Excerpted from Caring for Our Communities: A Blueprint for Better Outcomes in Population Health
by Mark Angelo, MD (Health Administration Press, 2024)

CHAPTER 3

Community Wellness: The Promise of More Equitable Outcomes

> *Of all of the forms of inequality, injustice in health is the most shocking and inhumane.*
> Martin Luther King, Jr.

Let's rewind for a moment to a fateful afternoon of an average day in a typically busy clinic early in my career as a physician. At the time, I was delivering primary care in a community office setting. I was covering for my office partner, who was out on maternity leave, and I saw a bunch of patients who were not known to me. In the midst of activity, I had a lovely encounter with a 40-something patient, Maria (not her real name). Maria was primarily Spanish speaking but understood English quite well. With my limited medical Spanish, we quickly determined together that we did not need an interpreter.

Maria was quick to smile, nod, and say, "Yes, doctor" to everything I said. As I quickly reviewed her record, I noticed she had a history of breast cancer, which had been treated several years ago. Aha. I knew exactly what to do. I quickly scoured the chart looking for evidence of BRCA testing (a blood test to determine whether she had DNA mutations that increase breast cancer risk). I did not find such testing, so I promptly brought this to her attention. I discussed the importance of breast cancer screening as well as genetic counseling in a woman of her demographic. She very politely nodded, seemingly acknowledging the importance of this intervention. As the encounter progressed, though, it became increasingly evident to me that Maria was telling me what she believed I wanted to hear.

At the end of the appointment, she nodded courteously and thanked me. I thanked her for our conversation and exited the room. I heard a rustling behind me, and I was somewhat surprised to see my office manager, Maureen, enter the room carrying a brown bag. She closed the door.

As often happens during a busy clinic session, I was running more than a half hour behind schedule at that time, so I dutifully moved on to my next patient and figured I would ask Maureen about the encounter later.

When I spoke to Maureen later that evening, I asked her about the brown bag and why she had the closed-door conversation with Maria. Maureen's response was jolting and altered my focus for the rest of my career: "You know she has no food in her house, right?"

No, I'd had no idea that Maria was suffering from food insecurity.

Perhaps if I had asked this nice woman the right questions, I would have found that out. Perhaps if I had used an interpreter for the encounter, Maria could have been connected to the right resources to help with her situation. The most fruitful part of the encounter for her was to leave the office with a bag of graham crackers and a few sample cans of Ensure.

I completely missed the opportunity to make an essential impact on Maria's health.

Later, I tried to call Maria to recover this missed opportunity. The next week was met with unanswered calls. I even sent a letter to her home as I was praying that she would contact me back. Unfortunately, for me and her, I was unable to reach her after several attempts. She never had any of the testing done as I ordered and never followed up with our office. Now I can only imagine the effect I could have had if I had understood Maria's true need and referred her to the right resources to help stabilize her home situation.

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EQUITY IN POPULATION HEALTH

A sad and stark reality of society is that despite so many years of struggle and attention, there are members of our communities who remain marginalized for one or more reasons. Perhaps for some individuals this is because of their primary language, their country of origin, their sexual orientation, a disability, or the tone of their skin. Racial, gender, and ethnic inequality in American society represents an ongoing health crisis for us all.

Those of us who are charged with navigating our populations to health must keep this reality at the forefront of our understanding. Often, individuals in marginalized populations are the most vulnerable, with shorter life expectancy, lower-quality care, limited healthcare access, higher costs, and poorer overall health outcomes (National Academies of Sciences, Engineering, and Medicine 2017). It is crystal-clear that managing our most vulnerable populations is the right thing to do—socially, morally, and fiscally. As chapter 2 pointed out, our goal in population health and value-based care is to improve the health of our communities. Achieving health equity across all populations is a top priority in population health management.

Often, individuals in marginalized populations are the most vulnerable, with shorter life expectancy, lower-quality care, limited healthcare access, higher costs, and poorer overall health outcomes.

Health equity means many things to different people, so I want to provide a definition widely accepted by many organizations, including the Centers for Disease Control and Prevention (CDC). In a report whose goal was to build consensus around defining health equity, Robert Wood Johnson Foundation researchers define the term as follows:

> Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care. (Braveman et al. 2017, 1)

This passage defines the goal of health equity and the obstacles to receiving it. But what happens when health inequity is allowed to persist? According to the CDC (2022), "health inequities are reflected in differences in length of life; quality of life; rates of disease, disability, and death; severity of disease; and access to treatment." The CDC adds that overcoming health inequities will require a concerted effort that involves patients, providers, payers, and policymakers.

The obstacles to health and how they present themselves in the population explain why healthcare providers working with patients cannot alone achieve health equity. For example, there is only so much that we as health providers can do to mitigate root-cause issues such as poverty or discrimination; we also need to be part of a much larger population-health/community-wellness team. Given the importance of health equity, let's further dissect some of consequences of inequity on the health of the community.

EXAMINING THE OBSTACLES TO HEALTH

If we have learned anything in medicine in the past 50 years, it is that cancer outcomes are improved if diagnosed at an early stage, when disease is localized. Delayed presentation and diagnosis result in worse outcomes. The negative effect of diagnosis in later stages of malignancy is demonstrated in an intensive literature review published in *Obstetrics & Gynecology* in 2022. The authors discovered that not only are Black women nearly twice as likely as White women to die of uterine cancer, but also "the disparities pervade the entire spectrum of care, including risk factors, comorbidities, diagnosis, treatment, and outcomes" (Whetstone et al. 2022, 654). In its startling analysis the review found that only 54 percent of Black women presented to healthcare providers with localized disease, compared to 71 percent of White women.

The COVID-19 pandemic has further underscored the health disparities seen in communities of color, with worsened outcomes, higher incidence within the community, increased likelihood of needing hospitalization, and higher death rates (Khanijahani et al. 2021). The tragedy of excess mortality and morbidity related to social drivers of health should be enough impetus to convince one of the need for a focus on health equity.

It turns out that failing to address health equity also results in astronomical costs. Research released in summer 2022 by Deloitte warned that the cost of inequities related to race, socioeconomic status, and sex/gender in the US healthcare system could exceed $1 trillion in annual spending by 2040 if we don't start doing something about them today. At the time of the report, the annual cost of these inequities was $320 billion (Davis et al. 2022). The report's authors state that the way to avoid this unsustainable level of spending while improving healthcare outcomes is for leaders and organizations to immediately begin "addressing the drivers of health, removing biases and inefficiencies in care, and enabling data and technology to help monitor, diagnose, and deliver care."

These drivers of health are known widely as "social determinants of health," though the naming convention for the social factors that affect health outcomes is not fully agreed upon. While many refer to these factors as social determinants of health, others take a different view—that social factors do not necessarily determine one's path—so they refer to them as social *drivers* of health. I, along with many in the population health community, believe that "social drivers of health" is a more accurate term.

THE IMPORTANCE OF ADDRESSING SOCIAL FACTORS IMPACTING HEALTH

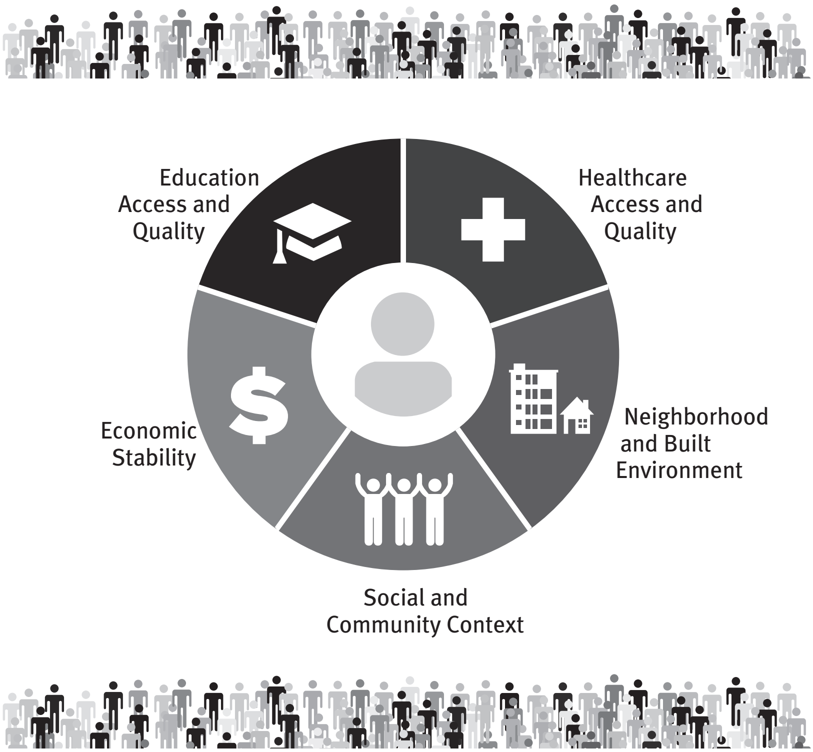
Many of the gaps in health equity in our society and patient populations are related more to social factors than to genetics. Social drivers of health are defined by the World Health Organization (WHO) as "conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies, and political systems" (WHO 2022, 1).

There are innumerable examples of the social drivers of health in various communities. For instance, some of us are fortunate enough to reside in areas with abundant markets and fresh food availability so that we can maintain a diet of healthful options. Meanwhile, others may reside in what is known as a "food desert," where they have very limited access to supermarkets with healthy, high-quality food options and the only affordable options in that community are fast food. Likewise, in some of those same communities, burning the calories and fat from consuming those foods is a challenge. Safety may be such a grave issue in some neighborhoods that walking or jogging to maintain a level of fitness is more perilous than just sitting at home.

Some of the most important drivers are related to people's health in subtle or unexpected ways. If you didn't know anything about social drivers of health and were asked to name what you thought was the top one, transportation would probably not be your first choice. However, a lack of transportation is one of the biggest and most impactful barriers to health that individuals in America can encounter. People who lack transportation may lack social connections, access to healthy food, and access to healthcare. Poor mobility often results in inability to get into chronic disease management programs or access their primary care physicians. Similarly, if you can't get to the pharmacy to pick up your prescription, medication adherence is out of the question.

Of the many social drivers of health, most concern a few broad areas: access to high-quality care, access to high-quality education, economic resources, and the safety of communities in which people live. Typically, social drivers of health do not exist in a vacuum, and individuals may experience multiple dimensions of them. Exhibit 3.1 below shows the five domains of social drivers of health that are the areas targeted for improvement efforts by the US Department of Health and Human Services (HHS) Healthy People 2030 initiative (HHS 2020).

Exhibit 3.1. Social Drivers of Health



Source: Adapted with permission from HHS (2020).

When people think of social drivers of health, poverty usually comes to mind, but as exhibit 3.1 shows, many factors are involved in social drivers of health:

- *Economic stability.* People with steady employment are more likely to be healthy and less likely to live in poverty. They are also more likely to have health insurance, which can pay for preventive health services. But many people have difficulty finding and holding on to well-paying jobs for various reasons. Health can be one of them—people with disabilities and chronic conditions are often limited in the kind of work they can do.
- *Education access and quality.* Getting a job that pays a living wage is largely determined by access to high-quality education. Individuals who grow up in areas with underfunded schools that perform poorly start life at a great disadvantage. These individuals are also less likely to have families who can afford to support them in gainful higher education.
- *Healthcare access and quality.* More than 10 percent of people in the United States lack health insurance, which means that they don't have access to a primary care provider (PCP)—the foundation of healthcare access. Lack of access to medical care results in inadequate utilization of preventive services and delays in treatment until health status is at a critical stage. Sometimes people live too far away from high-quality healthcare providers because they are shuttered in their communities. Individuals with limited or inappropriate access to comprehensive primary care will often end up utilizing resources such as the emergency department (ED) for acute care. As a site of service, the ED is expensive and simply not focused on chronic condition management.

- *Neighborhood and built environment.* Many environments in neighborhoods around the United States are not conducive to promoting the health and safety of their residents. Often, these neighborhoods are populated by people with low incomes and/or by racial and ethnic minorities. People in these neighborhoods are often subjected to violence, unsafe air and water, and many other health and safety hazards.
- *Social and community context.* People in affluent neighborhoods generally have a wide range of social and community support available to them where they live and work. This is not usually the case in low-income neighborhoods, where community and social-support organizations are lacking. If they are in crisis—for example, being unable to afford food, clothing, transportation, and healthcare—they often have few options for getting help (HHS 2020).

FURTHER SOCIAL DRIVERS OF HEALTH

The COVID-19 pandemic laid bare many of the inequities in testing and treatment, vaccination, education, care access, quality, and health outcomes experienced by people from underrepresented minority groups in our populations. Primary care access has been and remains a problem in these communities.

Since early April 2020, when CMS sent a letter to all Medicare organizations approving reimbursement for the expansion of "virtual care" to reduce the risk of spreading the coronavirus, the use of telehealth rapidly expanded. This revolution has been positive for population health in many ways, especially for meeting people where they want to receive their care and helping alleviate some of the effects of transportation issues on PCP access.

For some people, that is.

Telehealth has been generally welcomed with open arms by providers and patients alike. Before the COVID-19 pandemic, I had seen zero telehealth patients. Now 10 to 20 percent of encounters during a typical clinic session for me may be telehealth encounters. When we were transitioning to our telehealth options, I assumed that the biggest roadblock we would run into would be low technical literacy. It wasn't. The greatest impediment was a lack of connectivity. No Wi-Fi. No broadband. And no way to pay for it.

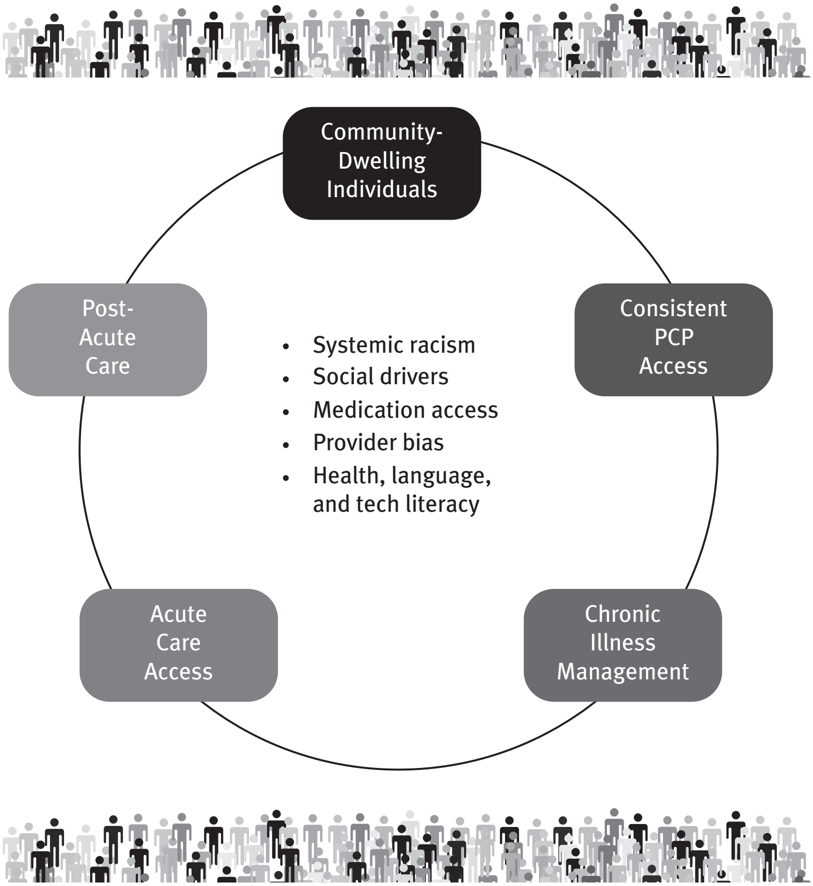
Poverty is behind many of the social drivers I mentioned earlier, including broadband access, lack of health insurance, food insecurity, housing insecurity, lack of education, and limited access to transportation. These economic hardships often result in individuals relying on poorly paying jobs or inadequate social programs to mitigate their challenges. Their resultant effects increase chronic stress and even isolation, thus worsening the predicament for many in the community.

ADDRESSING THE CONTINUUM OF CARE

As a practicing hospice and palliative care physician and a leader in value-based care, I continue to see health inequities in my practice and in healthcare delivery in general. Overcoming the negative social drivers of health starts with an understanding of the continuum of care—how we follow patients through their journey within the health system. We will dive deeply into the continuum of care in chapter 8, but this is a good point to address the disparities that impede it.

Exhibit 3.2 is a graphic representation of the patient journey and highlights disparities in care along that journey. We start off considering individuals who reside within the community. These folks may be well overall or may have some health condition. The first and typically most appropriate access point to the healthcare continuum is through a PCP.

Exhibit 3.2. Disparities in the Continuum of Care



PCPs can assess, diagnose, and typically treat many chronic illnesses. They may refer complex patients to a specialty care physician for an opinion or a procedure. Ultimately, the PCP is the owner of the relationship with the patient and has the best insight into whole-person care. The best PCPs will use specialty care where appropriate and receive patients back from specialists in a co-management or collaborative model.

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A surprising portion—nearly 60 percent—of adults suffer from at least one chronic illness (Buttorff, Ruder, and Bauman 2017). Typically, a chronic illness is defined as one that requires medical intervention, lasts more than a year, and may affect physical or emotional well-being. Chronic-illness management requires a thoughtful, comprehensive, team-based approach. PCPs are often the most adept at managing chronic illness, and they require the resources of team-based care to manage serious illness.

Value-based-care platforms help support these teams of nurses, social workers, pharmacists, behavioral health providers, dieticians, and more. A prime example of this is when a patient requires the skill of a dedicated care manager for their chronic disease navigation. These resources are integral to an accountable care organization. A skilled care manager will assist in navigating patients through the complex health system, ensuring proper follow-up, educating patients and caregivers, mitigating gaps that are discovered in care, and facilitating transitions from the hospital to home.

Ultimately, the PCP is the owner of the relationship with the patient and has the best insight into whole-person care.

People with chronic illnesses such as heart failure, lung disease, or diseases of the liver and kidneys may experience acute complications that may result in the need for acute care utilization. Acute care utilization often involves accessing the ED and/or an acute care hospitalization. Nowadays, the acute care setting is mainly used for the purpose of identifying and stabilizing the acute issue, such as treating an infection or administering some intervention that cannot be delivered in another setting. Typically, the acute care setting is the shortest stop along the care continuum.

If an individual is stabilized in an acute care environment, that patient will be discharged to post-acute care. Post-acute settings most frequently include management in the home, with or without professional support. This is the period when patients recover from their illnesses and return to their pre-hospitalization level of function if possible. If an individual's needs exceed the capacity of the patient and their family to safely navigate the home, an inpatient facility may be used for a short time to bridge their eventual return to the home.

CONTINUUM INEQUITIES

In addition to strong primary care, effective population health models require that members of a community have consistent access to their providers for preventive services and chronic care management. Unfortunately, individuals in underrepresented, marginalized populations often have substandard access to PCPs and specialty care physicians. If these individuals run into problems, they have no choice—they must go to the ED. Because of a lack of appropriate disease screening and attention to wellness, these folks are typically diagnosed with later-stage illness and may face fewer viable treatment options to return them to a state of wellness.

In the palliative care arena in which I practice, Black patients are particularly underserved. In 2021, the Project Equity workgroup of the Center to Advance Palliative Care (CAPC) conducted a comprehensive review of the peer-reviewed literature to learn more about healthcare and quality-of-life issues for Black individuals who live with serious illnesses and their families. Among their findings were that Black people living with serious illness experienced

- poorer-quality pain management from their providers,
- worse non-pain symptom management than White patients,
- an increased need for high-acuity care,
- higher medical costs during the course of their illness,
- fewer advanced-care planning discussions or documents (e.g., a living will or advanced directive) compared to White patients,

- mistrust of the healthcare system, and
- cultural factors that influence healthcare decision-making and are at odds with their health providers (CAPC 2021).

Solving inequities in the continuum of care will require wide-ranging determination on the part of people and organizations in every community. The Institute for Healthcare Improvement has been developing a consensus in the healthcare quality improvement community around what it calls the Triple Aim of better health outcomes, improved patient experience, and lower costs. More recently, thought leaders have added key areas of provider well-being and equity to these goals, as shown in exhibit 3.3.

Healthcare through the lens of the Quintuple Aim is beneficial for individuals and communities. The American health system will not succeed in its journey of transformation without clear focus on each of these areas. This is the path of healing for a health system

Exhibit 3.3. The Quintuple Aim

Source: Coleman et al. (2016).

that is bruised by a fee-for-service mentality; addicted to the latest, greatest technology; and hemorrhaging money as the life expectancy of Americans decreases.

To achieve population health and community wellness, we need to close gaps in the continuum of care, many of which I explained earlier in this chapter. Accountable care organizations are built on a platform of comprehensive population health management and equity in care. The next chapter will explore how accountable care organizations can help us move on from an ailing system to create a new paradigm of care delivery with a focus on quality, outcomes, and cost for all populations.

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