Achieving Health Equity in Ohio's Comprehensive Cancer Control Program (CCCP): A CCCP Equity Checklist

What is health equity?

Many definitions of health equity exist. Here we use the Robert Wood Johnson Foundation definition of Health Equity,[1] which is:

> "Health equity means that everyone has a **fair and just opportunity to be healthy**. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care."

Another way to think about equity is that you'll know equity has been achieved when race, gender, nationality, age, ethnicity, religion, sexual orientation, immigration status, language skills, health status, or socioeconomic status **can no longer be used to predict life outcomes**.[2]

What health equity is not

Health equity does not mean equality. Those with the greatest needs and least resources require more, not equal, effort and resources to equalize opportunities.[1] The image below provides a visualization of the difference between equality and equity.

Why does health equity matter?

In addition to upholding ethical principles of fairness and justice, equity also matters because inequities rob our communities of human potential. Dr. Camera Jones reminds us to "consider the health of children, who are born with nearly limitless potential which is then shaped and too often constrained by the environments into which they are born."[6] No one chooses to whom they are born, where they are born, or the color of their skin, yet these factors over which people have no control currently dictate the frequency and quality of opportunities they have to be healthy.

Other helpful definitions

(See references for source of definition)

Health disparities
Differences in health outcomes that are closely linked with social, economic, and environmental disadvantage.[3] It is how we measure progress toward equity.[1]

Health care disparities
Health care disparities refer to differences in care that cannot be explained by variations in health care needs, patient preferences, or treatment recommendations. This is important because sometimes racial and ethnic minorities who have the same cancer diagnosis as their white counterparts receive a poorer quality of care, which leads to poorer health outcomes and even death.[4]

Health inequities
Health disparities are referred to as health inequities when they result from systematic and unjust distribution of social determinants or critical conditions for health such as healthy food, good housing, good education, safe neighborhoods, and freedom from racism and other forms of discrimination.[5]

Opportunities to be healthy/ Social determinants of health
Nonmedical factors such as employment, income, housing, transportation, child care, education, discrimination, and the quality of the places where people live, work, learn, and play, which influence health. They are "social" in the sense that they are shaped by social policies.[1]

What does health equity look for cancer?

Health equity for cancer will be achieved when there are no longer vast differences in cancer incidence, prevalence or outcomes based on race, ethnicity or economic status. Cancer disparities are not accidents, but rather reflect inequitable systems and policies across the cancer control continuum from etiology to prevention, detection, diagnosis, treatment, and survivorship.[7]

Achieving cancer health equity means all Ohioans have a fair and just opportunity to live in environments safe from carcinogens with ample access to facilities and spaces to engage in health promoting activities and access to cancer screening, diagnostic testing, treatment, and survivorship care that is appropriate, effective, and of the highest possible quality.

Equity requires intervening at multiple levels

Achieving health equity will require interventions at multiple levels: upstream, midstream, and downstream. Downstream interventions are those that influence health status through direct services. However, downstream interventions do not often address the social or economic circumstances that place people at increased risk for experiencing compromised outcomes in the first place. Midstream interventions are those that occur as the result of an organization's sphere of influence. However, organizations alone cannot eliminate cancer-related disparities. Upstream interventions involve policy approaches such as laws, rules, and regulations. These interventions have the ability to influence the health of entire populations. While approaches at all levels are important, emphasizing midstream and upstream interventions may have the greatest impact on achieving equity.

Advancing health equity is a process

Advancing health equity is complex. It is important to understand that health equity more than an outcome, it is a process that requires at least four things: 1) valuing individuals and all populations equally 2) recognizing and rectifying historical injustices 3) understanding social and economic factors that drive health disparities, including cancer disparities, and 4) providing resources according to need[8] (note the difference between equity and equality above).

Race
A socially constructed system of categorizing humans largely based on observable physical features (phenotypes) such as skin color and on ancestry. There is no scientific basis for or discernible distinction between racial categories. The ideology of race has become embedded in our identities, institutions and culture and is used as a basis for discrimination and domination.[9]

Institutional racism
Differential access to the goods, services, and opportunities of society by race. It is normative, sometimes legalized, and often manifests as inherited disadvantage. It is structural, having been codified in our institutions of custom, practice, and law, so there need not be an identifiable perpetrator. Often evident as inaction in the face of need.[10]

Purpose of this tool

The purpose of this tool is to provide Ohio CCCP with background information about what health equity is and what it means for the Ohio Comprehensive Cancer Control Program. More specifically, this tool can be used to generate ideas for how to integrate equity and operationalize concepts in the CCC Program, Cancer Plan, and OPCC Partnership. It may also be used as an evaluation tool for assessing where Ohio is already implementing activities to advance health equity and where it can improve.

This tool is **not comprehensive,** and we expect you will add to, change, or remove ideas over time as your work and understanding around equity progresses. In this sense, this tool is only a starting point for this work. We encourage you to visit the references and resources below for a more in-depth introduction to equity and approaches for ensuring that the way the CCCP does its work demonstrates the value of all individuals and populations in Ohio.

Assumptions underlying use of this tool

- Institutionalizing health equity is a goal of Ohio CCCP.
- Practitioners recognize that understanding the root causes of health inequities is essential to developing the holistic strategies needed to eliminate cancer disparities.
- Ohio CCCP is ready and committed to addressing health equity.
- The CCCP knows who priority populations are based on quantitative and qualitative data sources.

How to use the CCCP Equity Checklist

Below are some ideas for how CCCP can use the equity checklist for evaluation, program planning, and accountability. The most important thing to keep in mind is that this checklist is a tool for helping Ohio CCCP be more intentional about integrating equity into its work. The expectation is not that the CCCP will implement all of the strategies or that the strategies are comprehensive or static. **The strategies you choose to implement will depend on the context and readiness of stakeholders involved. Remember that equity is a process!**

EVALUATION

Use the checklist as a self-assessment tool to see where and how Ohio CCCP is currently implementing strategies to promote equity and where it could do more.

Use findings from the self-assessment to identify gaps in equity efforts.

Use findings from the self-assessment to communicate and celebrate steps the CCCP *is* taking to promote equity.

You might also use results of the self-assessment to demonstrate progress in equity efforts over time.

PROGRAM PLANNING

Build on what you learned from using the checklist for evaluation to identify and prioritize new strategies to implement.

Tip: Creating a culture of equity starts with leadership. Consider prioritizing strategies related to The Program as these strategies are likely to have positive trickle-down effects on the Plan and Partnership.

Use the checklist to identify ways to integrate equity into project workplans. Share the checklist with OPCC subcommittees so they can do the same.

Use the checklist as a tool to inform strategies for engaging and diversifying OPCC membership.

Use the checklist to identify strategies for incorporating equity into the process for developing the next Cancer Plan as well as incorporating equity into the Cancer Plan itself. This checklist can also be used to develop explicit health equity targets.

ACCOUNTABILITY

Create a process for regularly reviewing and using the checklist for evaluation and planning. Examples might be including it as a standing agenda item for the first and last leadership meetings of the year or using it to generate an annual equity report – whatever is most appropriate and feasible for your program.

Regular use of the tool communicates to stakeholders that Ohio CCCP is committed to equity.

The CCCP Equity Checklist

The Program

#	Strategies for promoting equity	Description/Examples	Currently doing (X)	Description of Ohio activities
Administration of the grant program				
1	Establish an organizational/program commitment to equity	• Document Ohio CCCPs commitment to equity by including it in critical guiding documents including mission statements, strategic plans and measurable health equity targets. • Support your commitment with action by establishing permanent structures like workgroups or staff positions, to improve health equity practices. (see #7)		
2	Incorporate equity as a decision filter in all policy, programmatic, and practice activities	• Incorporate health equity criteria as part of all cancer program funding. • Incorporate health equity goals in Requests for Proposals, contract language and processes.		
3	Ensure all program staff understand equity and inclusion principles and have a shared language for talking about equity	Many people use equity related terms in different ways. Before building equity into the CCCP framework, program staff must have a clear understanding of what they are working toward. The definitions on page 1 can be a starting place for this discussion. More resources for defining equity are found at the end of this document.		
4	Hire or contract with staff from priority populations	These individuals bring a unique perspective on health issues and concerns and feasibility of approaches and strategies for addressing those concerns in their own context. This strategy also contributes to building wealth among historically under-resourced communities.		

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5	Encourage program staff participation in ongoing professional development on institutionalizing equity	As noted in the introduction to this tool, equity is a process. RWJF reminds us that "The pursuit of equity is never finished. It requires constant, systematic, and devoted effort. A sustained commitment to improving health for all—and particularly for those most in need—must be a deeply held value throughout society."[1] This includes ongoing training in cultural competency, cultural humility and implicit bias.		
6	Include explicit equity strategies and goals into work plans and goal setting	Examples include Ohio's current workplan objectives to "Increase percent or number of breast cancer screenings in LGBTQ population" and "Implement education and training for LGBTQ providers and consumers to remove barriers to breast cancer screening."		
7	Institute an accountability mechanism for ensuring equity is addressed in all CCCP planning and decision-making	Establish standing committees or workgroups to address health equity (Examples include Minnesota's Cancer Health Equity Network, Michigan's Health Equity Committee, and the Kansas Health Equity Workgroup). These committees/workgroups ensure equity is addressed in all aspects of the program, plan and partnership (see #2).		
8	Expand invitations to the monthly ODH cancer briefings to include ODH staff working on equity across programs	Consider inviting staff from other ODH divisions working on equity even if not directly related to cancer. As noted above, differential access to nonmedical factors such as employment, income, housing, transportation, child care, education, discrimination, and the quality of the places where people live, work, learn, and play, contribute to health inequities in multiple areas of health. This may provide an opportunity to learn how other programs are addressing equity and perhaps align work and resources.		

#	Strategies for promoting equity	Description/Examples	Currently doing (X)	Description of Ohio activities
9	Incorporate health literate practices in all cancer control activities[11]	Clear communication means using familiar concepts, words, numbers and images presented in ways that make sense to the people who need the information.[12]		
Collecting and Using Surveillance Data				
10	Disaggregate surveillance data by social determinants of health (e.g. income, race, ethnicity, LGBTQ, rural residence, gender, and other characteristics of groups experiencing a disproportionate burden of cancer-related outcomes).	As noted on page one, health disparities are how you measure progress toward health equity. Thus, it is critical to collect data on social determinants of health and then disaggregate by those data to identify where inequities exist and measure progress toward addressing them. An example include using cancer prevalence data that is fortified with geographic reference data to determine neighborhoods where cancer disparities are most prevalent. *The CDC 500 Cities Project: Local Data for Better Health* is an excellent source of data.[13]		
11	Engage stakeholders from priority populations in deciding what surveillance data to collect.	Stakeholders who are from or working with priority populations may bring a unique perspective on social determinants or contextual factors that influence cancer health outcomes that may be worth collecting data on.		

#	Strategies for promoting equity	Description/Examples	Currently doing (X)	Description of Ohio activities
Support, collaborate with the OPCC				
12	Inclusive agenda setting for OPCC meetings – Include voices of organizations led by / working with priority populations.	Create an inclusive process for designing the agenda for OPCC meetings. This offers OPCC members who are from or working with priority populations some power in decision-making to be able to raise awareness and address issues that may be invisible to dominant groups.		
13	Ensure OPCC coalition members have an understanding of equity and inclusion principles including a shared language for talking about equity	Many people use equity related terms in different ways. Before building equity into the CCCP framework OPCC coalition members must have a clear understanding of what they are working toward. The definitions on page 1 can be a starting place for this discussion. More resources for defining equity are found at the end of this document.		
14	OPCC governance documents include equity statement and a process for attending to equity in decision-making and membership on executive committees	One way to guarantee inclusion is to write it directly into OPCC governing documents. By identifying "seats" for key constituencies -- like rural Ohioans or members of other priority populations -- a certain degree of representation is assured.[14]		
Maintain, implement, review cancer plan				
15	Ensure process for creating the cancer plan includes input of organizations led by/serving priority populations	This strategy ensures that the perspectives of priority populations are included in the cancer plan.		
16	Coordinate with other statewide health improvement plans – e.g. SHIP	Changing systems and policies to improve health equity will require coordinated statewide efforts. Therefore, aligning the cancer plan with other statewide initiatives (e.g. SHIP) may generate synergy among statewide efforts leading to greater impact.		

#	Strategies for promoting equity	Description/Examples	Currently doing (X)	Description of Ohio activities
17	Address public policy as it relates to cancer-related health disparities	Addressing cancer health inequities includes addressing social determinants of health that often fall outside of what is traditionally considered the health sector (e.g. transportation, employment, education, etc.). • Approach CCCP activities from a Health in All Policies lens that incorporates health considerations into decision-making across sectors and policy areas.[15] (e.g. Ohio Public Health Association Health and Equity in All Policies work) • Collaborate with governmental and non-governmental organizations to support and implement policies that create social, environmental and economic conditions to realize healthy outcomes.		
Evaluation				
18	Collect multiple types of evidence (e.g. quantitative and qualitative) in program evaluations	Reflect on the type of data that is perceived as "valid" and privileged in decision-making. Understand strengths and limitations of different types of data and data collection methods (e.g. quantitative and qualitative data) recognizing that they all have utility for decision-making to promote health equity.		
19	"Center at the margins" by making the perspectives of socially marginalized groups, rather than those of people belonging to dominant race or culture, the central axis around which discourse on a topic revolves[16]	Centering at the margins necessitates redefining "normal." Dr. Hardeman provides an example from Minnesota of how "in describing Philando Castile's death, Minnesota's Governor noted that the tragedy was 'not the norm;' in our state, revealing a deep difference between the Governor's perception of 'normal' and the experiences of black Minnesotans."[17]		

#	Strategies for promoting equity	Description/Examples	Currently doing (X)	Description of Ohio activities
20	Practice inclusive data collection practices (e.g. allow people to self-report their race or gender using multiple options)	• Offer multiple options for self-identifying race, gender and sexual orientation. • Consider why you are collecting data on race. What are you really trying to measure? Often race data is collected as a proxy for discrimination or lived experience of racism. Be critical when interpreting this data. • Avoid "othering" by offering options such as "not listed" or "additional" when survey categories do not include a participant's response.		

The Cancer Plan

#	Strategies for promoting equity	Description/Examples		
21	Include a health equity statement in the cancer plan	See example from the Minnesota Cancer Plan in which the Cancer Alliance "recognizes that cancer health disparities exist in Minnesota and seeks to reduce the burden of cancer in all populations and cultures." It also states that "objectives put forth in Cancer Plan Minnesota 2025 will be approached through a health equity lens" followed by a definition of health equity and a commitment to reevaluating and improving cancer plan objectives "in response to the needs and priorities of the community."[18] Equity statement should reflect the optimal state of being for those living with the disease.		
22	Include at least one realistic health equity objective in each priority area.	Include at least one health equity objective in each priority area of primary prevention, early detection, patient-centered services.		
23	Include at least one strategy for each cancer plan objective that will improve health equity	In addition to including at least one strategy for improving health equity for each objective, prioritize implementation of those strategies that increase health equity.		
24	Call out cancer plan objectives that address health equity (e.g. by color coding, using icons, etc.)	Bring attention to cancer plan objectives that address health equity. Doing so makes equity visible and serves as a reminder of the CCCPs commitment to equity.		

#	Strategies for promoting equity	Description/Examples	Currently doing (X)	Description of Ohio activities
25	Include an objective specific to collecting data that can be disaggregated to identify disparities	As an example, the MN Cancer Plan includes an objective to "Expand the scope and quality of data used to measure the success of cancer control efforts in Minnesota" Strategies include Standardizing the collection and reporting of race, ethnicity, preferred language and country of origin for cancer-related datasets and Engaging under-represented communities in identifying critical data gaps.[11]		
26	Use language that acknowledges traditional uses of tobacco in American Indian communities	Some American Indian tribes have used traditional tobacco (which differs from commercial tobacco in the way it is grown and used) for centuries.[19] Use language to acknowledge this difference when describing objectives for commercial tobacco use in the cancer plan.		
27	Include objectives that specifically aim to reduce disparities	Example from Minnesota: Objective 12 of the MN Cancer Plan is to "reduce disparities in commercial tobacco use."[11]		
28	Identify strategies based on data sources which help identify specific social determinants of health of health that are associated with geographic areas with a high burden cancer.	• For example, include strategies for comparing data across different geographic or socioeconomic communities or • Include strategies that specifically seek to implement culturally appropriate interventions or facilitate culturally sensitive conversations between cancer patients and health care providers.[11] • Apply innovative techniques like the Disparate Health Outcome Convergent Analysis (DHOCA) and data from the Ohio Health Opportunity Index (HOI) and market research to improve your cancer plan. ODH has tools like the Health Opportunity Index that can determine opportunities for good health by neighborhood and social determinants associated with poor health outcomes.		
29	Ensure priority populations are included in "evidence" of Evidence Based Interventions (EBIs) included in the cancer plan	When considering which EBIs to implement as part of the plan, consider among what populations that evidence was generated. For example, in what populations was the research conducted? Did the sample include members of priority populations?		

#	Strategies for promoting equity	Description/Examples	Currently doing (X)	Description of Ohio activities
The Partnership				
	Strategies for promoting equity	**Description/Examples**		
30	Partner with other organizations in Ohio addressing health equity to implement activities of OPCC priority subcommittees	Ideas include partnering with: Health Policy Institute of Ohio; Center for Cancer Health Equity at the Ohio State University Comprehensive Cancer Center; Ohio Federation for Health Equity and Social Justice; Appalachia Community Cancer Network (ACCN).		
31	OPCC membership/recruitment plans include plans for recruiting and engaging organizations led by / serving priority populations	Systematically review and periodically reevaluate composition of the OPCC membership to ensure representation of organizations led by/ serving Ohio's priority populations.		
32	Ensure OPCC meetings are inclusive to members of or organizations led by/serving Ohio's priority populations	Examples include • Rotating the location of OPCC meetings to make meetings accessible to members from all parts of the state. • Offer options for remote participation perhaps streaming to various community sites around the state. • Coordinate regional network meetings to reach people around the state (maybe coordinate with BCCP or other local/regional health coalitions) • Consider language and accessibility needs to support participation of organizations led by or serving Ohioan's with disabilities or for whom English is not a first language • Inclusive agenda setting (addressed above in under ideas for the Program)		

Additional Resources

Robert Wood Johnson Foundation. **What is Health Equity? And What Difference Does a Definition Make?** https://www.rwjf.org/content/dam/farm/reports/issue_briefs/2017/rwjf437393

Minnesota Department of Health. **Conducting a Health Equity Data Analysis. A Guide for Local Health Departments in Minnesota** (Version 2). http://www.health.state.mn.us/divs/chs/genstats/heda/healthequitydataguideV2.0-final.pdf

Centers for Disease Control and Prevention. **A Practitioners Guide for Advancing Health Equity: Community Strategies for Preventing Chronic Disease**. https://www.cdc.gov/NCCDPHP/dch/pdf/health-equity-guide/Practitioners-Guide-section1.pdf

FSG. **Getting to Yes: How to Generate Consensus for Targeted Universalism.** file:///C:/Users/tbastian/Downloads/How%20to%20Generate%20Consensus%20forTargeted%20Universalism.pdf

Local and Regional Government Alliance on Race & Equity (GARE). https://www.racialequityalliance.org/about/our-approach/government/

Minnesota Department of Health. **Health Equity Resources by Practice.** A List of resources compiled by Minnesota Department of Health organized by practice (Spread the word about what creates health; Equip staff; Show organizational commitment; Authentically engage with the community; Collect and use data for change; Influence public policy; What do these practices mean?) http://www.health.state.mn.us/divs/opi/healthequity/resources/tag-practices.html#org

The **Health Opportunity and Equity (HOPE) Initiative**. An initiative funded by the Robert Wood Johnson Foundation to promote Health Equity that tracks 28 indicators that span the life course, including health outcomes and indicators related to opportunity such as socioeconomic factors, the physical and social environment, and access to health care at the state and national level. http://www.nationalcollaborative.org/our-programs/hope-initiative-project/

500 Cities Project: Local Data for Better Health. The 500 Cities project is a collaboration between CDC, the Robert Wood Johnson Foundation, and the CDC Foundation. The purpose of the 500 Cities Project is to provide city- and census tract-level small area estimates for chronic disease risk factors, health outcomes, and clinical preventive service use for the largest 500 cities in the United States. https://www.cdc.gov/500cities/index.htm

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