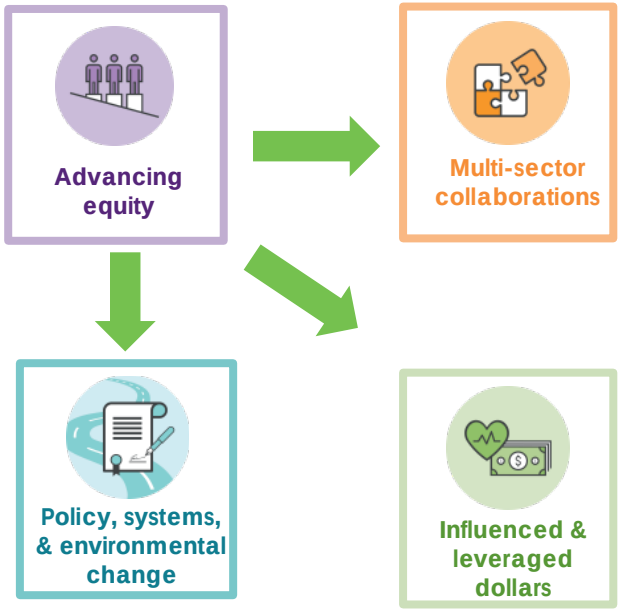
How the Mass in Motion Municipal Wellness & Leadership Initiative moved further upstream

HEALTHY COMMUNITY CHANGE FRAMEWORK



This is where Mass in Motion works!

SUSTAINABLE SOLUTIONS APPROACH



INCORPORATING RACIAL EQUITY

Leading with Race Framework

- Disaggregate data
- Engage priority populations
- Understand root cause inequities

Racial Justice Reframing

Who benefits?
Who is harmed?
Who influences?
Who decides?

Q/A

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