COVID-19 is transforming public health. It’s not the first time.

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Kaiser Permanente, through the affiliation of several of its physician-led Permanente Medical Groups, is an AMA Health System Program Partner. The integrated health care system, with eight different regions throughout the country, has long been at the forefront of taking on public health roles to address the social determinants of patients’ health. Most recently, this has included the release of a “COVID-19 Social Health Playbook.”

Two of Kaiser Permanente’s physician leaders took time to discuss how public health is evolving and how the system integrates public health services into its care delivery workflow.

Family physician Bechara Choucair, MD, the former commissioner of the Chicago Department of Health, serves as senior vice president and chief health officer for Kaiser Foundation Health Plan, Inc. and Hospitals. His recent book, *Precision Community Health: Four Innovations for Well-being*, describes three revolutions in public health.

Infectious disease specialist Stephen Parodi, MD, is the executive vice president, external affairs, communications and brand, The Permanente Federation and associate executive director, The Permanente Medical Group (in Northern California).

Dr. Parodi has written about the growing connection between health care and public health and how this can lead to “Breaking the COVID Curve.”

**AMA:** Dr. Choucair, COVID-19 has really focused everyone’s attention on the vital importance of public health. But public health today is different from what it was a century ago when the 1918 influenza pandemic hit. Tell us more about how public health has changed.
Dr. Choucair: There have been three distinct revolutions in the modern era of public health.

The first was around communicable disease and that was beginning in the second half of the 19th century. In Chicago in 1832, for example, troops on their way to the Black Hawk War brought cholera to the city, helping spread what was at the time a worldwide pandemic. As a result of this, about 6% of the Chicago population at that point died.

And that created action. Five years later, Chicago chartered the creation of the board of health, and created the position of health officer. And, over the following century—like many other big cities across the country—Chicago took on challenges like diphtheria, scarlet fever, typhoid fever, measles and whooping cough.

This was followed by a revolution around chronic disease. This revolution was a result of what we were seeing from a consumerist lifestyle, industrial processes and, to some degree, the success in medical progress, which turned some deadly acute diseases into chronic manageable ones.

There also was a lot of work to help people quit using tobacco. You also had all the developments related to seatbelts in cars and other innovations that allowed people to live longer.

We’ve seen significant improvement in life expectancy. People are healthier. But we also started to see inequities and disparities—and those are actually growing.
So, that’s why I feel we’re at this really important moment with a shift to the third revolution, which is more about creating a social movement. What is needed is a shift in public attitude about what really is public health. I think we all agree that, for us to really promote health, we need to think beyond just clinical medicine.

We have to be involved in social policy and fiscal policy. We know education and housing have big roles on health. All of these bear directly and indirectly on health.

**AMA:** Dr. Parodi, you’ve written about physicians and health systems integrating a public health infrastructure into their workflow. How did that evolve?

**Dr. Parodi:** I’m an infectious-disease physician and still practice. I’ve had a lot of experience working with public health and it’s been a very important part of my practice over the last 20 years.

We’re constantly working with people who have communicable diseases and coordinating to provide the clinical care that a person needs. We’re also making sure that there is an appropriate interface with public health to do communicable disease follow up—such as the contact tracing that needs to happen for a tuberculosis case, for example.

Sometimes, we as a health system provider can identify the case, but we don’t necessarily have the resources or, in some cases, even the authority to follow up on the contacts who aren’t part of our particular health system.
So, there’s a clear integration just from a communicable disease standpoint.

Increasingly, I would say—over the last couple of decades—there’s more and more interface with public health when it comes to addressing not just the medical disease, but also the social determinants of health of our patients.

Many of my own patients have issues with housing, with food insecurity, with safety-related problems in their neighborhood. Some of those things can be handled within the health system itself, through our social workers and case managers that are part of my team. We also help address these issues by connecting them to community resources. And often, public health is able to provide some of the safety net as well. So, I would say, at the very basic physician-practice level, this has become a very important part of our practice.

Now, taking a step back and putting on my hat as one of the associate executive directors of Northern California [The Permanente Medical Group], one of the area’s that I have responsibility for is the care of complex-needs patients. We’ve started developing more programs to have greater connections with community-benefit organizations [CBOs] as well as internally being able to provide that care.

Let me answer why we’re taking these steps. Over the past few decades, we’ve seen an erosion in the funding and support of our public health system in general. That’s come to the fore with the COVID-19 pandemic. Health systems are having to fill in some of the gaps that exist with our public health infrastructure.

AMA: There’s an increasing focus on so-called upstream health factors. What can physicians do about them?

Dr. Choucair: There are two ways we have to be thinking about upstream factors that impact on health.

One is directly in our clinical setting. When we’re interacting with patients, how do we make sure that we’re starting to think about their social health in the same way we think about their physical and mental health?

The second way is to think even a little bit further upstream, about what role we can play as physicians in really driving the policy, the systems and the environmental changes that we need to see so we can make an impact.

A Kaiser Permanente survey conducted last year found that about 68% of people living in this country have at least one unmet social need. Whether it’s housing instability, food insecurity, social isolation, transportation issues or even just the basic financial ability to pay their bills.
When we dug even deeper, we found that for one in four people, unmet social needs are a barrier to health. So, that means one in four people are having to make the tough choices between, for example, “Do I pay the co-pay to get my medication today, or do I to put food on my table? Do I pay rent this month, or do I pay the coinsurance for the surgery that I badly need?”

To me, that brings to mind how critical it is for us in our medical practices to think about our patients’ social health when we’re talking with them about their physical and mental health. And we have to think about how we fully integrate the way we think about physical, mental and social health so we can optimize the health of our members.

We have to think about how we can build networks of social health providers the same way we have networks of primary care doctors and specialists to take care of the physical health of our members, and the same way we have networks of mental health providers and psychiatrists to take care of the mental health needs of our members. We have to be thinking about how to build networks of social health providers to really take care of the critical elements that impact health—like food, housing and transportation.

That’s the journey Kaiser Permanente has been on over the last several years. We’ve partnered with an entity called Unite Us, and we’re on a track to build 39 social health provider networks in our communities to support our members and our doctors to be able to refer patients to get those services.

AMA: Kaiser Permanente started a project called Thrive Local. Tell us about that, and about the role of physicians in connecting patients to the resources they need?

Dr. Parodi: The physicians for complex-needs patients increasingly have case-management programs that help wrap around that physician and patient to provide the support they need. A number of these patients require subspecialty care—whether that be cancer care, cardiac care—and most of those have case managers embedded in the program.

Each of those case managers has an electronic or actual, believe it or not, Rolodex, where they are connected with various resources in a given locale.

Thrive Local, which is exciting, is essentially taking this to the next level. Instead of relying on the individual relationships that a particular case manager might have and often, locked up in a desk or on sticky notes, we can have an electronic catalog of community resources that are available and the physician can directly refer to those resources.

That requires that we have formal agreements and connectivity with those community-based organizations, and so Kaiser Permanente—along with a number of other health systems in our
locales—are working together to forge those relationships.

**AMA:** Dr. Parodi, you recently wrote about the underfunding of public health departments with problems running the gamut from fax machines running out of ink to test results being received late. How do problems like that play out in patients’ lives?

**Dr. Parodi:** It's been clear that if you want to have good control of communicable disease, you need to have things move at the speed of the disease—and not the speed of other limiting factors like a fax machine.

Whether it’s making sure that we get somebody a test in a timely fashion so we know whether or not that individual needs to be isolated, whether they can come out of isolation, or so you can do appropriate contact tracing, you have to have that. Otherwise, you cannot address the public health needs of a given community.

In a non-pandemic setting, I’ve had instances in which individuals with communicable disease trying to get in touch with me or I’m trying to get in touch with them, or you’re faxing things back and forth, and a week or two can go by. That’s not good from a public health perspective or a clinical care-delivery perspective.

Innovations like Thrive Local are going to become increasingly important because people’s ability to adhere either to public health recommendations or to our clinical care recommendations are really going to become increasingly dependent on the fact of whether or not they do have housing, access to food, the basics. If they can’t address economic insecurity—which I’m significantly concerned about, given the job losses people are experiencing—they’re not going to be able to attend to these other issues that are important.

**AMA:** What can the individual doctor do?

**Dr. Choucair:** Two things. When we’re interfacing with our patients, let’s make sure that we talk about their social health with the same rigor that we think about their physical and mental health. I’m hoping that our health care systems continue to build that social health practice to support our physicians and providers in addressing the social health needs of patients.

The second big piece is that I really encourage physicians to be active in their communities, in policy discussions, in engaging their local elected officials and in sitting on boards and adding their voice.

**AMA:** Kaiser Permanente decided to become carbon neutral. Do you see a strong tie between climate change and the public’s health?
Dr. Choucair: It is absolutely a public health issue. In 2016, we made a commitment to become carbon neutral and it’s been a lot of hard work and we’re really excited to have achieved carbon-neutrality status. …

When you think about climate change and its impact on health, we’re seeing it today. It’s no longer an issue that’s going to impact future generations. It’s here and now. We’re seeing it with the impact of the wildfires in California and the Pacific Northwest, and the hurricanes and other severe weather happening across the country.

We know that 10% of carbon emission comes from the health care system. We also know that climate change is impacting communities of color a lot more than the rest of the country. For us to have a role to play in lifting up the importance of the connection between climate and health is a no-brainer.