SelfMade Health Network

2016 Minority Health Conference
Practice, Research and Partnerships: Threading It All Together to Achieve Health Equity

Tobacco Use & Cancer Burden Influenced by Social Determinants of Health

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Mission

The mission of SMHN is to create a national cross-collaborative network that:

- *promotes, generates and applies "promising practices" as well as evidence-based models*
- *steers the process of innovation, exploration and discovery as a natural outgrowth of improved delivery of services impacting underserved, vulnerable and low-resourced populations*
- *ensures value associated with long-term, sustainable disparity reductions within regions and communities disproportionately impacted by cancers and tobacco use*

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SMHN Leadership Council

American Health Quality Association	National Health Care for the Homeless Council, Inc.	National Area Health Education Center (AHEC) Organization
Louisiana Food Bank Association	Virginia Federation of Food Banks	West Virginia University-Mary Babb Randolph Cancer Center
Academy of Oncology Nurse and Patient Navigators	Louisiana Public Health Institute (LPHI)	University of Wisconsin School of Medicine and Public Health
Catholic Health Association of the United States	West Virginia Division of Tobacco Prevention	Ohio Commission on Minority Health
Meharry Medical College	National Federation of Licensed Practical Nurses (LPNs), Inc.	Altarum Institute

Reference:
http://www.selfmadehealth.org/about/network-leadership-council/

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National Prevalence

Most common, costly and preventable chronic diseases and health conditions:

- Heart disease and Stroke
- Cancer
- Type 2 diabetes
- Obesity

Approximately ½ of all adults (117 million people) are living with one or more chronic health conditions.

- 1 of 4 adults are living with two or more chronic health conditions.
- 3 out of 4 adults (aged 65 and older) are living with multiple chronic conditions.

An increase in the number of chronic conditions is associated with an increased risks in hospitalizations.

National Costs Associated with Chronic Conditions

More than half or approximately 71% of the total healthcare spending is associated with care for the Americans with more than one chronic condition.

- Total costs of heart disease and stroke: $315.4 billion. Of this amount, $193.4 billion was for direct medical costs (*not including nursing home care costs)*
- Total costs of cancer care: $157 billion
- Total estimated cost of diagnosed diabetes: $245 billion (*including $176 billion in direct medical costs)*

People with multiple chronic conditions (MCC) face substantial out-of-pocket costs of their care, including higher costs for prescription drugs.

Reference: CDC-Multiple Chronic Conditions http://www.cdc.gov/chronicdisease/about/multiple-chronic.htm

Public Health Practice Support for CHWs (1)

Engaging Community Health Workers (CHWs) is an evidence-based public health practice supported by the following:

- 2011 National Prevention Strategy
- 2010 Patient Protection and Affordable Care Act
- 2010 Institute of Medicine Report: A Population-Based Policy and Systems Change Approach to Prevent and Control Hypertension
- 2002 Institute of Medicine (IOM) Report: Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care
- American Public Health Association (APHA) Position Statement
- American Association of Diabetes Educators (AADE)

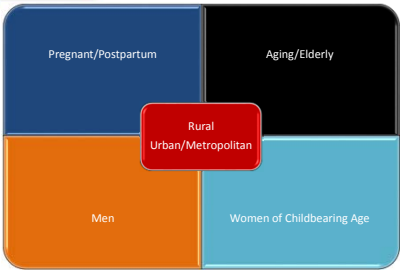
Public Health Practice Support for CHWs (2)

Excerpt from AADE Position Statement: *Community Health Workers in Diabetes Management and Prevention*

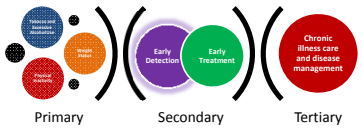
"The community-based system of care and social support provided by CHWs complements, but does not substitute for, the more specialized services of health care providers."

"Community Health Workers (CHWs) are uniquely skilled to serve as bridges between community members and healthcare services. CHWS are familiar with the cultural buffers, such as cultural identity, spiritual coping, and traditional health practices."

Potential Populations Impacted by CHWs Involvement



Levels of Prevention



Common Modifiable Risk Factors

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Primary Prevention

Reduction of modifiable risk factors to prevent disease onset or occurrence.

Examples include:

- Provision of health education and referrals (e.g. nutrition, physical activity, tobacco cessation counseling to prevent lung cancer, cervical and ovarian cancer risks among women of childbearing age, pregnant and postpartum women etc.)
- Immunizations against certain diseases
- Health promotion activities encourage healthy living (e.g. physical activity, weight management to prevent pre-diabetes, tobacco prevention, smoke-free environment policies-housing and worksite, etc.)

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Common Categories: Evidence-based strategies and Best Practices

Outreach	Community-Clinic Linkages	Inreach *(includes team-based care)*
Healthy eating and physical activity behaviors	Cancer Screenings	ABCS

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Secondary Prevention

Examples include: Early screening and detection programs (e.g., screening populations considered at "high" risk for certain diseases)

- ❑ Mammogram to detect breast cancer early
- ❑ FIT and colonoscopy to detect colorectal cancer
- ❑ HgA1c tests and other tests to detect Type 2 diabetes
- ❑ Lung cancer screening among tobacco users-heavy smokers, aged 55-80 years.
- ❑ Management of glucose levels to prevent diabetic complications
- ❑ Management of blood pressure and cholesterol levels to prevent cardiovascular complications: stroke, heart attack, etc.
- ❑ PSA screening to support early detection and treatment (Prostate)

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Levels of Prevention-Cardiovascular Disease

Primary CVD prevention include:

- set of interventions detection and control of risk factors designed to prevent the first occurrence of heart attack, heart failure, or stroke among people with identifiable risk factors.

Secondary CVD prevention include:

- set of interventions aimed at survivors of acute CVD events (e.g., heart attack, heart failure, stroke) or others with known CVD in which long-term case management is used to reduce disability and risk for subsequent CVD events.

Tertiary CVD prevention:

- set of intervention aimed at reducing disability among survivors of CVD events through rehabilitation.

Reference: http://www.cdc.gov/dhdsp/action_plan/pdfs/action_plan_7of7.pdf

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Examples of Potential Workplace Environments

Workplace Settings

Health Departments	Family Planning or Women, Infants and Children (WIC), Maternal and Child Health (MCH)	Hospitals, Clinics, or FQHCs	Aging or Social Services	Community-based or Non-Profit Organizations	Faith-based Organizations

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Overview of CHW Engagement: Primary & Secondary Prevention

Guide to Community Preventive Services included outcomes associated with CHW engagement related to:

- ❑ diabetes prevention and self management programs
- ❑ clinic community linkages for ABCS: glucose (A1c), blood pressure and cholesterol control, smoking cessation
- ❑ patient navigation related to cancer screening and diagnostic testing
- ❑ physical activity and nutrition interventions

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Examples of Community Health Workers Roles

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Overview of Primary & Secondary Prevention Strategies (1)

Chronic Conditions: Prevention and Management Examples

CDSMP (Stanford Chronic Self-Management Education Program)-patients with chronic conditions (*including Diabetes and Hypertension*)

- CHWs can function on one of two roles: CHW-led and CHW-supported Programs.
- CDMSP "master" trainers to train CHWs to lead programs in self-management.

Women's Health: Encouraging women to purse recommended maternal and child health care.

- Community Health Access Program (Ohio) "Pathways" CHWs role in reducing low birth weight and premature deliveries.

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Overview of Primary & Secondary Prevention Strategies (2)

Cancer: Prevention and Management Examples

CHW roles vary and may involve:

- establishing linkages, patient/client navigation and facilitating referrals to self-management programs, food banks, churches, and social workers
- following up on referrals
- assisting with coordination of transportation, scheduling appointments, follow-up on goal progress (care plans), post-physician visit support.

State Example

- Texas hospitals redirecting uninsured from Emergency Dept. to primary care.

Overview of Primary & Secondary Prevention Strategies (3)

Asthma Prevention and Management Examples

- provide educational information to the families and assist them with environmental remediation during home visits.
- conduct social assessments with primary caregivers to discover any problems that might keep the family from concentrating on their child's asthma.
- assist families acquire insurance coverage, and resolve transportation and school issues that affect asthma management.
- refer caregivers to social services or to a social worker when the family's specific social needs extend beyond the CHW's capacity.
- inform the clinic how well the child is complying with the medication regimen and provide an additional resource in the clinic for family orientation, asthma education, and scheduling.

Reference: CDC-Asthma Program: Social Care Coordination by a Community Health Worker (CHW)
http://www.cdc.gov/asthma/interventions/yes_we_can_programcomponents.htm

Resources (1)

Community Health Worker (CHW) Toolkit and other Resources-
CDC Division for Heart Disease and Stroke Prevention
http://www.cdc.gov/dhdsp/pubs/chw-toolkit.htm

A Community Health Worker Training Resource- CDC Division for Heart Disease and Stroke Prevention
http://www.cdc.gov/dhdsp/programs/spha/chw_training/

- Continuing education (0.9 CEU and 9.5 CHES) are available.

CDC-Road to Health Toolkit (bilingual)/National Diabetes Education Program (NDEP) www.cdc.gov/diabetes/ndep/index.htm

CDC: A Summary of State Community Health Worker Laws
http://www.cdc.gov/dhdsp/pubs/docs/chw_state_laws.pdf

Resources (2)

Stanford CDSMP (Chronic Disease Self-Management Program)
http://patienteducation.stanford.edu/programs/cdsmp.html

CDC-National Diabetes Prevention Program (DPP)
http://www.cdc.gov/diabetes/prevention/index.html

George Washington (GW) Cancer Institute: Survivorship and Patient Navigator Resources
https://smhs.gwu.edu/gwci/survivorship/center-advancement-cancer-survivorship-navigation-and-policy-casnp/patient-navigator

CDC Guide: Steps for Increasing Colorectal Cancer Screening Rates: A Manual for Community Health Centers (*includes patient navigator section)*
http://www.cancer.org/acs/groups/content/documents/document/acspc-044104.pdf

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Resources (3)

Diabetes Education Recognition Programs (American Diabetes Association)
http://professional2.diabetes.org/erp_zip_search.aspx

DSME Accredited Program and Patient Resources (AADE)
https://www.diabeteseducator.org/practice/diabetes-education-accreditation-program-(deap)

Million Hearts Campaign-Role of CHWs
http://www.cdc.gov/bloodpressure/docs/mh_commhealthworker_factsheet_english.pdf

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Resources (4)-Patient/Client Referral Sources

CDC- "Tips From Former Smokers" Campaign Resources (Tobacco Cessation)
http://www.cdc.gov/tobacco/campaign/tips/partners/index.html

National Breast and Cervical Cancer Early Detection Program (NBCCEDP)
http://www.cdc.gov/cancer/nbccedp/

Colorectal Cancer Control Program (CRCCP)
http://www.cdc.gov/cancer/crccp/contact.htm

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