

SECTION 3: The Case for Change

There are many ways to try to convince the public, policymakers, and professionals that a new approach is needed to address health inequities. One can make an ethical case for change, as highlighted by the guiding principles and values outlined in the previous section. Or, one can make a practical case for change using health statistics to argue that the current approach is not working and offer a conceptual or evidence-based rationale for an alternative approach, as highlighted by the shift in focus of *Healthy People 2020* towards the social determinants of health. One can also make an economic case for change by pointing out that our current system is unsustainable and inefficient.

The ethical, practical, *and* economic perspectives are evident in the implications of a 2011 study which estimated the total number of deaths in the United States that could be attributable to social factors. Researchers (Galea et al., 2011) found that in the year 2000 alone:

- ❖ 245,000 deaths were attributable to low education;
- ❖ 176,000 deaths were attributable to racial segregation;
- ❖ 162,000 deaths were attributable to low social support;
- ❖ 133,000 deaths were attributable to individual-level poverty;
- ❖ 119,000 deaths were attributable to income inequality; and
- ❖ 39,000 deaths were attributable to area-level poverty.

These data illustrate the interconnectedness of the ethical, practical, and economic perspectives and reflect the context seen in Delaware. This section highlights examples of social inequities in health, which makes the practical case for change directly relevant to local stakeholders. It also summarizes the economic case for change broadly and in relation to health care spending in Delaware. Inherent in both of these perspectives is an ethical perspective that may be understood and appreciated differently by individual readers. Many potential users of this guide may not need convincing, but rather need tools to help foster change. For those individuals, we suggest that this section be used to help convince partners and colleagues to build the broad base of support required to make necessary kinds of change.

This section also provides a discussion of the need for a more holistic, prevention-oriented health system across the continuum of clinical and non-clinical services and approaches. It concludes with a brief discussion of the opportunities for reforming our health system provided through the Affordable Care Act and Delaware's *State Health Care Innovation Plan*.

The Delaware Context

As discussed in Section 2, the health profile of the United States is poor relative to the rest of the world. The health profile of Delaware generally follows similar trends and patterns to those of the nation. For instance, the average life expectancy in 2010 in Delaware is 78.4 years (compared with 78.9 years nationally). Delaware’s infant mortality rate of 8.7 per 1,000 live births in 2011 was high relative to the national average of 6.1 per 1,000 live births.

Social Determinants of Health in Delaware

According to the *State of Delaware Community Health Status Assessment (CHSA)* published in 2013, “Quality of life and health status are intrinsically linked to economic, income and educational attainment of Delaware residents” (DHSS, 2013, p. 7). Recent economic trends have contributed to poor social conditions among certain communities in the state and the resulting inequities in income, education, and other social factors are apparent in Delaware’s population. For instance, according to the *CHSA*:

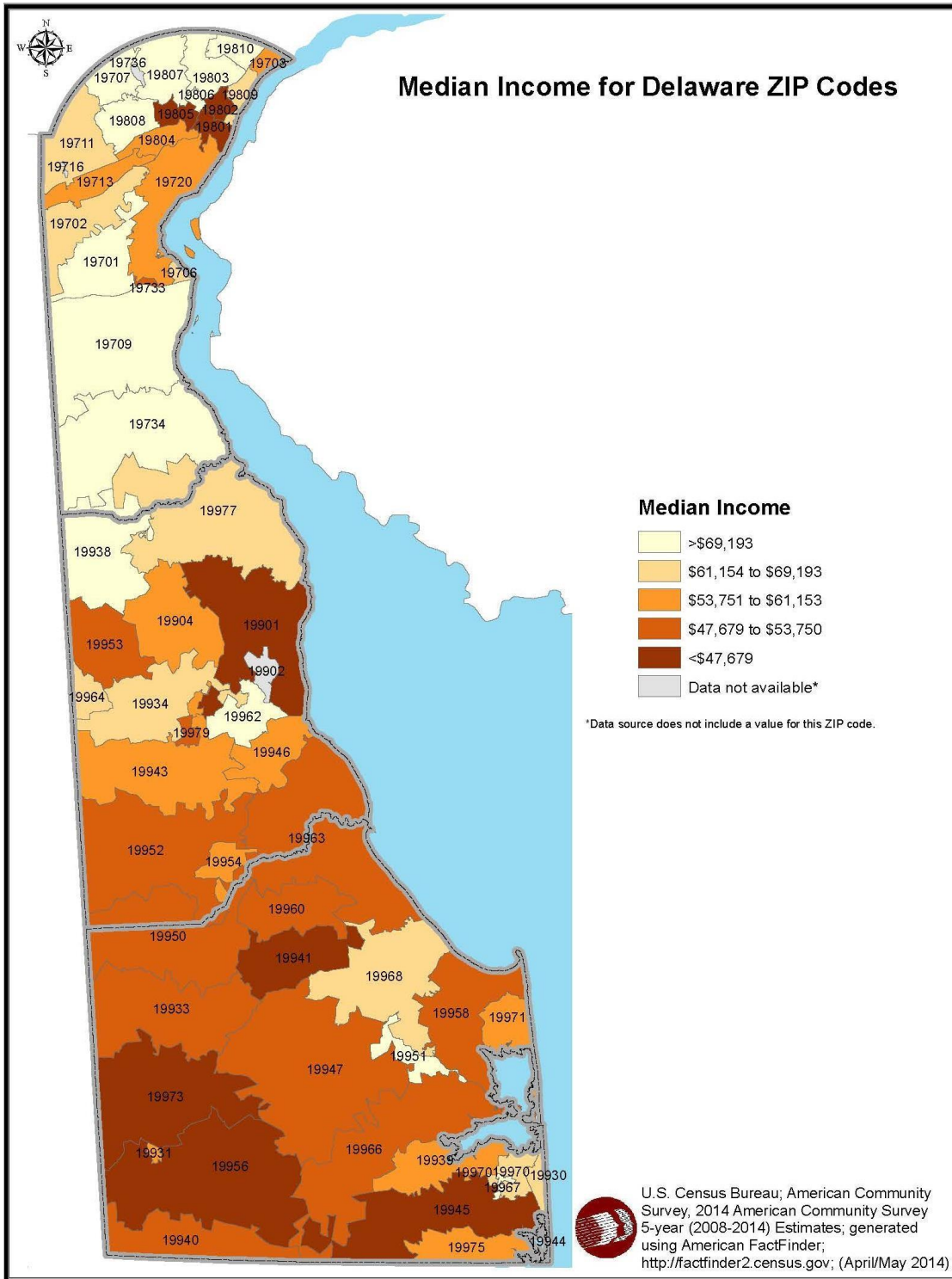
- ❖ Poverty levels increased by 20 percent between 2006 and 2012, contributing to a growing divide between the wealthy and the poor.
- ❖ In 2010, the percentage of children living in families at or below the poverty level was 18 percent. This was the highest child poverty rate in 10 years.
- ❖ The homeless population, the majority of whom are African American, has dramatically increased in Delaware.
- ❖ High school graduation rates have steadily increased, but Whites still have higher graduation rates than African Americans and Hispanics.

“Quality of life and health status are intrinsically linked to economic, income and educational attainment of Delaware residents” (DHSS, 2013).

It is particularly meaningful to consider such social determinants of health in the context of “place,” because the health of a community is directly linked to the physical and social conditions of that community. Healthy communities are characterized as those having an abundance of resources needed to create health, such as income, education, and quality housing.

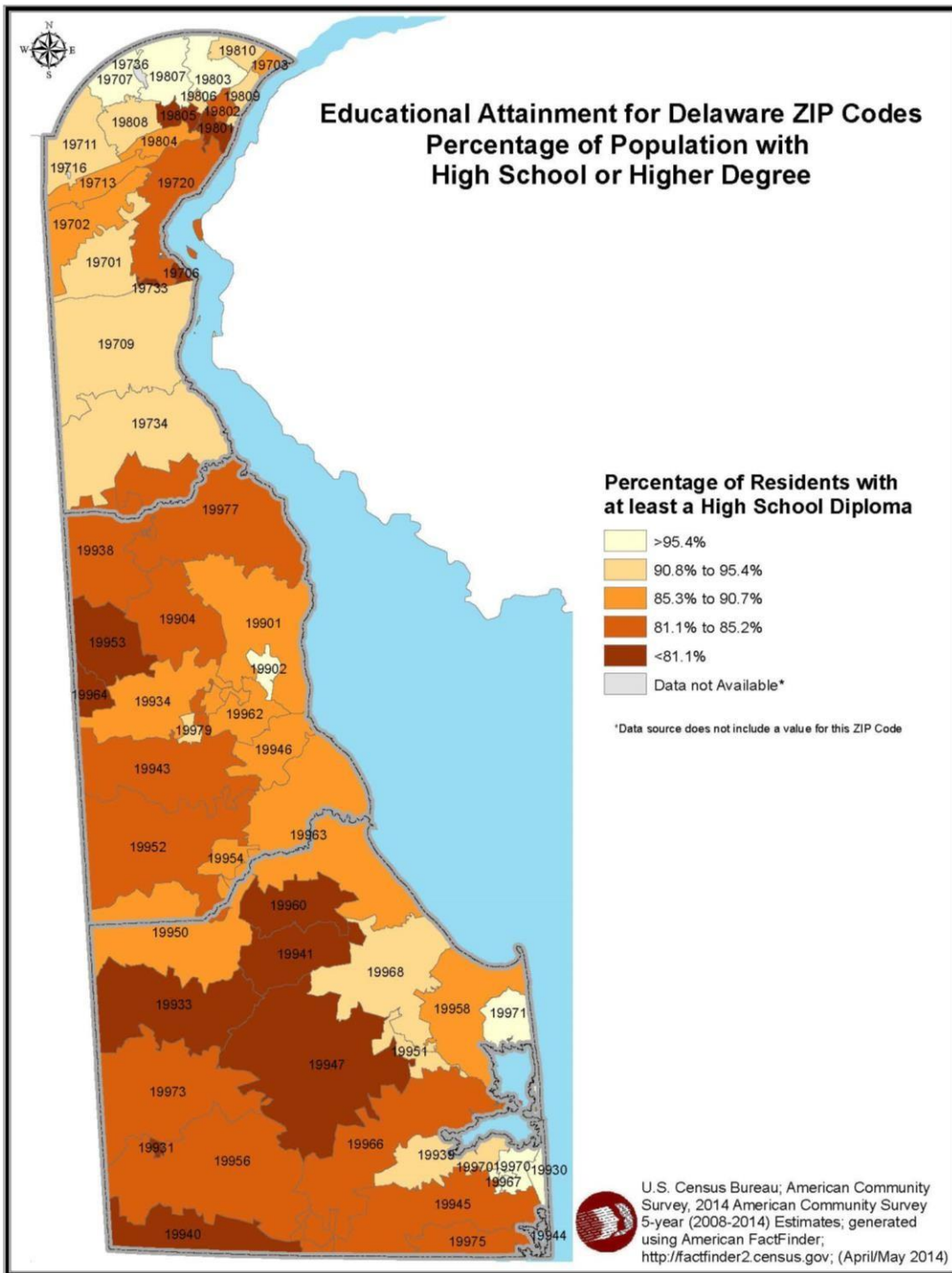
The maps in Figures 10 and 11, produced by the Delaware Division of Public Health (DPH) and the State Office of Planning Coordination (OSPC), illustrate how some of the resources needed for health are distributed. Figure 10 shows median income by ZIP code and indicates areas with large differences in income. In the northern part of Delaware, very high income communities border very low income communities. This is important given that emerging research suggests that income inequality is linked to poor health outcomes for everyone, not just those living in the poorer communities (Wilkinson & Pickett, 2006). Figure 11, which shows educational attainment by ZIP code, reveals similar patterns. Noticeably, many Delawareans who did not earn a high school diploma reside in low income communities. Although limitations in the statistical significance of Figures 10 and 11 prevent us from concluding definitively that there is a relation between these multiple risk factors, the concept of cumulative disadvantage is necessary to explore and understand. Explicitly, cumulative disadvantage is the increased likelihood of poor health outcomes with each additional risk factor. Each risk factor puts individuals increasingly in jeopardy of “falling into the river” of poor health outcomes.

Figure 10. Median income levels according to ZIP code in Delaware



Source: Delaware Division of Public Health and Office of State Planning Coordination, 2014.

Figure 11. Percent of residents with at least a high school diploma according to ZIP code in Delaware



Source: Delaware Division of Public Health and Office of State Planning Coordination, 2014.

Inequities in Health Status in Delaware

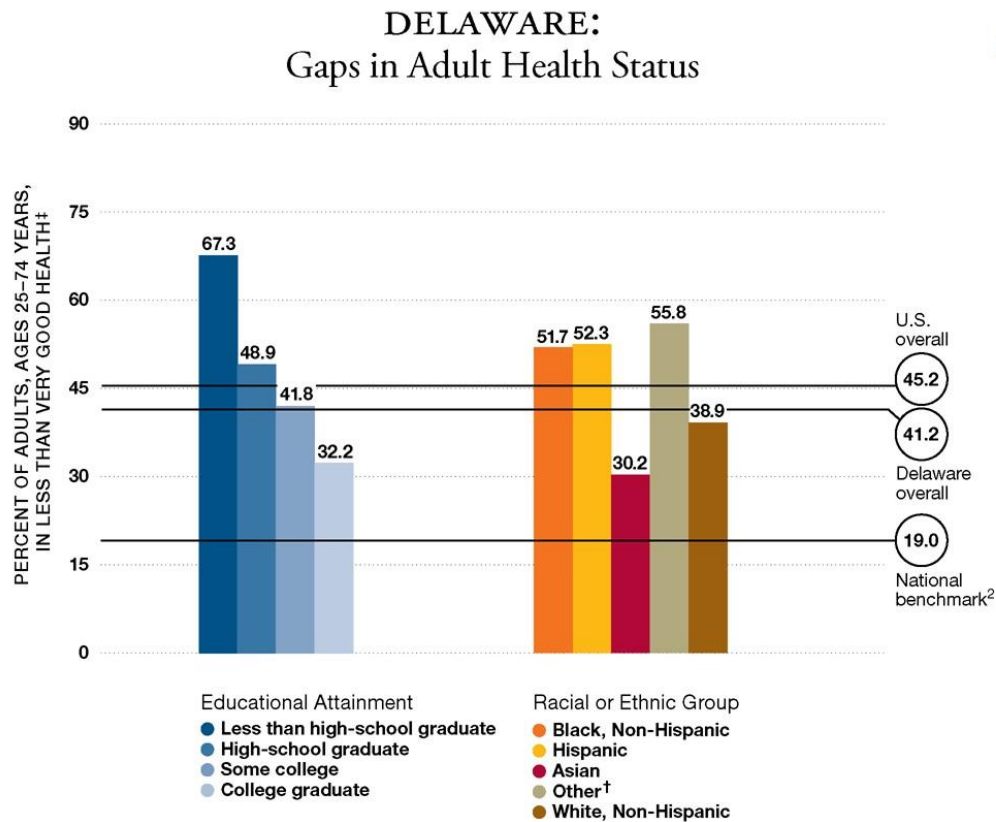
Health inequities may be understood as differences in health that are socially-determined. They are related to differences in the quality and distribution of the determinants of health, such as income and education, and are often most prominent across categories of race or ethnicity. The *CHSA* report highlights inequities in health outcomes by race and ethnicity (DHSS, 2013):

- ❖ African American infants have a significantly higher infant mortality rate than Caucasian infants, by as much as 2.8 times greater during some years. This gap is seen in all three of Delaware's counties.
- ❖ The homicide rate for African American men doubled between 1997 and 2009, and is four times higher than for Caucasian men.
- ❖ Sixty-six percent of the people living with HIV/AIDS in Delaware are African American, despite the fact that African Americans only account for 21 percent of the state's population. Hispanics account for 6 percent of the HIV/AIDS population and only 5 percent of the state's population.

Race/ethnicity, income, and education are related in complex ways and can interact to produce differences in health. Importantly, however, each is thought to contribute independently to health and health inequities. One should not be considered a proxy for another. Figures 12-14, reproduced courtesy of the Robert Wood Johnson Foundation Commission to Build a Healthier America, illustrate the patterns of health inequities in Delaware according to such social characteristics.

As seen in Figure 12, the average percentage of adults in less than very good health in Delaware is better than the national average, but is still far from the national benchmark. Furthermore, the Commission concludes "at every educational level and in every racial or ethnic group, adults in Delaware are not as healthy as they could be." Similar trends can be seen with infant mortality (Figure 13) and children's health status (Figure 14). With respect to the latter, the Commission concludes that there is "unrealized health potential among Delaware children in every income, education, and racial or ethnic group."

Figure 12. Percent of adults in less than very good health according to educational attainment and race/ethnicity in Delaware



In Delaware, adult health status¹ varies by level of educational attainment and by racial or ethnic group.

- Compared with college graduates, adults who have not graduated from high school are more than twice as likely—and those who have graduated from high school are 1.5 times as likely—to be in less than very good health.
- Hispanic and non-Hispanic black adults are approximately 30 percent more likely than non-Hispanic white adults to be in less than very good health.

Comparing Delaware’s experience against the national benchmark² for adult health status reveals that, at every education level and in every racial or ethnic group, adults in Delaware are not as healthy as they could be.

Prepared for the RWJF Commission to Build a Healthier America by the Center on Social Disparities in Health at the University of California, San Francisco. Source: 2005-2007 Behavioral Risk Factor Surveillance System Survey Data.

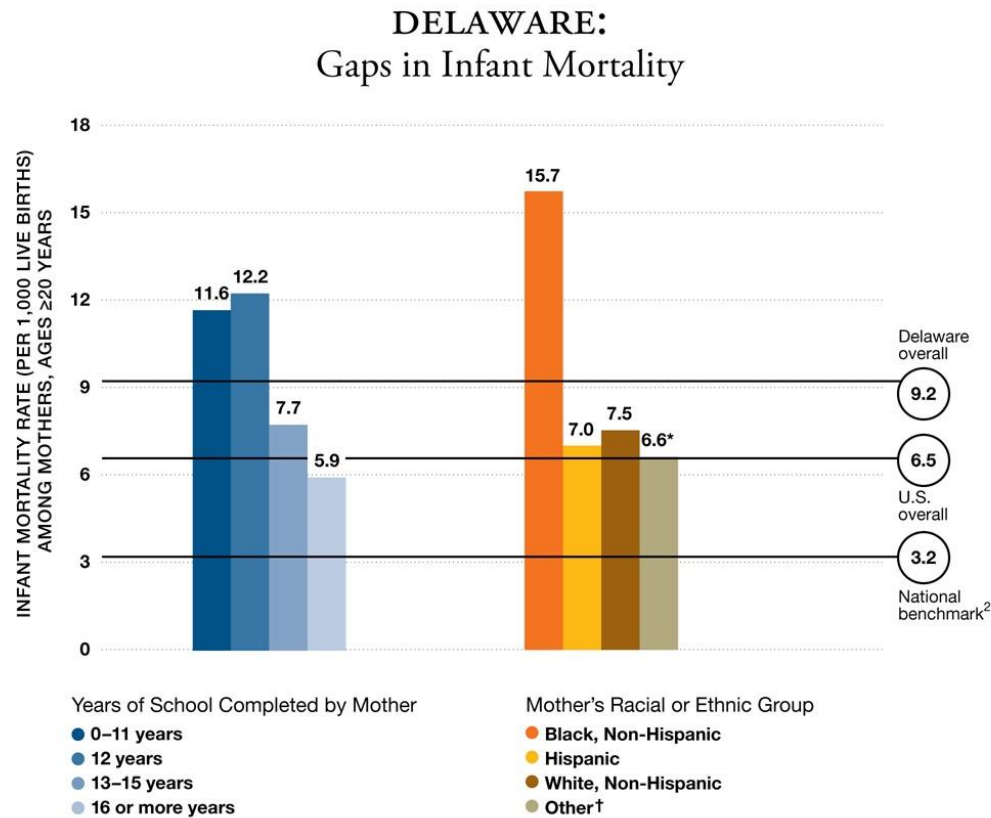
¹ Based on self-report and measured as poor, fair, good, very good or excellent.

² The national benchmark for adult health status represents the level of health that should be attainable for all adults in every state. The benchmark used here—19.0 percent of adults in less than very good health, seen in Vermont—is the lowest statistically reliable rate observed in any state among college graduates who were non-smokers with leisure-time physical exercise. Rates with relative standard errors of 30 percent or less were considered to be statistically reliable.

† Defined as any other or more than one racial or ethnic group, including any group with fewer than 3 percent of surveyed adults in the state in 2005-2007.

Source: Robert Wood Johnson Foundation, 2009.

Figure 13. Infant mortality rate according to educational attainment and race/ethnicity of mother in Delaware



Infant mortality rates¹—a key indicator of overall health—vary by mother’s education and racial or ethnic group in Delaware.

- Compared with babies born to the most-educated mothers, babies born to mothers with less education appear more likely to die before reaching their first birthdays. The infant mortality rates for babies born to mothers with 12 or fewer years of schooling are twice the rate for babies born to mothers with 16 or more years of schooling.
- The infant mortality rate among babies born to non-Hispanic black mothers is twice the rates seen among babies of non-Hispanic white or Hispanic mothers.

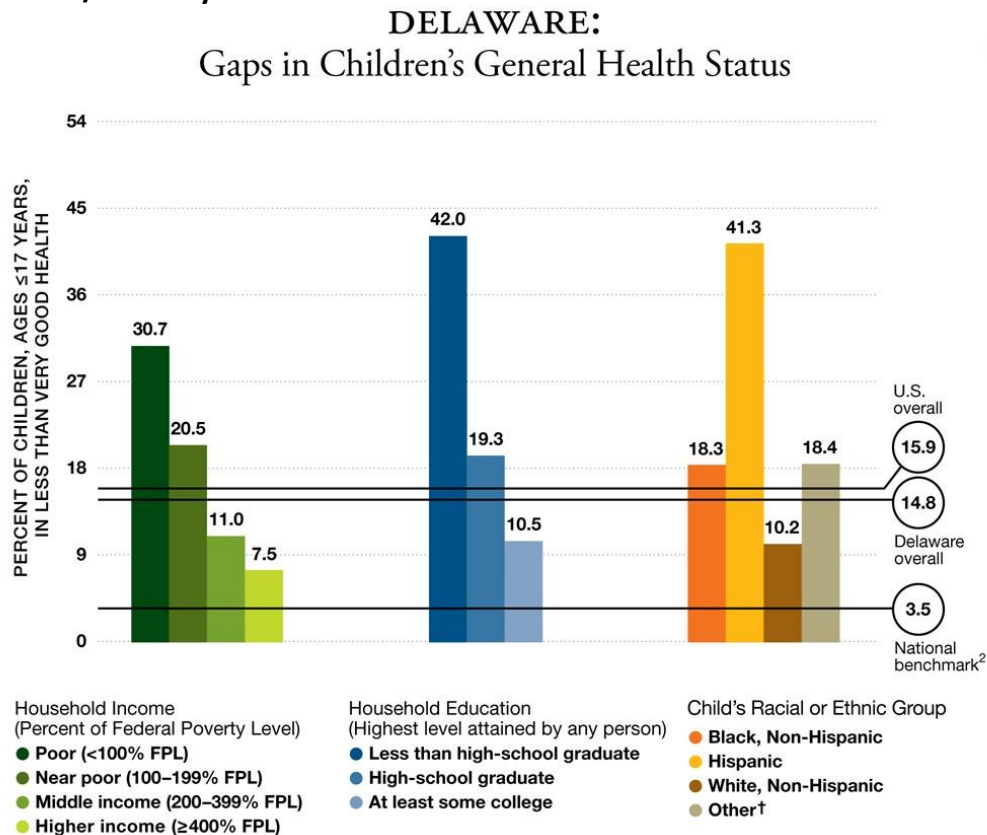
Comparing Delaware’s experience against the national benchmark² for infant mortality reveals unrealized health potential among Delaware babies across maternal education and racial or ethnic groups. Infants in every group could do better.

Prepared for the RWJF Commission to Build a Healthier America by the Center on Social Disparities in Health at the University of California, San Francisco.
 Source: 2000-2002 Period Linked Birth/Infant Death Data Set.
 1 The number of deaths in the first year of life per 1,000 live births.
 2 The national benchmark for infant mortality represents the level of mortality that should be attainable for all infants in every state. The benchmark used here—3.2 deaths per 1,000 live births, seen in New Jersey and Washington state—is the lowest statistically-reliable rate among babies born to the most-educated mothers in any state.
 * Rate based on fewer than 20 infant deaths and considered statistically unreliable.
 † Defined as any other or unknown racial or ethnic group, including any group representing fewer than 3 percent of all infants born in the state during 2000-2002.

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Source: Robert Wood Johnson Foundation, 2008.

Figure 14. Percent of children in less than very good health according to household income, educational attainment and race/ethnicity in Delaware



Within Delaware, children's general health status¹ varies by family income and education and by racial or ethnic group. Children in the least-advantaged groups typically experience the worst health, but even children in middle-class families appear to be less healthy than those with greater advantages.

- Children in poor families are four times as likely and children in near-poor families are approximately 2.5 times as likely to be in less than optimal health as children in higher-income families.
- Children in households without a high-school graduate are four times as likely to be in less than optimal health as children living with someone who has completed some college.
- Hispanic children are four times as likely and non-Hispanic black children are nearly twice as likely to be in less than optimal health as non-Hispanic white children.

Comparing Delaware's experience against the national benchmark² reveals unrealized health potential among Delaware children in every income, education and racial or ethnic group.

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Prepared for the RWJF Commission to Build a Healthier America by the Center on Social Disparities in Health at the University of California, San Francisco.

Source: 2003 National Survey of Children's Health.

¹ Based on parental assessment and measured as poor, fair, good, very good or excellent. Health reported as less than very good was considered to be less than optimal.

² The national benchmark for children's general health status represents the level of health that should be attainable for all children in every state. The benchmark used here—3.5 percent of children with health that was less than very good, seen in Colorado—is the lowest statistically-reliable rate observed in any state among children whose families were not only higher income but also practiced healthy behaviors (i.e., non-smokers and at least one person who exercised regularly).

† Defined as any other or more than one racial or ethnic group, including any group with fewer than 3 percent of children in the state in 2003.

Source: Robert Wood Johnson Foundation, 2008.

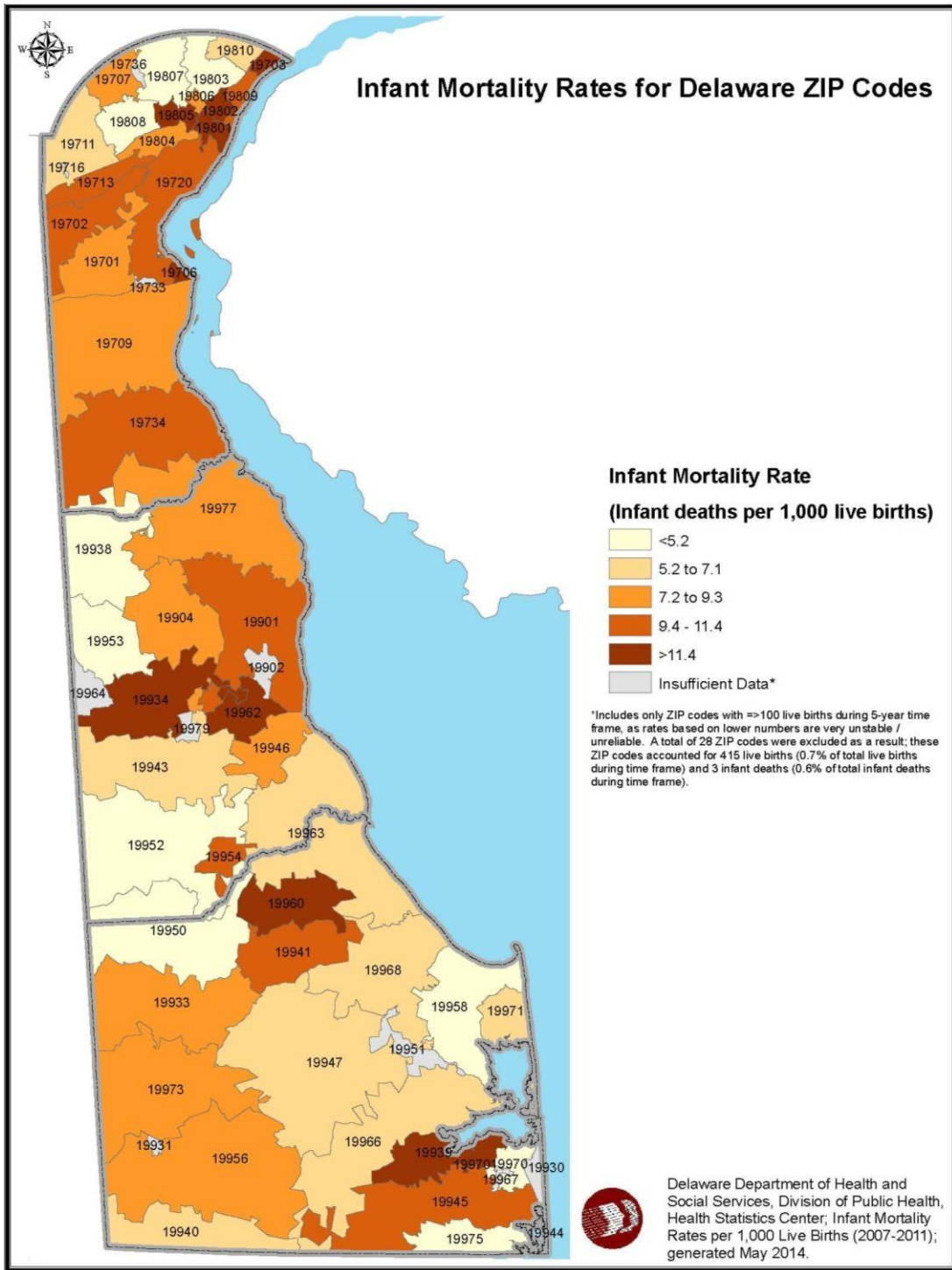
It is becoming increasingly evident that important differences in health indicators exist by geographic location, which is related to, but distinct from, other socioeconomic factors. According to the *CHSA* (DHSS, 2013):

- ❖ HIV/AIDS rates are highest in New Castle County (with a rate of 44.4 percent in the City of Wilmington).
- ❖ Obesity has increased at faster rates in recent years in New Castle County than in Kent or Sussex County.
- ❖ Although cancer death rates are generally decreasing, Kent County has the highest rate and is decreasing at the slowest pace.
- ❖ Kent County sheltered 337 women and children victims of domestic violence in 2010, compared to 212 women and children victims in Sussex and New Castle County combined.
- ❖ In 2010, there were 18 days on which ozone levels surpassed the eight-hour safe limit; 14 days were in New Castle County, five were in Kent County, and nine were in Sussex County. (Note that of the 18 days, there were some days in which the ozone levels were high in more than one county, hence the overlap.)

Figures 15, 16, and 17 depict maps, produced by DPH and the Office of State Planning Coordination (OSPC), which illustrate geographic variations in infant mortality rates (Figure 15) and life expectancy (Figure 16). Figure 17 depicts how certain geographic areas have a preponderance of health-related risk factors and burdens compared with other parts of the state. This map was generated by calculating a cumulative measure of selected variables: infant mortality, life expectancy, median income, and high school graduation rates. It should not be interpreted as confirming direct causal linkages between social determinants of health (SDOH) and health outcomes; more analysis is needed to provide that level of understanding. Rather, it is meant to provide a visual representation of selected SDOH and related health indicators across the state, and to highlight areas of opportunity for improvement.

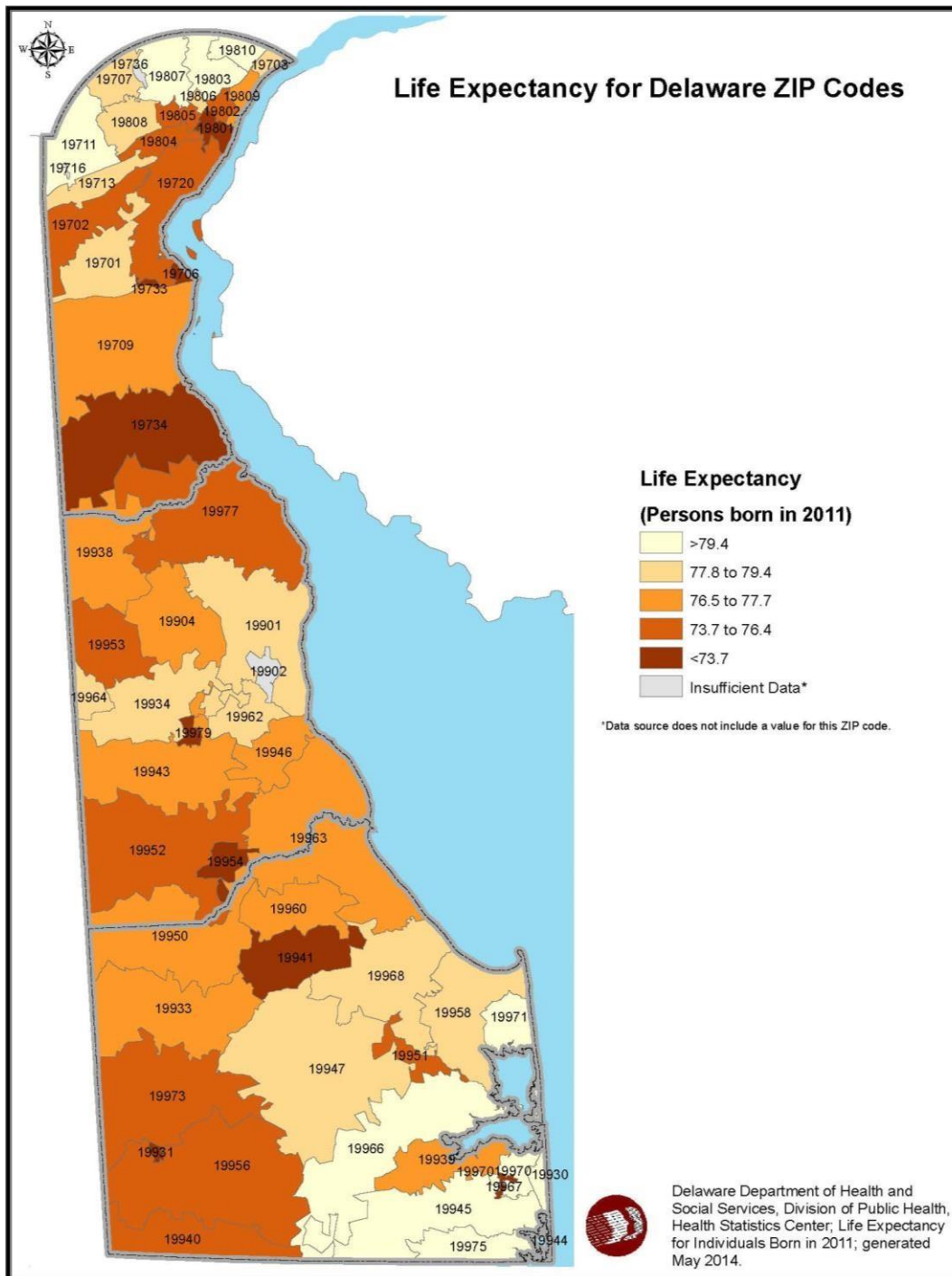
Importantly, these figures provide only snapshots of selected indicators of health status; they are not comprehensive nor do they reflect changes over time. Similarly, the data are aggregated at the ZIP code level, which may obscure differences that could emerge at smaller geographic levels (e.g. census tracts or block groups). Despite these limitations, and remembering the stream parable (Section 1), one can clearly see on these maps that the communities with the darkest shades are those with the weakest bridges and fences, and individuals living near them are more at risk of falling into the stream of poor health outcomes.

Figure 15. Infant mortality rates according to ZIP code in Delaware



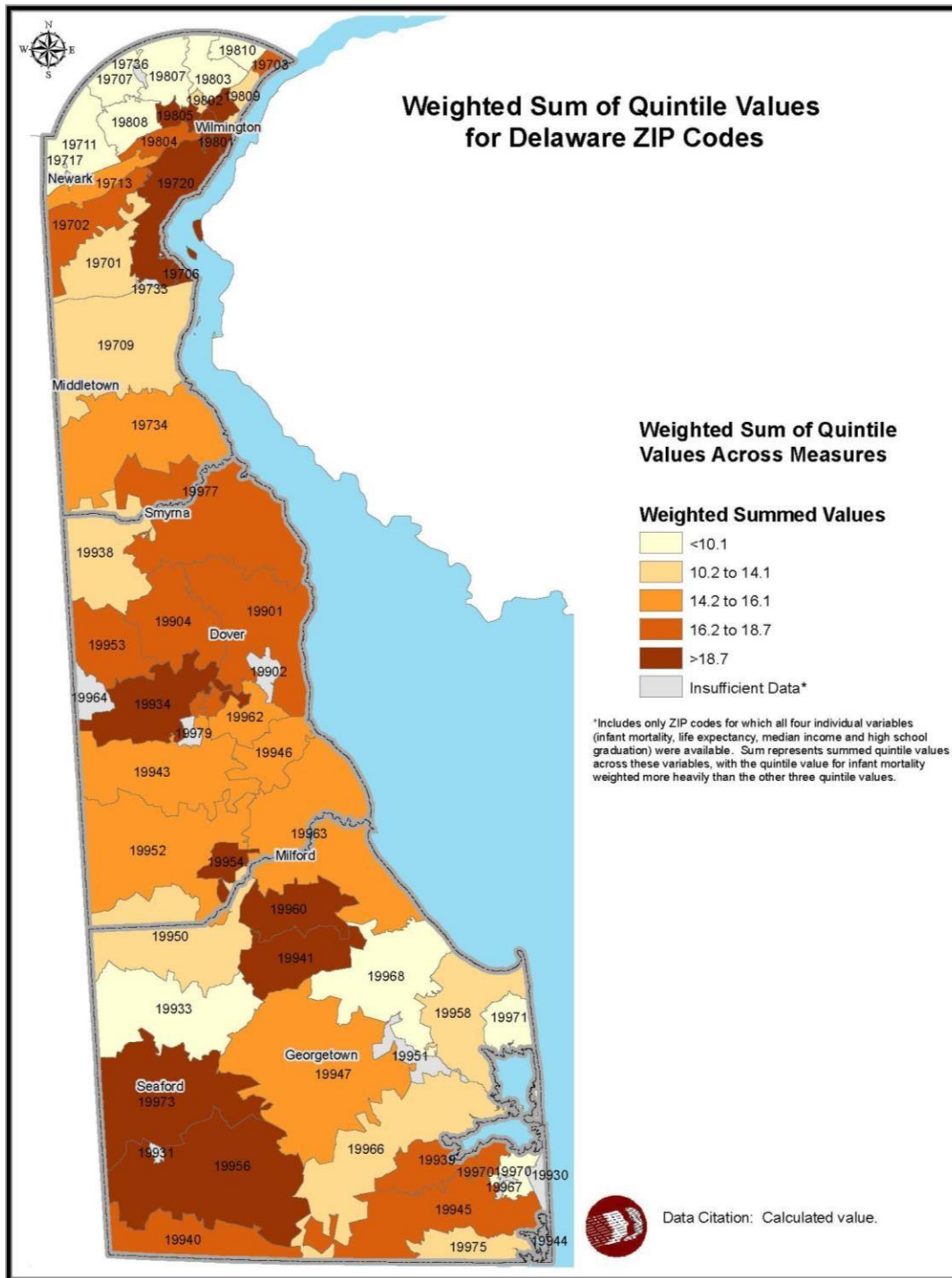
Source: Delaware Division of Public Health and Office of State Planning Coordination, 2014.

Figure 16. Life expectancy according to ZIP code in Delaware



Source: Delaware Division of Public Health and Office of State Planning Coordination, 2014.

Figure 17. Cumulative measure of selected health-related burdens according to ZIP code in Delaware



Source: Delaware Division of Public Health and Office of State Planning Coordination, 2014.

The Economic Case for Change

Health care spending in the United States has been described as excessive and unsustainable. The U.S. leads the world in per capita health care spending at almost twice the average of other wealthy developed countries. However, the health outcomes in the U.S. are relatively poor in comparison. Health care spending in the U.S. has generally grown faster than that in most other countries and, for several decades, has consumed a greater share of gross domestic product than other countries.

There is growing evidence that poor quality environments and unmet social needs have a negative impact on health care spending. This is not surprising, given the relation between social conditions and health. For instance, if poor quality housing contributes to increased rates of lead poisoning, asthma, and other respiratory conditions (Krieger & Higgins, 2002), it follows that spending to treat those conditions is higher in areas with poor housing than in areas with higher quality housing. While this makes sense intuitively, the tools to effectively measure the economic burden of social inequities in health have only recently become available.

In 2009, researchers LaVeist, Gaskin, and Richard conducted an analysis of the economic burden of racial inequalities in health. They estimated that

“Social justice can be cost effective” (LaVeist, Gaskin, & Richard, 2009).

eliminating health disparities would have reduced direct medical care expenditures by approximately \$230 billion between 2003 and 2006. Furthermore, indirect costs (such as lost productivity) associated with illness and premature death were estimated to be more than \$1 trillion for the same time period. Combined, this equates to \$309.3 billion lost annually from the United States’ economy due to health disparities. The authors of the study emphasize the ethical case for change, and offer this economic analysis as additional support for action. They conclude that “social justice can be cost effective” (LaVeist, Gaskin, and Richard, 2009, p. 235).

While aggregate health care spending hurts the overall economy and draws resources from other policy priorities, rising health care costs also burden private businesses. According to one report, businesses in the U.S. spent a staggering \$496 billion on health care services and supplies in 2006 alone. At the same time, employees who do not receive adequate health care have higher rates of absenteeism and lower rates of productivity, which negatively impacts the bottom line. One study found that indirect costs associated with unscheduled absences and productivity losses associated with family and personal health problems costs U.S. employers \$225.8 billion annually (Stewart, Ricci, Chee, & Morganstein, 2003).

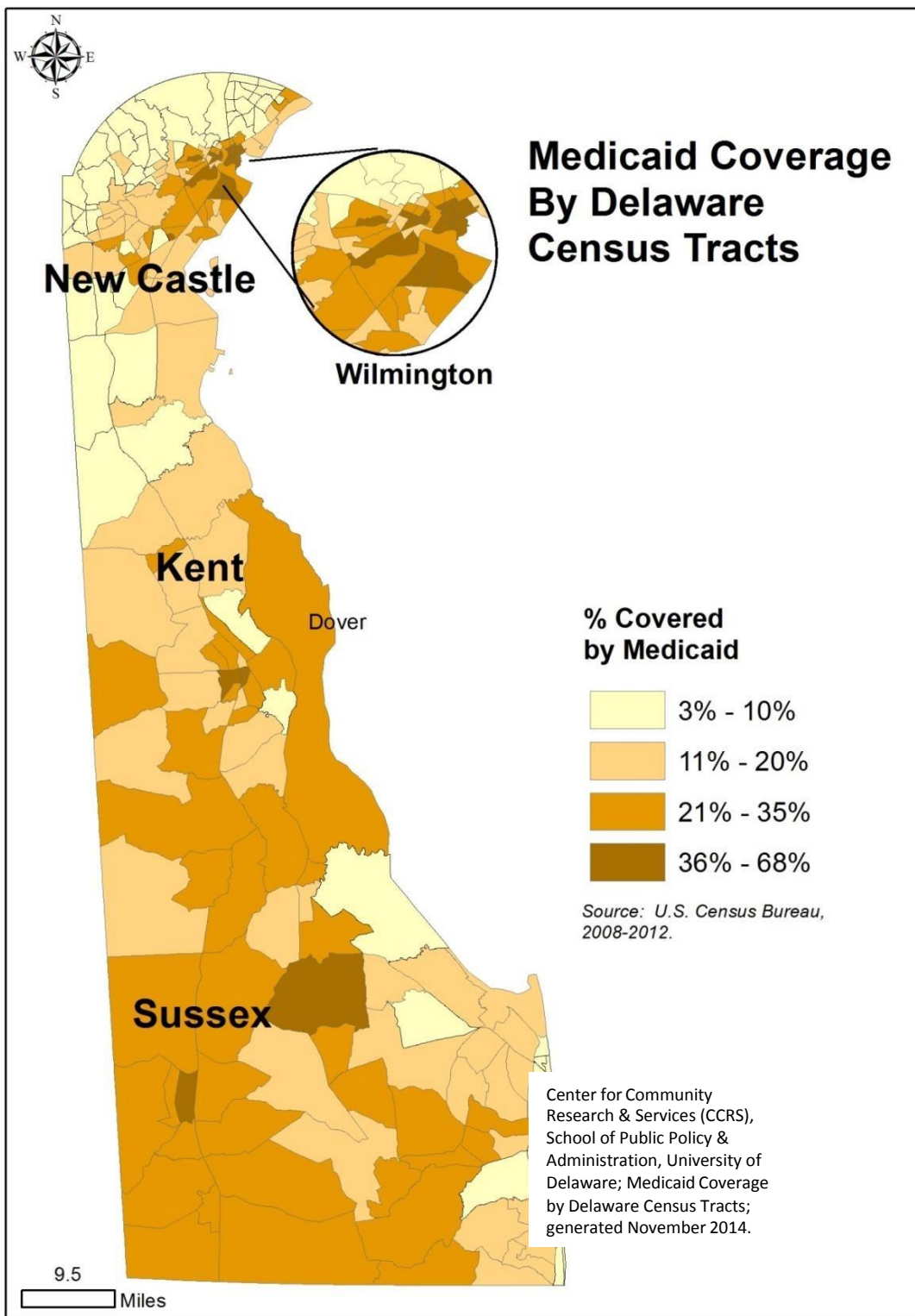
Health care Spending in Delaware

Health care expenditures in Delaware generally mirror national trends. In 2009, Delaware spent approximately \$8,480 per capita (including both public and private spending) for health care services. This places Delaware as one of the top five states in per capita health care spending (CMS, 2013).

Even prior to Medicaid expansion through the Affordable Care Act, Delaware's expenditures for Medicaid—the publicly funded insurance program for low income families, children, pregnant women, and people with disabilities—have increased steadily since 1996 and exceeded 17 percent of the state's 2013 budget (CMS, 2013). Approximately one-quarter of the state's population is enrolled in the Medicaid program and more than half of all births in the state were financed by Medicaid in 2009 (DPH, 2011). This is relevant to the economic case for change, considering that Medicaid is a resource available to low income persons and the amount of money spent due to income inequities exceeds what would be spent if those inequities were absent. Figure 18 illustrates the percent of Delaware's population covered by Medicaid. It is not surprising that the communities with the highest concentration of Medicaid enrollment mirror those communities with other social burdens and health needs. This further makes the case for investing in prevention in Delaware's low income communities.

Approximately 500,000 residents, or 55 percent of Delawareans, are covered by private insurance. The average family premium per enrolled employee in employer-based health insurance was approximately \$15,600 in 2012, slightly above the national average. This includes approximately \$4,100 paid by the employee and approximately \$11,500 paid by the employer.

Figure 18. Medicaid coverage by census tract in Delaware



Source: Center for Community Research & Services, 2014.

The rate of preventable hospitalization is an indicator often used to assess the quality of health care services in a particular area. According to the Agency for Healthcare Research and Quality (AHRQ), hospitalizations may be avoided if clinicians effectively diagnose, treat, and educate patients and if patients actively participate in their care and adopt healthy lifestyle behaviors. Higher rates of preventable hospitalizations may pinpoint areas in which improvements can be made in the quality of the health care system. Preventable hospitalizations may also be viewed as an indicator of efficiency within the system, based on the understanding that spending on preventable hospitalizations is unnecessary and less cost effective than prevention. For example, asthma is a condition that may result in preventable hospitalization because patients may be hospitalized if they do not receive adequate outpatient care or do not have access to appropriate medications. Asthma is also a condition that is directly influenced by environmental factors, such as air quality and housing conditions. Therefore, hospitalization may be avoided by increasing access to care and treatment and by improving air quality and housing conditions. Overall, Delaware ranks seventeenth in the country for its rate of preventable hospitalizations, according to America's Health Rankings, an annual report produced through a partnership between the United Health Foundation, the American Public Health Association, and the Partnership for Prevention.

Poor performance of the health care system—including excessive and potentially unnecessary spending, inadequate access to care, and poor or uneven quality of care—have driven reform efforts for decades. The Affordable Care Act (ACA), passed in 2010, aims to reduce costs, increase access, and improve quality of care. Embedded in many provisions of the ACA are opportunities to address social determinants of health and reduce health inequities, particularly through investments in community health.

Health System Reform and Incentives for Investing in Community Health

Increased awareness and understanding of how the social and physical environments impact health and health inequities is occurring at a time when the nation's health care system is undergoing immense change. The current health care landscape, including the passage of the ACA and promotion of the "Triple Aim," has created new opportunities and incentives for health care providers to pay more attention to the SDOH.

The Triple Aim is a framework originally developed by the Institute for Healthcare Improvement. It aims to optimize health system performance. The framework draws attention to three interrelated goals that are meant to be pursued simultaneously:

- Improving the patient experience of care (including quality and patient satisfaction)
- Improving the health of populations

➤ Reducing the per capita cost of health care

Many public and private health care providers have adopted this approach, which is supported and reinforced through various ACA provisions. The ACA's expansion of health insurance for low- and moderate-income individuals reduces the financial barrier to accessing primary care for millions of individuals. This also gives providers the opportunity to address patient care in a more holistic and prevention-oriented manner rather than the episodic or urgent care that is more typical among those without adequate health insurance. Additionally, new models of care have emerged which enhance patient care through improved care coordination, and allow real-time linkage of patients to local social service agencies and related services. One such model is the patient-centered medical home (PCMH).

The ACA's expansion of health insurance may also create new opportunities for hospital community benefit programs. According to a recent study, most non-profit hospitals, which are required to dedicate a portion of their revenue to provide community benefits, have done so in the form of discounted or uncompensated care for uninsured or underinsured individuals (Young et al., 2013). With fewer uninsured individuals, hospitals may now use their Community Benefit Programs for community-oriented prevention efforts. Similarly, the ACA now requires tax-exempt hospitals to regularly conduct community health needs assessments and to develop plans to address those needs (Young et al., 2013). This offers further incentive for hospitals to use community benefit programs to address upstream community needs and work to improve population health.

According to a recent report by the Commonwealth Fund (Bachrach et al., 2014), specific payment reform efforts, such as value-based purchasing and outcomes-based payment models, provide new economic incentives for providers to address patients' social needs. For instance, Medicare's Hospital Readmission and Reduction Program, created through the ACA, gives hospitals financial incentives to avoid readmissions by reducing payments to those hospitals where patients with certain medical conditions readmit within 30 days of their prior discharge. Although readmissions may be linked to health care quality, evidence also demonstrates a link between social factors and risk of readmissions. Other payment mechanisms that promote managing care, such as capitated, global, and bundled payments, also provide an incentive for providers to address patients' unmet social needs, which helps improve health outcomes. This is in contrast to traditional fee-for-service models that theoretically incentivize the quantity of services versus the quality of care.

The Commonwealth Fund report also highlights indirect economic benefits of health care providers investing in social interventions in the form of increased employee productivity, provider satisfaction, and patient satisfaction (Bachrach et al., 2014). Strategies that address patients' social needs free up physicians and other health care providers to address more

immediate physical needs and increase their time spent providing direct medical care to patients. Since providers can bill for the time spent with the patient, this increases provider income and promotes provider satisfaction, as they believe they are providing higher quality care. Higher quality care, in turn, translates into higher patient satisfaction.

Health System Reform in Delaware

The Affordable Care Act created a Center for Medicare and Medicaid Innovation (CMMI), housed within the Centers for Medicare and Medicaid Services (CMS), to test innovative payment and service delivery models to reduce expenditures, while preserving or enhancing quality of care. Delaware was awarded funding from the CMMI State Innovation Model (SIM) initiative to test a plan for transforming the State's health care system in ways that improve quality and reduce costs. Over \$622 million in Model Test awards will support 11 states that are ready to implement their State Health Care Innovation Plans.

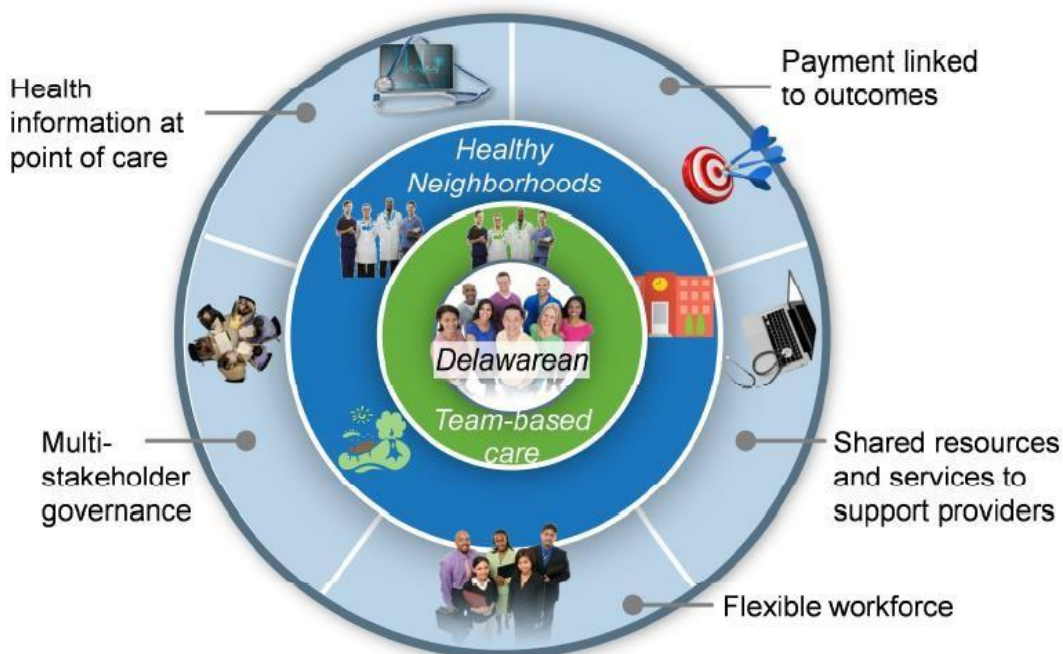
A State Health Care Innovation Plan is a fully developed proposal capable of creating statewide health transformation for the preponderance of care within a state. In addition, a State Health Care Innovation Plan describes a state's strategy to utilize available regulatory and policy levers to accelerate transformation, such as plans to align quality measures, leverage the adoption and implementation of health information technology and health information exchange, and evaluate innovative efforts. CMS will work with Model Test states for four years.

Delaware's State Healthcare Innovation Plan was developed through an extensive and collaborative planning process and provides the basis for a subsequent application to CMMI for funding to implement the plan. The Delaware SIM Plan is organized around six work-streams—delivery system, population health, payment model, data and analytics, workforce, and policy—that contribute to achieving the Triple Aim of improving the health of Delawareans, improving the patient experience of care, and reducing health care costs.

The Delaware SIM Plan is grounded in an understanding of three major structural barriers to an effective health system. The first barrier is that the prevailing payment model incentivizes volume or quantity, rather than quality of care provided. Secondly, the health system in Delaware is fragmented, and coordination of care is often lacking. Finally, Delaware's approach to population health does not integrate public health, health care delivery, and community resources in ways that promote health and an efficient use of resources. The framework illustrated in Figure 19 highlights the major components of Delaware's strategy to overcome these barriers.

Figure 19. Delaware’s framework for health system reform

EXHIBIT 1: FRAMEWORK FOR DELAWARE’S HEALTH TRANSFORMATION



Source: Delaware Health Care Commission, 2013.

The Delaware SIM Plan’s focus on *Healthy Neighborhoods* as a way to transform Delaware’s approach to population health is viewed as a critical element to achieving the Triple Aim and leveraging resources for health equity. More specifically, Delaware’s *Healthy Neighborhood* program will provide resources for individual communities to identify and address community-specific health needs through targeted interventions. The program’s intent is to integrate public health and health care delivery on the local level, match existing community assets and resources with community-defined needs, and prioritize investments accordingly. In this way, *Healthy Neighborhoods* is consistent with the integrated approach recommended by the Secretary’s Advisory Committee for *Healthy People 2020* and is supported by the Delaware Division of Public Health’s health equity strategy, both of which are described in (Section 2).

Combined, increased focus on the SDOH and shifting toward more prevention-oriented and integrated systems of care create an important window of opportunity to advance health equity. Delaware appears poised to create a more effective, inclusive, and comprehensive health system that better addresses the entire continuum of health determinants, from the upstream social conditions to the downstream delivery of care. The potential benefits of such a system—for individuals, communities, businesses, and the state—are immense.

Addressing the Health Equity Continuum

Addressing health equity requires a multi-pronged approach. Figure 20, reproduced courtesy of the Bay Area Regional Health Inequity Initiative (BARHII), highlights the continuum of strategies needed for advancing health equity. This framework illustrates the need for public health activities to refocus upstream, while simultaneously shifting the way that critical downstream services are provided. To refer to the river parable, we need to build stronger bridges and fences *and* we need to do a better job ensuring everyone who falls into the river of poor health/health outcomes gets rescued with high quality care. This continuum also reflects the multi-sector and integrated approach taken by *Healthy People 2020*, which is described on page 27.

Importantly, to address all components of the continuum, the public health workforce, health care workforce, and partners need to provide culturally competent care. The National Center for Cultural Competence acknowledges that there are multiple definitions of cultural competence. Of particular relevance to the themes of this guide, the Office of Minority Health within the U.S. DHHS defines cultural competence as “having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors and needs presented by consumers and their communities” (OMH, 2001). Due to the breadth of services that public health agencies, health care systems, and community-based organizations provide, and the range of populations that these services target, it is imperative that the workforces of these agencies are culturally competent. Workforces should represent the diversity of the populations that they serve, including the ability to communicate with non-English speaking populations. For more information regarding cultural competence, the National Center for Cultural Competence provides numerous resources and tools (see <http://nccc.georgetown.edu/>).

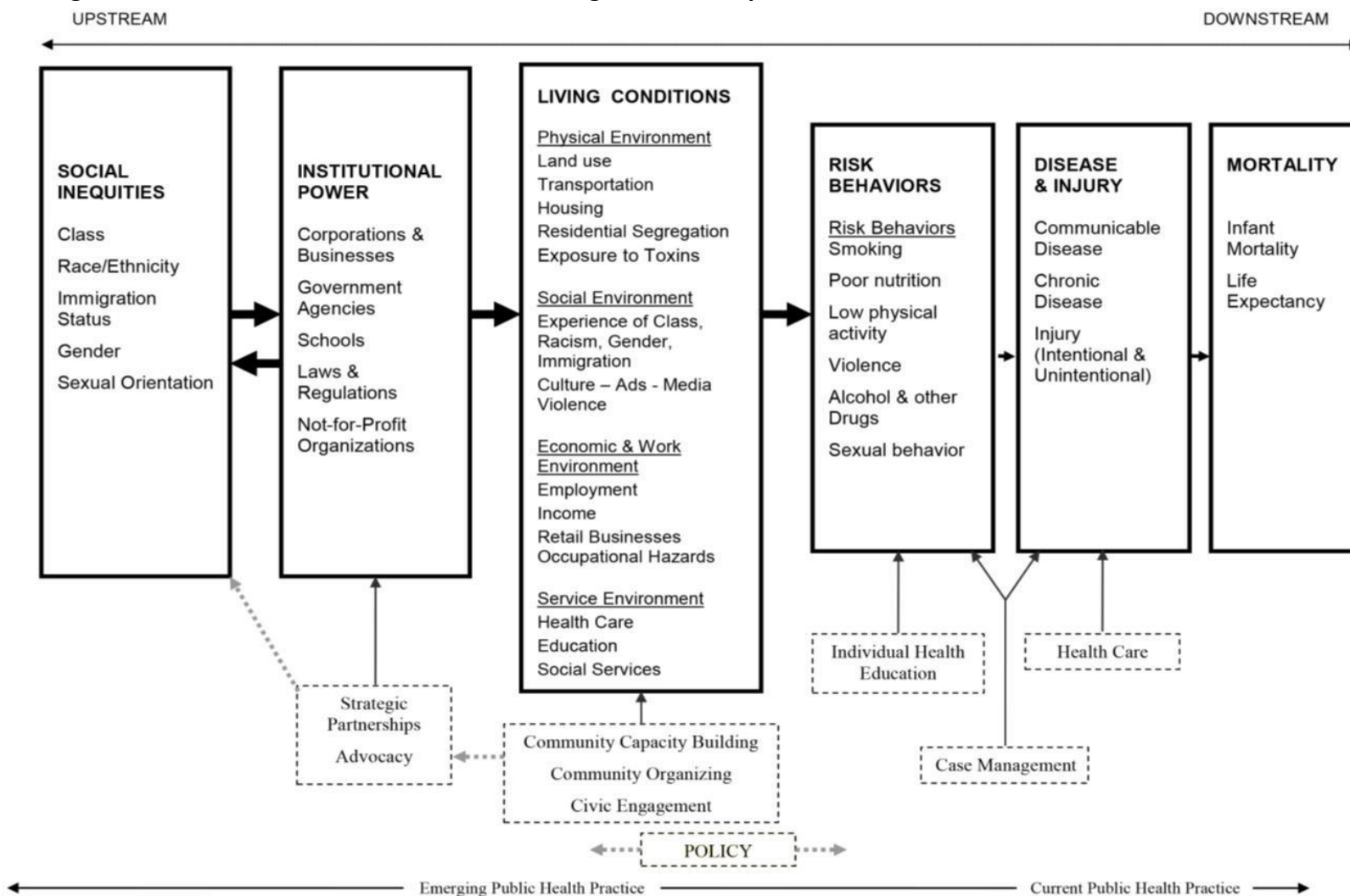
The following three sections provide examples of strategies and resources for public health professionals, health care providers, and others to improve the conditions that create health and those that reduce health inequities. Section 4 describes upstream strategies for community health, including place-based and community-oriented strategies to address living and working conditions. Consistent with the framework below, Section 4 includes a discussion of community capacity-building, partnerships, and civic engagement.

Section 5 describes upstream strategies for health care providers, including ways in which providers can incorporate upstream approaches in their service delivery and/or provide care that is more equity-oriented. Section 5 highlights opportunities within the health care system to address the psychosocial needs of patients and provide more coordinated care that can connect patients to resources in the community. Section 6 highlights policy-oriented

approaches that can support or facilitate the changes described in the previous two sections and address underlying social inequities in a more direct and systemic way.

Together, the information and examples provided in the following sections represent a comprehensive effort to address health equity. Although it may not be feasible to address all of the factors identified in the framework in every community in our state, a comprehensive approach is ideal for achieving meaningful and sustainable change.

Figure 20. Public Health Framework for Reducing Health Inequities



Source: Bay Area Regional Health Inequity Initiative, 2013.

Glossary – Section 3

Community Benefit Program: Most hospitals and health systems in the United States are incorporated as not-for-profit entities. To maintain tax exemption status, not-for-profit hospitals must dedicate a portion of their revenue to providing community benefits. Activities often include improving access to care for uninsured or under-insured individuals, health education efforts, and other strategies to promote community health.

Cultural Competence: “Having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities” (OMH, 2001).

Medicaid: A publicly funded insurance program for low-income families and other eligible aged, blind, and/or disabled people whose income is insufficient to meet the cost of necessary medical services. Medicaid pays for: doctor visits, hospital care, labs, prescription drugs, transportation, routine shots for children, and mental health and substance abuse services.

Preventable hospitalizations: Hospitalizations that may be avoided with high quality primary and preventive care, including living a healthy lifestyle; also referred to as “potentially preventable hospitalizations” or “ambulatory care sensitive conditions.”

Primary Care Medical Home: A team-based health care delivery model led by a physician that provides comprehensive and coordinated medical care to patients with the goal of obtaining maximized health outcomes. Care coordination, which may require additional resources such as health information technology and payment incentives, is an essential component of the PCMH. PCMHs are also referred to as “patient-centered medical homes” or simply “medical homes.”

Triple Aim: A framework developed by the Institute for Health care Improvement to optimize health system performance by simultaneously pursuing three dimensions: improving the patient experience of care (including quality and satisfaction), improving the health of populations, and reducing the per capita cost of health care.

References and Additional Resources

Association of State and Territorial Health Officials. *The Economic Case for Health Equity Issue Brief*. Retrieved from <http://www.astho.org/Programs/Health-Equity/Economic-Case-Issue-Brief/>

Bachrach, D., Pfister, H., Wallis, K. & Lipson, M. (2014). *Addressing patients' social needs: An emerging business case for provider investment*. Retrieved from http://www.commonwealthfund.org/~media/files/publications/fund-report/2014/may/1749_bachrach_addressing_patients_social_needs_v2.pdf

Bay Area Regional Health Inequalities Initiative. (2013) *Health Equity and Community Engagement Report*. Retrieved from <http://barhii.org/resources/health-equity-community-engagement-reports/>

Centers for Medicare and Medicaid Services [CMS]. (2013). National Health Expenditure Data. Retrieved from <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet.html>

Choose Health Delaware. December 2013. *Delaware's State Health Care Innovation Plan*. Retrieved from <http://dhss.delaware.gov/dhss/dhcc/cmmi/files/choosehealthplan.pdf>

Delaware Health and Social Services. Delaware Health Care Commission. <http://dhss.delaware.gov/dhcc/>

Delaware Health and Social Services, Division of Public Health [DE DPH]. (2011). *Delaware vital statistics annual report, 2009*. Delaware Health Statistics Center. Retrieved from <http://www.dhss.delaware.gov/dph/hp/files/lb09.pdf>

Delaware Health and Social Services, Division of Public Health [DHSS]. (2013). *Community Health Status Assessment 2013*. Retrieved from <http://www.dhss.delaware.gov/dhss/dph/files/shachsa.pdf>

Delaware Division of Public Health. (2008). *Delaware racial and ethnic health disparities health status report card*. Retrieved from <http://www.dhss.delaware.gov/dhss/dph/mh/files/2008dredreportcard.pdf>

Galea, S., Tracy, M., Hoggatt, K., Dimaggio, C., Karpati, A., et al. (2011). Estimated deaths attributed to social factors in the United States. *American Journal of Public Health, 101*(8), 1456-1465.

Georgetown University. (n.d.). National Center for Cultural Competence. Retrieved from <http://nccc.georgetown.edu/>.

Georgetown University. (n.d.). *Definitions of Cultural Competence*. Retrieved from <http://www.ncccricula.info/culturalcompetence.html>

The Henry J. Kaiser Family Foundation. (2014). State Health Facts. Retrieved from www.kff.org/statedata

Himmelstein, D., Warren, E., Thorne, D., Woolhandler, S. MarketWatch: Illness and injury as contributors to bankruptcy. *Health Affairs, Web Exclusive*. Retrieved from <http://content.healthaffairs.org/content/suppl/2005/01/28/hlthaff.w5.63.DC1>

Institute for Healthcare Improvement. *IHI Triple Aim Initiative*. Retrieved from <http://www.ihl.org/engage/initiatives/TripleAim/Pages/default.aspx>

Kabel, C. What is the future of hospital community benefit programs? *Stanford Social Innovation Review*. Retrieved from http://www.ssireview.org/blog/entry/what_is_the_future_of_hospital_community_benefit_programs

Kids Count. (2015). Infant Mortality. Retrieved from <http://datacenter.kidscount.org/data/tables/6051-infant-mortality#detailed/2/9/true/867,133,38,35,18/any/12718,12719>

LaVeist, Gaskin, & Richard. (2009). *The Economic Burden of Health Inequalities in the United States*. Washington, D.C.: Joint Center for Political and Economic Studies. Retrieved from http://hsrc.himmelfarb.gwu.edu/cgi/viewcontent.cgi?article=1224&context=sphhs_policy_facpubs

Methodist Healthcare. (2013). Health Systems Learning Group (HSLG) Executive Summary. Retrieved from <http://www.methodisthealth.org/about-us/faith-and-health/research/learning-collaborative/>

National Business Group on Health. (February 2009). *Eliminating racial and ethnic health disparities; a business case update for employers*. Retrieved from http://www.minorityhealth.hhs.gov/Assets/pdf/checked/1/Eliminating_Racial_Ethnic_Health_Disparities_A_Business_Case_Update_for_Employers.pdf

Robert Wood Johnson Foundation Commission to Build a Healthier America. (2009). Adult health status: Snapshot of Delaware. Retrieved from <http://www.commissiononhealth.org/PDF/DelawareSnap.pdf>

Robert Wood Johnson Foundation Commission to Build a Healthier America. (2009). A snapshot of Delaware's children. Retrieved from http://www.commissiononhealth.org/PDF/RWJ039_StateSnaps_Delaware.pdf

State of Delaware, Division of Public Health & Office of State Planning Coordination [DPH/OSPC]. (2014).

Stewart, W., Ricci, J., Chee, E., Morganstein, D. (2003). Lost productive work time costs from health conditions in the United States: results from the American Productivity Audit. *Journal of Occupational and Environmental Medicine*, 45(12), 1234-46.

United Health Foundation. (2014). America's Health Rankings. Retrieved from <http://www.americashealthrankings.org/>

U.S. Department of Health and Human Services, Office of Minority Health [OMH]. (2001). *National Standards for Culturally and Linguistically Appropriate Services in Health Care: Final Report*. Retrieved from <http://minorityhealth.hhs.gov/assets/pdf/checked/finalreport.pdf>

Wilkinson, R. G., & Pickett, K. E. (2006). Income inequality and population health: A review and explanation of the evidence. *Social Science & Medicine*, 62(7), 1768-1784.

Young, G., Chou, C., Alexander, J. Lee, S.D., & Raver (2013). Provision of community benefits by tax-exempt U.S. hospitals. *NEJM*, 368, 1519-1527.