No Equity, No Triple Aim: Strategic Proposals to Advance Health Equity in a Volatile Policy Environment

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Health professionals, including social workers, community health workers, public health workers, and licensed health care providers, share common interests and responsibilities in promoting health equity and improving social determinants of health—the conditions in which people live, work, play, and learn. We summarize the underlying causes of health inequity and comparatively poor health outcomes in the United States. We describe barriers to realizing the hope embedded in the 2010 Patient Protection and Affordable Care Act, that moving away from fee-for-service payments will naturally drive care upstream as providers respond to greater financial risk by undertaking greater prevention efforts for the health of their patients.

We assert that health equity should serve as the guiding framework for achieving the Triple Aim of health care reform and outline practical opportunities for improving care and promoting stronger efforts to address social determinants of health.

These proposals include developing a dashboard of measures to assist providers committed to health equity and community-based prevention and to promote institutional accountability for addressing socioeconomic factors that influence health. (*Am J Public Health.* 2017;107:S223–S228. doi:10.2105/AJPH.2017.304000)

Social workers share a common commitment with public health workers and health care providers to promote health equity and improve social determinants of health (SDOH)—the conditions in which people live, work, play, and learn. We summarize the case for advancing governmental and institutional policy change to address structural racism and rebalance the nation's spending priorities. The article breaks new ground with a critical analysis of the strategy embedded in the 2010 Patient Protection and Affordable Care Act (ACA)[1] to promote population health and includes recommendations for advancing health equity in the current political environment. The article also articulates the historic role of the social work profession in addressing the SDOH and emphasizes the importance of strategic collaboration involving social work, public health, and health care professionals.

HEALTH EQUITY AND COMMUNITY-BASED PREVENTION

The United States spends proportionately more on medical care than other developed countries and less on addressing socioeconomic factors that influence health.[2] This helps explain the US health care paradox of achieving comparatively poor population health outcomes despite leading the world in health spending.[3] It also helps explain persistent health inequities—systematic, avoidable, and unjust differences in health status among population groups—linked disproportionately to race and ethnicity in longevity, access to quality care, and a wide array of diseases and conditions.[4,5]

Health care reform under the ACA left intact the nation's significant reliance on private provision of health services and did little to address overall medical system spending. US health spending was projected to be $3.35 trillion in 2016, accounting for 18.1% of gross domestic product.[6] At least one third of that spending is estimated to be wasted annually, driven by clinical inefficiencies (ineffective care, overtreatment, and failure in care coordination), administrative complexity, excessive pricing, and fraud and abuse, in that order.[7,8] This translates to a waste of more than $1 trillion in health spending each year, more than the direct US military budget of $611 billion.[9] Compounding the immorality of health inequity, research has suggested that eliminating racial and ethnic disparities would reduce medical care costs by $230 billion and indirect costs of excess mortality and morbidity by more than $1 trillion over 4 years.[10]

To achieve health equity and improve the overall health of the population, it is necessary to invest more, as other developed nations do, in advancing SDOH, including education, housing, food security, income supports, employment, maternal and early childhood development, and other services that promote health.[10] It is also necessary to improve the effectiveness and efficiency of health care delivery and to ensure medical security to all US residents through

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universal access to affordable, high-quality health care.

Where can the resources to advance this agenda be found? One approach would be to adopt a Medicare for All program[11] and allocate savings from reduced waste in health spending to social investments. This is implausible in the current political environment, but incremental progress may be possible. To implement President Trump's campaign pledge to control prescription drug prices, for instance, Congress might allow the Centers for Medicare and Medicaid Services to negotiate price discounts with pharmaceutical suppliers.

A second strategy for increased SDOH investment is embedded in the ACA's complex design, which seeks to promote the Triple Aim[12] of cost containment, improved population health, and improved patient experience through an amalgam of mandates and incentives. Public health advocates lobbied successfully for increased funding, a national strategy to prevent injury and disease, workforce innovations, and elimination of cost sharing for many preventive medical services.[13] In addition, the ACA authorized accountable care organizations to shift financial risk to medical caregivers and incentivize payment for value over volume, with the hope that paying for healthier outcomes rather than services delivered would spur caregivers to focus more on preventing illness and injury to avert often costly treatments.

ASSESSING PROSPECTS FOR HEALTH TRANSFORMATION

Optimism about the transformative potential of the ACA to achieve Triple Aim objectives is undermined by financial forces in the health care industry and prevailing assumptions about who bears responsibility for promoting social welfare. Institutional behavior suggests the business case for investing in community-based prevention is not yet compelling for most health system executives. Investment in social infrastructure is generally understood to be a public sector responsibility, even when the benefits of public spending and tax exemptions enhance private sector bottom lines.

The Triple Aim construct suggests that improved population health, patient experience, and cost control are mutually reinforcing, but there is a skewed emphasis now on trying to achieve cost control. Near-term financial interests drive health executives to protect revenues, increase market shares of "covered lives," and extract value through improved efficiency of care, particularly for the most expensive patients. Health system transformation is generally focused on the 5% of patients who account for 50% of Medicaid expenditures, particularly so-called "super-utilizers"—the 1% of patients who account for 22.7% of Medicaid costs—with complex comorbidities who frequent emergency departments and require regular hospitalization.[14] Interventions principally focus on case management strategies, with some measure of secondary and tertiary prevention activities. Without fundamental attention to health equity and corresponding investments in primary prevention to promote community-level health, this population threatens to further overwhelm the capacity of the health system.

Hope that the ACA's design will advance primary prevention strategies—driving care upstream—is also undermined by questions including how much savings can be achieved from advances in coordinated health care and how managers will allocate savings derived from successful quality improvement and workforce innovations. Will effective utilization of social workers in behavioral health programs—or increased integration of community health workers (CHWs) into interdisciplinary care teams—lead to further investments in those workforces, or will the savings they help achieve be funneled into costly new technologies, capital investments, and net corporate earnings?

To compound matters, current innovations in "upstream medicine"—in which health care providers screen patients for nonmedical conditions and make referrals to social service agencies—depend on community-based services that are inadequately available, unevenly distributed, and vulnerable to funding cuts. Where services are in short supply, a referral-based strategy is a bridge to nowhere for improving population health. Patients in some areas certainly benefit, but overall health transformation requires a more systematic approach to improving SDOH.

More fundamentally, the structure of power and resources in US society undermines the potential of ACA reforms to promote the Triple Aim. Not only does determination by Republican leaders to repeal and replace Obamacare threaten to unravel progress that has been made in expanding access to health insurance and preventive services, but it also exposes the fragility of the ACA's unproven array of incentives and mandates to promote upstream care by shifting risk to providers. The administration's budget and tax policy proposals, moreover, threaten to exacerbate health inequities by exaggerating imbalances in spending that already result in poor population health at unsustainable cost. Core social spending is limited to accommodate tax cuts, corporate welfare, and military spending, despite historic income and asset inequality.

Ultimately, population health goals cannot be achieved without a focus on equity. The Institute for Healthcare Improvement says, "The Triple Aim will not be achieved until it is achieved for all."[15(p5)] The fundamental challenge of structural racism in US society, along with intersecting inequities based on class, gender, physical and cognitive ability, age, sexual orientation, and gender identity must be addressed.

Strategic Responsibilities

Professionals committed to equity must take practical steps to improve care delivery and promote community-based prevention, despite legislative challenges to the ACA. They must also confront the political and economic factors underlying the SDOH,[16] which the ACA does little to address. This requires policy change, as well as reorganization of care systems. It means

- defending health care reform in the political arena;
- promoting direct investment in primary prevention by health care providers;
- helping to build power for patients and communities through a combination of organizing, advocacy, and multisector partnerships; and
- engaging in campaigns to promote affordable housing,

economic development, safe neighborhoods, food security, environmental quality, and other issues that help determine health.

Social workers have played a prominent role in organizing to protect science and democratic institutions and to influence policy on issues ranging from civil rights to climate change since the 2016 presidential election. They continue the profession's legacy of addressing the root causes of poverty and oppression since the 19th-century settlement house movement.[17] Long before the phrase *social determinants of health* was coined, social workers were addressing them through policy and system change, as well as through direct services to individuals, families, and communities. The profession is uniquely positioned now to partner with public health and other disciplines to seize opportunities to defend and advance a health equity agenda in this political environment.

Practical tools are emerging to support this work. The Institute for Healthcare Improvement offers a framework for health care organizations to achieve health equity and encourages providers to "take into consideration the resources available to particular populations"[12(p6)] such as where they live, financial status, education level, access to transportation, and cultural factors, beginning with their own employees, campuses, and neighborhoods. Similar recommendations are included in the Robert Wood Johnson Foundation's Culture of Health action framework.[18]

An emerging body of practice in this area is educational and worthy of emulation. Examples include the Henry Ford Health System in Detroit, Michigan, which provides financial incentives for its employees to purchase homes near the hospital, uses minority- and women-owned suppliers, hires local residents as CHWs, operates a "complete streets" program to improve pedestrian safety and promote walking and bicycling, develops mixed-use housing, runs youth leadership and health career path programs for high school students, and convenes a regional partnership to reduce infant mortality, among other exemplary programs.[19]

Much of the current discourse identifies opportunities, rather than responsibilities, for health systems to invest in programs such as these. Decisions about whether and how to move care upstream are optional. Some organizations recognize these opportunities as fundamental to achieving their missions and protecting their bottom lines. For their practices to be adopted into mainstream corporate behavior, a new set of expectations must be advanced and new tools must be developed to promote accountability for health systems to invest in improving SDOH, including support for community organizing and advocacy to achieve policy change, redistribution of resources, and the empowerment of disenfranchised communities.

Action Proposals for Health Professionals

Adopt equity as the guiding framework for health transformation. Professionals in health policy and practice, across disciplines, must cooperate to emphasize structural foundations of inequity, particularly racism, in promoting health.[20] New York City Health Commissioner Mary Bassett proposed the adoption of an "equity in all policies" framework for health promotion. Her initial appeal to fellow city department heads for cooperation to pursue health in all policies was misinterpreted by them as a request to do her job. Equity in all policies and planning, she reported, is a framework that applies to all of the responsibilities in city government.[21]

Promoting equity requires learning and talking specifically about racism and its impacts in the health arena. Training tools are available to help organizations take action to overcome the unconscious bias that undermines equitable practice.[22] A consortium of hospitals and community-based health providers in Boston, Massachusetts, is pioneering a "Liberation Health" program that enables clinicians to share effective ways of addressing racism with patients and others.[23] The Movement for Black Lives has published a detailed vision statement outlining specific actions to promote racial justice.[24]

Promoting health equity as the guiding framework for health transformation is a multisector responsibility. The Robert Wood Johnson Foundation's Communities in Action: Pathways to Health Equity[25] initiative underscores the importance of collaboration by health care, public health, academic, philanthropic, community, business, and government organizations at all levels; it emphasizes equity not just in health but also in education, housing, transportation, community and economic development, and other SDOH.

Engage community members and patients directly in health transformation. Professionals involved in health transformation at all levels should take time, foster relationships, and commit resources to involve grassroots community members in planning and decision making, not just "grass tips" agency representatives who may not live in the communities they serve. The Boston Alliance for Community Health, for instance, has funded a cadre of nearly 80 community members, called *Healthy Community Champions,* to inform planning and implementation of programs to reduce the burden of chronic disease.[26]

Grassroots community participation in assessment, planning, and implementation promotes successful policy and program development. Not only does it result in more effective use of limited resources, but it also fosters collective empowerment, democracy, and social justice. Similarly, a person-centered approach to care must provide opportunities for patients—particularly marginalized patients—to speak for themselves, rather than only through providers.

"Community" is a complex construct, difficult to define because it involves not only geography, but also factors involving personal identity and common experience that may transcend place.[27] Who represents a geographic community? Whose interests are paramount in assessing community needs and assets? How does one improve the health status of communities of identity that transcend geographic boundaries? Addressing these questions is essential to successful health transformation efforts.

Participate in health planning and improvement processes. Social workers and health professionals should also themselves participate in community-based efforts to shape policy and allocate resources. For instance, they may represent their organizations or volunteer to help develop community health assessments and health improvement plans required for national accreditation of state and local public health

departments. They may also help develop health impact assessments used to shape planning of transportation and other major capital projects.[28]

Hospital community benefits programs also provide important opportunities to influence the allocation of resources to meet community-defined priorities. Hospital community benefits spending in the United States was estimated at $55 to $60 billion in 2012.[29] Hospitals are required under the ACA to conduct community health needs assessments (CHNAs) every 3 years, to engage local representatives in those planning processes, and to address identified needs through community benefits investments.[30] Health equity champions should seek involvement in these processes. Grassroots community leaders and nontraditional organizational partners, such as community development corporations, faith-based communities, and advocacy groups, should be involved, and not just organizations that already benefit from hospital contributions.

Anecdotal evidence has suggested that social workers are seldom present at these planning tables, despite the profession's long-standing commitment to addressing environmental factors that shape personal and family experience and behavior. Participation takes time and effort, but the opportunities for impact are potentially powerful. Social workers, CHWs, and other health equity advocates should be wary that if they are not at the table, they might be on the menu.

Use a full strategic toolbox to challenge inertia, intransigence, and profiteering. The literature of social work macro practice—that is, community organizing, planning, program development, management, and policy—distinguishes 3 core strategies available for social transformation: collaboration, campaign, and contest.[31] Each is appropriate for different situations, depending on the degree to which stakeholders share values, interests, and consensus about how to define and solve problems.

Professionals from all disciplines—including social work, health care, and public health—and public officials charged with care delivery transformation should appreciate the need for campaign and contest strategies when they are most appropriate. Collaboration, for instance, may not be the appropriate strategy for dealing with predatory landlords who create or fail to remediate environmental hazards that drive vulnerable community members into hospital emergency rooms. Professionals need to be able to use all available tools to persuade or compel institutional power holders to address community needs. This includes interprofessional and cross-sector partnerships, political and legislative campaigns, legal advocacy, strategic social media, community organizing, and direct action.

Accelerate and expand effective models for promoting integrated and community-connected care. Health professionals and advocates should encourage provider systems to take advantage of emerging best practices, quality measures, training tools, workforce development initiatives, ACA incentives, and demonstration grants to improve care within and beyond the walls of hospitals, health centers, and other settings. Providers, payers, and regulators should accelerate integration of CHWs into care teams and care delivery models, taking advantage of the emerging national consensus on CHWs' roles and skills[32] and the burgeoning literature showing CHWs' efficacy as members of integrated care teams.[33] CHWs, in turn, must organize with support from other disciplines for mainstream integration into health care and public health systems with sustainable financing. Social workers must assume leadership in behavioral health integration and cooperate with CHWs in demonstrating new models for care coordination and community-based care. Health equity champions should become involved in the efforts of local institutions to develop health homes under Section 2703 of the ACA, which requires multidisciplinary approaches to serving populations with complex needs related to social risk factors and chronic conditions. Similarly, professionals from multiple disciplines should take advantage of opportunities to shape implementation of federally funded accountable health communities.

Adopt patient screening for nonmedical needs into mainstream clinical health practice and associated data analytics. The practice of screening patients for nonmedical needs related to SDOH and linking them to community-based services is gaining traction, but it is not yet mainstream practice. Such data are not collected or reported in standard electronic health record protocols; they are not integrated with all payer claims data or public health surveillance data; and they do not factor into the data sets that typically drive decision making for health care providers and payers. Public and private organizations are disseminating screening tools[34] (see also http://www.nachc.org/research-and-data/prapare, http://healthleadsusa.org/resources/tools, and https://www.aamc.org/download/442878/data/chahandout1.pdf) that provide valuable models. Providers should ensure that individuals and families are screened to determine their eligibility for services and public benefits, such as subsidized housing, supplemental food programs, maternal and child health services, behavioral health care, and income supports. They should refer patients to services for which they are eligible and supply documentation required by public agencies to determine eligibility. Care coordination performance metrics should demonstrate that people are receiving services and benefits to which they were referred.

Develop measures to assist institutions to address social determinants of health and hold them accountable for doing so. The classic axiom of performance management—what gets measured gets done—underscores the need to develop measures to promote health equity and community-based prevention. Quality measurement is a key focus of attention for states developing accountable care organizations authorized under the ACA, but only 1 state identified in a recent study has defined measures to foster progress toward integration of physical and behavioral health, long-term services and support, and health-related social services.[35] Even those measures, adopted in Massachusetts, are better described as measurement concepts, because they lack evidence-based metrics and have not been endorsed by independent organizations such as the National Quality Forum.

A growing literature seeks to expand the use of measures to promote health equity and population health. Frameworks such as the Institute of Medicine's *Vital Signs*[36] feature measures to identify health disparities, desired population health outcomes, and conditions related to them.

Unlike clinical care measures, however, they tend not to provide specific guides for institutional action nor means to support accountability. *Vital Signs,* for instance, identifies high school graduation rate as the best available core measure for healthy communities, but it offers no guidance as to how health care systems can help promote improved educational attainment at the community level. Similarly, county health rankings,[37] developed by the Robert Wood Johnson Foundation, provide a valuable conceptual framework and useful measures for comparing population health outcomes among different jurisdictions, but they are fundamentally a descriptive tool.

As health systems adjust to alternative payment schemes, it is time to create a dashboard of measures that may be used to guide institutional action and accountability for promoting community-based prevention. Reliance on prevention-oriented strategy embedded in the ACA is inadequate, especially considering the law's political fragility. Systems and structures need to be built to incentivize upstream care and investment, rather than hoping that the exemplary practices of visionary providers will somehow transform mainstream practice. A performance management approach, as well as social movement building, is needed if progress toward health equity is a serious goal.

Defining such measures will require considerable research, time, and cross-sectoral collaboration. It is necessary to address questions involving reasonable expectations for health providers and other organizations, as well as how to define metrics that can be applied effectively in the context of capitated and risk-adjusted payments. It is also necessary to construct measures that respect the constraints of health data systems and accommodate the variety of needs and assets in different communities across the nation. Developing a set of action-oriented measures requires flexibility in the context of a unifying framework. Toward that end, we offer the following recommendations. Dashboards should

- measure whether and how health care institutions are using Institute for Healthcare Improvement protocols to improve health equity;
- aggregate variables related to CHNAs, including diversity of participants, inclusiveness of study methods, community engagement in funding decisions, and levels of funding to address community needs unrelated to subsidized care and professional education;
- measure whether and how health providers screen patients for nonmedical needs, provide and follow up referrals to social services, and collect and analyze data related to SDOH;
- determine whether and how data from CHNAs and patient screening of nonmedical needs are compared, integrated, and incorporated into developing community benefits plans;
- measure the degree to which community–clinical linkages and community partnerships are integrated, as a means of assessing the effectiveness of care coordination and provision of health services in vulnerable communities;
- track whether and how hospitals and other institutions are going beyond community benefits programs to invest in addressing SDOH; and
- measure direct, sustained investment to support community organizing and policy advocacy partnerships.

When considering tracking how institutions address SDOH, questions to address include: Are they integrating public interest lawyers into their multidisciplinary care teams? Are they providing CHW services at a scale commensurate with the needs of their patients and communities? Are they supporting community-based service providers? Are they using minority and women-owned contractors in purchasing goods and services? Are they building facilities in neighborhoods that would particularly benefit from community development? Are they paying living wages to all employees? Best practices from model health systems across the nation should be used to develop such measures.

A recent report by the Boston Public Health Commission has documented positive health impacts resulting from changes to that city's living wage ordinance.[38] When measuring investment in community organizing, questions to address include: Are institutions supporting "Fight for $15" living wage campaigns? Are they supporting community organizing efforts to prevent mortgage foreclosures and Section 8 displacements? Are they backing community coalitions working for criminal justice reform and interruption of the school-to-prison pipeline? Are they investing in public–private partnerships focused on health equity, such as the Government Alliance on Race and Equity?[39] A dashboard intended for widespread use need not list specific issues or campaigns as litmus items, but examples such as these may be useful in guiding thinking further upstream than is typically the case.

Improve interprofessional health education and training. Health professionals should be trained in the scope and capacities of their respective colleagues and should receive opportunities for cooperative learning in clinical and field settings. The social work profession should undertake systematic efforts to educate professionals and students about the profound relationship between social work and health. Both the social work and the public health professions should emphasize the founding values of their respective professions and improve training in organizing, advocacy, and environmental system change to improve community well-being and population health outcomes. This interprofessional, interdisciplinary training should include education in the principles of care integration and shared accountability.

CONCLUSIONS

Health equity should serve as the guiding framework for achieving the Triple Aim of health care reform. Strategy embedded in the ACA is valuable but inadequate to promote equity and community-based prevention. Recommendations outlined in this article identify productive opportunities for cooperation among social workers, public health workers, health care providers, and community members. Possible dismantling of the ACA and elimination of core social programs underscores the importance of building a movement for social and economic justice as the foundation for health equity and optimized population health. AJPH

CONTRIBUTORS

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