Upstream Communication Toolkit

Tools to improve communication about
social needs, social determinants of health, and
structural determinants of health equity

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Overview

Across the country, clinical-community partnerships & multi-sector collaboratives to advance health equity and address social determinants of health are on the rise. As stakeholders from healthcare, social services, public health, businesses, and government come together, we often use different terms and definitions when describing our values, work, and goals. This lack of clarity, precision, and agreement about the words we use makes it harder to communicate and collaborate.

Language shouldn't be a barrier to moving upstream rapidly and effectively. That's why we developed the *Upstream Communication Toolkit,* a living document designed to help healthcare, human service, and public health leaders find common ground quickly. It includes the *Glossary of Upstream Terms,* an *Upstream Integration Continuum*, and a *Discussion Guide*. We welcome your feedback.

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Glossary of Upstream Terms

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Upstream Integration Continuum

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Glossary of Upstream Terms

❯❯ Start

The purpose of the *Glossary of Upstream Terms* is to provide general and understandable explanations for the most important terms and definitions used in practice in relation to the social and structural drivers of health equity.

❯❯ Review

As you review terms, associated explanations, and the term mapping table, consider the terms that your organization and its partners use to communicate with each other. Write down thoughts, questions, or concerns as they arise.

❯❯ Discuss

Share the *Glossary of Upstream Terms* and your notes with your colleagues and external partners. Convene to discuss and decide how these terms can help you better communicate and represent your shared aspirations and goals. The *Discussion Guide* can help.

❯❯ Share

This is a living document, designed to reflect a rapidly evolving landscape of important terms and definitions used in practice, and provoke new ways of thinking and communicating. We welcome your feedback and suggestions.

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Glossary of Upstream Terms

Health disparities

Differences in health status rates between population groups.

Health inequities

Disparities that are due to differences in social, economic, environmental, or healthcare resources. Simply put, health inequities = health disparities that are unfair and unjust. Health inequities are shaped by social and structural drivers (social needs, social determinants of health, structural determinants of health equity).

Health equity

Everyone has the opportunities and resources they need to be as healthy as possible and that no one is disadvantaged due to social circumstances or policies. Because structural racism has systematically denied opportunities and resources and disadvantaged people based on race, health equity is inextricably linked to racial equity.

Racial equity

"The systematic fair treatment of people of all races, resulting in equitable opportunities and outcomes for all. It is not just the absence of discrimination and inequities, but also the presence of deliberate systems and supports to achieve and sustain racial equity through proactive and preventative measures."

Social risk factors

Social risk factors are specific individual-level adverse social conditions (i.e., adverse material and psychosocial circumstances) that are associated with poor health. Behavioral risk factors are not social risk factors.

Source: Alderwick H, Gottlieb LM. Meanings and Misunderstandings: A Social Determinants of Health Lexicon for Health Care Systems. Milbank Q. 2019;97(2):407–419. doi: 10.1111/1468-0009.12390.

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Glossary of Upstream Terms

Social needs   see also: health-related social needs (HRSNs), basic human needs

Social needs are the social risk factors that individuals (e.g., patients, clients, beneficiaries) identify and prioritize. They represent individual material resources and psychosocial circumstances required for long-term physical and mental health and wellbeing. <u>Example: Food insecurity</u>

•   Material circumstances describe physical living and working conditions and include factors such as housing, food, water, air, sanitation.

•   Psychosocial circumstances include stressors such as negative life events, stressful living circumstances, and (lack of) social support.

•   Commonly refers to specific individuals or defined populations, typically defined by attribution.

Note: Historically, this definition is rooted in a Basic Needs approach, which contrasts with the Capability Approach and human rights frameworks, which focus on freedoms and opportunities, not only material circumstances.

Source: https://www.who.int/sdhconference/resources/ConceptualframeworkforactiononSDH_eng.pdf https://owlcation.com/social-sciences/Understanding-Poverty-Comparing-Basic-Needs-and-Capabilities-Approaches

Social determinants of health (SDoH)

Underlying community-wide social, economic, and physical conditions in which people are born, grow, live, work, and age. These conditions shape the distribution, chronicity, and severity of individual social risk factors and social needs. <u>Example: food deserts</u>

•   As intermediary determinants, SDoH shape individual material and psychosocial circumstances *(see also social needs)* as well as biologic and behavioral factors. The accessibility, affordability, and quality of healthcare and social services are themselves a SDoH for communities.

•   Commonly refers to defined communities or regions, typically defined by geography.

Source: https://www.who.int/sdhconference/resources/ConceptualframeworkforactiononSDH_eng.pdf

Structural determinants of health equity

The climate, the socioeconomic-political context (e.g. societal norms and macroeconomic, social & health policies) and the structural mechanisms that shape social hierarchy and gradients (e.g. power, class, racism, sexism, exclusion). "The causes of the causes" . <u>Example: supermarket redlining.</u>

•   Commonly refers to cities, states, nations, or the world, typically defined by political jurisdictions, cultural boundaries, or economic relationships.

Source: https://www.who.int/sdhconference/resources/ConceptualframeworkforactiononSDH_eng.pdf

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Glossary of Upstream Terms

Population health

The health outcome of a group of individuals including the distribution of such outcomes within a group.

•	Often used by healthcare stakeholders in association with the Triple Aim of improving the quality of care, improving the health of populations, and reducing the per capita cost of healthcare.

•	*"Population health management"* manages health needs, including HRSNs, to improve health status, utilization, and cost indicators for defined populations.

Source: https://www.ajmc.com/journals/ajac/2017/2017-vol5-n2/creating-clarity-distinguishing-between-community-and-population-health

Community health

A multi-sector, multi-disciplinary collaborative enterprise that uses public health science, evidence-based strategies, and other approaches to engage and work with communities, in a culturally appropriate manner, to optimize the health, quality of life and SDoH of all persons who live, work, or are otherwise active in defined communities.

Source: https://www.ajmc.com/journals/ajac/2017/2017-vol5-n2/creating-clarity-distinguishing-between-community-and-population-health

Public health 3.0

In addition to maintaining essential governmental public health functions, this model emphasizes collaborative engagement and actions that directly affect SDoH, health inequities, and structural determinants of health equity.

•	Acts to confront institutionalized racism, sexism, and other systems of oppression that create inequitable conditions leading to poor health

Source: https://www.cdc.gov/pcd/issues/2017/17_0017.htm

https://www.naccho.org/uploads/downloadable-resources/NACCHO-PH-3.0-Issue-Brief-2016.pdf

Levels of change (or analysis)

•	Micro: involves direct interaction with clients to address individual problems. Common examples of micro-level work include helping people find housing, health care, and social services.

•	Meso: involves interaction with groups, not just individuals, to address group problems. At this level, groups and organizations work to create smaller-scale institutional, social, and cultural change.

•	Macro: involves interventions and advocacy on a larger scale, affecting entire communities, states or even countries. This can involve crafting laws, petitioning policymakers, or shaping social norms.

Source: https://dworakpeck.usc.edu/news/do-you-know-the-difference-between-micro-mezzo-and-macro-level-social-work

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Moving Upstream: Levels of Action

The terms and associated explanations in the Glossary of Upstream Terms can be better understood in relation to each other. Moving upstream to advance health equity requires multi-level action that is coordinated, strategic, and sustained. Review the term mapping table below to consider the ways your organization and its partners can better communicate with each other. Write down thoughts, questions, or concerns as they arise.

Social Needs

Social Determinants of Health

Structural Determinants of Health Equity
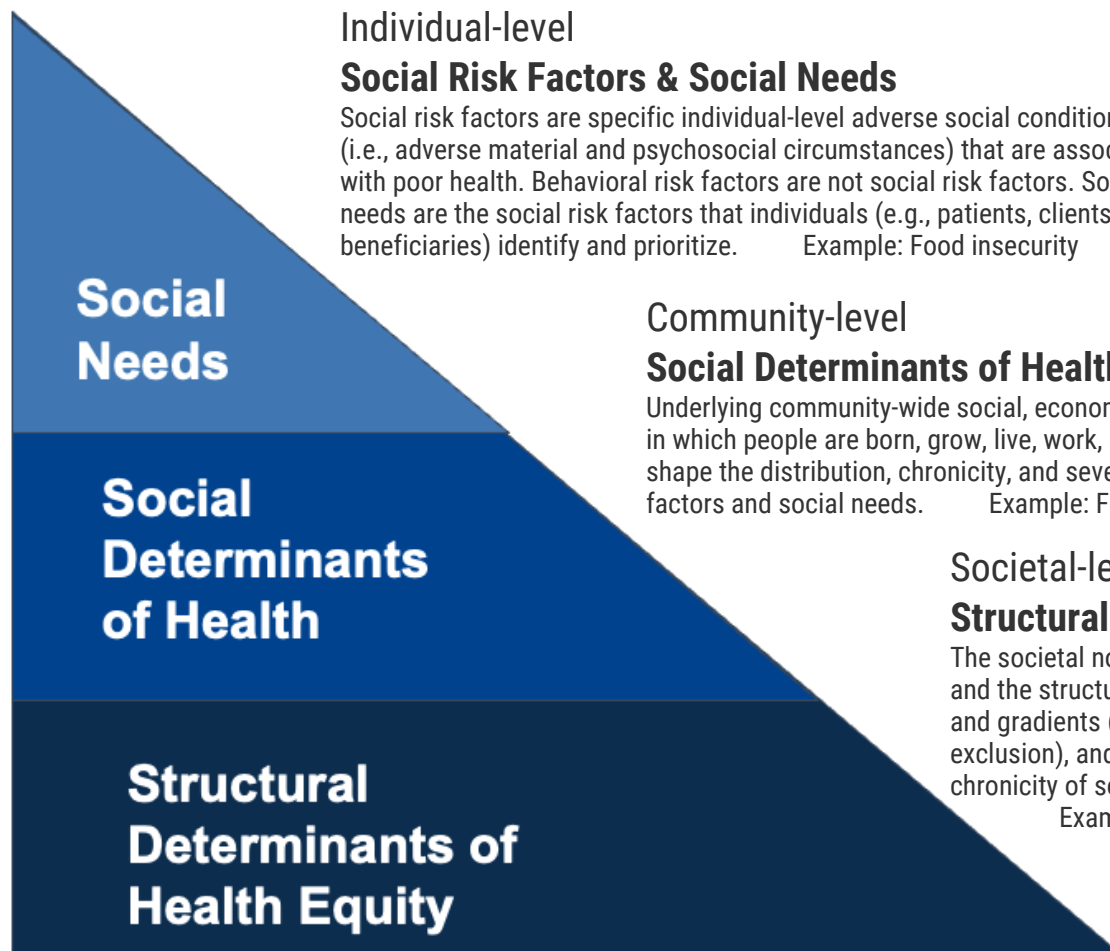
Individual-level
Social Risk Factors & Social Needs
Social risk factors are specific individual-level adverse social conditions (i.e., adverse material and psychosocial circumstances) that are associated with poor health. Behavioral risk factors are not social risk factors. Social needs are the social risk factors that individuals (e.g., patients, clients, beneficiaries) identify and prioritize.   Example: Food insecurity

Community-level
Social Determinants of Health
Underlying community-wide social, economic, and physical conditions in which people are born, grow, live, work, and age. These conditions shape the distribution, chronicity, and severity of individual social risk factors and social needs.   Example: Food desert

Societal-level
Structural Determinants of Health Equity:
The societal norms; macroeconomic, social & health policies; and the structural mechanisms that shape social hierarchy and gradients (e.g., power, racism, sexism, class, and exclusion), and, in turn, the distribution, quality, and chronicity of social determinants of health and social needs.   Example: Supermarket redlining, structural racism

Source: HealthBegins. Upstream Communications Toolkit

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Mapping Terms

The terms and associated explanations in the Glossary of Upstream Terms can be better understood in relation to each other. Review the term mapping table below to consider the ways your organization and its partners can better communicate with each other. Write down thoughts, questions, or concerns as they arise.

Terms	Common Definition	Populations Targeted	Level of Change	Associated Approaches
Social needs / Health-related social needs (HRSNs)	"The effects of the causes" Individual material and psychosocial circumstances	Specific individuals or defined populations	Micro +/- Meso	Population Health - Population Health Management - Clinical-community partnerships - CMS AHC Model (assistance track) - Community-oriented primary care - Preventive Medicine
Social determinants of health (SDoH)	"The causes of poor health" Underlying community-wide social, economic, and physical conditions	Defined communities or regions	Meso +/- Macro	Community Health - Multisector collaboratives - Accountable Communities for Health - Community Health Needs Assessments (CHNAs)
Structural determinants / SDoH inequities	"The causes of the causes" The climate, socioeconomic-political context and the structural mechanisms that shape social hierarchy, gradients, and equity	Cities, states, nations, or the world	Macro +/- Meso	Public Health 3.0 - 100 Million Healthier Lives - Pursuing Equity - IHI - National Collaborative for Health Equity Capability Approach Human-rights based approach

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Discussion Guide

1 **As you consider relationships with other organizations, what is your target population ?** Defined patient or client populations; geographically defined communities; and/or broad city, state, or national jurisdictions?

2 **What terms does each partner use to describe their respective interest in 'social determinants of health?'**

3 **What is the existing business model for each partner?** What are your main revenue sources, customer base, services and/or products, and typical financing arrangements?

4 **What experiences and resources does each partner already bring to the table in addressing HRSNs, SDoH, and/or structural determinants of health equity?** In general? For your target population?

5 **What types of interventions do you want to pursue together to address HRSNs, SDoH, and/or structural determinants of health equity?** What levels of change (micro, meso, macro) do these interventions align with? What is the timeframe for each intervention?

6 **What are the measures of success for each intervention or strategy we wish to pursue together?** What financial, economic, social, and structural benefits should we expect to see?

7 **What is our shared capacity to support each level of action?** To address HRSNs for defined populations, address SDoH for defined communities, address structural determinants? What will we do when we hit capacity?

8 **If we view our interventions as an investment portfolio that seeks to achieve short, medium, and long-term goals, do we have the right balance of interventions?** How are we ensuring these interventions center and advance equity?

9 **What are each partner's concerns?** Are we concerned about unintended consequences, like 'medicalizing' social services? If so, how do we plan to address these concerns?

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Upstream Integration Continuum

The Upstream Integration Continuum (formerly known as the Levels of HRSN & SDH Integration Framework) is an eight-page document that draws on HealthBegins' direct experience in the field and the evolving traditional and gray literature. Most notably, it adapts a taxonomy developed in 2013 by SAMHSA-HRSA Center for Integrated Health Solutions to describe levels of behavioral health integration in primary care.[1] After reviewing the *Glossary of Upstream Terms* and *Discussion Guide,* partners can then use this framework to apply these terms in the context of their own settings to clarify shared goals, priorities, and approaches to integrating services and advancing health equity.

This practical six level framework begins with coordination and moves through increasing levels of collaboration and integration. By implication, the numbering of levels suggests that the higher the level of integration, the more potential for positive impact on health for defined populations and, more broadly, whole communities. The goal of the framework is to provide healthcare, social service, and public health stakeholders with clarity, increase the precision of their communication, and accelerate practice and system redesign and integration related to the social and structural drivers of health equity. **To download a free complete copy of the Integration Framework, please visit www.healthbegins.org**

[1]Heath B, Wise Romero P, and Reynolds K. A Review and Proposed Standard Framework for Levels of Integrated Healthcare. Washington, D.C. SAMHSA-HRSA Center for Integrated Health Solutions. March 2013.

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