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ENTRY POINT



Focus on families: Kimberly Allen and her daughter meet with a parent educator from St. Louis-based BJC HealthCare. Parent educators, part of BJC's Raising St. Louis program, meet regularly with pregnant women and new parents to help parents create healthy environments for their children.

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Building Healthy Communities Beyond The Hospital Walls

Large medical centers have begun to tackle the kinds of persistent health challenges that no surgery or drug can fix.

BY T. R. GOLDMAN

It might be a near-universal fact of life, but it is especially stark in the United States: The lower a person's socioeconomic status, the poorer that person's health. Limited education and low wages—the markers of poor socioeconomic status—can be linked directly to a host of other

factors ranging from poor diet and lack of exercise to too much television and too little prenatal care. All of these factors are connected, in turn, to worse health outcomes.

Poor health makes it tough to improve one's socioeconomic status, and low socioeconomic status can lead to poor

health. The cycle is intractable and circular and difficult to break. In response, some large hospitals and academic medical centers, many in the middle of impoverished neighborhoods, are testing a variety of ways to improve their clients' socioeconomic status and, ultimately, their health. Some have launched targeted programs that could involve, for example, blood pressure screenings at a housing project or ensuring that a certain percentage of hospital food is locally sourced. Others are building a more complex web of civic partnerships to reach into the fabric of a community.

These actions are all based on the same concept: that social determinants, those nonmedical factors such as a patient's income, education, environment, and behavior—far more than the latest surgical gadgetry or powerful pill—are what determine the health outcomes of a local population.

Dig down into the National Center for Health Statistics' *Health, United States, 2011* report, which that year featured socioeconomic status and health.¹ The correlations between education and health, to take one example, are staggering: Between 2007 and 2010, obesity among boys ages 2–19 where the head of household had less than a high school education was 24 percent. Compare that to the 11 percent obesity rate among boys in the same age range where the head of household had at least a bachelor's degree. In 2010, nearly one-third of adults with a high school diploma or less were smokers. When adults had at least a bachelor's degree, that figure dropped to 9 percent. And in 2006, on average, twenty-five-year-old men without a high school diploma lived almost ten years less than those with at least a bachelor's degree. And the list goes on.

Researchers, public health officials, and many policy makers have recognized the impact of social determinants of health for years. It's an intuitive idea not difficult to grasp. But at least for the past few decades, modern health care—driven by doctors, hospitals, and academic medical institutions—has been more inward looking, priding itself on

developing and promoting sophisticated tools and treatments to fix specific medical problems. Broad social determinants, such as patients' limited education or a lack of well-paying jobs, were simply not clinicians' responsibility. Nor were large medical institutions interested in using their prestige to pressure local politicians to enact socially conscious legislation—from dedicated bus lanes that reduce air pollution and commuting times to requiring new development to include a certain percentage of affordable housing units.

Indeed, until very recently the debate over improving health outcomes—and what hospitals and academic medical centers could do about it within their communities—has focused almost exclusively on increasing the availability of care. “People think that if you die young, it’s because you didn’t have access to a doctor,” notes Adriana Lleras-Muney, an economics professor at the University of California, Los Angeles, who studies the relationship between socioeconomic status and health. But, she says, “whether you have a heart attack at 40 or at 60—or whether you have a heart attack in the first place—that is mostly related to lifestyle.” Yet lifestyle as a determinant of health is something that rarely comes into play inside the walls of the doctor’s office.

Now, however, those boundaries are beginning to blur. Spurred in part by provisions in the Affordable Care Act (ACA) that tie more provider payments to patient outcomes—not simply the volume of procedures performed—hospitals and academic health centers have a new incentive to discover the wider world of their local communities. And they are making some efforts at attacking the type of societal problems that play such a big role in their patients’ lives—problems that often take root at an early age, or in utero, and that effectively marginalize people their entire lives.

How rapidly this new approach is taking hold, however, and whether it’s fast and comprehensive enough, is open to debate.

A New Mission

“The conversation has changed quite a bit in the last ten, maybe the last five years,” says Victor Dzau, the outgoing

president and CEO of Duke University Health System, who became head of the National Academy of Sciences’ Institute of Medicine this summer. “The ACA has actually heightened people’s sensitivity towards population health. Now I find that many of my peers running academic health centers are using that same language, and talking that same talk.”

Still, he says, while the social determinants of health are well established, many people in the medical community continue to believe that such factors are outside their sphere of work or ability to control. His response: “Well, we may not be able to control it. But we certainly can influence it, using the kind of capital we have.”

All businesses have a vested interest in the health of their local communities, from its impact on employee productivity to their customers’ financial security. But for large health care institutions, the connection is even more direct. “Addressing poverty as a way of improving health is fundamental to the mission of a health center in a way that it is not fundamental to an industrial plant,” argues David Dodson, the president of MDC (formerly known as Manpower Development Corporation), in Durham, North Carolina, an antipoverty think tank partnering with Duke Medicine to try to improve education and job prospects at the community level. MDC is focused on preparing local “disconnected” youth to work for the city’s high-growth, living-wage employers. That would be a big change from the status quo. “For all intents and purposes, Durham [business] does not view the local labor supply as a source of its talent pool,” notes Dodson. “And the limiting factor on youth is that they can’t get work experience.”

For most of the twentieth century, Durham’s tobacco economy was the bedrock of a solid working and middle class—until a spate of successful state-led lawsuits against the tobacco industry in the 1990s effectively led to its demise. That’s when Durham accelerated its transformation into a center of information technology and health sciences—career fields that favor advanced degrees and highly marketable skills. This shift, in turn, has solidified a societal rift right through the middle of town. A 2012 MDC study reported that more than half of Durham’s 44,000 youth ages 16–24

lived below 200 percent of poverty.

Dodson and a host of local public- and private-sector leaders, including the county school system and Duke University Health System, concluded that Durham’s growing income inequality was bad for everyone. Economic mobility has traditionally been the escape route out of poverty, but moving up the economic ladder is now tougher than ever.

“The hardest thing was getting the private-sector leadership to see that it had a vested interest in these outcomes,” says Dodson. “We did this by courting Dr. Dzau and making the link between his social determinants,” he says, referring to Dzau’s advocacy of the concept, “and our work.”

In May 2013 Dodson, along with senior local education and government officials and top local leaders at Cisco Systems, GlaxoSmithKline, Biogen Idec, Wells Fargo, and several others, created Made in Durham, a public-private partnership with Dzau as chair. Its goal is to build an “education to career” pathway for the city’s entire youth population. This will be done, says Dodson, through a “rich array of internships and apprenticeships that are sharply relevant” to the city’s workaday world. “That means connecting what you learn in class and what you learn outside, being able to actually see what goes on in a lab or medical setting.”

In the summer of 2014, the program started raising the \$1.8 million estimated to be needed to set up its infrastructure over the next two years and to start the small nonprofit that will run the operation. Both Duke Medicine and GlaxoSmithKline have donated approximately \$100,000 each. Dodson says that there’s a provisional commitment of \$300,000 from local government, contingent upon the first \$600,000 being raised in private-sector money.

Most challenging, says Dodson, will be confronting the 5,000 young people who are “significantly off track,” including a large number who have already been involved with the criminal justice system. “This is the real hard work. This is where we have to build, not tweak,” he says, adding that Made in Durham plans to create a series of “on ramps” through community organizations and transitional employment that will also include the same kinds of intensive internships

that he hopes will become a hallmark of the program.

Thinking Big

It is the rare hospital or large academic medical center with no community involvement at all. Most traditional neighborhood interventions, though, are narrowly targeted: from purchasing requirements, which might mandate that a hospital spend a certain percentage of its budget on locally made products, to offering a free asthma clinic or teen outreach program to explain the human papillomavirus. Rarely do they look further, toward a “system-to-system approach,” says Marc Nivet, chief diversity officer at the Association of American Medical Colleges. “We haven’t worked to improve the whole K–12 system, to leverage all of our science to train the trainers,” he says, imagining how leading medical center–based clinicians might share their experience and skills with local educators.

The separation between such institutions and the local community may be shrinking, however. Anthony Knettel, senior director of policy and strategy at the Association of Academic Health Centers, whose roughly one hundred members range from Harvard and Johns Hopkins to East Tennessee State, says he’s noticing a “shift” toward “population and community-based interventions rather than diagnosis interventions.” Knettel, who wrote a paper making the “business case” for academic health centers to address the social determinants of health, says that the conventional wisdom about the expense of community-based intervention misses a crucial point: Relatively small but carefully designed investments can help achieve better overall health outcomes.² That might take the form of funding a nurse practitioner to provide first-stage screenings in a low-income housing complex. Or it could involve partnering with a community agency to build affordable housing that provides the kind of stability needed to stop the “frequent

flyers”—many of whom are uninsured—from cycling in and out of hospital emergency departments.

Halfway across the country from Durham, BJC HealthCare, a St. Louis, Missouri–based nonprofit health system comprising twelve hospitals and multiple community health facilities, is taking a similarly ambitious approach to address some of the social determinants of health. BJC launched Raising St. Louis in January after two years of planning. The effort is focused directly on the health and well-being of almost fifty low-income families and their children from four St. Louis ZIP codes. “The idea is to get children to third grade, fully immunized, with complete eye and dental care, appropriate body mass, and reading to grade level,” says BJC HealthCare CEO Steven Lipstein. By third grade, a child is reading to learn, not learning to read; those who fail to read proficiently by then are four times as likely as others not to get a high school diploma.³

Raising St. Louis uses a home visitation model in which nurses screen mothers as early in their pregnancies as possible and train them to be more effective parents. “We’re balancing what we can do with the resources we have, and what’s been proven to work best—and home visits are one of the most effective models,” says Tom Santel, a former Anheuser-Busch executive now running the program, funded principally by BJC HealthCare, a nonprofit health care organization, which will provide \$1 million in 2015. The program has two educators who each work with twenty-four mothers ages 14–36. Nearly 80 percent are single, and half are unemployed. “The way to get to a kid,” says Santel, “is to get to his parents.” The program plans to double in size next year to cover one hundred families.

Given the fixed administrative costs, scaling up the numbers served is the only way to bring down the cost per family served, currently at about \$10,000, to the goal of a more manageable \$3,000.

To do that, however, requires the type of systematic results-based data that can attract big investment from “the Pews, Kelloggs, and Gateses of the world,” says Santel. “They want a lot of evidence, they don’t want anecdotes.”

Academic health centers such as BJC HealthCare’s Barnes-Jewish Hospital have one big advantage in developing community programs: With the many child health care experts, nutritionists, statisticians, and others already on staff, collecting data is a lot easier. In fact, proving the benefits of community-based interventions with evidence-based data is important not just for attracting donors—it is the crux of any future large-scale, long-term funding from federal programs such as Medicare and Medicaid, and the private payers that are likely to follow suit. “It is a mission issue for us, but like all missions, we have to be paid for it,” says Dzau. “The problem is that lots of people talk about lots of things, but we don’t always have enough evidence that [community interventions] make a difference. I think that as we evolve, health care reimbursements in population health will depend on a much truer measurement of outcomes.”

As the country moves slowly toward a population health–centered model, hospitals and academic health centers could assume the preeminent community role they once played many decades ago, speculates Yale University professor Elizabeth Bradley, coauthor of *The American Health Care Paradox: Why Spending More Is Getting Us Less*. “They have the research, the clout, the respect of patients and the community. In the old days, the hospital administrator was like the mayor of the town, someone who was wanted on every board,” she says. “Can we come back to that? I’m not sure.” ■

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NOTES

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