

Achieving Health Equity for Future Generations: Priorities for Action in Social Work Research and Practice

Michael S. Spencer

University of Michigan

Karina L. Walters

University of Washington

Heidi L. Allen

Columbia University

Christina Andrews

University of South Carolina

Audrey Begun

Ohio State University

Teri Browne

University of South Carolina

John Clapp

Ohio State University

Diana DiNitto

University of Texas

Peter Maramaldi

Simmons College

Darrell P. Wheeler

University at Albany, State University of New
York

Brad Zebrack

University of Michigan

Edwina Uehara

University of Washington

The Alcohol Misuse Grand Challenge
Collective

Achieving Health Equity for Future Generations: Priorities for Action in Social Work Research and Practice

Tāne, the deity of the forest, lived with his siblings in darkness within the eternal embrace of his parents, Ranginui (sky father) and Papatūānuku (earth mother). Becoming increasingly frustrated at living in the darkness, Tāne successfully pushed the pair apart by planting his head in the earth and using his feet to lift the sky—to expose Te Ao Mārama—the world of light.

—Māori creation story

Among the Māori, the indigenous people of Aotearoa/New Zealand, Tāne serves as a model for action in the world: His roots are in earth, and his head is in the heavens. Tāne is able to bear the weight of action to procure necessary change. Similar to Tāne, social work must assert itself, bring new light, and bear the weight of action—in collaboration with allied health professions—to achieve health equity within the next generation. Social work has already had a significant impact on health interventions in the United States—from the health-policy reform efforts of the Progressive Era to the development of innovative community-based prevention interventions in modern times. Social work's perspective is in line with approaches that go beyond population surveillance, prompting action to address health inequities and social determinants of health.

Specifically, social work has an unyielding focus on lifting the health of a nation by lifting the health of the most disenfranchised and marginalized populations. Also, the profession's historical social-reform efforts have sought to procure health by addressing the conditions in which people live, work, play, learn, and age. These perspectives match the calls by the World Health Organization (WHO, 2014a), U.S. Centers for Disease Control and Prevention (Brennan Ramirez, Baker, & Metzler, 2008), and the Healthy People 2020 national strategy (U.S. Department of Health and Human Services, n.d.) to focus contemporary research and intervention efforts on the social conditions that produce health and health inequities.

Additionally, the reassertion of social work into the national strategy and debate is timely given the precarious position of the Patient Protection and Affordable Care Act (PPACA; 2010) and the burgeoning national effort to create culturally, linguistically, and communally grounded interventions that affect the upstream determinants of the nation's poor health.

Although the United States is among the wealthiest nations in the world and spends far more per person on health care than any other industrialized nation, the population's health is rapidly deteriorating. Over the past three decades, the U.S. population has been dying at younger ages than those of the populations in peer nations and has endured a pervasive pattern of poorer health throughout the life course, from birth to old age (Institute of Medicine, 2013). Moreover, population health diminishes along a social gradient: Populations that experience high rates of social, racial, and economic exclusion bear the greatest burden of poor health and premature mortality. Although poor health follows a social gradient, deteriorating U.S. health cannot be fully explained by the health disparities that exist among people who are uninsured or poor; in fact, even the health of relatively elite Americans—those who are White, insured, and college educated, as well as those with high income—is worse than that of their peers in other industrialized countries (Avendano, Glymour, Banks, & Mackenbach, 2009; Institute of Medicine, 2013).

U.S. health professions have become increasingly myopic, focusing on individualized health care rather than on population health. By prioritizing interventions that target individual behavioral change, research tends to neglect upstream opportunities to intervene upon the settings and environments in which health is produced and maintained. Attention to individual and behavioral interventions are important but alone are not sufficient to eradicate health inequities (Hood, Gennuso, Swain, & Catlin, 2015). To secure true, sustainable, population-

based health changes, the health professions must unite and develop transdisciplinary approaches to examining the multilayered contributions of political, economic, and social determinants of population health inequities. Indeed, the nation's health depends on the development of this next wave of interprofessional and transdisciplinary collaboration (McGovern, Miller, & Hughes-Cromwick, 2014). Thus, if we are to truly turn the tide, health disciplines, particularly social work, must train professionals in how to invest in the social determinants of good health. We must also train professionals to develop the practice and research tools, community partnerships, and localized programs necessary to combat social and economic inequities (Hood et al., 2015; Uehara et al., 2013).

ACHIEVING HEALTH EQUITY: SOCIAL WORK ACTION PRIORITIES

We are at a critical juncture in U.S. history. The ACA and Healthy People 2020 produced national momentum to address health inequities. However changes in political leadership may sway this momentum away from this goal without active social work leadership. Although the ACA's primary focus falls on expanding insurance coverage, it also invites innovations that fall within particular domains of social work expertise: the creation of equitable health care systems by expanding health care into and in collaboration with the communities where people live and work, increasing health workforce diversity, improving cultural competency throughout health-care delivery systems, fostering community-based approaches to prevention, and creating community health centers in medically underserved areas. All of these efforts are hallmarks of social work practice and history. Consistent with social work's approach and values, Healthy People 2020 advocates for an ecological, multilevel approach to examining health determinants. It focuses on building healthful social and physical environments that will promote health and well-being (U.S. Department of Health and Human Services, n.d.) through place-based

approaches. These approaches consist of “five key social determinants of health [areas]: economic stability, education, social and community context[s], health and health care, and the neighborhood and built environment (for example, buildings, bike lanes, and roads)” (Mitchell, 2015, p. e71). Although the ACA and Healthy People 2020 provide the impetus for addressing health inequities, neither offers “definitive strategies for communities and health professionals” (Mitchell, 2015, p. e71). Also, Mitchell (2015) notes, there remains limited evidence-based research on the fundamental determinants of health and limited evidence of settings-based interventions that affect population health.

This chapter seeks to address these deficiencies through a “geography of science” approach that draws upon diverse disciplines, community leaders, and theoretical and community-centered perspectives (Logie, Dimaras, Fortin, & Ramón-García, 2014, p. 2). The American Academy of Social Work and Social Welfare (AASWSW) *Close the Health Gap* Grand Challenge Initiative is made up of three subgroups aimed at addressing health equity in the following areas through a geography of science approach: (1) Population Health through Community and Setting-based Approaches, (2) Strengthening Health Care Systems: Better Health Across America, (3) Reducing and Preventing Alcohol Misuse and Its Consequences. In this frame, social work and the health professions can activate ten priority areas. While they do not comprehensively address health equity in its entirety, these priorities are proposed as the first steps in initiating community and scientific conversations and launching broad, multi-sectorial, and interprofessional collaboration.

Population Health through Community and Setting-based Approaches

1. Focus on settings to improve the conditions of daily life.

2. *Advance community empowerment for sustainable health.*
3. *Generate research on social determinants of health inequities.*
4. *Stimulate multi-sectorial advocacy to promote health equity policies.*

Strengthening Health Care Systems: Better Health Across America

5. *Cultivate innovation in primary care.*
6. *Promote full access to health care.*
7. *Foster development of an interprofessional health workforce.*

Reducing and Preventing Alcohol Misuse and Its Consequences

8. *Develop research and scholarship in alcohol misuse and its consequences*
9. *Develop interdisciplinary, multi-sectorial and sustainable collaborations*
10. *Develop the workforce in social work to address alcohol misuse*

COMING TO TERMS: SOCIAL DETERMINANTS AND HEALTH EQUITY

In assessing population health, research has typically considered such indicators as mortality, life expectancy, morbidity, health status (physical and mental), functional limitations, disability, and quality of life (Hood et al., 2015; McGovern et al., 2014). Health determinants, also known as social determinants of health, refer to the economic and “social conditions into which people are born, grow, live, work, play, and age” –the conditions that “influence health” (Newman, Baum, Javanparast, O’ Rourke, & Carlon, 2015, p. ii127). In the United States, these conditions are shaped by the specific social structures that differentiate access to and distribution of money, wealth, power, knowledge, prestige, resources, and social connectedness (Link & Phelan, 1995; McGovern et al., 2014). Health inequalities are the persistent, systematic

differences in the health of social groups within a nation—differences resulting from unequal exposure to and distributions of the social determinants of health (Farrer, Marinetti, Cavaco, & Costongs, 2015). Quite often, impoverished conditions attend populations that have endured significant legacies of discrimination based on their racial, ethnic, class, or gender identity, or on their sexuality. Such conditions include unequal distribution of resources—such as quality education, culturally relevant medical care, and housing—that are typically tied to good health (Mitchell, 2015).

Racial and ethnic minorities bear the greatest burden from conditions that give rise to poor health and premature mortality. Those conditions have structural components as well as social ones (Agency for Healthcare Research and Quality, 2013; Mitchell, 2015; Smedley, Stith, & Nelson, 2003). Social determinants of health inequities are conditions of social stratification. These conditions “create ... differences in health status between population groups that are socially produced, systematic in their distribution across the population and avoidable and unfair” (Dahlgren & Whitehead, 1992, as cited in Newman et al., 2015, p. ii127). Social determinants give rise to a common soil in which health disparities grow, health inequalities take root, and inequities become reproduced at distal, intermediate, and proximal levels.

Health equity refers to a state characterized by the “absence of systematic inequalities in health” (Farrer et al., 2015, p. 394). A large body of research has established the strong links between socioeconomic disadvantage and poor health outcomes across the life span (Braveman & Gottlieb, 2014; Commission on Social Determinants for Health, 2008; Kaplan, Shema, & Leite, 2008; Marmot & Bell, 2012). Although lack of access to health insurance and health services contributes to poor health outcomes, disparities in access to coverage and services also

stem from significant social, economic, and environmental deprivation (i.e., social disadvantage) grounded in race- and culture-based discrimination. Those disparities often produce cumulative, intergenerational disadvantage that profoundly affects health (Braveman & Gottlieb, 2014). Such disadvantage is positively correlated with levels of debilitating chronic disease (Gordon-Larsen, Nelson, Page, & Popkin, 2006) and rates of premature mortality (Commission on Social Determinants of Health, 2008). Environmental disadvantage, a manifestation of this stratification and the underlying determinants, is a condition tied to residing in communities with concentrated poverty, food deserts, and high rates of trauma and violence.

Meeting the grand challenge of health equity and eliminating health inequities require dealing with “root causes” ; focusing on what can be seen as upstream interventions and primary prevention; and addressing “unequal distribution of power, income, goods and services ” (WHO, 2014a, p. 2; see also, Gehlert, Mininger, Sohmer, & Berg, 2008). This challenge entails an explicit commitment to eliminating health disparities at individual and population levels. Meeting the challenge also involves eliminating social determinants that function as precursors to adverse health conditions and outcomes. Social work’ s pursuit of health equity as a grand challenge means that the profession strives to ensure the highest possible standard of health and wellness for all people while prioritizing upstream interventions and primary prevention efforts among those who are at greatest risk for poor health—those who, because of social and economic disadvantage, experience the extremes of health inequalities. To be healthy, people require access to quality, culturally resonant care as well as to socioeconomic conditions that promote well-being in community, family, school, workplace, recreation, and environmental systems.

ACHIEVING POPULATION HEALTH: MOVING BEYOND THE INDIVIDUAL/CLINICAL TO THE COMMUNITY AND SOCIAL DETERMINANTS

Priority 1: Focus on Settings to Improve the Conditions of Daily Life

Combating the distal-level influence of racial and socioeconomic inequity on health and the intermediate-level consequences in a community's institutions (e.g., inadequate schools, unsafe streets, food deserts, families with an incarcerated member) requires a sphere of interventions centered on changing the community environment to elevate the health prospects of a local population. Although large-scale social and economic (distal-level) policy changes may be the ultimate instrument for resolving the nation's health crisis, an accessible starting place for social work is to build the community-enhanced evidence base for change from the bottom up (Institute of Medicine, 2013).

Highly promising components of community-based research and practice for addressing social determinants of health inequities are found in the “places” and “social contexts where people engage in daily activities, in which environmental, organizational and personal factors interact to affect health and well-being, and where people actively use and shape the environment, thus creating or solving health problems” (Newman et al., 2015, p. ii127; WHO, 1998). Such settings include but are not limited to geographical places (e.g., cities), physical spaces where people congregate (e.g., religious centers), workplaces, green spaces (e.g., community gardens or playgrounds), and virtual worlds (i.e., social websites; Newman et al., 2015). It is critical for social work to be particularly present in settings that target and include young people—from birth to young adulthood—to address the cycle of intergenerational disadvantage.

The importance of addressing the social determinants of health inequities within settings has been highlighted by the Commission on Social Determinants of Health (2008) as well as by social determinant researchers (Marmot, 2005 Marmot & Bell, 2012). Newman and colleagues (2015, p. ii135) note that, in addressing the social determinants of health within settings, there is room to “integrate individual behavior approaches with approaches at structural” or distal levels. Moreover, they note that settings approaches require cross-sectorial collaboration, committed leadership, genuine involvement of stakeholders, and strong research.

Priority 2: Advance Community Empowerment for Sustainable Health

A community organized for health improvement may work on either or both of two goals: representation in governance of the health-care delivery system and interventions that create sustainable community changes. Representation in the governance of disadvantaged communities is critical for (a) efforts to ensure the enrollment in health care of as many community residents as possible and (b) active participation in evaluating services and resolving deficiencies to the community’s benefit. Maximizing health-care enrollment, especially among children and youth, ensures that they are counted in the assessment of efforts to improve the health of a vulnerable community. Representation in the governance of the health system may be accomplished through community organizing that strives to improve health equity. The particular task of securing representation over the long term calls for continued commitment to face-to-face, community-level education on the issues (Horton & Freire, 1990). It also calls for engagement with all of the organic social/cultural threads and groups in the community (e.g., religious and spiritual institutions; Stout, 2010). Community health coalitions and local learning communities can also play critical roles in developing local capacity for representation, monitoring progress, training volunteers, and demonstrating local options if reform

implementations break down. By focusing on the community as the center of efforts to advance health—efforts that will complement those of the health-service sector—activists build community-based interventions that are not only culturally grounded but sustainable.

In parallel to practice-based research networks, community-oriented research networks can be developed to identify common measures and themes as well as lead in the design and development of culturally grounded health promotion interventions. Finally, social work can also partner with existing organizations, such as the National Community Building Network, the U.S. Department of Housing and Urban Development’s Office of University Partnerships, and the Alliance for Children and Families, to identify common interests and strategies for community-engaged research and action (Johnson, 2004).

Priority 3: Generate Research on Social Determinants of Health Inequities

Research on social determinants of health is essential for analyzing how environmental and traumatic stressors, racism (and other isms) harm health and how these determinants become embodied over time, generations, and political-historical contexts (Krieger 2012, p. 939). There are many social and cultural pathways by which discrimination harms health, including “economic and social deprivation; excess exposure to toxins, hazards, and pathogens; social trauma; health-harming responses to discrimination; targeted marketing of harmful commodities; and ecosystem degradation” (2012, p. 937). In particular, stress in response to these determinants may be an underdeveloped mechanism influencing how people respond to upstream and downstream determinants (McGovern et al., 2014).

Many emerging models of social determinants of health equity need testing. Moreover, there is quite often a gap between what is known through health equity research and what is actually taken up within communities. Davison, Ndumbe-Eyoh, and Clement (2015) identified six health-equity models that bridge research and practice but require further testing: the Knowledge Brokering Framework (Oldham & McLean, 1997), the Framework for Research Transfer (Nieva et al., 2005), the Joint Venture Model of Knowledge Utilization (Edgar et al., 2006), the Translational Research Framework to Address Health Disparities (Fleming et al., 2008), the Model of Knowledge Translation and Exchange with Northern Aboriginal Communities (Jardine & Furgal, 2010), and the Ecohealth Model applied to knowledge translation (Arredondo & Orozco, 2012). The models have many strengths. They value the direct participation of community stakeholders; prioritize multi-sectorial engagement; recognize the importance of environmental and contextual determinants; have a proactive, collaborative, problem-solving approach; and support an inclusive conceptualization of knowledge (community and traditional, culture-based knowledge, as well as qualitative and quantitative forms).

Priority 4: Stimulate Multi-sectorial Advocacy to Promote Health Equity Policies

Social work's disciplinary competencies related to the person-in-environment perspective and applied ecological theory offer unique opportunities to forge broad alliances capable of advocating for a more comprehensive, multi-sectorial view of health determinants as well as for practices and policies to address the racial and economic injustices that form the bedrock for health inequities. Part of the strategy to close the gaps in health among subgroups is “ ‘leveling up’ the health of less advantaged groups” (Farrer et al., 2015, p. 394). The WHO has demonstrated the utility of multi-sectorial approaches to leveling up conditions for vulnerable and marginalized populations. Government, health care, public health, and university entities

have been the traditional participants in efforts to eliminate health disparities, but many settings within communities could be employed in advocacy and change efforts. According to Williams and Wyatt (2015, p. 556), “Multilevel policies ... in homes, schools, neighborhoods, workplaces, and religious organizations can help remove barriers to healthy living and create opportunities to usher in a new culture of health in which the healthy choice is the easy choice.”

Multi-sectorial approaches have effectively translated research into action through networks of individuals, communities, government entities, health providers, institutions, businesses, and industries, but more innovation is needed. The urgency of the need to make rapid progress in the health of poor communities and communities of color calls for national collaboration both to advance the science for breaking the cycle of intergenerational disadvantage and to translate that science into action.

STRENGTHENING HEALTH CARE SYSTEMS: BETTER HEALTH ACROSS AMERICA

Priority 5: Cultivate Innovation in Primary Care

Improving the health of those suffering lifelong and even intergenerational disadvantage, especially those previously without regular primary health care will require innovation in primary and other care. An exemplar of the viability of innovation in primary care is the emergence of accountable care organizations (ACOs) in which groups of providers agree to improve the overall healthcare experience of a defined patient population through efficiency of care delivery that reduces costs and improves quality of healthcare and health (DeVores & Champion, 2011). The first ACOs were in fact targeting what might be considered disadvantaged populations through the CMS Medicare Shared Savings Program (MSSP) (Fischer, Shortell, Kreinder, Van Citter & Larson, 2012). ACOs have demonstrated the need for

more integrated approaches in primary care. A more widely adopted and far-reaching innovation is the SAMHSA SBIRT (screening, brief intervention and referral) initiative to address substance abuse issues in primary care (Babor, Del Boca & Bray, 2017). Given that one-third of all healthcare resources in the US are spent on individuals with behavioral health needs associated with persistent medical illness (Kathol, Patel, Sacks, Sargent & Melek, 2015), ACOs and SBIRT are timely innovations that promote health equity and benefit society.

In addition, as members of practice-based research networks, social workers now cooperate with other groups in identifying successful social innovations for medical, hospital, community, and mental-health settings. Social workers examine health care processes and care of patients, designing and developing culturally grounded health interventions. Finally, social workers provide an organizational structure for surveillance and research.

Priority 6: Promote Full Access to Health Care

To achieve health equity, the profession must focus on financial and bureaucratic barriers that have plagued access to the health care system for decades and offer systemic solutions as well as interventions that are rooted in community and culture. The ACA offered unparalleled opportunities to reduce inequality in healthcare access and health. First, the ACA dramatically expanded health insurance coverage in the United States through major expansions of Medicaid and the creation of health insurance marketplaces. After these expansions went into full effect in 2014, more than 23 million U.S. residents gained health insurance (Carman, Eibner, & Paddock, 2015). Second, the ACA established patient navigation funding to assist people in getting insurance and accessing health care (Andrews, Darnell, McBride, & Gehlert, 2013). Third, the ACA established new incentives to promote innovative models for coordinating and integrating

health care. Such incentives were designed to make it easier for patients to find and receive the services they need (ACA, 2010). Fourth, the ACA mandated that any federally funded health care or public health care program must collect self-reported data on race, ethnicity, sex, primary language, and disability (DHHS, n.d.). Efforts to identify systemic inequality in the healthcare system have long been undermined by inconsistent collection and reporting of race and ethnicity data.

However, challenges remained. The ACA was not successful in obtaining universal access to insurance coverage. A surprise Supreme Court decision (2012) allowed states to opt-out of Medicaid expansion and subsequently, only 32 states expanded. This decision left millions in a “coverage gap” without access to Medicaid and too poor to be eligible for the subsidized private marketplaces (Garfield, Rachel et al., 2016). African Americans and American Indians and Alaska Natives are more likely to reside in states that have not expanded Medicaid, exacerbating within state disparities (Andrews, 2014; Andrews, Guerrero, Wooten, & Legnick-Hall, 2015). The ACA also did not provide an avenue for undocumented immigrants to gain coverage, even without receiving government support (Joseph, 2016). Thus, it is not surprising that ACA has been effective in narrowing, but not closing, national racial and ethnic gaps in insurance coverage (Buckmueller, et al 2016).

Ordinarily, we would argue that social work should be targeting our advocacy efforts towards moving the ACA forward: closing the coverage gap by promoting universal adoption of Medicaid expansion, supporting states such as California and Massachusetts who are attempting to insure undocumented immigrants (Joseph, 2016), advancing culturally-specific approaches to insurance enrollment and patient navigation, and urging the use of race/ethnicity data to identify and redress disparities in quality. However, at this moment in time, the future of the ACA and its

component protections is entirely uncertain. Social workers will need to unite as a profession and join forces with allies of health care justice to educate the electorate, engage communities in grassroots organizing, and petition members of Congress against ACA repeal and an inadequate replacement. We must be vigilant against policy proposals that would move access to health care and health equity back decades from the only recent advancements offered by the ACA.

Priority 7: Foster Development of an Interprofessional Health Workforce

According to the Bureau of Labor Statistics (2014), between 2012 and 2022, employment of health-care social workers is projected to grow by 27% and employment of mental health and substance abuse social workers is projected to grow by 23%. Because of these occupational trends, social work can create integrated pathways to health careers in social intervention. Social work can lead integrated initiatives for evidence-based workforce development by reviewing practitioner preparation for transdisciplinary social interventions, defining a core curriculum for such initiatives, establishing training standards for advanced practice in specialized areas, and identifying new competence areas for the emerging health system (e.g., prevention science, place- and settings-based research, community engagement, improvement science, health-data analytics, and team methods for collaborative behavioral and physical health care). Additionally, we should develop an integrated public health social work curriculum across master of social work programs that goes beyond master of social work- master of public health dual-degree programs.

Reducing and Preventing Alcohol Misuse and Its Consequences

Alcohol misuse is a compelling problem for the social work profession, encountered in almost every practice setting, and directly or indirectly relating to every domain of well-being

about which the profession is concerned. The biopsychosocial and multi-sectorial nature of the social work profession makes it uniquely suited to lead a transdisciplinary effort for reducing and preventing the wide range of consequences associated with alcohol misuse. Alcohol issues intersect with multiple other Grand Challenges for Social Work. Among the priority areas that emerged in the Reducing and Preventing Alcohol Misuse and Its Consequences workgroup (Begun et al., 2016a) are: (1) develop research and scholarship, (2) develop interdisciplinary, multi-sectorial, and sustainable collaborations, and (3) workforce development.

Priority 8: Develop Research and Scholarship.

In both the United States and throughout the world, alcohol misuse is associated with high rates of morbidity, mortality, and co-occurring physical, mental health, and social problems. It causes an array of acute and chronic health problems, globally accounting for 3.3 million deaths annually: “The harmful use of alcohol ranks among the top five risk factors for disease, disability and death throughout the world” (WHO, 2014b, p. 2). Alcohol is among the leading risk factors for mortality in the United States and is a recognized contributor to the top 10 causes of death, including heart disease, cancer, stroke, fatal injuries, and suicide (CDC, 2014), as well as maternal-child health complications (e.g., fetal alcohol exposure). In addition to these health consequences, alcohol misuse often accompanies the misuse of other substances, significant cognitive impairments, multiple forms of mental disorder, physical disability, and a host of social problems: intimate partner violence, child maltreatment, human trafficking, sexual assault, problem gambling, school failure, criminal justice system involvement, and insecurity around employment, housing, and safety.

Alcoholic beverages are by far the most commonly used and abused psychoactive substances, and use has increased over the past decade (Dawson, Goldstein, Saha, & Grant, 2015). More than 66 million individuals aged 12 years and older in the United States engage in

binge drinking and 17.3 million in heavy drinking (SAMHSA, 2016). Over 15.7 million persons in this age group met criteria for an alcohol use disorder during the past year, and an additional 2.67 million experienced substance use disorders involving alcohol and other substances, as well. There exists a considerable health care gap between the many millions of individuals needing treatment for an alcohol (or other substance) use disorder and the estimated 2.5 million receiving care in specialized alcohol or other drug treatment (SAMHSA, 2014). In the United States, the cost estimate for untreated alcohol misuse is \$223.5 billion annually (RSA, 2015).

Once depicted as entrenched, unalterable problems, decades of research have proven that evidence-informed strategies can successfully address alcohol misuse and its consequences (Warren & Hewitt, 2010). Alcohol researchers utilize varied methods and designs, and include variables ranging from the micro-level (e.g., neuroscience, genomics, epigenetics, proteomics, metabolomics) to the macro-level (e.g., population-based epidemiology, “big data, small n” studies, econometrics, health/human services, and policy at local, state, regional, national, and global level). Contemporary and emerging research approaches to studying alcohol misuse are among many that social work scholars employ and around which we should continue to develop mastery. Social work scholars need to highlight their alcohol research contributions both within the profession and in transdisciplinary ways.

Priority 9: Developing Interdisciplinary, Multi-Sectorial, and Sustainable Collaborations.

Partnerships working across disciplines and across the various service delivery sectors that serve individuals, families, communities and larger social systems can “bring the pieces together” to meet the AGC. For instance, social workers researchers and engineers at The Ohio State University are working on systems dynamic approaches to drinking behavior for developing inexpensive, sustainable, “smart” application interventions to prevent acute alcohol problems, such as driving under the influence behavior (Girlando et al., 2015; Clapp et al., *in press*). A

somewhat controversial recommendation presented in the original AGC paper was to collaborate with the alcohol beverage industry to reduce alcohol-related harms. One such project consistent with the AGC is the AB InBev Global Smart Drinking Goals initiative (<http://www.ab-inbev.com/better-world/a-healthier-world/global-smart-drinking-goals.html>). The collaborative partnership is a decade long investment of over 1 billion US dollars to reduce alcohol related harms globally by 10%. AGC progress is also dependent on collaboration with governmental and nongovernmental organizations, locally, nationally and globally (e.g., state mental health and substance use agencies, NIH and WHO) to build the infrastructures and funding for solutions to this challenge.

Priority 10: Developing the Workforce in Social Work to Address Alcohol Misuse.

Social work and inter-professional curricula that tap into the evidence base related to alcohol misuse prepare individuals intervene in ways that reduce or prevent alcohol misuse and its consequences. For example, social work and other curricula are available to train practitioners to deliver evidence-based screening, brief intervention, and referral to treatment (SBIRT) for alcohol misuse (see JSWPA volume 17, issue 1/2 for examples). The advent of open source online training mechanisms offer innovative opportunities for both pre-service and in-service/continuing education related to meeting workforce demands associated with the AGC.

SOCIAL WORK' S ROLES IN LEADING A HEALTH EQUITY GRAND CHALLENGE

Social work is uniquely positioned for a leadership role in addressing health inequities because, as indicated in Jane Addams' speech at the 1930 National Conference of Social Work, "social work' s special genius is its closeness to the people it serves" (Johnson, 2004, p. 319). Social work' s historical social justice mission as well as its commitment to serve the most

disenfranchised and health burdened populations affirms the profession's ability to provide leadership in association with allied health professions. The attributes also speak to the profession's ability to design and develop community-based approaches to eradicate health inequities.

Several factors demonstrate why social work should lead a grand challenge to achieve health equity. First, social workers understand the complex pathways from disadvantage to health risks and outcomes. Those pathways run through the vulnerable communities in which social workers routinely operate. Additionally, health risks and outcomes among disadvantaged populations are correlated with structural and sociodemographic disadvantages (e.g., poverty, low levels of education, substandard housing, and poor access to services) as well as with high rates of co-occurring physical health problems (e.g., alcohol misuse, diabetes and cardiovascular disease). Also, trauma and violence exposure (including intergenerational and historical trauma exposures) are associated with co-occurring psychopathology (e.g., post-traumatic stress disorder and depression; Brand et al., 2010; Matthews & Phillips, 2010; Walters et al., 2011). Addressing these associations will require multitasking across multiple levels of intervention, and such a broad deployment of effort is a hallmark of social work practice. Put simply, health is not created in a clinic, and we cannot rely on traditional health services alone to heal the wrongs of history and persistent inequality.

Second, social work's leadership is needed to elucidate problems and test solutions. Despite the glaring health disparities, there is a paucity of culturally relevant research on some of the most vulnerable populations. Because of this, the health fields have little data on important risk factors, coping behaviors, and health outcomes. Without a larger body of evidence, it will be

difficult to identify the strategies and develop the programs necessary to reduce health inequalities and improve health equity within the United States. Many social work researchers are already at the forefront of research on health disparities and prevention needs among vulnerable populations, particularly among racial and ethnic minorities as well as lesbian, gay, bisexual, and transgender populations (e.g., Evans-Campbell, Lincoln, K., & Takeuchi, 2007; Fredriksen-Goldsen et al., 2014; Marsiglia, Kulis, Yabiku, Nieri, & Coleman, 2011; Wheeler, 2003). Moreover, social work researchers have advanced innovative, community-based, participatory-research approaches as well as conceptual models that include multilevel influences on health (e.g., Gehlert & Coleman, 2010; Gehlert, Sohmer, et al., 2008; Spencer et al., 2011; Walters & Simoni, 2002; Walters et al., 2012).

Social work's longstanding commitment to a diverse workforce with full representation of all stakeholders is a third reason for the profession to lead the health equity grand challenge. The ACA and recent national reports, including one from the National Institutes of Health, call for more inclusion of underrepresented ethnic and racial minorities among funded investigators and community-based researchers (Shavers et al., 2005; Sopher et al., 2015). Despite these calls, a very limited number of underrepresented ethnic and racial minorities have served as principal investigators for awards by the National Institutes of Health. Moreover, racial and ethnic minorities remain significantly underrepresented in higher education. In the United States, they account for only 12% of all people with doctorates and less than 3% of medical school professors (Sopher et al., 2015). A broad and dense network of highly trained and productive health-science scholars, a network that includes underrepresented ethnic and racial minorities and is dedicated to culturally grounded research, is needed to ameliorate health disparities.

Finally, as we have suggested above, the legacy of social work and the roles historically played by social workers should spur the profession to lead the grand challenge of health equity. Throughout history, social workers have played pivotal roles in efforts to increase critical consciousness within competing systems, linked key health-system stakeholders, and led in efforts to incorporate social and ecological realities into assessment and treatment. This distinctive legacy enables social work to provide leadership at a time when the ACA is driving promotion of community involvement. The legacy also provides paradigms for creative solutions to problems that extend across systems.

The social work profession is also positioned to facilitate interdisciplinary efforts among applied social and behavioral scientists, educators, and practitioners. As members of interprofessional teams, social workers already contribute in the movement toward patient-centered care. They also are engaged in the implementation of integrated care models to better address physical, mental, and behavioral health issues (e.g., alcohol and substance abuse). The next decade offers an opportunity to develop a strategy for leveraging the momentum of health-care reform efforts to create a social-determinants focused agenda for research, practice, and action. Such a strategy would enable social workers to set measureable targets and timeframes for alleviating the deep and persistent health inequities in the United States.

Social work is poised and primed to bring our research, education, policy, and practice skills together to adapt and apply what we know for use in national efforts to reduce health disparities; improve mental and physical health outcomes, particularly among society's most vulnerable and marginalized; and ultimately to promote health equity and well-being for our society as a whole. As our science and profession have matured, we have grown in readiness to tackle the "scale, complexity, and interrelatedness of societal problems—from poverty and

dramatic inequality to the sustainability of health and human service infrastructures across the globe—[and to] demand problem-solving skill and collaboration at levels perhaps unprecedented in our history” (Uehara et al., 2013, p. 165). The health of future generations depends on the actions we take in our current generation. Let us be remembered not only for our science and practice but also for our resolve to harness our collective will and intelligence to transform the health of the nation.

REFERENCES

Agency for Healthcare Research and Quality. (2013). 2012 National Healthcare Disparities Report 2012 (AHRQ publication No. 13-0003). Rockville, MD: U.S. Department of Health and Human Services.

Andrews, C. M. (2014). Unintended consequences: Medicaid expansion and racial inequality in access to health insurance. *Health & Social Work, 39*(3), 131-133. doi:[10.1093/hsw/hlu024](https://doi.org/10.1093/hsw/hlu024)

Andrews, C. M., Darnell, J. S., McBride, T. D., & Gehlert, S. (2013). Social work and implementation of the Affordable Care Act. *Health & Social Work, 38*(2), 67-71. doi:[10.1093/hsw/hlt002](https://doi.org/10.1093/hsw/hlt002)

Andrews, C. M., Guerrero, E. G., Wooten, N. R., Legnick-Hall, R. (2015). The Medicaid expansion gap and racial and ethnic minorities with substance use disorders. *American Journal of Public Health, 105*(Suppl. 3), S452-S454. doi:[10.2105/AJPH.2015.302560](https://doi.org/10.2105/AJPH.2015.302560)

Arredondo, A., & Orozco, E. (2012). Application of the Ecohealth model to translate knowledge into action in the health sciences. *Environmental Health Perspectives, 120*(3), A104-A105. doi:[10.1289/ehp.1104847](https://doi.org/10.1289/ehp.1104847)

Avendano, M., Glymour, M. M., Banks, J., & Mackenbach, J. P. (2009). Health disadvantage in US adults aged 50 to 74 years: A comparison of the health of rich and poor Americans with that of Europeans. *American Journal of Public Health, 99*(3), 540-548. doi:[10.2105/AJPH.2008.139469](https://doi.org/10.2105/AJPH.2008.139469)

Babor, T. F., Del Boca, F., and Bray, J. W. (2017) Screening, Brief Intervention and Referral to Treatment: implications of SAMHSA's SBIRT initiative for substance abuse policy and practice. *Addiction, 112*: 110–117. doi: [10.1111/add.13675](https://doi.org/10.1111/add.13675).

Begun, A.L., Clapp, J.D., & The Alcohol Misuse Grand Challenge Collective. (2016). Reducing and preventing alcohol misuse and its consequences: A grand challenge for social work. (Grand

Challenges for Social Work Initiative Working Paper No. 17). Cleveland, OH: American Academy of Social Work and Social Welfare. <http://aaswsw.org/wp-content/uploads/2015/12/WP14-with-cover.pdf>

Brand, S. R., Brennan, P. A., Newport, D. J., Smith, A. K., Weiss, T., & Stowe, Z. N. (2010). The impact of maternal childhood abuse on maternal and infant HPA axis function in the postpartum period. *Psychoneuroendocrinology*, 35(5), 686-693. doi:[10.1016/j.psyneuen.2009.10.009](https://doi.org/10.1016/j.psyneuen.2009.10.009)

Braveman, P., & Gottlieb, L. (2014). The social determinants of health: It's time to consider the causes of the causes. *Public Health Reports*, 129(Suppl. 2), 19-31.

Brennan Ramirez, L. K., Baker, E. A., & Metzler, M. (2008). Promoting health equity: A resource to help communities address social determinants of health. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention.

Buchmueller, Thomas C., et al. "Effect of the Affordable Care Act on racial and ethnic disparities in health insurance coverage." *American journal of public health* 106.8 (2016): 1416-1421.

Bureau of Labor Statistics. (2014, January 8). Social workers. In *Occupational outlook handbook* (2014-15 ed.). Retrieved from <http://www.bls.gov/ooh/community-and-social-service/social-workers.htm#tab-6>

Carman, K. G., Eibner, C., & Paddock, S. M. (2015). Trends in health insurance enrollment, 2013-15. *Health Affairs*. doi:[10.1377/hlthaff.2015.0266](https://doi.org/10.1377/hlthaff.2015.0266)

Centers for Disease Control and Prevention (CDC). (2014). *CDC national health report: Leading causes of morbidity and mortality and associated behavioral risk and protective factors—United States, 2005-2013*. Retrieved from <http://stacks.cdc.gov/view/cdc/25809>

Clapp, J. D., Madden, D. R., Gonzalez Villasanti, H. J., Giraldo, L. F., Passino, K. M., Reed, M. B., & Fernandez Puentes, I. (*in press*). A system dynamics model of drinking events: Multi-level ecological approach. *Systems Research and Behavioral Science*.

Commission on Social Determinants of Health. (2008). Closing the gap in a generation: Health equity through action on the social determinants of health (Final Report). Retrieved from the World Health Organization website: http://whqlibdoc.who.int/publications/2008/9789241563703_eng.pdf

Dahlgren, G., & Whitehead, M. (1992). Policies and strategies to promote equity in health. Copenhagen, Denmark: World Health Organization Regional Office for Europe.

Davison, C. M., Ndumbe-Eyoh, S., & Clement, C. (2015). Critical examination of knowledge to action models and implications for promoting health equity. *International Journal for Equity in Health*, 14, article 49. doi:[10.1186/s12939-015-0178-7](https://doi.org/10.1186/s12939-015-0178-7)

Dawson, D. A., Goldstein, R. B., Saha, T. D., & Grant, B. F. (2015). Changes in alcohol consumption: United States 2001-2002 to 2012-2013. *Drug and Alcohol Dependence*, 148, 56–61. doi:0.1016/j.drugalcdep.2014.12.016.Epub 2014 Dec 23.

Department of Health and Human Services, Retrieved from:
minorityhealth.hhs.gov/assets/pdf/checked/1/Fact_Sheet_Section_4302.pdf

DeVore S, Champion RW. Driving population health through accountable care organizations. *Health Aff (Millwood)*. 2011;30(1):41-50. doi: 10.1377/hlthaff.2010.0935.

Edgar, L., Herbert, R., Lambert, S., MacDonald, J.-A., Dubois, S., & Latimer, M. (2006). The joint venture model of knowledge utilization: A guide for change in nursing. *Nursing Leadership*, 19(2), 41-55. doi:10.12927/cjnl.2006.18172

Evans-Campbell, T., Lincoln, K. D., & Takeuchi, D. T. (2007). Race and mental health: Past debates, new opportunities. In W. R. Avison, J. D. McLeod, & B. A. Pescosolido (Eds.), *Mental health, social mirror* (pp. 169-189). New York, NY: Springer.

Farrer, L., Marinetti, C., Cavaco, Y. K., & Costongs, C. (2015). Advocacy for health equity: A synthesis review. *Milbank Quarterly*, 93(2), 392-437. doi:10.1111/1468-0009.12112

Fisher ES, Shortell SM, Kreindler SA, Van Citters AD, Larson BK. A framework for evaluating the formation, implementation, and performance of accountable care organizations. *Health Aff (Millwood)*. 2012;31(11):2368-2378. doi: 10.1377/hlthaff.2012.0544.

Fleming, E. S., Perkins, J., Easa, D., Conde, J. G., Baker, R. S., Southerland, W. M., ... Norris, K. C. (2008). The role of translational research in addressing health disparities: A conceptual framework. *Ethnicity & Disease*, 18(Suppl. 2), S2-155-S2-160.

Fredriksen-Goldsen, K. I., Simoni, J. M., Kim, H.-J., Lehavot, K., Walters, K. L., Yang, J., Hoy-Ellis, C. P. & Muraco, A. (2014). The Health Equity Promotion Model: Reconceptualization of lesbian, gay, bisexual, and transgender (LGBT) health disparities. *American Journal of Orthopsychiatry*, 84(6), 653-663. doi:10.1037/ort0000030

Garfield, Rachel, et al. "New estimates of eligibility for ACA coverage among the uninsured." *The Henry J. Kaiser Family Foundation*, <http://kff.org/health-reform/issue-brief/new-estimates-of-eligibility-for-aca-coverage-among-the-uninsured/January> 16 (2016): 2016.

Gehlert, S., & Coleman, R. (2010). Using community-based participatory research to ameliorate cancer disparities. *Health & Social Work*, 35(4), 302-309. doi:10.1093/hsw/35.4.302

Gehlert, S., Mininger, C., Sohmer, D., & Berg, K. (2008). (Not so) gently down the stream: Choosing targets to ameliorate health disparities. *Health & Social Work*, 33(3), 163-167. doi:10.1093/hsw/33.3.163

- Gehlert, S., Sohmer, D., Sacks, T., Mininger, C., McClintock, M., & Olopade, O. (2008). Targeting health disparities: A model linking upstream determinants to downstream interventions. *Health Affairs*, 27(2), 339-349. doi:[10.1377/hlthaff.27.2.339](https://doi.org/10.1377/hlthaff.27.2.339)
- Giraldo, L. F., Passino, K. M., & Clapp, J. D. (2015). Modeling and analysis of group dynamics in alcohol-consumption environments. *IEEE Transactions on Cybernetics*, 99, 1-12.
- Gordon-Larsen, P., Nelson, M. C., Page, P., & Popkin, B. M. (2006). Inequality in the built environment underlies key health disparities in physical activity and obesity. *Pediatrics*, 117(2), 417-424. doi:[10.1542/peds.2005-0058](https://doi.org/10.1542/peds.2005-0058)
- Hood, C. M., Gennuso, K. P., Swain, G. R., & Catlin, B. B. (2015). County health rankings: Relationships between determinant factors and health outcomes. *American Journal of Preventive Medicine*. Advance online publication. doi:[10.1016/j.amepre.2015.08.024](https://doi.org/10.1016/j.amepre.2015.08.024)
- Horton, M., & Freire, P. (1990). *We make the road by walking: Conversations on education and social change* (B. Bell, J. Gaventa, & J. Peters, Eds.). Philadelphia, PA: Temple University Press.
- Institute of Medicine. (2013, January). U.S. health in international perspective: Shorter lives, poorer health (Institute of Medicine Report Brief). Retrieved from <http://www.iom.edu/intlmortalityrates>
- Jardine, C., & Furgal, C. (2010). Knowledge translation with northern Aboriginal communities: A case study. *Canadian Journal of Nursing Research*, 42(1), 119-127.
- Joseph, Tiffany D. "What health care reform means for immigrants: comparing the Affordable Care Act and Massachusetts health reforms." *Journal of health politics, policy and law* 41.1 (2016): 101-116.
- Johnson, A. K. (2004). Social work is standing on the legacy of Jane Addams: But are we sitting on the sidelines? *Social Work*, 49(2), 319-322. doi:[10.1093/sw/49.2.319](https://doi.org/10.1093/sw/49.2.319)
- Kaplan, G. A., Shema, S. J., & Leite, C. M. A. (2008). Socioeconomic determinants of psychological well-being: The role of income, income change, and income sources during the course of 29 years. *Annals of Epidemiology*, 18(7), 531-537. doi:[10.1016/j.annepidem.2008.03.006](https://doi.org/10.1016/j.annepidem.2008.03.006)
- Kathol, R.G., Patel, K., Sacks, L., Sargent, S., & Melek, S.P. (2015). The role of behavioral health services in accountable care organizations. *American Journal of Managed Care*, 21(2), pp.e95-8.
- Krieger, N. (2012). Methods for the scientific study of discrimination and health: An ecosocial approach. *American Journal of Public Health*, 102(5), 936-945. doi:[10.2105/AJPH.2011.300544](https://doi.org/10.2105/AJPH.2011.300544)
- Link, B. G., & Phelan, J. C. (1995). Social conditions as fundamental causes of disease. *Journal of Health and Social Behavior*, 35(Extra issue), 80-94. doi:[10.2307/2626958](https://doi.org/10.2307/2626958)

- Logie, C., Dimaras, H., Fortin, A., & Ramón-García, S. (2014). Challenges faced by multidisciplinary new investigators on addressing grand challenges in global health. *Globalization and Health*, 10, article 27. doi:[10.1186/1744-8603-10-27](https://doi.org/10.1186/1744-8603-10-27)
- Marmot, M. (2005). Social determinants of health inequalities. *Lancet*, 365(9464), 1099-1104. doi:[10.1016/S0140-6736\(05\)71146-6](https://doi.org/10.1016/S0140-6736(05)71146-6)
- Marmot, M., & Bell, R. (2012). Fair society, healthy lives. *Public Health*, 126(Suppl. 1), S4-S10. doi:[10.1016/j.puhe.2012.05.014](https://doi.org/10.1016/j.puhe.2012.05.014)
- Marsiglia, F. F., Kulis, S., Yabiku, S. T., Nieri, T. A., & Coleman, E. (2011). When to intervene: Elementary school, middle school or both? Effects of Keepin' It REAL on substance use trajectories of Mexican heritage youth. *Prevention Science*, 12(1), 48-62. doi:[10.1007/s11121-010-0189-y](https://doi.org/10.1007/s11121-010-0189-y)
- Matthews, S. G., & Phillips, D. I. W. (2010). Minireview: Transgenerational inheritance of the stress response: A new frontier in stress research. *Endocrinology*, 151(1), 7-13. doi:[10.1210/en.2009-0916](https://doi.org/10.1210/en.2009-0916)
- McGovern, L., Miller, G., & Hughes-Cromwick, P. (2014, August 21). The relative contribution of multiple determinants to health outcomes (Health Policy Brief). Retrieved from <http://www.healthaffairs.org>
- Mitchell, F. M. (2015). Racial and ethnic health disparities in an era of health care reform. *Health and Social Work*, 40(3), e66-e74. doi:[10.1093/hsw/hlv038](https://doi.org/10.1093/hsw/hlv038)
- Newman, L., Baum, F., Javanparast, S., O'Rourke, K., & Carlon, L. (2015). Addressing social determinants of health inequities through settings: A rapid review. *Health Promotion International*, 30(Suppl. 2), ii126-ii143. doi:[10.1093/heapro/dav054](https://doi.org/10.1093/heapro/dav054)
- Nieva, V. F., Murphy, R., Ridley, N., Donaldson, N., Combes, J., Mitchell, P., ... Carpenter, D. (2005). From science to service: A framework for the transfer of patient safety research into practice. In K. Henriksen, J. B. Battles, E. S. Marks, D. I. Lewin (Eds.), *Advances in patient safety: From research to implementation: Vol. 2. Concepts, and methodology* (pp. 441-453). Rockville, MD: Agency for Healthcare Research and Quality.
- Oldham, G., & McLean, R. (1997). Approaches to knowledge-brokering [Paper]. Retrieved from International Institute for Sustainable Development website: https://www.iisd.org/sites/default/files/pdf/2001/networks_knowledge_brokering.pdf
- Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 (2010).
- Research Society on Alcoholism (RSA). (2015). White paper: Impact of alcoholism and alcohol induced disease and disorders on America. Retrieved from <http://rsoa.org/RSA-2014WhitePaperFinalVersionVH.pdf>

Shavers, V. L., Fagan, P., Lawrence D., McCaskill-Stevens, W., McDonald, P., Browne, D., ... Trimble, E. (2005). Barriers to racial/ethnic minority application and competition for NIH research funding. *Journal of the National Medical Association*, 97(8), 1063-1077.

Smedley, B. D., Stith, A. Y., & Nelson, A. R. (Eds.). (2003). *Unequal treatment: Confronting racial and ethnic disparities in health care*. Washington, DC: National Academies Press.

Sopher, C. J., Adamson, B. J. S, Andrasik, M. P., Flood, D. M., Wakefield, S. F., Stoff, D. M., ... Fuchs, J. D. (2015). Enhancing diversity in the public health research workforce: The research and mentorship program for future HIV vaccine scientists. *American Journal of Public Health*, 105(4), 823-830. doi:[10.2105/AJPH.2014.302076](https://doi.org/10.2105/AJPH.2014.302076)

Spencer, M. S., Rosland, A.-M., Kieffer, E. C., Sinco, B. R., Valerio, M., Palmisano, G., ... Heisler, M. E. (2011). Effectiveness of a community health worker intervention among African American and Latino adults with Type 2 Diabetes: A randomized controlled trial. *American Journal of Public Health*, 101(12), 2253-2260. doi:[10.2105/AJPH.2010.300106](https://doi.org/10.2105/AJPH.2010.300106)

Stout, J. (2010). *Blessed are the organized: Grassroots democracy in America*. Princeton, NJ: Princeton University Press.

Substance Abuse and Mental Health Administration (SAMHSA). (2014). Results from the 2013 National Survey on Drug Use and Health: Summary of National Findings. Retrieved from <http://www.samhsa.gov/data/sites/default/files/NSDUHresultsPDFWHTML2013/Web/NSDUHresults2013.pdf>

Substance Abuse and Mental Health Administration (SAMHSA). (2016). Results from the 2015 National Survey on Drug Use and Health: Summary of National Findings. Retrieved from <https://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs-2015/NSDUH-DetTabs-2015/NSDUH-DetTabs-2015.pdf>

Uehara, E., Flynn, M., Fong, R., Brekke, J., Barth, R. P., Coulton, C., ... Walters, K. (2013). Grand challenges for social work. *Journal of the Society for Social Work and Research*, 4(3), 165-170. doi:[10.5243/jsswr.2013.11](https://doi.org/10.5243/jsswr.2013.11)

<http://www.healthypeople.gov/2020/default.aspx>

Walters, K. L., LaMarr, J., Levy, R. L., Pearson, C., Maresca, T., Mohammed, S. A., ... *həli?dx^w* Intervention Team. (2012). Project *həli?d^w*/Healthy Hearts Across Generations: Development and evaluation design of a tribally based cardiovascular disease prevention intervention for American Indian families. *Journal of Primary Prevention*, 33(4), 197-207. doi:[10.1007/s10935-012-0274-z](https://doi.org/10.1007/s10935-012-0274-z)

Walters, K. L., Mohammed, S. A., Evans-Campbell, T., Beltrán, R. E., Chae, D. H., & Duran, B. (2011). Bodies don't just tell stories, they tell histories: Embodiment of historical trauma among American Indians and Alaska Natives. *Dubois Review*, 8(1), 179-189. doi:[10.1017/S1742058X1100018X](https://doi.org/10.1017/S1742058X1100018X)

Walters, K. L., & Simoni, J. M. (2002). Reconceptualizing Native women's health: An "Indigenist" stress-coping model. *American Journal of Public Health*, 92(4), 520-524. doi:[10.2105/AJPH.92.4.520](https://doi.org/10.2105/AJPH.92.4.520)

Warren, K.R., & Hewitt, B. G. (2010). NIAAA: Advancing alcohol research for 40 years. *Alcohol Research & Health*, 33(1/2), 5-17.

Wheeler, D. P. (2003). Methodological issues in conducting community-based health and social services research among urban Black and African American LGBT populations. *Journal of Gay & Lesbian Social Services*, 15(1-2), 65-78. doi:[10.1300/J041v15n01_05](https://doi.org/10.1300/J041v15n01_05)

Williams, D. R., & Wyatt, R. (2015). Racial bias in health care and health challenges and opportunities. *JAMA*, 314(6): 555-556. doi:[10.1001/jama.2015.9260](https://doi.org/10.1001/jama.2015.9260)

World Health Organization. (2014a). Global status report on alcohol and health. Retrieved from http://www.who.int/substance_abuse/publications/global_alcohol_report/en/

World Health Organization. (2014b). Promoting health and reducing health inequities by addressing the social determinants of health. Retrieved from http://www.euro.who.int/__data/assets/pdf_file/0016/141226/Brochure_promoting_health.pdf