BEING A GOOD NEIGHBOR: STRATEGIES AND RESOURCES FOR PRIMARY CARE PROVIDERS TO ADDRESS LOCALIZED URBAN HEALTH DISPARITIES

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ABSTRACT

Many community-based organizations in urban areas of the United States exist to address the needs of their neighborhood and bridge the gap between the healthcare system and their community. In the Primary Care setting, healthcare providers have the opportunity to address those needs, either through their own expertise or through connecting patients with other resources. Despite this unique role of Primary Care Providers (PCPs), many of them are unaware of the resources that exist in their very own community. PCPs need awareness of, as well as partnership with, these community-based organizations. Integrating these resources into patient care will allow providers to improve health on a population level through a more robust response to patient and community needs. This will ultimately lead to a reduction of health disparities and improved quality of life in the community. This thesis seeks to explore strategies and resources that PCPs can use to better address patient and community needs.

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CHAPTER 1: PROLOGUE

My initial interest in accessible community resources stemmed from the disparities I have personally witnessed and learned about in North Philadelphia. Vast food deserts, overwhelming incarceration rates, rampant substance use disorders, and seemingly never-ending cycles of gun violence plagued my mind as they did the community. As a physician-in-training, how can one begin to focus on treating chronic conditions like diabetes, hypertension, and heart disease when the basic necessities of life aren't being met? How could I ask a patient to exercise and eat more fruits and vegetables when the only calories available come from the corner liquor store, and you can't go outside without fear of being shot? It was clear to me early on in medical school and my paralleled studies in urban bioethics that these issues need to be addressed if there is any hope of improving patient health and quality of life.

The questions I had about addressing the needs of the North Philadelphia community lead me to learning about the resources and organizations that actually exist in the city to attempt to address these issues. I learned about *The Simple Way*, a faith-based non-profit organization in the Kensington neighborhood of North Philadelphia, one of the most socioeconomically disadvantaged neighborhoods in the city and arguably the hardest hit by the overdose crisis in the entire nation. I reached out to Shane Claiborne, founder of the organization, and he invited me for a tour of the neighborhood and a conversation about what they were doing in Kensington.

My time with Shane was nothing short of surreal. We met at his house and took a tour of The Simple Way building (he lives across the street) where they have a food bank

serving food and groceries twice a week. He showed me the anvil that he uses to beat guns into gardening tools, which he has many of thanks to the community gun donation drives held by the organization. He showed me the letters written by his own neighbors, written to the Philadelphia mayor and public health officials, begging them to acknowledge the devastating effect the overdose crisis has had on their community. He also explained the various group meetings they hold at the organization, mental health groups, diabetic support groups, etc. He was especially proud to talk about their partnership with Esperanza Health Center, a Federally Qualified Health Center (FQHC) one block away, that allows patients and neighbors alike to share in the unique resources each organization has to offer. It was evident to me, more so than nearly any treatment or procedure I've observed in medicine, that Shane and *The Simple Way* were addressing the needs of their neighborhood and improving the health and quality of life of it's community members.

What makes this organization / model so successful at fulfilling it's mission? The highly localized model implemented by this well-established organization has clearly built trust with it's fellow neighbors. There is a decades-long relationship between the organization and it's community that is built on the devotion to the community that the organization has established. While it's clear that *The Simple Way* is tangibly helping people, how many more could they help if there was greater awareness of its existence in the community, or if their business was better supported through other community partnerships?

As a soon-to-be Family Medicine resident physician, I want to understand the tools available for addressing patient needs that extend beyond the scope of the clinic.

Too often I've heard or seen patient-physician interactions where the patient is labeled "non-compliant" for their poorly-controlled chronic conditions (ie hypertension, diabetes). These physicians usually know the patients basic social history (neighborhood of residence, drug/alcohol history, etc.) but have not learned more about the patients day-to-day life and existing barriers that may prevent the patient from adequately caring for themselves and staying "compliant". Even when physicians do take the time to learn about barriers to care (such as underlying mental health issues, domestic abuse, inadequate health literacy, etc.) these problems are not always addressed, but merely acknowledged. While it is of utmost importance to recognize the social determinants of health and let the patient know that their life situation is understood, it is imperative that these factors are actually addressed and action is taken.

CHAPTER 2: INTRODUCTION

It is well established that urban underserved communities in US cities, such as Philadelphia, have numerous Community-Based Organizations (CBOs) and resources devoted to the particular needs of their own community (Michener, 2016). Primary Care Providers (PCPs) have the privilege of understanding and addressing those particular needs (ie food, housing, mental health, physical safety) on both an individual and community level. While PCPs are limited in their scope of practice to personally meet all these needs, they can address these needs by connecting patients with the proper services. Despite their intermediary role, research shows that many PCPs have troubling gaps in knowledge of available resources and lack ability to connect patients to those resources (Ploeg, 2017).

Gaps in knowledge of essential community resources is problematic amongst PCPs, but addressing this problem must include a broader examination of the US health care system as a whole. Our system prioritizes specialized treatment of discrete diseases and symptoms, rather than fixing the causes of illness or addressing the social determinants of health. Furthermore, the medical system is specialty-driven and lacks incentive for adequate collaboration between specialties, primary care, and public health. This has led to a fragmented delivery of health care and social services that fail to address the complex and diverse needs of populations throughout the US, especially those in urban underserved communities (Stange, 2009).

This thesis explores strategies and resources that PCPs can use to better address patient and community needs while also acknowledging the flaws and limitations of the

US healthcare system. CBOs such as *The Simple Way* in Philadelphia exist to address the needs of their neighborhood and bridge the gap between the healthcare system and their community, yet many providers are unaware of such organizations and have little incentive to gain awareness. PCPs need awareness of, as well as partnership with, these CBOs. To make that possible, health policy needs to be directed towards incentivizing these partnerships. Integrating these resources into patient care will allow providers to improve health on a population level through a more robust response to patient and community needs. This will ultimately lead to a reduction of health disparities and improved quality of life in the community.

CHAPTER 3: POPULATION HEALTH IN A BROKEN SYSTEM

To understand the shortcomings of PCPs in addressing patient needs, the flaws of the US healthcare system need to be recognized. The system has generally failed at moving beyond treatment of individual diseases and has failed at addressing the social determinants of health. A recent article from the New England Journal of Medicine states that "each chronic disease crisis is dumped on the shoulders of physicians, who are constrained by a system that does not address the root causes: It is like repeatedly mopping up a wet floor while the roof continues to leak" (Jonas et. al, 2019). More robust primary care could be part of the solution to those failures, but US health policy has not historically prioritized primary care, public health, or community engagement. The combination of those components help form the notion of Population Health, which is regarded as an approach to health that aims at improving the health of entire populations through a focus on health outcomes, patterns of health determinants, and policies/interventions (Kindig & Stoddart, 2003). The Affordable Care Act attempted to address population health with several helpful provisions, but had much of it's original intended policy watered down before becoming law. While health policy and healthcare laws are essential for influencing population health, there are practices that PCPs can implement in their own practices to combat our broken system and improve the health of their individual patients as well as their communities.

A Fragmentated Health Care System

Lack of awareness to existing resources cannot be blamed entirely on PCPs, but needs to be recognized as a problem with our healthcare system as a whole. Our system incentivizes treating discrete diseases and symptoms as opposed to addressing the cause of disease. Specialized disease management is prioritized while preventative care is diminished and personalized wholistic care is neglected. These issues were highlighted in a 2010 editorial series on Integrative approaches to Promoting Health and Personalized, High-Value Care in the Annals of Family Medicine. In the editorial, Dr. Kurt Stange states:

> *Healing requires relationships - relationships which lead to trust, hope, and a sense of being known. But our healthcare system doesn't deliver healing. It doesn't deliver relationships. Increasingly it delivers commodities that can be sold, bought, quantified, and incentivized. While the whole – whole people, whole systems, whole communities – gets worse.* (Stange, 2009)

This commoditization of our healthcare system has led to a focus on disease without consideration of the whole person. Further, it has failed to foster interaction and relationships between the different parts of the system.

Dr. Stange argues that a major underlying problem to our failing medical system is the fragmentation of health care. Fragmentation in this context is "focusing and acting on the parts without adequately appreciating their relation to the evolving whole" (Stange, 2019). This term perfectly explains the dysfunctional nature of our healthcare system. Our hyper-focus on niche research and sub-specialized fields have made way for

an environment where collaboration is inconvenient yet attempting to move outside ones given realm of expertise is discouraged. Consequently, integration of each specialty / sector of health care is not pieced together. When the pieces are not brought together, the fragmentation of the system allows patients to fall through the cracks without notice, until it is too late… Emergency medical care is sought at the end of life and millions of dollars are spent on highly-invasive procedures, drastic interventions, and organ-specific care from numerous specialists. These efforts are predominantly futile attempts at fixing bodies destroyed by irreversible end-organ damage caused by years of preventable chronic disease.

The Generalist Approach

There must be a more effective approach to providing health care in a way that addresses patient needs before those needs lead to irreversible illness. In a subsequent editorial by Dr. Stange titled *The Generalist Approach*, he argues that prioritization of primary care is essential for integrated, personalized, high-value health care. Some of the aspects of primary care that should be brought into focus are "first-contact access, a comprehensive approach, coordination, and personalization of care" (Stange, 2009). With these aspects of primary care prioritized in our health care system, specialists can apply their technical skills and narrow expertise when necessary, but the core foundation of the system should be widely-available, robust primary care.

A system with a foundation of primary care and extensions to additional resources and specialized care as needed will allow the system to better address the complex, multiple issues affecting patients and their communities. As Dr. Stange states, "a

narrowly focused approach is fine when an obvious problem is linked to a clear solution. When multiple problems are woven into the fabric of life, however, the generalist approach is critical" (Stange, 2009). As opposed to the discrete medical specialties that exist today with lack of incentive for adequate collaboration, a generalist approach that connects specialists, public health workers, and the community through primary care will create a stronger system overall. Primary care is kept at the core yet remains a single part of the connected whole, and can be thought of as a "gatekeeper" to specific needs of patients requiring higher levels of care or resources. This framework of health care delivery, as exemplified in other societies (Starfield et al., 2005), will result in less wasted spending, lower cost of care, greater equity, and better population health.

Population Health

Population Health is a relatively recent idea that involves the collaboration of the multiple fields of medicine, public health, policy, and community-based organizations to improve health outcomes at the community level. In a 2013 article by Dr. Michael Stoto titled *Population Health in the Affordable Care Act Era*, he states that, "population health is instrumental as a means to improving the health care system rather than the end goal." There are a wide range of definitions used for population health, but it's essence is distinct from the field of public health in that it is less tied to government health departments and directly includes the health care system. It has a collaborative, holistic focus that aims at improving health outcomes by reducing disparities and inequities. There is an emphasis on health promotion and disease prevention as well as the

recognition of shared responsibility amongst the different sectors that have an influence over population health.

Over the past decade and a half, several efforts have been made to improve population health in the US. For example, in 2008 the Institute for Healthcare Improvement's Triple Aim listed "improving the health of populations" as one of the 3 essential elements for improving the US healthcare system (the other 2 components involve improved patient satisfaction and decreased cost of care). Furthermore, The Center for Medicare & Medicaid Innovation list one of the 3 elements of their mission as, "better health by encouraging healthier lifestyles in the entire population." Most notably, the Affordable Care Act (ACA) created several provisions that aimed at addressing population health from multiple different positions.

The ACA addressed population health in four major ways. First, insurance coverage was expanded through Medicaid expansion, the individual mandate for health insurance, and increased funding for federally qualified health centers. These measures aimed at improving population health through increased access to healthcare across all US populations. Secondly, provisions were made to improve the quality of care delivered through the establishment of programs like the Patient-Centered Outcomes Research Institute. Thirdly, measures for enhancing prevention and health promotion were taken, such as implementation of Accountable Care Organizations (ACOs) to incentivize providers to take responsibility for population health outcomes. Lastly, provisions were made for the promotion of community and population based activities. This included the creation of the National Prevention, Health Promotion and Public Health program. Also

included were provisional grants for small businesses to form workplace wellness programs for their employees and insurance discounts for the employees who participate.

The ACA added an additional IRS requirement that confronts the lack of incentivization of health care to address community needs and collaborate with public health officials. Community Health Needs Assessments (CHNA) are required to be conducted every three years by hospitals. “These reports must describe the community served, identify existing health care resources, and prioritize community needs” (Stoto, 2013). With the 3 year CHNA requirement, hospitals must also develop a plan for meeting the needs identified in the CHNA. This requirement gets to the heart of the problem with our health care system and mandates the identification and improvement of the needs of communities.

On paper, the provisions of the ACA sound like every step that needs to be taken to fix our health care system and move from treating individual diseases and symptoms to addressing the root causes of illness and health inequity. Unfortunately, these steps taken by the ACA are not enough. Much more research needs to be done on population health outcomes and the impact of upstream population-level interventions (Stoto, 2013). However, the provisions within the ACA were a massive step in the right direction, despite all the political attempts at sabotaging its permanency over the past decade. Still, there is more work to be done in increasing the partnerships and collaboration between health-related sectors to have a solidified impact on population health. More research is needed on how exactly to measure population health, and what models are effective for collaboration and ultimate improvement of population health.

How do primary care physicians actually address health disparities and make the system better for underserved communities? Provisions in the ACA allowed for a more consistent baseline of advocacy for patients, but is that enough? The World Health Organization identifies five key elements to achieving the ultimate goal of primary care, which is "better health for all" (Stange, 2010). The five elements include reducing exclusion and social disparities (universal coverage reforms), integrating health into all sectors (public policy reforms), organizing health services around people's needs and expectations (service delivery reforms), pursuing collaborative modes of policy dialogue (leadership reforms), and increasing stakeholder participation (World Health Organization, 2010). These 5 elements as well as WHOs goal of primary health care recognize the necessary shift from becoming health advocates of diseases, to health advocates of people. It is inclusive to the social determinants of health, and recognizes the need for collaboration.

Institutions like WHO and laws like the ACA acknowledge the theoretical steps that must be taken to improve population health, but the practical steps that PCPs need to take are in more of a grey zone. What is clear, however, is that "moving upstream" to influence change on a population level to address disparities, systemic racism, poverty, etc. is necessary. Health policy, hospital leadership, and local/state/federal government have a problematic track record of being run by those unfamiliar with healthcare at best, and those with special financial interests at the determent of population health at worse. PCPs must move into these higher positions of power to truly make systemic changes that

will improve population health. But until those higher level positions are filled with PCPs, what can be done at the level of individual patients?

In a 2021 New England Journal of Medicine editorial titled *Doctor As Street Level Bureaucrat,* the physicians role beyond the scope of medical care is contemplated:

> *Is housing a doctor's problem? Perhaps not. But if the consequences of poor housing are no different from those of nonadherence or the wrong antiretroviral regimen, we can't afford to ignore it even if we can't single-handedly remedy it… We have come to see health care as a system, in which we've found ways to standardize and simplify, to create productive routines. Quality-improvement skills are now taught in medical school. Yet despite our efforts, much of the system is still broken. Information systems are still not well linked. The price of insurance can be exorbitant. Unnecessary clinical documentation for billing saps our morale. Referrals are a labyrinth. Differential and discriminatory access that further disadvantages the poor, African Americans, and other minorities are unjust. Why assiduously defend the system if it has betrayed us and our patients? Though doctors may not be able to immediately fix the system, we may sometimes find ourselves uniquely positioned to resist its failings — and to thereby help both ourselves and our patients. Such resistance may offer some, if incomplete, redemption for the ways in which our systems have fallen short of our ideals.* (Geng 2021)

While moving upstream and changing health policy is essential for systematic change, primary care providers must make individual efforts to know the community resources that are available in their area. This is how immediate resistance can be placed against the failings of our health care system.

CHAPTER 4: KNOW YOUR RESOURCES

Given the recent focus amongst medical professionals and institutions on Population Health and the Social Determinants of Health, there has been hope and expectation that health care providers, especially PCPs, would improve their knowledge and ability to utilize community resources. This was examined in a 2017 qualitative case study by Ploeg et. al on PCP perspectives on facilitating patient access to community support services (CSSs). The results of this study were troubling: Between lack of knowledge of available CSSs and the perspective that connecting patients with CSSs is not the responsibility of PCPs, it becomes evident why improved population health has yet to be observed.

There are many perspectives to unpack from Ploeg et. al. In the study, some physicians expressed a lack of experience or a gap in knowledge and skill to connect patients with appropriate resources. One physician had the following thoughts:

> *Family doctors have some knowledge but it's an incomplete amount of knowledge. It's just that there's a lot of stuff to know and a lot of services and it's hard to keep up… My financial resources are limited …. I've got to deal with all these issues within the 10-minute [patient visit] period. It's time-consuming. Time is dollars. And there's no extra funds allotted to the family doctors to sit down and talk about all these things. It's nice to have other people out there.* (Ploeg et. al, 2017)

Other physicians noted strong reliance on their supporting staff, especially nurses and clerical staff. While some physicians were fortunate enough to have social workers and case managers on their clinical team, many relied on staff without any more knowledge or training in connecting patients to CSSs than the physicians had. Still, some physicians felt that making these connections were not just beyond their expertise, but also outside of their role:

> *I'm now becoming a coordinator of social services, which is going outside of my own personal realm of expertise .... And that's where I start questioning what is my role as a trained physician, trained in medicine. Am I really the most effective person?* (Ploeg et. al, 2017)

Though it may be understandable for a PCP to question whether they are the most effective person to connect patients with resources, the reality of many clinical care teams is that there are not more effective people on the team apart from the PCP who are qualified to address social needs. Thankfully, some physicians appreciate the importance of CSSs in supporting their patients and families:

> *We recognize that linking to the community support services is really key along with patient engagement and empowerment in their care. We recognize that we can't do it all alone ... It's about the patient and their family ... and community agencies are a really important part of the network of care and support.* (Ploeg et. al, 2017)

Other physicians stated that they would provide patients with CSS information through pamphlets or brochures, or by simply giving patients the name and contact information of a CSS. Some physicians acknowledged that if they were familiar with certain services

that would be helpful to their patient and/or their family, they would provide that information. As one physician stated, “If I happen to know of something, I will tell them about it” (Ploeg et. al, 2017). This notion is promising, and suggests that if PCPs know of available community resources, they will be willing to utilize them.

The willingness of PCPs to connect patients with CSSs is not enough… Up-to-date, reliable knowledge of resources is also essential. Many physicians referred to the use of out-of-date resources and search strategies that are ineffective at selecting and referring patients to the proper CSS. For example, many cited “The Red Book” as their source of CSS information. This source is a hard copy binder that lists CSSs but is not regularly updated (the last update was in 2007) and lacks an accessible search mechanism.

The Ploeg et. al study included a number of recommendations made by the participating PCPs on ways to improve their ability to connect patients with CSSs. One of the most consistently mentioned recommendations was the need for an easily searchable, regularly updated “one-stop-shop” online database that included all available CSSs and pertinent information about each service. This would solve the problem of using inaccurate or outdated information, and improve the lack of awareness of available resources. A willingness to utilize resources combined with current knowledge of available community services is the combination that will allow patients to receive the help they need and ultimately improve the health of the individuals and the community as a whole. Thankfully, “one-stop-shop” online databases already exist and countless community resources are available in Philadelphia and beyond… they just need to be made known to providers.

The EveryONE Project

In 2018, the American Academy of Family Physicians (AAFP) launched a program to identify and address the social determinants of health and ultimately improve optimal health outcomes. The EveryONE Project is a comprehensive screening toolkit that that helps physicians recognize and respond to various social factors that impact their patients' health (Crawford, 2018). Created by Danielle Jones, MPH, manager of the AAFP Center for Diversity and Health Equity, the toolkit consists of three parts. The first part, Practice Leadership for Health Equity, focuses on creating a culture within medical practices that value health equity and addressing the social determinants of health through team-based approaches. The resources in this aspect of the toolkit are designed to help family physicians build that type of culture, an important foundation to have when attempting to address the social determinants of health.

Most practically, the second aspect of the toolkit is Assessment and Action, which offers tools to screen patients and help with the referral process of connecting them with the necessary services. Included are tools like the Neighborhood Navigator that is used at the point of care to directly connect patients with resources in their own neighborhood. Over 40,000 social services are listed by zip code, including resources for food, housing, transportation, employment, legal & financial aid, etc. Lastly, the third part of the toolkit is Community Collaboration and Advocacy. This provides further information and resources for helping providers engage with their community and advocate for policies that will decrease health inequities. This singular resource contains the necessary tools to address the social determinants of health and improve health equity while allowing

shared decision making with patients on which services would be most helpful to their needs.

Aunt Bertha

The Aunt Bertha online search tool (findhelp.org) is the leading search and referral platform of social services in the US. It is used by providers to connect people seeking help with verified social care providers in their community. It allows ease-of-access for patient looking for local social services, for nonprofit organizations to coordinate their efforts, and for clinics, hospitals, organizations, etc. to integrate social care into the work they already do (Aunt Bertha, 2021). The platform is effectively the "one-stop-shop" online database that so many physicians were hoping for.

On January 15, 2021, Aunt Bertha was selected to partner with DHS to build Resource Information and Services (RISE PA) a statewide resource and referral tool in Pennsylvania. An interactive online platform is being created to serve as a care coordination system for health care providers and social service organizations. It will provide the people of Pennsylvania with an online portal to obtain information and connect with service providers at any given point. With Aunt Bertha already being used extensively, this expansion in Pennsylvania will help the State's DHS provide a more accessible path in referring patients to services in their own communities.

RISE PA will also allow service providers to perform individual needs assessments during doctor visits in the clinic or emergency department, or when seeking help from a CBO. This tool will collect data that will allow improved identification of social service gaps and aid in closing those gaps. This focus on the social determinants of

health will help achieve improved population health. Pennsylvania DHS Secretary Teresa Miller stated the following about the RISE PA program:

> *No one person or provider can help a person fully address all of their needs on their own, and that is okay. We want to make sure that we are focused on how to promote a more holistic approach to health and well-being and that we are ensuring that individuals' and families' needs are met through the delivery of the right service at the right time. RISE PA will allow us to break down walls in the health care and social service system and improve health outcomes and quality of life for Pennsylvanians at a time when a seamless connection is needed more than ever.* (Aunt Bertha, 2021)

The acknowledgement that individual providers will fall short when attempting to address patient and community needs alone is crucial. The needs of patients and their community can only be adequately addressed with a wholistic, collaborative approach. PCPs need to know and utilize resources, but these "resources" are composed of people and CBOs who are just as important in their role of forming relationships, connections, and addressing community needs. The relationships between these entities (PCPs, patients, CBOs, Public Health) is the essential next step forward in addressing localized health disparities.

CHAPTER 5: IMPORTANCE OF COMMUNITY PARTNERSHIPS

PCPs have both an interest and a need to address the social determinants of health as the field of primary care is held increasingly accountable for population health in a system steadily shifting towards value-based care (Michener et. al, 2016). The field of public health has also been going through a recent transformation that has progressed towards recognition of the critical need for public health to partner with the health care system (Michener et. al, 2016). Both primary care and public health have recognized their complimentary nature and, therefore, the need to collaborate together for the good of the community.

In *The Practical Playbook: Public Health and Primary Care Together* the proposal is made that, "Clinicians can work with partners, including public health, to refer patients to community-based sources of healthy foods, transportation, and job support" (Michener et. al, 2016). The important additional piece to the connection between primary care and public health is partnership with CBOs themselves. For example:

> *If housing conditions were found to be a broader issue seen by multiple providers in a community, primary care providers and public health officials could work together to meet with community leaders and decision makers to highlight the issue and possible steps to intervene.* (Michener et. al, 2016)

This is one of countless scenarios where community partnerships and collaboration amongst PCPs and other sectors is necessary to potentiate real change. To explore the importance of these community partnerships, current examples from the city of Philadelphia and beyond will be highlighted to emphasize how these partnerships become so vital for the well-being of the community, especially those that are urban underserved.

The Simple Way & Esperanza Medical Center

The value in primary care partnership with CBOs is exemplified in the relationship between Esperanza Health Center, a Federally Qualified Health Center (FQHC) in the Kensington neighborhood of North Philadelphia, and The Simple Way, the faith-based non-profit CBO devoted to the exceptionally tremendous needs of their neighborhood (see CHAPTER 1: PROLOGUE). Esperanza is a faith-based healthcare organization devoted to the predominantly Latinx community in Kensington. They have funding through there FQHC status, have admitting privileges at Temple University Hospital, and also happen to have a close-knit, long-term partnership with The Simple Way. While the PCPs at Esperanza have the benefit of in-house social workers, case managers, behavioral health specialists, and medication assisted therapy for Opioid Use Disorder, they still rely on meeting patient needs by connecting patients with the services available across the street at The Simple Way.

Here is an excerpt from The Simple Way email newsletter from February 19, 2020, written by director Caz Tod-Pearson:

> *We love finding new ways to support our neighborhood thriving. Our partner Esperanza Health Center has boosted our community's health by*

> *providing quality, affordable, and local health care. They're going further, and we get to deepen our partnership and go with them. Last week, we started a new initiative to distribute fresh and healthy food to a group of their patients.*
>
> *Food is medicine. Patients without stable access to quality food have an even harder time managing chronic conditions like high blood pressure or diabetes. The doctors and nurses of Esperanza are building relationships with people whose care means better access to nutrition. We love getting to support those relationships, and support our neighbors' health this way!*
>
> *Together, we're building a neighborhood where we all belong and thrive. We need your encouragement as we start this exciting chapter!* (Tod-Pearson, 2020)

This simple message (consistent with their name) highlights the bi-directional nature of the PCP - CBO relationship. Meeting the nutritional needs of the neighborhood through the food bank at The Simple Way is vital for primary and secondary prevention of chronic diseases, just as medical care at Esperanza is necessary for treating those chronic conditions once they are present.

The fact that both The Simple Way and Esperanza have similar mission statements and values while being in such close proximity is no coincidence. The two organizations have grown as individual entities through the relationship they have with

one another. Each groups values have positively influenced the other, and together they are an exponentially more powerful force in addressing the needs of the neighborhood then they could ever be as isolated entities. In speaking with several other PCPs in North Philadelphia, none were familiar with The Simple Way outside of the PCPs from Esperanza. These other PCPs have patients living in the same neighborhood as The Simple Way and these patients could very well have unmet needs that The Simple Way is capable of addressing. How many more people could be helped just through awareness of such resources available to them?

Black Doctors COVID-19 Consortium

When community relationships are not prioritized, population health worsens and health inequities increase. In planning the rollout of the COVID-19 vaccine in North Philadelphia, city and hospital partnership with Black Doctors COVID-19 Consortium seemed like a no-brainer. Black Doctors Consortium is a Philadelphia organization with physicians and public health officials alike with knowledge of the health inequities affecting black Philadelphia neighborhoods as well as experience vaccinating the community.

Despite their credentials and expertise, the city government failed to partner with Black Doctors COVID-19 Consortium to distribute and administer COVID-19 vaccine. This partnership could have drastically improved the vaccine rollout into communities in North Philadelphia and West Philadelphia. Skepticism in pandemic, vaccine hesitancy, and general distrust in the medical field could have been addressed and improved.

Instead of partnering with Black Doctors COVID-19 Consortium, the city government selected a for-profit start-up company composed of graduate college students with no expertise in medicine or public health, to plan the vaccine rollout in Philadelphia. This startup not only had no medical expertise, but no relationship with the black & brown communities of North Philadelphia. Statistics came out soon after the initial rollout about the disparity in distribution between white residents living in Center City, South Philly, etc versus black residents in North Philadelphia.

If the initial partnership was made with the more-qualified CBO, Black Doctors COVID-19 Consortium, the outcomes of vaccine distribution would have looked much different across the city. Lawrence Gostin, director of the O'Neill Institute for National and Global Health Law at the Georgetown University Law Center, stated the following in a Philadelphia Inquirer article:

> *The city has a legal and ethical obligation to be good stewards of the COVID-19 vaccine rollout. That includes rigorous vetting of partners in the vaccine program… Episodes like this sow increased distrust and could be harmful to the overall goal of vaccinating the entire population*.
>
> (Owens, 2021)

The implications of failing to partner with CBOs and utilize community resources are drastic. Not only were black Philadelphians disproportionately excluded from initial vaccines, but the repercussions of the city's actions could have adversely impacted attitudes towards health care now and in the future.

Thankfully, the city reversed course and removed the for-profit small business from continuing the vaccination efforts. Temple University Hospital later connected with

Black Doctors COVID-19 Consortium and the vaccination rates of black Philadelphia neighborhoods skyrocketed. This adds to the overwhelming evidence of community partnerships being essential for the health of the population. It is clear that the community partnership model should be implemented by urban communities experiencing health disparities.

The Medical Neighborhood

The "medical neighborhood" is defined by the Patient-Centered Primary Care Collaborative as, "a clinical-community partnership that includes the medical and social supports necessary to enhance health, with the PCMH [Patient-Centered Medical Home] serving as the patient's primary "hub" and coordinator of health care delivery" (Primary Care Collaborative, 2021). The PCMH has the goal of collaborating with "medical neighbors" to encourage the flow of information amongst clinicians and patients. Hospitals, specialists, long-term facility care, and other clinical providers are included in these collaboration.

Most pertinently, the addition of "non-clinical partners like community centers, faith-based organizations, schools, employers, public health agencies, YMCAs, and even Meals on Wheels. Together these organizations can actively promote care coordination, fitness, healthy behaviors, proper nutrition, as well as healthy environments and workplaces" (Primary Care Collaborative, 2021). Just like the partnerships between The Simple Way, Esperanza, and Temple University Hospital, the "medical neighborhood" uses relationships to elevate the community in a way that could not be done with isolated

providers, resources, or patients. The focus is on meeting the needs of the individual patient as well as the community as a whole.

CHAPTER 6: CONCLUSION

We all have limitations as providers of health care. No provider can single handedly offer every patient comprehensive medical care as well as connections to services and resources that meet every patient need. For those of us who are urban bioethicists, our tendency to have a heightened social awareness can make our limitations even more obvious as we attempt to engage with social determinants in health, systemic inequities, patient-centered care, etc. Our social safety net is so flawed and inequities run so deep that there is no hope of closing the gap without all hands on deck.

If you are a PCP, become aware of the resources in the community you practice in. Create relationships amongst your practice and the CBOs in your area. Partner with public health officials and utilize one another and allow the bi-directional relationship to enhance the outcomes in both fields. Advocate for your community to become a "medical neighborhood". Of course, eventually try to move up-stream and influence policy and health administration from a higher level. But to start? Immerse yourself in the process of being a good neighbor.

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APPENDIX: LOCAL RESOURCES IN PHILADELPHIA, PA

Aunt Bertha (also available outside of Philadelphia)

Aunt Bertha picks up where Uncle Sam leaves off by connecting people in need to free & reduced cost social services

www.findhelp.org

Black Doctors COVID-19 Consortium

"Education and Advocacy for African Americans to reduce the incidence of disease and death from coronavirus."

https://blackdoctorsconsortium.com/

Broad Street Ministry

"Broad Street Ministry is an organization that helps Philadelphians living in deep poverty stabilize their lives through a unique offering of meals and social services that is welcoming to everyone."

315 S. Broad St / 215-735-4847 / broadstreetministry.org

Christian Legal Clinics of Philadelphia

"We are an urban legal ministry which seeks to address injustice and poverty in partnership with existing inner city host ministries by bringing volunteer attorneys into neighborhoods where their services are most needed."

4455 N. 6th St. Ste 100 / 215-399-0064 / www.clcphila.org

Esperanza Health Center

"Our mission is to provide affordable, quality, bilingual primary health care and support services to our patients in Jesus' name, and to promote the health of the North Philadelphia community we serve. All people in need of health care services are welcome at Esperanza Health Center."

861 E Alleghany Ave / 215-302-3600 / https://esperanzahealth.com/

The EveryONE Project Toolkit (also available outside of Philadelphia)

"The AAFP's EveryONE Project promotes diversity and addresses SDOH to advance health equity in all communities. This toolkit offers strategies for use in your practice and community to improve your patients' health and help them thrive."

https://www.aafp.org/family-physician/patient-care/the-everyone-project/toolkit.html

Mazzoni Center

LGBT-focused health & wellness services

1348 Bainbridge St / 215-563-0652 / mazzonicenter.org

Mother of Mercy House

"We began our outreach to the neighborhood by conducting mass on a regular basis, established a food cupboard and began holding aa meetings. We distribute food to the poor and we distribute coats, etc. To the homeless in the neighborhood."

720 E Allegheny Ave / 267-930-3348 / motherofmercyhouse.org

New Jerusalem Recovery House

"New Jerusalem Now is a residential addiction recovery community located on the west side of North Philadelphia, where nearly 50% of the population suffers from drug or alcohol addiction. We are a non-denominational spiritual community, focused on the principles of nonviolence, simplicity, and cooperative living."

2011 W Norris St / 215-787-9988 / https://newjerusalemnow.org/

New Kensington Community Development Corporation

"NKCDC provides free housing services to anyone in Philadelphia."

2515 Frankford Ave. / 215-427-0350 ext 109 / https://nkcdc.org/

Pathways to Housing PA

"We start by housing people directly from the streets, without precondition. Then we address their underlying issues around mental health, addiction, medical care, income, and education to help integrate and welcome them back into our community. We also provide furniture to folks moving out of homelessness from all over the city through our furniture bank."

5201 Old York Road 4th floor / 215-390-1500 / pathwaystohousingpa.org

Philabundance

"Philabundance is a proud member of Feeding America, a nationwide network of food banks leading the fight against hunger in the United States."

3616 South Galloway Street / 215-339-0900 / https://www.philabundance.org/

Philadelphia Access Center

"Access Centers provide Philadelphia's most vulnerable students with a safe place for digital learning when caregivers work outside the home, have no childcare options, or cannot support students with online learning."

1832 S. 11th St. / 215-389-1985 / www.phila.gov/programs/access-centers/

Prevention Point Philadelphia

Nonprofit public health organization providing harm reduction services including Medication-Assisted Treatment, needle exchange, overdose prevention, PREP and HCV clinic, case management, etc.

2913-15 Kensington Ave / 215-634-5272 / ppponline.org

Puentes de Salud

501(c)3 nonprofit organization promotes the health and wellness of South Philadelphia's rapidly growing Latino immigrant population.

1700 South St / 215-454-8000 / puentesdesalud.org

The Simple Way

"Small organization supporting neighbors in building a neighborhood we're all proud of in Kensington, Philadelphia."

3234 Potter St. / 215-423-3598 / https://www.thesimpleway.org/

St. Francis Inn Ministries

"We are a Franciscan, Eucharistic community called to minister with the poor and homeless of Philadelphia, Pennsylvania. Formed in the spirit of the Gospel and inspired by the life and compassion of Sts. Francis and Clare of Assisi, we try to meet the immediate daily needs of the people we serve with food, clothing and hospitality. Furthermore, we empower persons to break the cycle of homelessness and poverty and address structural injustices. We seek to build relationships with those that we serve by respecting their human dignity and by helping them to restore hope in their lives, and by living simply among them."

2441 Kensington Ave / 215-423-5845 / stfrancisinn.org

Women Against Abuse

"The mission of Women Against Abuse is to provide quality, compassionate, and nonjudgmental services in a manner that fosters self-respect and independence in persons experiencing intimate partner violence and to lead the struggle to end domestic violence through advocacy and community education."

100 South Broad Street, Suite 1341 / 215-386-1280 / womenagainstabuse.org