Hello and welcome to today's Coffee Break presented by the Applied Research and Evaluation Branch in the Division for Heart Disease and Stroke Prevention at the Centers for Disease Control and Prevention.

My name is Ally Chase, and I am an ORISE Fellow and I will be acting as today's moderator. Our presenters today are Refilwe Moeti, a Public Health Educator, and Cindy Huang, a Health Policy and Translation fellow, both on the Applied Research and Translation Team within the Division for Heart Disease and Stroke Prevention's Applied Research and Evaluation Branch.

Before We Begin…

- Any issues or questions?
  - Use Q & A box on your screen
  - Email AREBHeartInfo@cdc.gov

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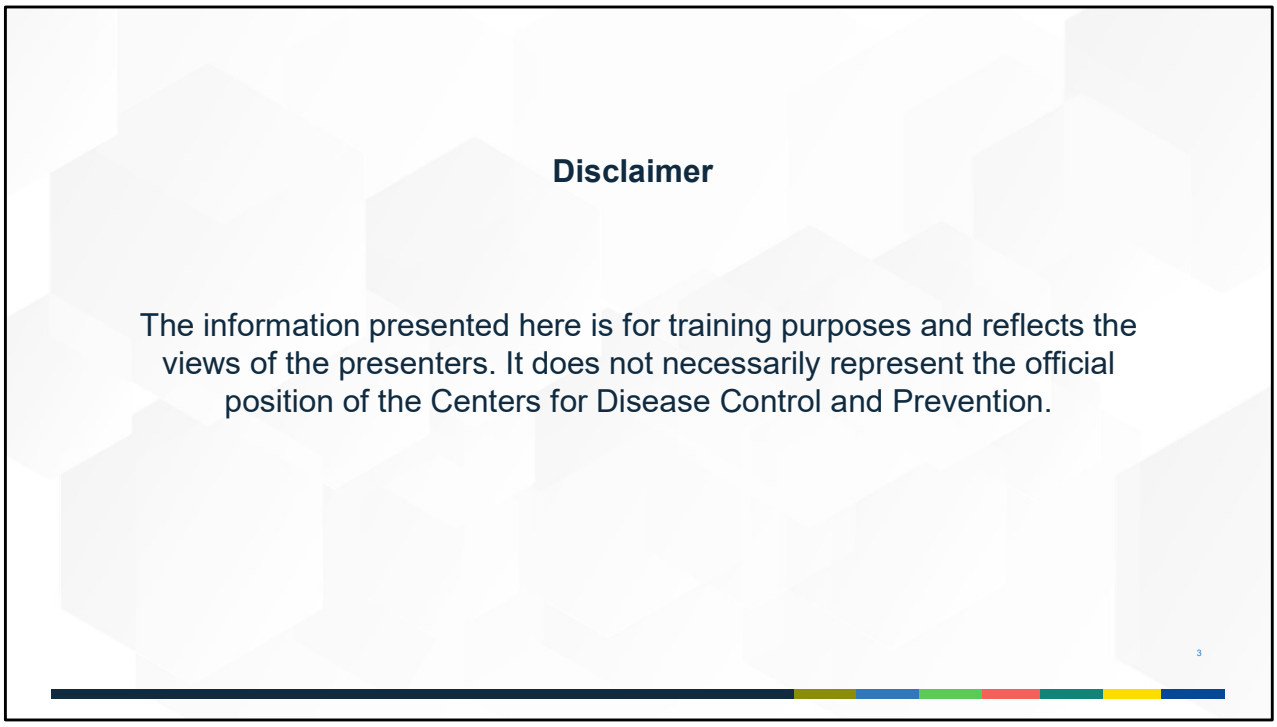
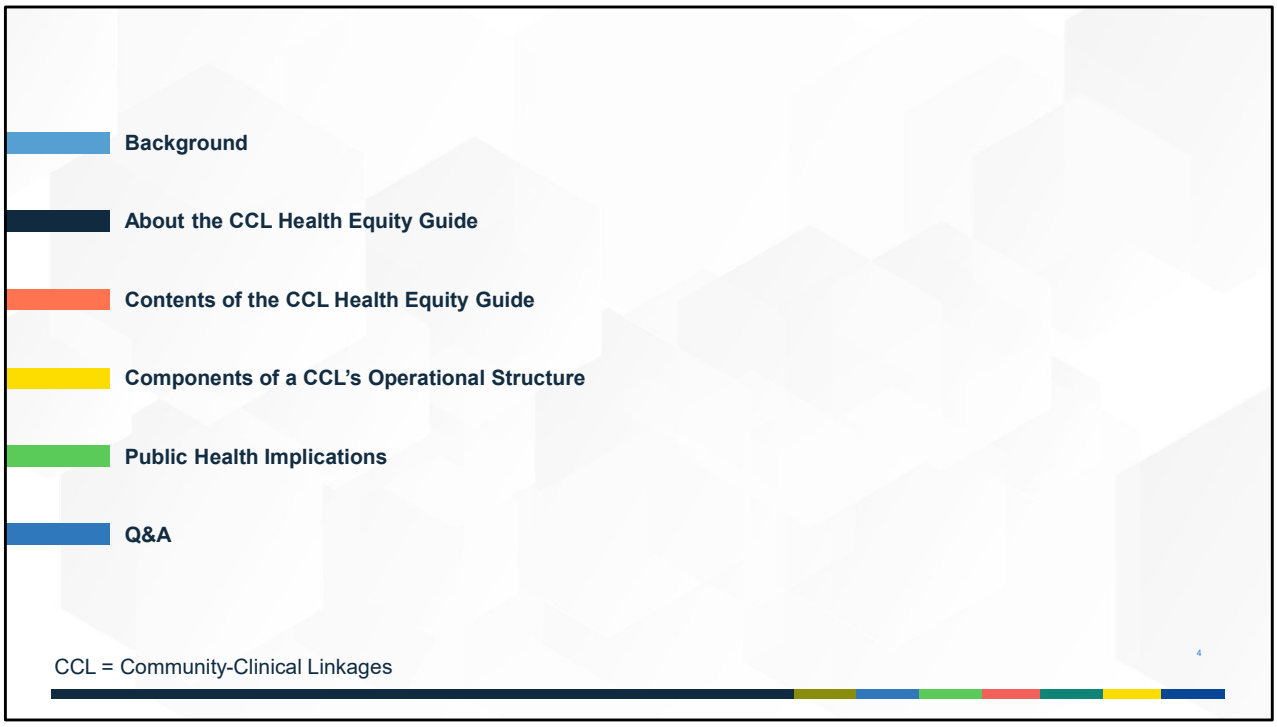
Before we begin, there are some housekeeping items. If you are having issues with audio or seeing the presentation, please message us using the Q&A or send us an email at AREBheartinfo@cdc.gov. Please submit any questions for the presenters using the Q&A as well. Since this is a training series on applied research and evaluation, we hope you will complete the poll at the end of the presentation and provide us with your feedback.

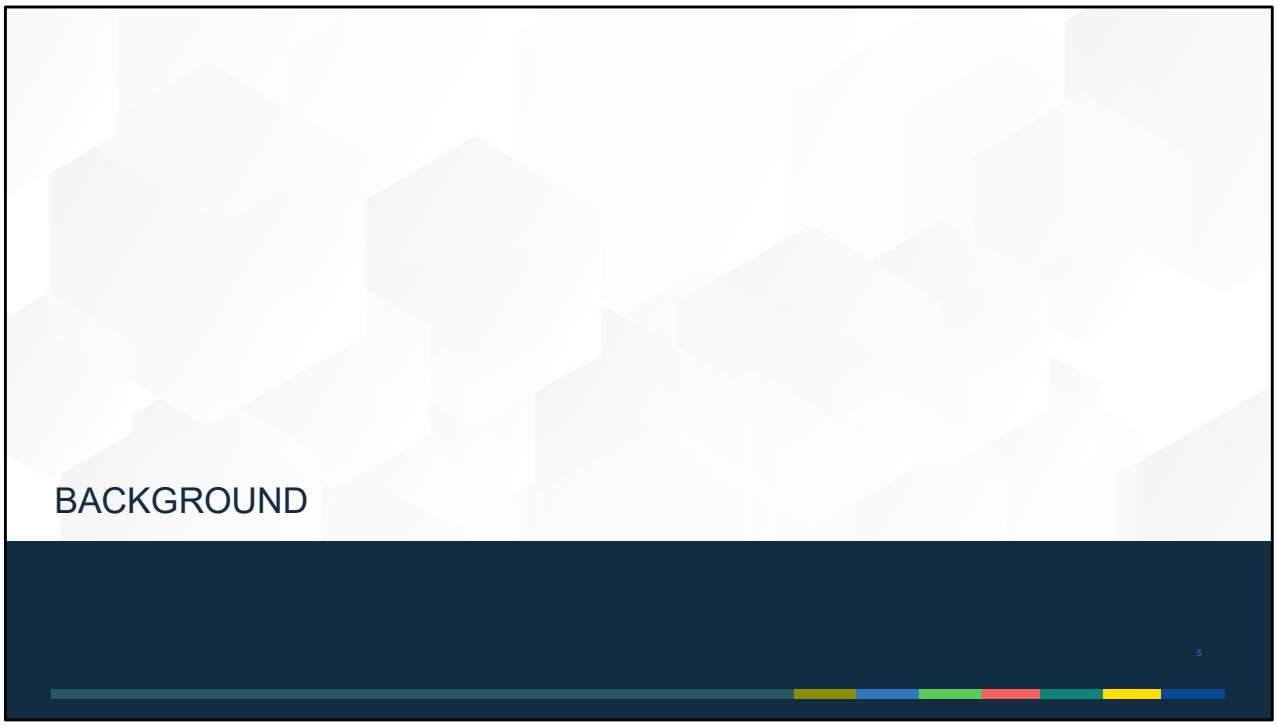


As a disclaimer, the information presented here is for training purposes and reflects the views of the presenters. It does not necessarily represent the official position of the Centers for Disease Control and Prevention.

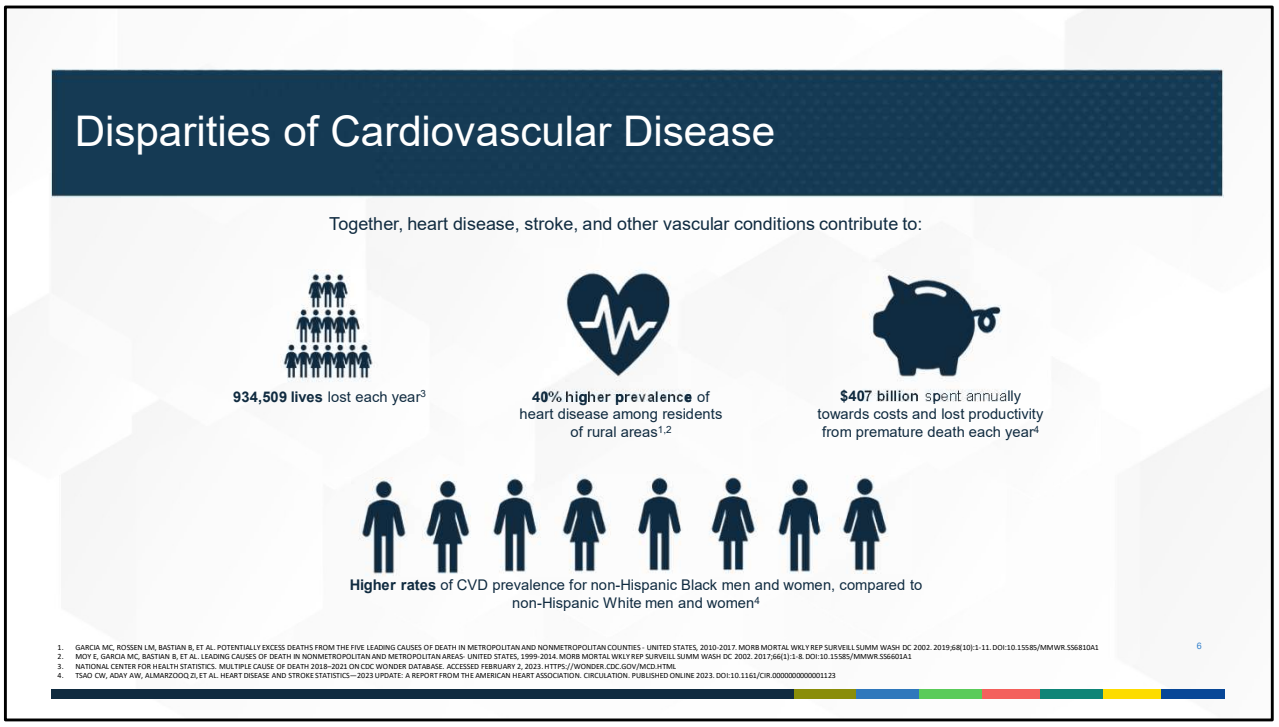
So, without further delay. Let's get started. Refilwe and Cindy, the floor is yours.



Thank you, Ally.
In today's presentation, we will start with some contextual background on the disparities of Cardiovascular Disease. We'll then discuss the overview and contents of the Community-Clinical Linkages Health Equity Guide (which I'll continue to refer to as CCL Health Equity Guide). We'll also discuss components to consider when creating a CCL operational structure with a health equity lens. Next, we'll review the public health implications of the CCL Health Equity Guide. Lastly, we'll end the call with a Q&A.



So, before we dive into an overview of the CCL Health Equity Guide, I want to level-set with a brief overview of the disparities and inequities of cardiovascular disease.



Cardiovascular disease places substantial health and economic burdens on the United States. It also is the greatest contributor to racial disparities in life expectancy.

In 2020, approximately 930,000 people lost their lives to cardiovascular disease.

It has continued to cost the nation hundreds of billions of dollars each year, including direct healthcare costs and the loss of productivity due to premature death.

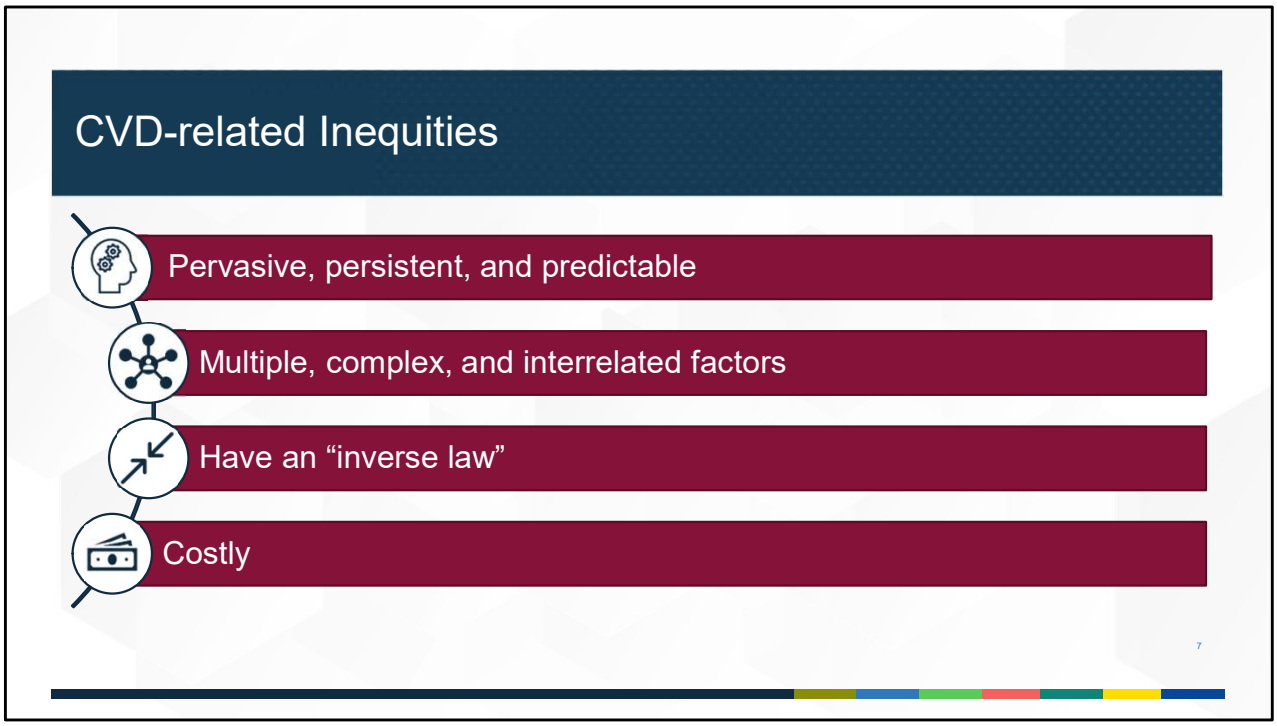
Heart disease, stroke, and their modifiable risk factors are experienced disproportionately throughout the US population based on race and ethnicity, social factors, and geography.

Structural racism, discriminatory economic policies, and other systemic factors have contributed to these disparities by either:

- Increasing financial stress.
- Creating distrust of the medical system.
- Curtailing access to quality health care, and/or
- Segregating populations into unsafe and unhealthy neighborhoods.

Thus, making cardiovascular disease a health equity issue with significant health, social, and economic consequences.

In order to achieve health equity in cardiovascular disease, there is a need for evidence-based approaches specifically designed with a health equity lens. This would not only help us identify people who were at an increased risk for cardiovascular disease, but also acknowledge and address the historical and structural factors associated with cardiovascular disease inequities.



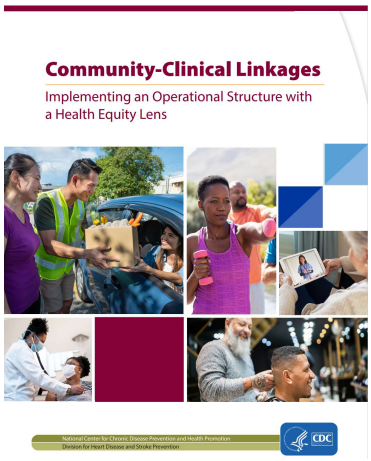
As with all our work and projects, we continually attend to the fact that are significant inequities in cardiovascular disease and its risk factors. It is evident that CVD-related inequities:

- Are everywhere around us; they are pervasive;
- They’re persistent, as reflected by trend data;
- They tend to predictably impact certain groups of people – for example those of racial and ethnic minorities, people with low SES, and residents or populations of rural areas.

Additionally,

- There are no quick fixes to address CVD-related inequities as they result from multiple, complex, and interrelated factors.
- Inequities invariably play out according to an inverse law. This means that people who have a greater need for healthcare services due to significant CVD burden and negative social determinants of health also have the least access to the quality healthcare they need to improve their health.
- Lastly, CVD-inequities are costly.

About the CCL Health Equity Guide



Community-Clinical Linkages: Implementing an Operational Structure with a Health Equity Lens

- About the Guide
- Introduction
- Components of a CCL's Operational Structure
- Resources
- References

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The CCL Health Equity Guide which was launched last August can be found in PDF format at the link provided in the chat box (https://www.cdc.gov/dhdsp/evaluation_resources/guides/health-equity.htm)

The overall Guide is divided into five main sections:

- About the Guide
- Introduction
- Components of a CCL's Operational Structure
- Resources
- References

CCLs are connections between community and clinical sectors which strive to improve health within a community. CCLs are an effective, evidence-based approach to prevent and manage chronic diseases such as CVD.

Although the term “community-clinical linkages” highlights only the community and clinical sectors. The public health sector is integral to CCLs and is a central feature of the Health Equity Guide.

Key Roles for Public Health Practitioners

- Connect the community and clinical sectors
- Collect, analyze, share, review, or use Social Determinants of Health data
- Address structural and community factors that create and perpetuate CVD inequities
- Highlight heterogeneity and intersectionality
- Identify and share evidence-based approaches
- Provide infrastructure and support to increase capacity
- Link and align local and state efforts to national initiatives

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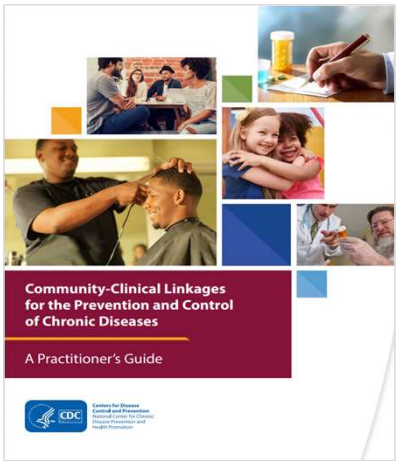
CCL = Community-Clinical Linkages

Touching on key roles public health organizations can play in CCL efforts to address health equity. They can play roles as leaders, facilitators, or partners. To just mention a few on the screen, public health practitioner key role examples can range from:

- Using their relationships with organizations in community and clinical sectors to connect the sectors, such as barbershops or Federally Qualified Health Centers (FQHCs), particularly in “upstream” areas not typically within the purview of public health such as transportation and housing
- To linking and aligning local and state efforts to national initiatives that explicitly address health equity, racial equity, or people who are at increased risk for CVD.

About the CCL Health Equity Guide



L earn about community and clinical sectors.

I dentify and engage key stakeholders from community and clinical sectors.

N egotiate and agree on goals and objectives of the linkage.

K now which operational structure to implement.

A im to coordinate and manage the linkage.

G row the linkage with sustainability in mind.

E valuate the linkage.

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CCL = Community-Clinical Linkages

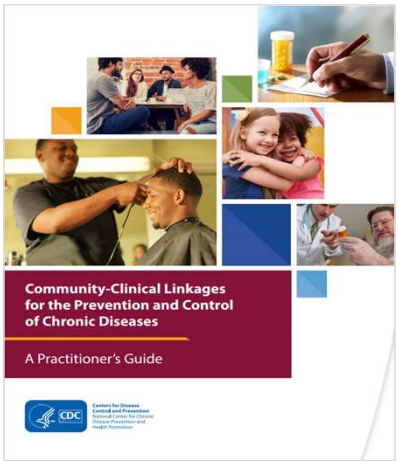
It's important to note the CCL Health Equity Guide is based on a Community-Clinical Linkages Guide that was written for public health practitioners, which was published in 2016 and was designed to present general information on implementing CCLs.

This Practitioner's Guide highlights seven strategies for implementing a CCL. These strategies spell out the word "LINKAGE", so it's a really easy mnemonic to remember.

The first 3 strategies are preliminary stages of implementation, and these include doing your homework to learn about sectors, as well as meeting and negotiating with key partners.

The next 4 strategies represent latter stages of implementation, and they range from being clear about the CCL's operational structure, all the way through to ensuring that you evaluate the CCL.

About the CCL Health Equity Guide



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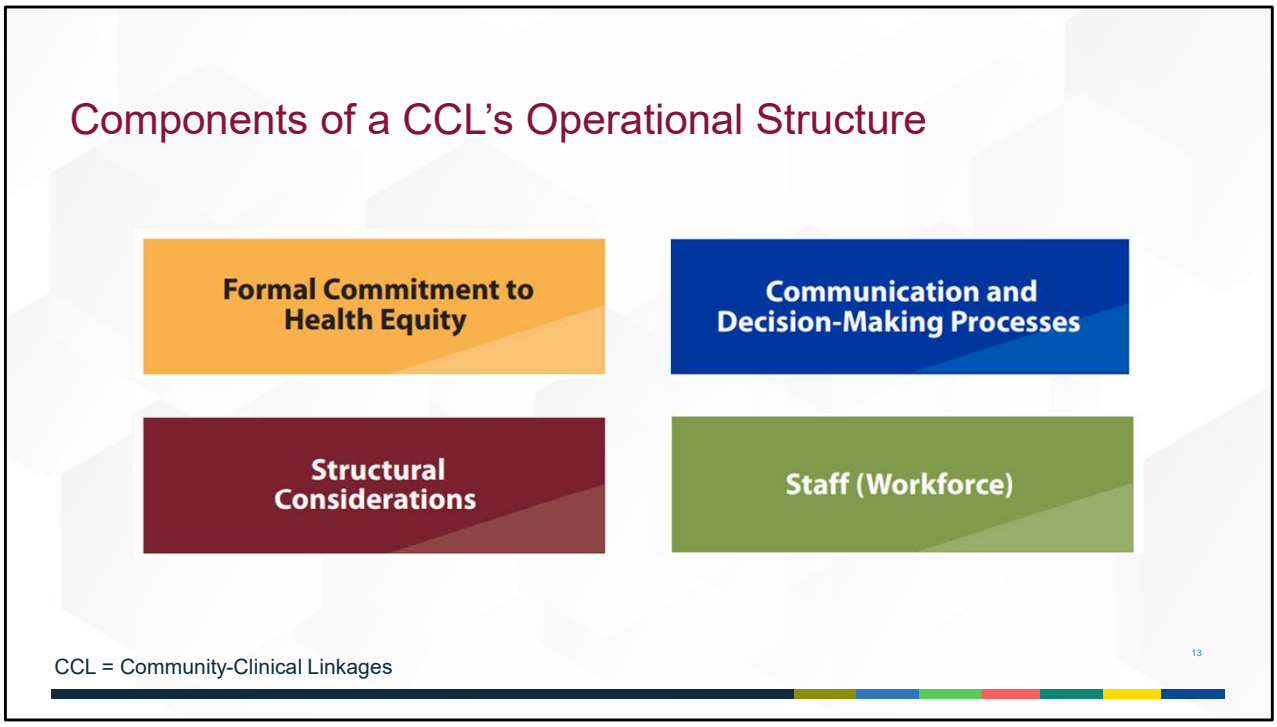
CCL = Community-Clinical Linkages

The CCLs Health Equity Guide aims to help practitioners incorporate health equity when they focus on a CCL's operational structure; operational structure essentially refers to organizing a CCL's structure and supporting its operations.

We use a health equity lens because it acknowledges the disparity rates of, and death from, cardiovascular disease among people from different racial and ethnic groups. These disparities are closely linked with unfair and unjust social, economic, and environmental disadvantages. Thus, CVD is a health equity issue with significant health, social, and economic consequences.

Now that I've given you a little bit of contextual and background information, and described the overarching purpose of the CCL Health Equity Guide, I'll pass the mic to Refilwe to touch on the key roles and highlight contents of the CCL Health Equity Guide.



Thank you so much, Cindy!

For my portion of the presentation, I'll be talking about four health equity-related components of a CCL's operational structure.

The components include health equity principles, and are related to:
- A Formal Commitment to Health Equity;
- Communication and Decision-making Processes;
- Structural Considerations; and
- Staff or Workforce

Though the CCL Health Equity Guide presents these four components in a distinct and linear fashion, in practice they're actually quite interdependent.
Given that, the components can be addressed in whatever order you deem appropriate.
For example, in some cases, you may decide to tackle multiple components at the same time.
And in other cases, it may make more sense to skip a component and then come back to it later.

Decisions about the sequencing and which components require the most attention will vary, and depend on the context in which the CCL operates and its resources.

Now, I will describe the components by highlighting three examples of potential action steps in each one.

Formal Commitment to Health Equity

- Include health equity in formal documents
- Include community members as well as traditional and non-traditional partners
- Develop formal agreements among partners

CCL = Community-Clinical Linkages

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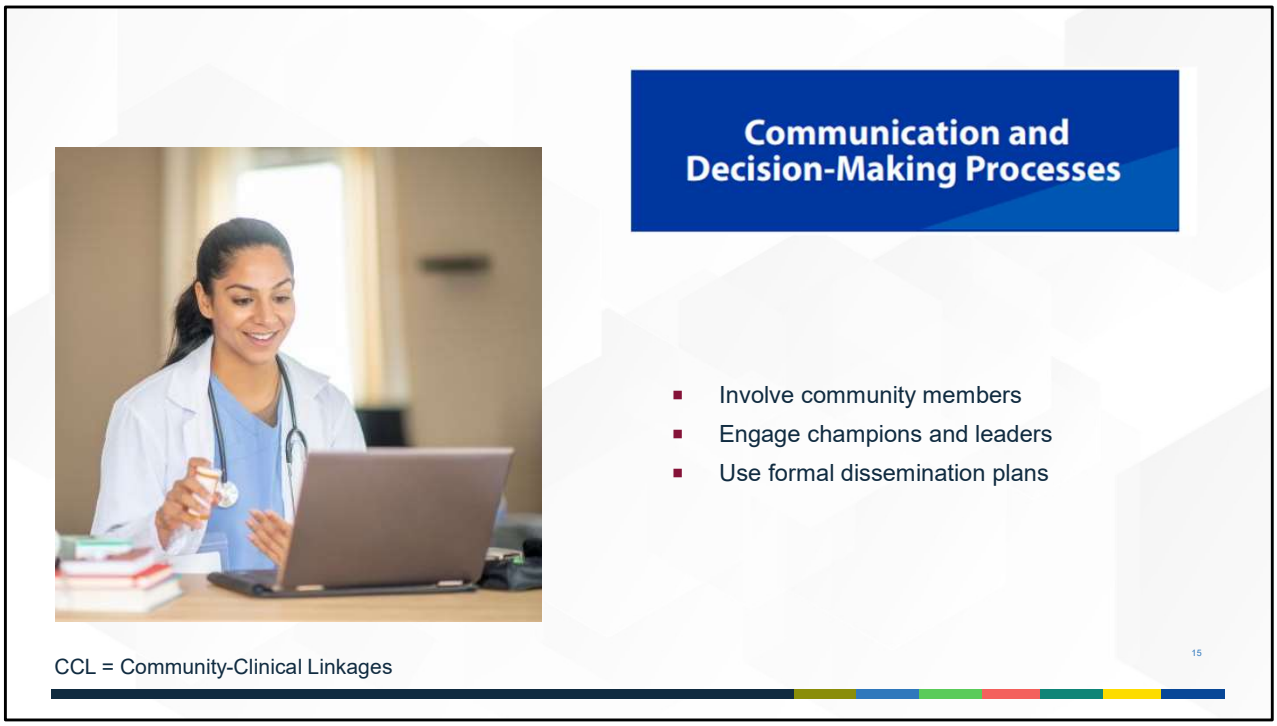
A foundational component of a CCL is for it to have an explicit, formal commitment to health equity. This means including health equity, and related concepts like social justice and structural racism, in formal documents, such as strategic plans or vision and mission statements. Community members and partners from both sectors can equitably be involved in all aspects of developing these formal documents.

As was mentioned earlier in the presentation, CVD inequities are the result of complex, interrelated factors.
Accordingly, it is imperative to include community members who are most impacted by CVD inequities.
In addition to traditional partners, a health equity CCL can include non-traditional organizations who address “upstream” social determinants of health and who recognize that groups most affected by CVD inequities often face challenges that they may view as more urgent than preventing or managing CVD.

Partners in a CCL can show their commitment by developing formal agreements which, for example:

- Outline a health equity–focused vision or mission;
- Provide a timeline that includes roles and responsibilities;
- Describe each entity’s support for the CCL’s purpose; and

- Incorporate health equity principles and the CCL into their ongoing initiatives.



To help make equity a reality, a CCL needs communication and decision-making processes that authentically and meaningfully engage partners, especially community members who are impacted by health inequities.

Unfortunately, community members have often indicated that program implementers only ask them to provide input, serve as advisors, or endorse information after it's been completed.
Instead, community members can be involved as integral and equal partners in all phases of a CCL's development, implementation, and evaluation.

Champions' and leaders' influence can be positive or negative, because they impact several factors such as a CCL's scope, scale, and success.
For example, if champions or leaders feel that a CCL is not aligned with their organizational interests, they likely will not support or allocate any resources to it.

Formal dissemination plans can be used with community members and CCL partners to share practice- and evidence-based information.
Notably, they often do not adopt evidence-based strategies and practices because they feel that the evidence is not applicable to their specific populations.
Other reasons for not adopting evidence-based strategies and practices include limited

ability to assess published research, information overload, and limited time to keep abreast of the latest research.
Thus, the CCL Health Equity Guide suggests making sure that evidence-based information is relevant to community members and partner organizations, and that it is shared in culturally appropriate formats.

Structural Considerations

- Reflect the needs and assets of patients and community members
- Include strategies and activities that explicitly address structural inequities
- Build on the strengths of the priority populations and SDOH-related assets of the organizations

CCL = Community-Clinical Linkages

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A health equity-related CCL can be structured in ways that help remove obstacles and increase opportunities for patients and community members to receive quality health care.

This can be done by designing every aspect of the CCL to reflect the needs, assets, and authentic engagement of patients and community members who are most impacted by health inequities.
Pertaining to engagement, it is important to attend to and set up structures that balance perceptions of power among community members and partners from the two sectors.

- For example, some CCLs stipulate that community members, patients, or clients have to make up at least 50% of their representatives. This practice aims to ensure that community voices are heard, and to include the priorities, knowledge, and experiences of people receiving services.

Approaches that reduce disparities or inequities in CVD are ones that explicitly address structural inequities.
However, many efforts tend to focus on individual and interpersonal factors.

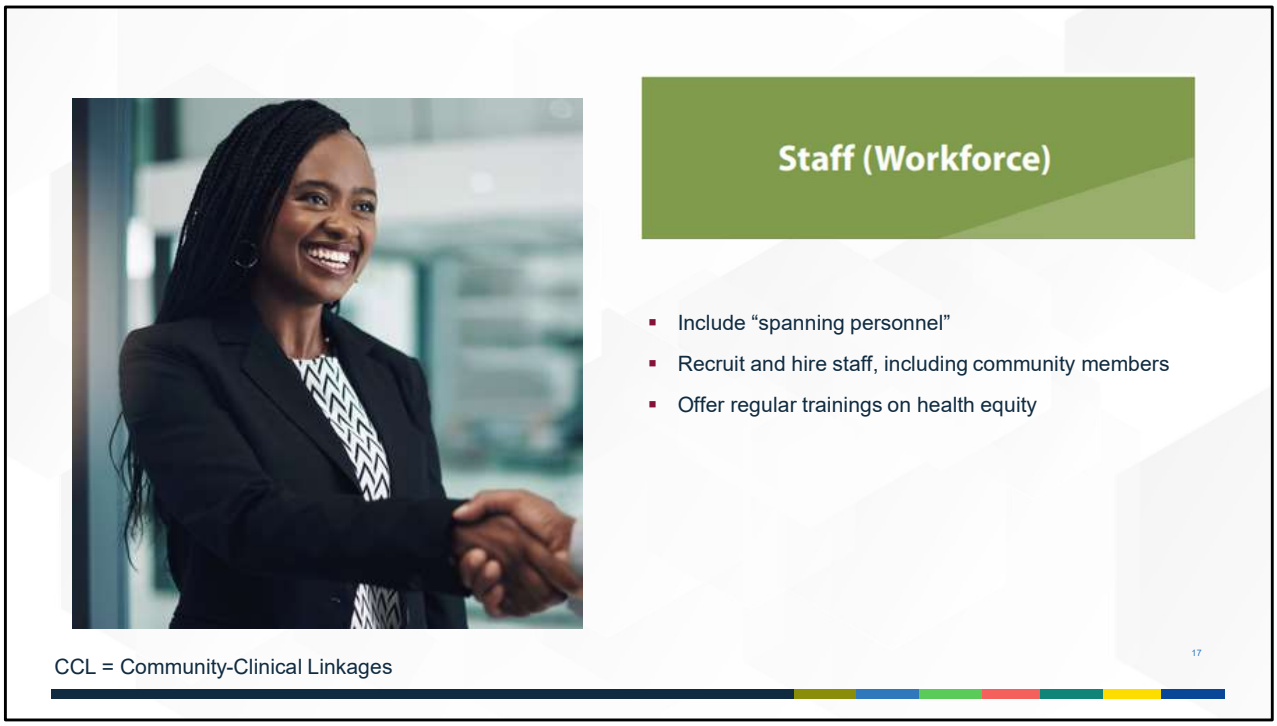
- For example, efforts might include addressing health literacy among patients with limited or no English proficiency, or conducting cultural sensitivity trainings with health care providers.

Instead, a health equity-related CCL calls for approaches to also focus on organizational,

community, and public policy factors, such as enacting policies related to health equity in partner organizations.

A CCL can take an asset-based approach by building on the strengths of priority populations. It can also leverage SDOH-related assets of organizations in both sectors.

- Take, for example, FQHCs, which are in the clinical sector. They are located in high-need areas and accept all patients regardless of insurance status or ability to pay. In addition, they provide services that include on-site interpretation or translation, transportation, or eligibility assistance for public programs.
- In the community sector, a CCL might draw on the YMCA, which provides financial assistance to support use of its resources and participation.



When addressing the CCL’s Staff or Workforce, the CCL can include spanning personnel, who are people who act as the glue that bonds the community and clinical systems. Of particular importance are those who have expertise in addressing health inequities.

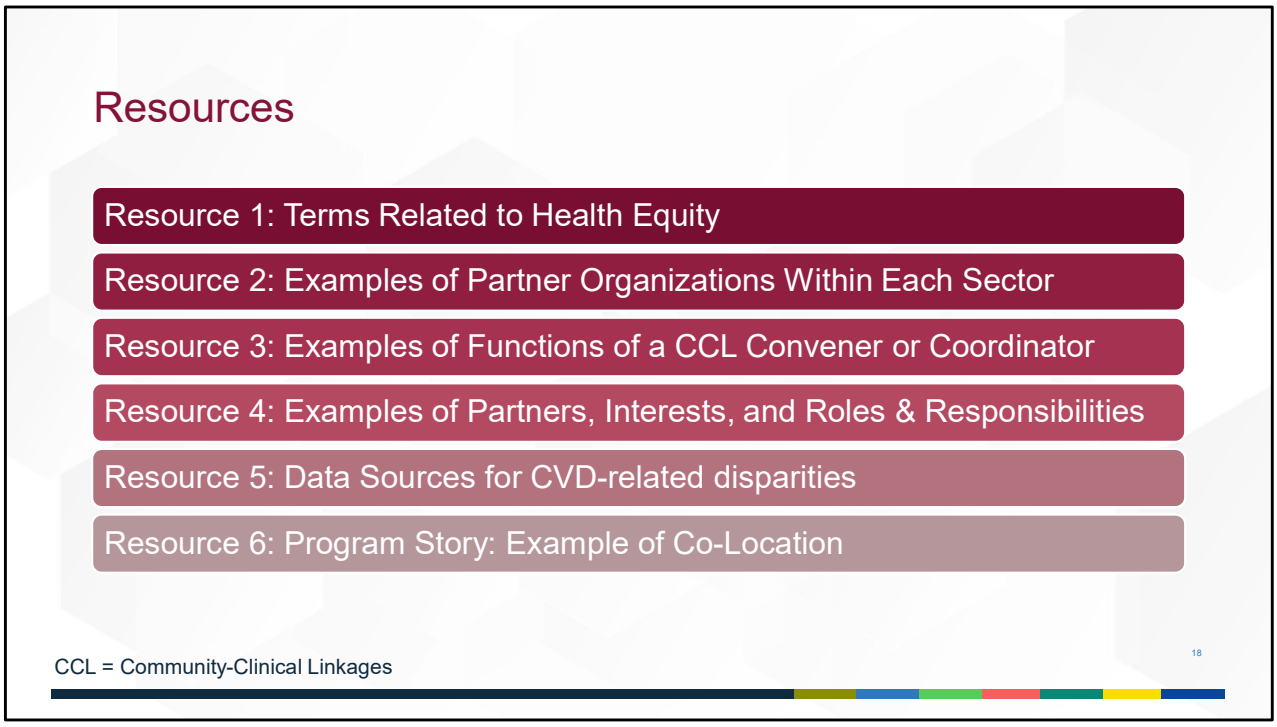
Staff who reflect populations affected by CVD inequities or have experience working with them can be prioritized for a CCL’s recruitment and hiring, as they can speak up for the needs of community members by addressing the structures and systems that create inequities.

- Importantly, staff members who come from the communities they serve can be offered fair compensation and opportunities for advancement.

Generally, training can boost knowledge, skills, and competency. Specifically related to a CCL, training can help improve staff members’ ability to implement and integrate it into their organization’s structure and operations.

- As such, consider offering regular trainings on health equity to staff at different levels in all sectors. For example:
    - In the public health sector, training can be conducted with leadership, implementation, and communications staff.
    - Staff in the clinical sector could include doctors, nurses, and social workers.
    - And staff in the community sector might include CHWs, program coordinators,

and field staff.



The Guide has six resources.

Like every discipline, public health has its own jargon and acronyms. There are also wide variations in how terms are used in community and clinical sectors. For instance, doctors may use the term “obesogenic environments” for what community advocates call “food deserts” and “food swamps.” Therefore, all partners who are involved in the CCL need to have a shared understanding of key health equity terms and concepts.
These are presented in Resource 1.
The CCL Health Equity Guide suggests that these terms and concepts be used often and consistently in documents, meetings, presentations, and other forums.

Throughout our presentation today, Cindy and I have referred to partner organizations in the public health, community, and clinical sectors.
Resource 2 provides a robust list of examples of these organizations.

- For example, the public health sector includes state and local health departments.
- The community sector includes organizations with missions related to food access, housing, criminal justice, and many others.
- Organizations mentioned for the clinical sector include FQHCs, pharmacy-based clinics, cardiac rehabilitation clinics, etc.

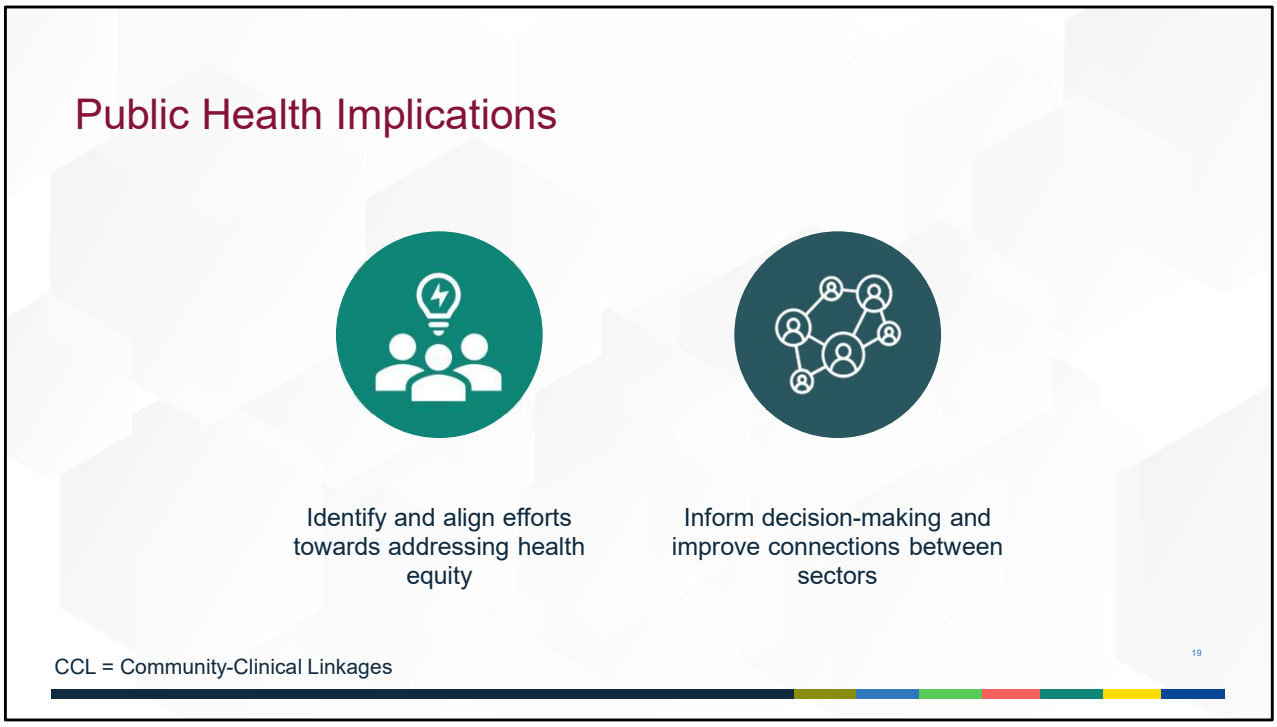
CCLs can include conveners or coordinators to attend to its basic organizational functions. Resource 3 provides examples of their functions.
Conveners or coordinators can strive to build trust among community members disproportionately affected by CVD inequities, and among partners in both sectors. Engaging racial and ethnic minority groups in ways that build or enhance trust is especially important as they may distrust health care systems. They also may have experienced public health efforts that were not sustained.

Previously, we mentioned that partners in a CCL can develop formal agreements. Resource 4 can help partners think through their interests, and align them with roles and responsibilities for the CCL.

Health equity data can be used to continuously adapt, improve, and communicate about the CCL. However, it is a common finding that collecting data is much easier than using it. Taking this into account, many CCLs have formal meetings to discuss and guide their ongoing use of data. These meetings promote smooth implementation and process improvement. They also can help build trust, support collaborative learning, improve transparency, and foster positive relationships.
Resource 5 presents examples of data sources related to national, state, and local disparities in CVD.

Included in the CCL Health Equity Guide is a story that serves as a real-life example of how public health practitioners implemented a CCL operational structure. It highlights a program created by the Veterans Health Administration.

- This program integrates health and social services for veterans experiencing homelessness, as well as who have multiple chronic conditions and face barriers to getting primary care.
- The structure of the program emphasizes the integration of services, whereby mental health and primary care services are co-located with community programs and social services to create a continuum of care.
- Ultimately, the success of the program was in integrating medical care with social services to address SDOH.

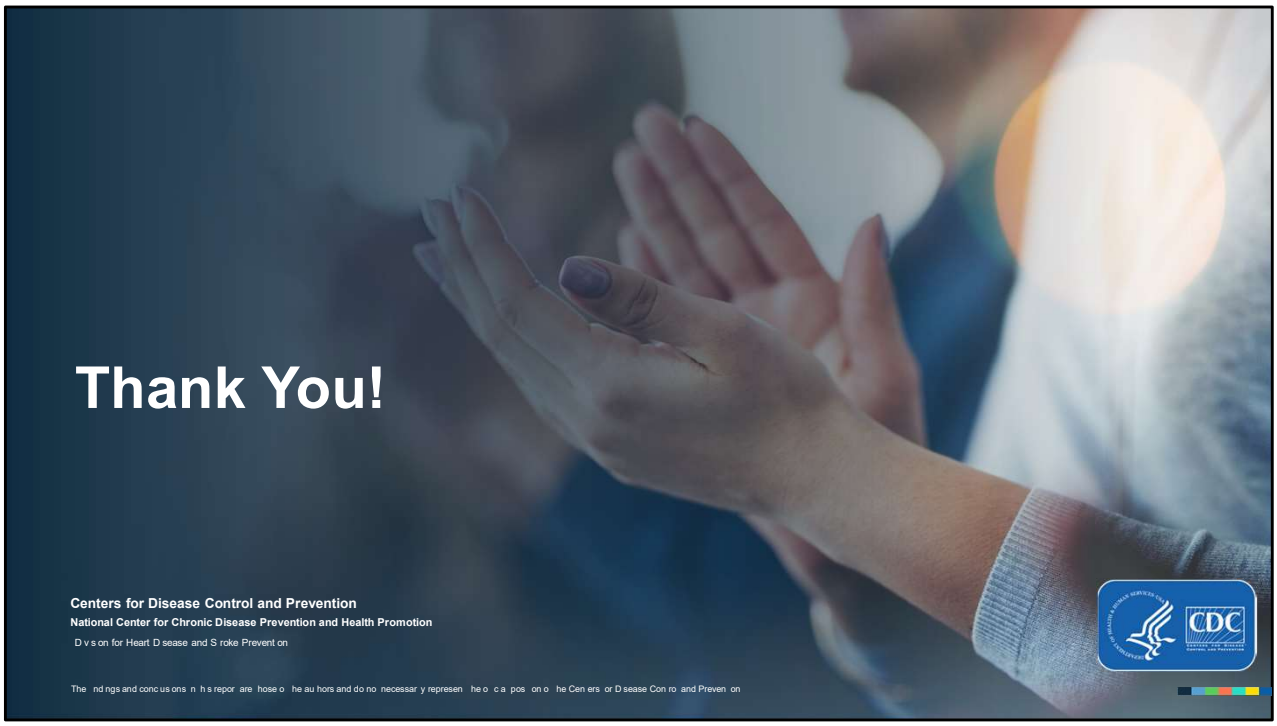


So, how does the CCL Health Equity Guide advance cardiovascular public health?

As mentioned at the beginning of this presentation, CCLs are an effective, evidence-based approach to preventing and managing chronic diseases such as CVD.
However, little is known about how to implement CCLs with a health equity lens.

Accordingly, the guide was written to fill that gap, and accomplish two key things:

- One is to explicitly incorporate health equity in a CCL's operational structure; and
- Another is to inform decision-making and improve connections between community members most impacted by health inequities and partner organizations in community and clinical sectors.



Thank you, Refilwe and Cindy! At this time, we'll take questions,. First, we'll check to see if any questions have come in through the Q&A box.

Question #1: Especially because a CCL has many different partners from different sectors, how would you suggest proactively addressing or managing potential challenges?
Answer #1: I would suggest allowing flexibility in the CCL's structure. Helping organizations in both sectors remain true to their mission and vision while adapting to changing or challenging environments. Changing environments could essentially involve new or emerging practice- and evidence-based information or policy changes. Whereas, challenging environments could include public health crises, such as the COVID-19 pandemic.
Another suggestion would be to consider hiring a facilitator for the CCL. The role of a facilitator can help obtain buy-in from community members most affected by inequities as well as traditional and nontraditional partners. Having a facilitator who can convey the purpose of the CCL can build participant support for a common vision. This step is important for a few reasons. For example:

- Health equity topics tend to include implicit bias, privilege, and racism. Confronting these topics can foster discomfort or defensiveness in people.
- Also, sometimes in medical settings, there are doctors who do not believe their patients may be affected by health inequities or do not necessarily support addressing SDOH.

Question #2: Given the roles that community health workers play in CCLs, are they highlighted in the Guide?
Answer #2: Yes, they are!
The CCL Health Equity Guide provides information on who CHWs are and specific roles they can play in a CCL. It provides the APHA CHW definition which asserts that community health workers are frontline public health workers, who come from and/or who have a deep understanding of the populations they serve. They work with community members most affected by inequities.
The CCL Health Equity Guide highlights that CHWs' trusting relationship with community members enables them to serve liaisons – also called "boundary spanners" or "spanning personnel."
In addition, the CCL Health Equity Guide include CHWs as an example in the Resource 4, which is a table of partners, interests, and roles and responsibilities.