

SECTION 5: Upstream Strategies for Health Care Providers

As discussed in Section 4, the social determinants of health and health equity are generally outside the scope of what is typically considered part of the health care system. Health care providers are usually trained to address their patients' immediate needs based on individual symptoms, risk factors, and biological or genetic characteristics. Medical education and health care models in the U.S. typically reflect a biomedical and individualistic concept of health. Similarly, the United States' health care system is biased toward treatment rather than prevention and health promotion, as well as toward specialization instead of a more holistic and comprehensive approach to health and well-being. Finally, payment systems and incentives tend to prioritize innovation and high end technology, which creates additional barriers for providers to attend to their patients' social needs. These characteristics of the health care system, which are at odds with efforts to advance health equity, are driven by long-standing cultural barriers, numerous regulatory barriers, and financial challenges related to payment mechanisms and our insurance system (Manchanda, 2013).

Fortunately, passage of the Affordable Care Act and increasing attention to the Triple Aim (see Section 3), have created opportunities for reforming the health care system in ways that can better address the social determinants of health and promote equity. Providers are positioned to better address their patients' social needs by creating stronger linkages with other community resources; coordinating care more effectively; and ultimately ensuring high quality, accessible care to a diverse patient population. Strategies in each of these three areas can contribute to a more equity-oriented health care system, which is part of the broader continuum of strategies needed to advance health equity overall. This is important because, while health care is only one determinant of health, it is an important lever of change and can open the door to other changes in the broader community context.

Addressing the Social Needs of Patients

Providers inherently understand the social needs of their patients. They recognize that prescribed treatments may be of limited value when patients leave the clinic, only to return to the conditions that caused their illnesses in the first place.

Providers are frequently frustrated by an apparent lack of ability to address the challenges their patients face with respect to poverty, poor housing, and other environmental factors. However, there is much that providers can do to address the social needs of their patients and several resources exist to help them do so:

1. Screening Tools

First, to support a paradigm shift from addressing symptoms to addressing causes, providers can systematically screen and assess their patients for social needs. Various assessment tools have been developed to identify patients' social needs as the first step to connecting them to community supports and resources. Some screening mechanisms are administered by clinicians and others are self-administered (e.g. in the clinic waiting room before an appointment). A variety of screening tools focused on a variety of social needs—such as food insecurity, housing insecurity, financial stability, stress, and social isolation—are available to clinicians on the HealthBegins websites (<http://www.healthbegins.org/> and <http://healthbegins.ning.com/>). Dr. Rishi Manchanda and other “Upstream Doctors”⁷ created this site to help improve the health care system by sharing information and resources among clinicians. The site includes more comprehensive instruments that address a multitude of social needs in single surveys of varying lengths and with different purposes. Recently, the founders of HealthBegins developed a composite questionnaire for clinical settings, based on a compilation of available, evidence-based instruments. Health care providers may visit the website for more information or contact Dr. Manchanda directly for a copy of this composite questionnaire (<http://healthbegins.ning.com/page/social-screening-tools>).

2. Community Health Workers

Community Health Workers (CHWs)—also referred to as community health advocates, lay health educators, health navigators, or promotores de salud—are uniquely qualified to create linkages between patients, providers, and community resources. CHWs serve in a variety of roles, including:

- cultural mediation between communities and the health care system;
- providing culturally appropriate and accessible health education and information;
- assuring that people get the services they need;

⁷ *The Upstream Doctors* by Rishi Manchanda is a TED Book available for download as an e-book. Dr. Manchanda is the founder of HealthBegins, a social network where clinicians can learn and share upstream strategies. For more information, visit: <http://healthbegins.ning.com/>.

- providing informal counseling and social support;
- advocating for individuals and communities within the health and social service systems;
- providing direct services (such as basic first aid) and administering health screening tests; and
- building individual and community capacity (Wiggins & Borbon, 1998).

CHWs' unique qualifications include understanding the communities they serve. They typically reside in the community, speak the language, and share the community's culture. This allows them to connect individuals with needed services and to educate providers about community needs and important cultural considerations in the delivery of care. Growing evidence documents the value of CHWs in improved health outcomes and reduced health care costs (e.g., see <http://www.cdc.gov/diabetes/projects/pdfs/comm.pdf>). The Institute of Medicine recommends increased using CHWs to help address racial and ethnic disparities in health care (Smedley et al., 2002).

Massachusetts was one of the first states to create a supportive, statewide infrastructure for expanding and institutionalizing the role of CHWs. After considerable research and collaborative planning, the state Executive Office of Health and Human Services formally recognized CHWs as a vital component of the health care system because they play an important role in reducing health inequities among vulnerable communities. Massachusetts instituted several initiatives to promote CHWs. The state's experience led to the development of several recommendations within four domains aimed at institutionalizing CHWs (Anthony, Gowler, Hirsch, & Wilkinson, 2009):

1. Infrastructure

- Establish a CHW advisory body to assist with the development and implementation of a sustainable program.

2. Professional Identity

- Encourage the adoption of the term "community health worker," a unified definition of CHW core competencies, and a common scope of practice.
- Incorporate information about the role of CHWs into training for health care providers.

3. Workforce Development

- Develop statewide infrastructure for CHW training and education.
- Develop a CHW certification process and training curriculum, including defined core competencies and skills.
- Require continuing education and recertification.

4. Financing

- Include CHW services in Medicaid administrative cost claims.
- Integrate CHWs into managed or team-based care models.
- Increase and sustain grant funding for outreach.
- Provide incentives for private insurers to use CHWs.

CHWs can be particularly effective in connecting with hard-to-reach community members, especially those who are socially isolated and/or have multiple and complex social needs. However, CHWs have yet to become fully integrated members of the health care delivery system in most parts of the country due to cultural, financial, and regulatory barriers. Because they perform a wide range of services and activities, they lack a unified professional identity with a defined scope of practice and educational credentials. Minnesota has led efforts to remedy some of these barriers and promote the integration of CHWs. A coalition of educational institutions, health care systems, government agencies, foundations, businesses, and non-profits created a statewide, standardized training program called the Minnesota Community Health Worker Alliance. The coalition is also working to develop a sustainable funding stream to support CHWs. Additional information and lessons learned can be found at:

http://www.rwjf.org/content/dam/farm/reports/program_results_reports/2012/rwif403543.

Sample Strategy

Several programs that incorporate the use of CHWs exist in Delaware. The Health Ambassador Program is a joint initiative between the Delaware Department of Health and Social Services and the Christiana Care Health System. The program promotes the health of pregnant women, fathers, and young families through outreach and education on reproductive health and pregnancy, parenting, and healthy infant and early childhood development. Health Ambassadors working at the Claymont Community Center, the

Henrietta Johnson Medical Center, Westside Family Health, and the Wilmington Hospital Health Center connect people to needed health care and social services.

Using a similar approach, the Promotoras Program at Christiana Care Health System teaches Hispanic volunteers about various health issues, such as breast cancer screening and overall wellness. The volunteers, or Promotoras, then teach others in the community about the importance of screening and other ways to be healthy. The Promotoras provide health education and help people navigate the health care system, improving access to care. This approach facilitates outreach to community members who may otherwise be difficult to reach, while simultaneously encouraging community cohesion.

These and similar CHW programs in Delaware are making a positive impact on the individuals and families that they serve and can provide a foundation for a more comprehensive and supportive infrastructure across the state. Additional attention is needed to implement the recommendations emerging from Massachusetts's experience and the lessons from Minnesota to ensure the systematic integration of high quality CHWs into health care delivery in Delaware.

3. Medical-Legal Partnerships

Another promising strategy for addressing patients' social needs is through a Medical-Legal Partnership. As the name implies, the approach includes collaboration between health care providers and legal institutions to improve the health care system's response to social determinants of health. The approach is grounded in the idea that poor living conditions and the unequal distribution of resources needed for health can be traced to laws that are unfairly applied or under-enforced, which has often led to denial of services and benefits that are designed to help vulnerable people (<http://medical-legalpartnership.org/>). One might view the MLP strategy as increasing access to justice, which is synonymous with equity. According to the National Center for Medical-Legal Partnerships, there are five main domains where complicated bureaucracies, wrongfully denied benefits, and unenforced laws commonly impact health and require legal intervention: income support and insurance; housing and utilities; education and employment; legal status or citizenship; and personal and family stability. In response to these legal challenges to health, Medical-Legal Partnerships:

- Train health care, public health, and legal teams to work collaboratively and identify needs upstream;

- Address individual patients' health-harming social and legal needs with interventions ranging from triage and consultations to legal representation;
- Transform clinical practice and institutional policies to better respond to patients' health-harming social and legal needs; and
- Prevent health-harming legal needs broadly by detecting patterns and improving policies and regulations that have an impact on population health.

The number of MLPs has grown tremendously in recent years due to evidence of their effectiveness in addressing the social needs of patients. According to the National Center, Medical-Legal Partnerships exist in 262 health care institutions in 36 states. In an assessment of their impact, researchers found that these partnerships positively impact patient health, and offer a significant return on investment, justifying the expansion of the model (Beeson, McAllister & Regenstein, 2013).

Medical-Legal Partnerships are usually financed at the local level through hospitals' operating budgets, community benefit programs, and/or private grants. However, state and federal grants for addressing health inequities and social determinants of health (SDOH) are becoming increasingly supportive of Medical-Legal Partnerships (Bachrach, Pfister, Wallis, & Lipson, 2014). Both the American Medical Association and the American Bar Association currently endorse them.

Support for developing a Medical-Legal Partnership can be found on the National Center for Medical-Legal Partnerships' website (<http://medical-legalpartnership.org/>). The website includes a toolkit to help partners assess a community's needs and the feasibility of implementing a partnership. Following the initial assessment phase, the National Center provides more in-depth consultation and support to local partnerships in relation to building the infrastructure for Medical-Legal Partnerships, and to plan for growth and sustainability.

4. **Health Leads**

Other promising initiatives to create linkages between health care and community resources include programs such as Health Leads (<https://healthleadsusa.org/>). Health Leads allows health care providers to prescribe basic resources like food and heat just as they do medication. Patients are referred to a Health Leads advocate to fill these prescriptions and help connect patients to basic resources they need to be healthy. The program is unique in that college students are trained to serve as volunteer Health Leads advocates and are, therefore, contributing to community needs as they are gaining

important knowledge and skills to become future health care leaders. Health Leads programs currently operate in seven U.S. cities. Early findings about the impact of the Health Leads model can be found on the Health Leads website.

Sample Strategy

In Delaware, a telephone hotline called Delaware 2-1-1 and its companion website (www.delaware211.org) are available to individuals seeking help with a wide range of health and social service needs. Delaware 2-1-1 is a free and confidential service for residents that provides a central access point for information about services related to basic needs (e.g. food, housing, transportation, etc.), criminal justice and legal services, health care, individual and family support, substance abuse, education, and employment services. Individuals can access the hotline directly, but professionals may also use it to link patients or clients with support services in the community. In addition, community organizations can contact Delaware 2-1-1 to be included in its inventory of resources. The 2-1-1 service is offered by Delaware Helpline with support from United Way of Delaware and the State of Delaware. Staff is bilingual and can help callers in English or Spanish.

Care Coordination

Advancing health equity through the health care system requires the delivery of high quality, accessible care that is comprehensive, patient-centered, and coordinated for individual patients. At the same time, the provision of health care must be better integrated with population and behavioral health strategies. Changes to the health care delivery landscape, including new regulations and funding streams provided through the Affordable Care Act (ACA), have created opportunities for improved coordination between providers and patients, as well as between providers. (For a general overview of the ACA, visit <http://kff.org/health-reform/fact-sheet/summary-of-the-affordable-care-act/>. For a recent analysis of grant opportunities available as a result of the ACA, visit <http://www.chrt.org/publications/price-of-care/affordable-care-act-funding-an-analysis-of-grant-programs-under-health-care-reform/>).

The following are examples of interventions, tools, and options to improve care coordination:

A. Health System Integration

Although health care and public health institutions share the goal of the improving health of the populations that they serve, they have traditionally practiced independently of each other. Better integration and alignment of resources can improve population health and reduce health inequities. Recognizing that lack of integration was a barrier to health improvement, the Institute of Medicine recently convened a committee of experts to develop recommendations for enhanced integration, particularly between primary care and public health. The committee defined integration as “the linkage of programs and activities to promote overall efficiency and effectiveness and achieve gains in population health” (IOM, 2012, p. 3). They found that the unique needs of communities, differences in local resources, and the varied nature of health delivery systems made it difficult for the committee to recommend specific models of integration. Rather, their research led to the development of a set of principles thought to be essential for successful integration of primary care and public health:

1. a shared goal of population health improvement;
2. community engagement in defining and addressing population health needs;
3. aligned leadership that:
 - a. bridges disciplines, programs, and jurisdictions to reduce fragmentation and foster continuity,
 - b. clarifies roles and ensures accountability,
 - c. develops and supports appropriate incentives, and
 - d. has the capacity to manage change;
4. sustainability, the key to which is the establishment of a shared infrastructure and foundation for enduring value and impact; and
5. the sharing and collaborative use of data and analysis (IOM, 2012, pp. 5-6).

“The status quo of siloed enterprises is not good enough. Moving along a path of integration will promote better health and wellbeing for all Americans” (IOM, 2012).

Sample Strategy

Delaware's Healthy Weight Collaborative is an example of integration between primary care and public health. The collaborative includes a range of partners: the Delaware Division of Public Health, La Red Health Center, Henrietta Johnson Medical Center, Delaware State University Health Center, Christiana Care Health System, the Governor's Council on Health Promotion and Disease Prevention, the Healthy Eating and Active Living Coalition, the Medical Society of Delaware, Nemours Health and Preventive Services, the University of Delaware, Health Sciences Alliance, Westside Family Health, United Way of Delaware, and the YMCA of Delaware. Supported by funding through the Affordable Care Act, the initiative's goal is to address obesity among targeted populations. The leadership is particularly focused on creating a permanent capacity for system-wide integration to promote health and prevent illness.

Community Health Centers offer an important avenue for health system integration. According to the U.S. Department of Health and Human Services (HHS), Community Health Centers are community-based and patient-directed organizations that serve populations who otherwise experience limited access to health care (<http://www.bphc.hrsa.gov/about/>). They are located in communities with great needs; are governed by a community board that must be comprised of at least 51 percent patients; provide comprehensive services (often including dental care, mental health and other supportive services); and do not turn anyone away from receiving services. Community Health Centers are a critical component of the health care safety net and an increasingly important provider of primary care services to newly insured patients under the ACA. Typically, Community Health Centers provide high quality primary care services based upon a keen understanding of community needs and prioritizing services in response to those needs. By their very nature, Community Health Centers are models of primary care and public health integration that promote the health of communities and help to advance health equity.

In Delaware, Community Health Centers exist in the form of Federally Qualified Health Centers and are located in each county. They include: Henrietta Johnson Medical Center, Westside Family Health, and La Red Health Center. (View a map of the Delaware's FQHCs at <http://www.dhss.delaware.gov/dph/hp/files/fqhcs.pdf>.) Future efforts to integrate primary care and public health may benefit from ensuring one of our Community Health Centers is included in the initiative. For additional information on the role of Community Health Centers in addressing the SDOH, read a 2012 report by the Institute for Alternative Futures at <http://www.altfutures.org/pubs/leveragingSDH/IAF-CHCsLeveragingSDH.pdf>.

B. Medical Homes

The health care system can be strengthened by addressing the organization and delivery of primary care so that more attention is focused on access, coordination, and prevention. The medical home model, also referred to as the patient-centered medical home, delivers primary care that is comprehensive, patient-centered, coordinated, accessible, and of high quality. The Agency for Healthcare Research and Quality (AHRQ) Patient-Centered Medical Home Resource Center describes five functions or attributes of medical homes:

1. **Comprehensive Care.** Patient-centered medical homes are accountable for meeting the large majority of each patient’s physical and mental health care needs, including prevention, wellness, acute care, and chronic care. Providing comprehensive care requires a team of providers that may include physicians, advanced practice nurses, physician assistants, nurses, pharmacists, nutritionists, social workers, educators, and care coordinators. As an alternative to having in-person access to a wide range of care providers, many medical homes, including smaller practices, build virtual teams that link their patients to providers and services in their communities.
2. **Patient-Centered Care.** Patient-centered medical homes provide primary care that is personalized for each patient. Patient-centered care relies on partnerships between providers and patients (and their families) so that providers can gain an understanding and respect for each patient’s unique needs, culture, values, and preferences. Medical home practices actively support patients in learning to manage and organize their own care at the level the patient chooses. Recognizing that patients and families are core members of the care team, medical home practices ensure that these individuals are fully informed partners in establishing care plans.
3. **Coordinated Care.** Patient-centered medical homes coordinate care across all elements of the health care system, including specialty care, hospitals, home health care, and community services and supports. Coordination is particularly critical during transitions between sites of care, such as when patients are being discharged from the hospital. Medical home practices also excel at building clear and open communication among patients and families, their medical homes, and members of the care team, which facilitates coordination of care.
4. **Accessible Services.** Patient-centered medical homes deliver accessible services with shorter waiting times for urgent needs, enhanced in-person hours, around-the-clock telephone or electronic access to a member of the care team, and alternative

methods of communication, such as email and telephone care. Medical home practices are responsive to patients' preferences regarding access.

5. **Quality and Safety.** Patient-centered medical homes demonstrate a commitment to quality assurance and quality improvement. This is done through ongoing engagement in activities such as using evidence-based medicine and clinical decision-support tools to guide collaborative decision-making with patients and families. Similarly, patient-centered medical homes engage in performance measurement and improvement, evaluating and responding to patient experiences and patient satisfaction, and practicing population health management. Medical homes exhibit a systems-level commitment to quality and safety by sharing robust data and improvement activities publicly.

More about each of these attributes, including academic papers, research briefs, and other resources that support the patient-centered medical home model can be found on AHRQ's PCMH Resource Center website: <http://www.pcmh.ahrq.gov/>. Additionally, the *Joint Principles of the Patient Centered Medical Home* (2007) provide guidelines for primary care organizations. In 2008, the Medical Society of Delaware adopted the guidelines, which have guided the development of 37 patient-centered medical homes across the state (AAFP, 2007).

Implementing the patient-centered medical home model supports health equity in a number of ways. For instance, there is evidence that racial and ethnic disparities in access to health care are reduced through medical homes (Hernandez, Doty, Shea, Davis & Beal, 2007). In addition, medical homes have been found to improve the quality of care for vulnerable patients by, for example, promoting higher rates of routine preventive screening (Hernandez, Doty, Shea, Davis & Beal, 2007). Medical home initiatives can also promote linkages to social supports. Blue Cross Blue Shield of Michigan supports a patient-centered medical home program in which providers use a systematic approach to assess patients' social needs. Providers maintain a database of community resources and refer patients to those resources as appropriate. Providers then track referrals for high-risk patients to ensure follow-up (Bachrach, Pfister, Wallis & Lipson, 2014).

Although the concept of medical homes has been in practice for some time, implementing the patient-centered medical home model is just recently spreading across the U.S. due in part to new incentives created through the ACA. Furthermore, according to a recent review by the National Academy for State Health Policy, state and federal governments are increasingly looking to primary care as a foundation for broader system reform and patient-centered medical homes offer an important mechanism for achieving

many of the reform goals (Kinsler & Worth, 2014, p. 7). Although not listed in the review, Delaware is piloting patient-centered medical home PCMHs through a partnership between the Medical Society of Delaware and Highmark Delaware. An overview of the pilot can be found at

<http://www.medicalsocietyofdelaware.org/Portals/1/PCMH/PCMH%20Report%204-9-13.pdf>. Additionally, care coordination, including efforts to support patient-centered medical homes, is an integral part of Delaware’s health care system transformation plan (i.e. the State Innovation Model plan) referenced in the “Health System Reform in Delaware” sub-section (beginning on page 60).

Improving Quality and Access to Culturally Competent Care

Although the health care system is an important lever of change for addressing patients’ social needs and advancing health equity, it was identified as a contributor to existing health inequities. *The National Healthcare Disparities Report* (AHRQ, 2012), produced annually since 2003, provides a summary of trends in health care disparities and reports on progress with efforts to reduce such disparities. The most recent report highlights persistent challenges within the health care system and the need for urgent attention to issues related to access and quality of care, especially for minority and low-income groups. The report finds that quality is improving in some areas, but that access is worsening and disparities related to access are largely unchanged. Therefore, fundamental aspects of the health care system need to be addressed to reduce disparities in care while advancing health equity. Recommendations for remediating such disparities in care include the following:

1. **Collect valid and reliable data on race, ethnicity, and language preference.** Although data collection alone is not sufficient for reducing disparities, it is a critical first step to identifying the health care needs of specific populations and gaps in care. National efforts, including requirements of the ACA and data standards produced by the HHS Office of Minority Health, are promoting better data systems. In addition, the Institute of Medicine developed recommendations to identify of disparities in care, including: collecting standardized self-reported patient race, ethnicity, and language (REL) data and using those data to examine differences in quality of care between groups (Ulmer, McFadden, & Nerenz, 2009). Ultimately, these data can be used to develop quality improvement interventions tailored to specific groups, and the Institute of Medicine provides additional guidelines to this end. Lessons learned regarding efforts to collect and incorporate REL data into quality improvement initiatives are highlighted in an issue brief describing the Robert Wood Johnson Foundation’s (RWJF) Aligning Forces for

Quality (AF4Q) Initiative, which can be found at www.rwjf.org/content/dam/farm/reports/issue_briefs/2014/rwjf412949. Related tools and additional resources to support REL data collection and standardization can be found in the *RWJF Equity Resource Guide*: http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2014/rwjf412949/subassets/rwjf412949_3.

- 2. Diversify and ensure a culturally competent workforce.** There is evidence that the quality of care for racial and ethnic minorities improves when the workforce reflects the characteristics of the patient population (Smedley, Stith Butler, & Bristow, 2004). Provider diversity is a key element of patient-centered care and may be achieved through the recruitment, retention, and training of racially, ethnically, and culturally diverse individuals. This requires a concerted effort, particularly by leadership within health care organizations and other state systems. *The HHS Action Plan for Reducing Racial and Ethnic Health Disparities* (2011) specifically recommends creating an undergraduate pipeline program to increase the diversity of students entering health professions. Other strategies to address gaps in the diversity of the workforce include expanding the use of interpreters to overcome language barriers and improving cultural competence education and professional development for health care providers. The U.S. Department of Health Human Services (HHS) provides a web-based training opportunity for physicians regarding cultural competency, called *A Physician's Practical Guide to Culturally Competent Care*. Although the training focuses on physicians, all health care providers may benefit from the training, which can be found at <https://cccm.thinkculturalhealth.hhs.gov/>.
- 3. Build community partnerships for research and action.** Similar to the principles underlying place-based strategies for promoting health equity, providers and researchers need to embrace community partnerships. The National Partnership for Action's *National Stakeholder Strategy* (2011) specifically calls for greater investments in community-based participatory research, which is research that involves community engagement throughout the entire research process, and evaluates community-oriented intervention strategies. Similarly, to promote health equity across the continuum of health-related services, the *National Stakeholder Strategy* recommends increased support for and improved coordination of research that enhances our understanding of strategies. Finally, more attention is needed to enhance the transfer of

knowledge and translation of research at the program, community, system and policy levels.

Sample Strategy

In Delaware, the Delaware Clinical and Translational Research ACCEL Program (DE-CTR) offers a mechanism for community partnerships and research translation. The DE-CTR is a partnership between the University of Delaware, Christiana Care Health Services, Nemours Health and Prevention Services/Alfred I. duPont Hospital for Children, and the Medical University of South Carolina (MUSC). It aims to improve the state's infrastructure and capacity for conducting research that can be applied to effective interventions that lead to better clinical outcomes. The DE-CTR ACCEL program is supported by an Institutional Development Award (IDeA) from the National Institute of General Medical Sciences of the National Institutes of Health (under grant number U54-GM104941, PI: Binder-Macleod). The DE-CTR program includes a strategic partnership with the Medical University of South Carolina, which provides technical assistance and support. With an emphasis on community outreach and engagement, the DE-CTR is particularly well positioned to support community-based participatory research and research translation for health equity. For more information about the DE-CTR program and related funding and research opportunities, visit: <https://de-ctr.org/>.

- 4. Implement evidence-based interventions and promising practices for advancing health equity.** Scholars and professionals alike are increasingly recognizing the potential impact of health care system changes and specific interventions for advancing health equity. Providers can find ideas, emerging practices, lessons learned, tools, and other resources through linkages with other providers. As mentioned on page 99, HealthBegins is a social network where clinicians can learn and share upstream strategies. Examples of promising strategies shared by this network include the “Yelp for Help” pilot program in Los Angeles, where providers partnered with a charter school focused on preparing students for careers in the health field. Students learned about social determinants and then helped to map over 230 local “health-critical” community resources related to food insecurity, slum housing, adult education, job training, and other social determinants. The resources were uploaded to a searchable web-based platform with mapping capabilities. To learn more about “Yelp for Help,” visit:

<http://healthbegins.ning.com/page/hsa-resource-search>. For more information about the HealthBegins network and to access all of the shared resources, visit: <http://healthbegins.ning.com/> or <http://healthbegins.org>.

5. **Engage in the policy process.** Health and health equity are inherently political. The SDOH are determined by policy processes and decisions that tend to favor those with power and other resources. Policy changes are needed to facilitate the health care system changes that will help alleviate health inequities. Health care providers can be leaders in the policy arena by advocating for their patients' social needs. Similarly, providers can lend their expertise to policy discussions outside of the health care sector, but which have an impact on health. Because policy generally has such large implications on health, it is discussed in more detail in the next section.

Conclusion

As researchers have explained, re-orienting health care systems toward health equity through a social determinants of health lens is not for the faint-hearted (Baum, Bégin, Houweling & Taylor, 2009, p. 1967). It requires leadership within the health care sector and stewardship working with other sectors. More specifically, according to Baum and colleagues (2009), the characteristics of a health equity-oriented health care sector include the following:

1. Leadership to improve the equity performance of the health care system, including:
 - A focus on comprehensive primary care;
 - Decision-making processes that involve local communities;
 - Accessible and high quality care for all;
 - Planning, including allocation of resources, based on the needs of populations within a SDOH framework;
 - Policy statements and strategies that are explicit about closing the health equity gap and the need for action on SDOH to achieve this goal; and
 - A shift in funding for community-based services and incentives that align with prevention.
2. Stewardship in working with other sectors to improve health and equity, including:

- The presence of health sector advocacy in other sectors that influence SDOH and the importance of inter-sectoral action;
- Development of expertise to establish a health equity surveillance system and to conduct cross-sector impact assessments on health;
- Reform of medical and health professional education such that the importance of SDOH is reinforced in clinical training and an understanding of population health perspectives and related skills is promoted;
- Training and education of professionals in other sectors (including urban and transport planners, teachers, and others) on the SDOH; and
- Increased funding for research on the impact of SDOH and evaluation of interventions designed to address them (Baum, Bégin, Houweling & Taylor, 2009, p. 1970).

Delaware's health care system is undergoing intense changes due to the passage of the ACA and related reform initiatives. Many local providers are already engaging in leadership and stewardship to advance health equity by identifying and implementing specific upstream interventions. These efforts can be expanded and enhanced. New initiatives grounded in the recommendations highlighted above can be developed in an environment conducive to such changes. The next section describes policy strategies needed to support and reinforce the efforts of providers. It also includes policy strategies to promote healthier living conditions overall.

Glossary – Section 5

Community-Based Participatory Research (CBPR): An approach to research that involves an equitable partnership between and among community members and researchers in all aspects of the research process and in which all partners contribute expertise and share decision making and ownership. The aim of CBPR is to increase knowledge and understanding of a given phenomenon and integrate the knowledge gained with interventions, policy, and social change to improve the health and quality of life of community members.

Community Health Center (CHC): Clinics that generally serve people who are uninsured, underinsured, low-income, or those living in areas where little access to primary health care is available. They are located in communities with great needs; are governed by a community board that must be comprised of at least 51 percent patients; provide comprehensive services (often including dental care, mental health, and other supportive services); and do not turn anyone away.

Community Health Workers (CHWs): Members of a community that provide basic, culturally appropriate, and accessible health information to hard-to-reach members of the community. CHWs can provide basic health services, counseling, and other support services or linkages to community resources. They can be considered as a link between health care providers and community members.

Medical Home: A model of primary care that provides whole-person, accessible, comprehensive, ongoing and coordinated, patient-centered care. It is also referred to as a patient-centered medical home (PCMH) or primary care medical home.

Medical-Legal Partnership: A health care delivery model that combines the expertise of health and legal professionals to identify, address, and prevent health-harming legal needs for patients, clinics, and populations.

Care Coordination: Organization of patient care through communication between health care providers as well as the patient, mobilization of resources, and completion of patient care activities.

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