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EDITORIAL

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Lulled into a false sense of security: Mortality for vulnerable populations may remain elevated even during the lull between COVID-19 waves

The coronavirus disease 2019 (COVID-19) pandemic has disproportionately affected vulnerable populations, with clear inequities in outcomes.[1] The period in-between COVID-19 waves have been welcomed by hospitalists as intermissions in morbidity and mortality, and we know that timely preventive outpatient care can avoid complications and stave off hospitalizations. Unfortunately, for some subsets of our communities with ambulatory care sensitive conditions (ACSCs), the increased mortality during the first year of the pandemic did not ease off during the 2020 "summer lull" between the first two waves of COVID-19. As hospitalists, we must be attentive to this added risk so that we can strategize care pathways toward health equity.

In this issue of *Journal of Hospital Medicine*, Kendzerska et al.[2] suggest that the period between peaks in the pandemic waves is only an intermission for the privileged when it comes to health care. The investigators conducted a population-level study in Ontario, Canada, comparing observed versus expected mortality as well as emergency department (ED) and hospital visits for several ACSCs. The study focused on vulnerable subpopulations including those who immigrated between 1985 and 2017 to Canada as well as patients who were receiving treatment for mental health conditions including substance use disorders. As expected, during the first wave of COVID-19 in Spring 2020, the authors found that all-cause mortality rates were higher than a similar period in prior years (about 80 deaths per 100,000 people at risk vs. 71, rate ratio [RR] of 1.13). However, during the "summer lull," when the mortality rate dropped back down for the general population, it regrettably remained higher than expected through the first year of the pandemic for immigrants (RR of 1.33) and patients receiving mental health treatment (RR of 1.09). Mortality rates did not decrease in the intermission between the first two waves of COVID-19 for patients with mental health conditions and for immigrants; this was despite low hospitalizations and ED visits for this subset of patients and outpatient visits being at expected levels. The study was not designed to delineate which of the excess deaths were due to COVID-19 itself or a byproduct of the larger pandemic.

We know that the COVID-19 pandemic led to patients forgoing or delaying necessary care, and these delays were both patient-driven and system-related, including barriers to accessing ambulatory care, delays in timely outpatient tests or procedures, and inequities in community telehealth penetration.[3] This burden has been borne disproportionately by historically marginalized groups due to losses of community health networks and the social safety net.[4] Kendzerska et al.[2] provide unfortunate evidence that, even in a population with universal health insurance, inequities in health outcomes reach our most vulnerable neighbors. This study raises many important questions for future research. Was the initial decline in outpatient visit rates during the first wave of this pandemic more directly or deeply felt by immigrants and patients with mental health conditions? And, is that merely correlation or is it causation of higher than expected mortality rates, and why? Was it an issue of access or navigation? Was the implementation of virtual visits flawed? Were these patients' personal circumstances too burdensome to allow prioritization of health? This study was not designed to answer the fundamental question of "why" being an immigrant or having a mental health condition makes one vulnerable to negative health outcomes. Nevertheless, in describing the phenomenon in the population of Ontario, Canada, the authors underscore an important tenet: universal health insurance does not automatically equal universal health.

An essential area for future research is understanding why insurance and access alone are not enough to achieve equitable health outcomes. Health services researchers must explore the question of "Why?" in addition to describing the problem of poor outcomes. We as hospitalists view the acute care setting as intertwined with its surroundings.[5] Essien and Corbie-Smith[4] have described the COVID-19 pandemic as a "plastic hour" during which our otherwise rigid healthcare system is pliable; researchers and policymakers must take advantage of one crisis to address underlying smoldering crises, including investing resources into improving health for these populations. We as hospitalists can advocate for imaginative interventions for access and continuity, such as accelerated pathways for postdischarge care or integrating primary care and mental health services into each system touchpoint. We should not be lulled into a false sense of community well-being simply because our inpatient census drops between COVID-19 waves, as hospitals are not the health-equalizing solution. Immigrants and patients with mental health conditions were not hospitalized at differing rates but did have mortality differences in this study population. As Kendzerska et al. describe in their findings, the COVID-19 intermission is not equally enjoyed by some vulnerable groups. President Kennedy orated, "The time to repair the roof is when the sun is shining"; future lulls

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between the next waves of the COVID-19 pandemic are shining opportunities for clinicians, researchers, and policymakers to strategize around achieving equitable health outcomes.

CONFLICT OF INTEREST

The authors declare no conflict of interest.

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