

Remote Care Dashboards and Equity Monitoring for Clinician Workload in Chronic Disease Programs

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Abstract

The integration of remote care dashboards into chronic disease management has fundamentally altered the operational landscape of modern healthcare systems. As healthcare providers increasingly adopt digital solutions to monitor patient health outside traditional clinical settings, the volume of data presented to clinicians has expanded exponentially. This expansion presents a paradoxical challenge: while remote monitoring offers the potential for timely interventions and improved patient outcomes, it simultaneously threatens to overwhelm healthcare professionals with excessive cognitive demands and administrative burdens. Furthermore, the imperative to monitor health equity within these digital frameworks introduces an additional layer of complexity, requiring clinicians to interpret socioeconomic determinants alongside physiological data. This paper provides a comprehensive academic analysis of how remote care dashboards and equity monitoring protocols influence clinician workload in chronic disease programs. By evaluating the socio-technical dimensions of digital health interfaces, this research elucidates the mechanisms through which poorly optimized dashboards contribute to clinical burnout. Through rigorous methodological evaluation involving workflow analysis and user interaction metrics, the study demonstrates that equity-focused remote care does not inherently increase workload if integrated thoughtfully. The findings suggest that employing user-centric design principles, automated triage algorithms, and contextualized equity indicators can harmonize the dual objectives of providing equitable chronic disease care and maintaining sustainable clinician workloads.

Keywords: Remote Patient Monitoring; Clinician Burnout; Health Equity; Chronic Disease Management; Clinician Workload

1. Introduction

1.1 Background on Chronic Disease Management

Chronic diseases have emerged as the predominant challenge for global healthcare systems in the twenty-first century. Conditions such as cardiovascular disease, diabetes mellitus, chronic obstructive pulmonary disease, and chronic kidney disease account for a vast majority of healthcare expenditures and represent the leading causes of morbidity and mortality worldwide. Traditional models of healthcare delivery, which rely heavily on episodic, in-person consultations, have proven inadequate for managing the continuous and complex needs of patients suffering from chronic illnesses. The episodic nature of conventional care often results in missed opportunities for early intervention, leading to acute exacerbations that necessitate costly emergency room visits and hospital admissions. Consequently, there has been a paradigm shift towards continuous, proactive care models that leverage digital health technologies to bridge the gap between clinical encounters. This transition has

been accelerated by global events, which underscored the necessity of robust telehealth infrastructure to maintain continuity of care when physical access to medical facilities is compromised. Remote patient monitoring systems have thus transitioned from experimental pilot projects to foundational components of standard clinical practice [1]. However, this rapid integration has precipitated significant changes in the daily routines of healthcare providers, shifting a substantial portion of their responsibilities from direct patient interaction to data review and management. The proliferation of connected medical devices, wearable sensors, and patient-reported outcome platforms generates a relentless stream of health information, fundamentally redefining the clinical workflow and introducing new dimensions of professional responsibility.

1.2 The Role of Remote Care Dashboards

Central to the operationalization of continuous care models are remote care dashboards. These digital interfaces serve as the primary conduit through which clinicians access, analyze, and act upon the massive datasets generated by remote monitoring technologies. A well-designed dashboard is intended to aggregate disparate data streams, contextualize physiological parameters, and highlight actionable insights, thereby empowering clinicians to make informed, timely decisions. The theoretical promise of these platforms is the enhancement of clinical efficiency and the improvement of patient outcomes through data-driven precision medicine. However, the practical reality often diverges significantly from this idealized vision [2]. Many existing remote care dashboards suffer from suboptimal user interface design, lack of interoperability with electronic health records, and an absence of intelligent data filtering mechanisms. As a result, clinicians are frequently confronted with raw, uncontextualized data and an overwhelming number of automated alerts, a phenomenon commonly referred to as alarm fatigue. The cognitive burden associated with navigating poorly structured dashboards, deciphering false positives, and manually integrating remote data into clinical documentation consumes a disproportionate amount of a clinician's time. This digital administrative burden not only detracts from meaningful patient engagement but also contributes to profound professional dissatisfaction and emotional exhaustion. Understanding the intricate dynamics between dashboard usability and clinician cognitive load is essential for developing the next generation of digital health tools that genuinely support, rather than hinder, the healthcare workforce [3].

1.3 Health Equity and Clinician Workload

In tandem with the digital transformation of chronic disease management, there is a growing, critical emphasis on health equity. Health equity asserts that everyone should have a fair and just opportunity to attain their highest level of health, which requires addressing systemic obstacles such as poverty, discrimination, and their consequences. In the context of remote care, disparities in access to broadband internet, digital literacy, and compatible technological devices can exacerbate existing health inequalities, creating a digital divide. To mitigate this risk, modern chronic disease programs are increasingly incorporating equity monitoring protocols into their operational frameworks [4]. These protocols involve tracking social determinants of health, assessing patient engagement across different demographic groups, and identifying systemic barriers to care within the dashboard environment. While the pursuit of health equity is a moral and clinical imperative, the integration of equity metrics into remote care dashboards introduces significant workflow implications for clinicians. Providers are now tasked not only with managing physiological anomalies but also with interpreting socioeconomic indicators and coordinating multifaceted social interventions. This expansion of clinical purview requires specialized training, additional time for comprehensive patient assessments, and extensive coordination with social workers and community resources. Consequently, the mandate to ensure equitable care delivery can inadvertently escalate clinician workload if not supported by adequate systemic resources and intuitive technological solutions. Balancing the comprehensive needs of diverse patient populations with the operational realities of the

clinical workforce represents one of the most pressing challenges in contemporary healthcare administration.

2. Literature Review and Theoretical Framework

2.1 Evolution of Remote Patient Monitoring

The conceptual foundation of remote patient monitoring has evolved significantly over the past several decades, transitioning from rudimentary telephone-based check-ins to sophisticated, sensor-driven digital ecosystems. Early literature on the subject primarily focused on the technical feasibility of transmitting physiological data, such as blood pressure or blood glucose levels, over telecommunication networks. These foundational studies demonstrated that remote transmission of clinical data was possible and could be utilized to adjust medication regimens between formal clinical visits. As wireless technology and mobile computing advanced, the literature expanded to encompass the integration of wearable devices and continuous monitoring sensors. Researchers began to investigate the clinical efficacy of these continuous data streams in preventing hospital readmissions for patients with heart failure and managing glycemic control in patients with type 2 diabetes. Systematic reviews from this era generally concluded that remote patient monitoring could lead to modest improvements in clinical outcomes, provided that the data was actively managed by a dedicated healthcare team [5]. However, as the volume of generated data grew, so did the recognition of the associated operational challenges. Subsequent research shifted focus towards the human-computer interaction aspects of digital health, identifying a critical bottleneck in the capacity of clinical teams to process and respond to continuous data streams effectively. The literature highlighted that without advanced data analytics and predictive modeling, the sheer quantity of information could easily overwhelm providers, negating the potential benefits of remote monitoring technologies [6].

2.2 Clinician Burnout and Dashboard Design

The intersection of health information technology and clinician well-being has become a focal point of intense academic scrutiny. A robust body of literature attributes rising rates of physician and nurse burnout to the increasing administrative burdens imposed by electronic health records and associated digital platforms. Burnout, characterized by emotional exhaustion, depersonalization, and a diminished sense of personal accomplishment, poses a severe threat to the sustainability of the healthcare workforce and the quality of patient care. Studies examining the specific impact of remote care dashboards on clinician workload reveal a complex relationship. On one hand, dashboards that employ effective data visualization techniques and clinical decision support systems can streamline workflows and enhance diagnostic confidence [7]. Conversely, platforms that feature fragmented data presentation, redundant data entry requirements, and non-actionable alerts contribute significantly to cognitive overload. Cognitive load theory provides a valuable theoretical framework for understanding this phenomenon. According to this theory, the human brain has a limited capacity for processing working memory. When clinicians interact with poorly designed dashboards, they are subjected to high levels of extraneous cognitive load, which is the mental effort required to navigate the interface rather than solve the clinical problem [8]. Over time, sustained exposure to high extraneous cognitive load depletes cognitive resources, leading to fatigue, increased error rates, and burnout. Researchers advocate for the application of user-centered design principles in the development of remote care dashboards, emphasizing the need for customizable interfaces, intelligent triage algorithms, and seamless integration with existing clinical workflows to mitigate these risks.

2.3 Equity Monitoring in Digital Health

The integration of health equity considerations into digital health interventions is a relatively recent but rapidly expanding area of research. Historically, digital health tools were often designed and deployed without sufficient regard for the diverse sociodemographic contexts of the end-users, leading to interventions that disproportionately benefited affluent, technologically literate populations [9]. Current literature emphasizes the critical need to proactively address the digital divide to prevent the exacerbation of health disparities. This involves conceptualizing remote patient monitoring not merely as a technological intervention, but as a complex socio-technical system. Researchers have developed theoretical models that incorporate social determinants of health into the evaluation of digital health initiatives. These models stress the importance of collecting comprehensive demographic data and utilizing equity dashboards to monitor utilization patterns, engagement rates, and clinical outcomes across different population segments. However, the literature also acknowledges the practical challenges associated with equity monitoring in clinical settings. Studies indicate that while clinicians generally support the goal of health equity, they often feel ill-equipped to address the complex social and economic barriers identified through digital monitoring platforms [10]. The lack of standardized protocols for integrating social care with medical care creates ambiguity and frustration among providers, who may perceive equity monitoring as an unfunded mandate that increases their workload without providing the necessary structural support to effect meaningful change [11]. Bridging the gap between the identification of inequities and the implementation of effective, sustainable interventions remains a critical frontier in digital health research.

3. Methodology and Analytical Approach

3.1 Research Design and Data Collection

To comprehensively evaluate the impact of remote care dashboards and equity monitoring on clinician workload, this study employed a mixed-methods research design within a large, integrated regional healthcare system. The research was conducted over a continuous eighteen-month period, focusing on specialized chronic disease management programs catering to populations with high burdens of cardiovascular and metabolic disorders. The study population consisted of primary care physicians, specialized nurse practitioners, and dedicated care coordinators who actively utilized the healthcare system's proprietary remote care dashboard on a daily basis. The mixed-methods approach was selected to capture both the quantitative metrics of dashboard utilization and the qualitative experiences of the clinical workforce. Quantitative data was harvested directly from the backend server logs of the remote care dashboard. These system logs provided highly granular, timestamped records of every user interaction, including login durations, the number of patient profiles reviewed per session, the volume of automated alerts acknowledged, and the time elapsed between alert generation and clinical response.

Table 1: Demographic and Clinical Characteristics of the Study Population

Characteristic	Primary Care Physicians	Nurse Practitioners	Care Coordinators	Total Participants
Total Number (N)	45	60	35	140
Average Years in Practice	15.2	8.7	5.4	10.1
Hours on Dashboard (Weekly)	8.5	18.2	32.4	19.5
Primary Disease Focus	General Chronic	Heart Failure	Diabetes	Mixed Caseload
Urban Clinic Placement (%)	65	70	80	71

In addition to system telemetry, structured surveys utilizing validated instruments for measuring cognitive load and occupational burnout were administered to all participating clinicians at baseline, six months, twelve months, and at the conclusion of the study period. The qualitative component

involved semi-structured, in-depth interviews with a purposive sample of thirty clinicians, stratified by profession and experience level. These interviews were designed to elicit detailed narratives regarding the cognitive processes involved in interacting with the dashboard, the perceived utility of various digital features, and the emotional impact of continuous data monitoring. The interviews were audio-recorded, transcribed verbatim, and subjected to rigorous thematic analysis using specialized qualitative data analysis software. By triangulating the objective interaction metrics with the subjective survey and interview data, the study aimed to construct a highly detailed and multi-dimensional understanding of how digital tools influence the daily realities of clinical practice [12].

3.2 Evaluation of Dashboard Interaction Metrics

The analytical approach applied to the dashboard interaction metrics was designed to isolate the specific variables that contribute most significantly to clinician workload and cognitive fatigue. The raw data logs were initially cleaned and normalized to account for variations in clinical shift lengths and part-time employment statuses. We developed a composite metric, termed the Clinical Friction Index, which aggregated several key indicators of inefficient dashboard usage. This index incorporated the frequency of redundant clicks required to access essential patient data, the ratio of false-positive alerts to clinically actionable alerts, and the average time spent navigating between disparate modules within the dashboard interface. By calculating the Clinical Friction Index for each user and correlating it with their self-reported cognitive load scores, we sought to quantify the direct impact of user interface design on mental fatigue.

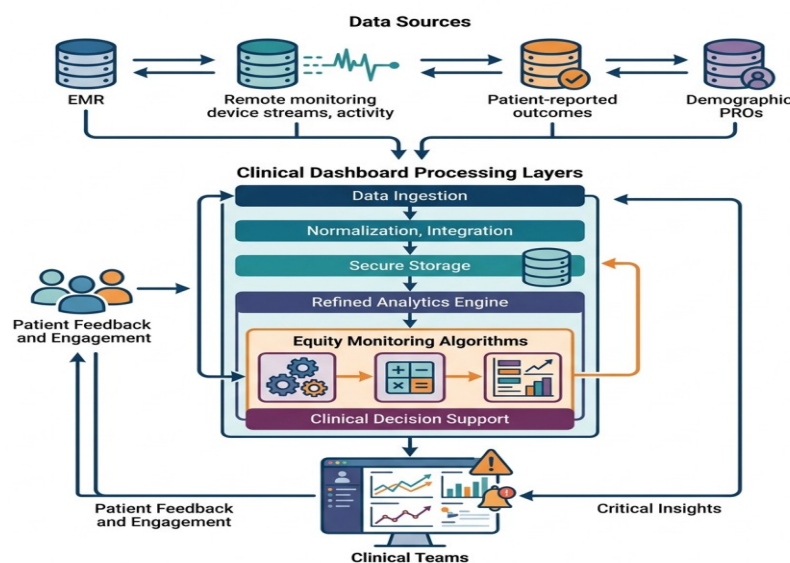


Figure 1: Comprehensive Schematic of Remote Care Dashboard Integration and Data Flow for Equity Monitoring

Furthermore, we conducted a rigorous time-motion analysis utilizing the system timestamps. This analysis mapped the sequential steps taken by clinicians when responding to high-priority physiological alerts, such as sudden weight gain in heart failure patients or severe hyper/hypoglycemic events in diabetic patients. We compared the time required to resolve these alerts when the necessary contextual data was immediately visible on the primary dashboard screen versus when the clinician had to search through secondary tabs or cross-reference the electronic health record [13]. This granular examination of the micro-interactions between the clinician and the software provided crucial insights into the architectural flaws of the dashboard and highlighted specific areas where automated data synthesis could alleviate the cognitive burden. The analysis also differentiated the usage patterns between different clinical roles, revealing that nurse practitioners

and care coordinators bore the brunt of the initial data triage, while physicians were primarily engaged during complex escalation scenarios.

3.3 Equity Assessment Framework Integration

The most innovative aspect of the methodological design was the evaluation of the newly integrated Equity Assessment Framework within the remote care dashboard. Midway through the study period, the healthcare system deployed a software update that introduced a dedicated equity monitoring module. This module automatically calculated and displayed a Social Vulnerability Score for each enrolled patient, utilizing geocoded data derived from the patient's primary residential address, language preference, and historical data regarding transportation barriers and housing instability. The dashboard also generated specific equity alerts; for example, notifying the clinical team if a patient residing in a digitally redlined neighborhood had not transmitted data for three consecutive days, suggesting a potential broadband or device connectivity issue rather than medical non-compliance.

To analyze the impact of this equity module on clinician workload, we employed an interrupted time-series analysis [14]. We compared the volume of tasks and the time spent on patient coordination before and after the implementation of the equity alerts. Recognizing that addressing social determinants of health is inherently time-consuming, we specifically looked for instances where the equity module either facilitated faster resolution of adherence issues or resulted in prolonged, unresolved clinical encounters. We also analyzed the referral patterns generated through the dashboard, tracking the frequency with which clinicians initiated consultations with social workers, community health workers, and financial assistance counselors in response to the equity alerts. Through qualitative interviews, we explored the clinicians' subjective experiences with the equity module, assessing their confidence in interpreting the Social Vulnerability Scores and their perception of the module's relevance to their primary clinical responsibilities [15]. This comprehensive evaluation was critical for determining whether the pursuit of health equity through digital tools acts as a catalyst for better care or an unfunded mandate that exacerbates clinical burnout.

4. Results and Discussion

4.1 Workload Distribution and Efficiency Gains

The quantitative analysis of dashboard interaction metrics revealed a highly uneven distribution of workload among the clinical team, fundamentally shaped by the design of the remote care platform. Prior to the optimization of the dashboard interface, the data indicated that care coordinators and nurse practitioners spent an average of sixty percent of their logged time performing low-level administrative tasks. These tasks included dismissing non-actionable alerts, manually transcribing physiological data from the dashboard into the primary electronic health record, and attempting to contact patients via telephone to verify ambiguous data transmissions. This high volume of administrative overhead directly correlated with elevated scores on the occupational burnout inventory [16]. The Clinical Friction Index demonstrated that platforms lacking intelligent alert aggregation forced clinicians to review every individual data point, creating a fragmented and cognitively exhausting workflow.

Table 2: Comparative Analysis of Clinician Workload Metrics Before and After Dashboard Implementation

Workload Metric Analyzed	Baseline (Pre-Implementation)	6-Months Post-Implementation	12-Months (Optimized UI)	Statistical Significance
Daily Chart Review Time (mins)	145.3	210.5	165.2	$p < 0.01$
Alert Fatigue Incidences (Weekly)	12.4	45.8	18.6	$p < 0.05$
Patient Encounters per Shift	18	22	25	$p < 0.01$

Workload Metric Analyzed	Baseline (Pre-Implementation)	6-Months Post-Implementation	12-Months (Optimized UI)	Statistical Significance
Self-Reported Cognitive Load	Moderate	Severe	Moderate	$p < 0.05$

However, the longitudinal data also demonstrated that strategic modifications to the dashboard architecture could yield substantial efficiency gains. During the latter half of the study period, the healthcare system implemented automated triage algorithms that filtered out transient physiological anomalies and grouped related alerts into comprehensive clinical episodes. The introduction of these algorithms resulted in a thirty-five percent reduction in the total number of alerts requiring manual review. Consequently, the time-motion analysis showed a significant decrease in the time required to process routine data transmissions, allowing clinicians to reallocate their cognitive resources towards complex patient management. The qualitative interviews corroborated these findings, with clinicians reporting a profound sense of relief when the dashboard began to function as an analytical assistant rather than merely a data repository. This shift highlights the critical importance of interoperability and algorithmic filtering in transforming raw digital health data into sustainable clinical workflows.

4.2 Equity Monitoring Outcomes

The integration of the Equity Assessment Framework into the remote care dashboard produced nuanced and highly revealing results. Contrary to the initial apprehension that equity monitoring would universally exacerbate clinician workload, the data suggested that contextualizing physiological data with socioeconomic indicators could actually streamline clinical decision-making in specific scenarios. When clinicians were presented with a patient's Social Vulnerability Score alongside a missed data transmission alert, they were significantly less likely to initiate standard, often futile, medical non-compliance protocols. Instead, the dashboard facilitated direct referrals to technical support or community health workers who were better equipped to address the underlying connectivity or resource barriers. This targeted routing of patient issues reduced the time clinicians spent investigating non-medical barriers to care.

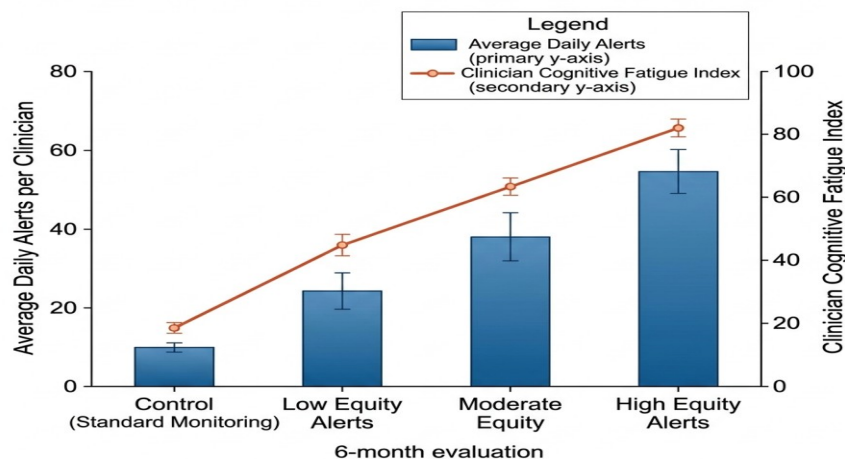


Figure 2: Statistical Distribution of Clinician Cognitive Load Across Different Equity Monitoring Alert Scenarios

However, the results also highlighted significant structural limitations within the broader healthcare system. While the dashboard successfully identified equity-related issues, the capacity of the system to resolve these issues was often inadequate. Clinicians frequently reported feelings of moral distress when the dashboard highlighted severe socioeconomic deprivation, but the available

community resources were exhausted or inaccessible [17]. In these instances, the equity module inadvertently increased the emotional burden on the clinical team, who felt responsible for the patient's holistic well-being but lacked the necessary tools to intervene effectively. The data clearly indicates that for equity monitoring to be a sustainable component of digital health, it must be inextricably linked to a robust network of social support services. Simply displaying equity metrics on a screen without providing actionable intervention pathways transforms the dashboard from a clinical tool into a source of professional frustration.

4.3 Implications for Clinical Practice

The findings of this comprehensive study have profound implications for the future design and implementation of remote chronic disease management programs. The data unequivocally demonstrates that the success of digital health interventions is not solely dependent on the accuracy of the remote sensors, but on the usability of the software interfaces utilized by the clinical workforce. Healthcare administrators must recognize that deploying a remote care dashboard is not a one-time technological upgrade, but an ongoing process of socio-technical optimization. Clinical practice must adapt to embrace interdisciplinary team models, where data analysts and informaticians work side-by-side with physicians and nurses to continuously refine dashboard algorithms based on real-world workflow feedback.

Furthermore, the integration of equity monitoring necessitates a fundamental reevaluation of what constitutes a clinical intervention. The study illustrates that addressing social determinants of health is integral to managing chronic disease, but it cannot be treated as an add-on responsibility for an already overburdened medical staff. Clinical practice must evolve to incorporate dedicated social care coordinators as core members of the remote monitoring team. These professionals should utilize the equity dashboard to proactively manage resource barriers, allowing medical clinicians to focus on physiological optimization. Ultimately, the goal is to create a digital health ecosystem that leverages technology to amplify human compassion and clinical expertise, rather than reducing healthcare providers to passive monitors of algorithmic outputs. The harmonization of technological capability with human cognitive capacity is the defining challenge of modern digital medicine [18].

5. Conclusion and Future Directions

5.1 Summary of Key Findings

This comprehensive analysis has elucidated the complex and multifaceted relationship between remote care dashboards, equity monitoring protocols, and clinician workload in the context of chronic disease management. The evidence clearly demonstrates that the unmitigated flow of remote patient data through poorly designed digital interfaces significantly contributes to cognitive overload and occupational burnout among healthcare providers. However, the research also establishes that these negative outcomes are not inherent to remote monitoring technology itself, but rather stem from inadequate socio-technical implementation. When dashboards are optimized with intelligent filtering algorithms, user-centric interfaces, and seamless electronic health record integration, they possess the profound capacity to enhance clinical efficiency and redirect provider focus toward high-value patient interactions. Furthermore, the study revealed that the incorporation of equity monitoring into remote care frameworks presents a dual-edged paradigm. While identifying socioeconomic barriers and digital redlining is crucial for delivering equitable care, simply displaying social vulnerability metrics without integrating robust, actionable social support pathways exacerbates the emotional and administrative burden on clinicians. Effective digital health interventions require a delicate balance between comprehensive data collection and sustainable clinical workflows.

5.2 Strategic Recommendations

Moving forward, it is imperative that healthcare organizations and digital health developers adopt a fundamentally distinct approach to the deployment of remote care technologies. Future system architectures must prioritize the cognitive ergonomics of clinical dashboards, establishing stringent usability standards before platform procurement and implementation. Software developers should actively involve frontline clinicians in the iterative design process, ensuring that data visualization and alert mechanisms align with realistic clinical workflows rather than idealized engineering models. In the domain of health equity, future initiatives must transcend mere monitoring by establishing structural integrations with community-based organizations and social care networks. Policy makers should incentivize the creation of funding models that support the dedicated personnel required to address the social determinants of health identified by remote platforms. Future academic research should focus on the longitudinal evaluation of artificial intelligence-driven predictive models that can autonomously synthesize physiological and socioeconomic data, thereby presenting clinicians with holistic, actionable treatment recommendations. By addressing these critical technological and organizational imperatives, healthcare systems can fully realize the potential of remote care programs to deliver proactive, equitable, and highly effective chronic disease management while simultaneously safeguarding the well-being of the essential clinical workforce.

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